University Hospitals Bristol **NHS**

NHS Foundation Trust

Quality Report
2011/2012

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Statement from the Chief Executive

Welcome to University Hospitals Bristol NHS Foundation Trust's Quality Report for 2011/12.

This is the fourth year the Trust has published an annual report about the quality of its services.

As Chief Executive, I believe passionately in our Trust's mission to provide patient care, education and research of the highest quality. I am also committed to our core organisational values: respecting everyone, embracing change, recognising success and working together. These are the values I expect our staff to live and breathe as we seek to deliver world class healthcare for the people of Bristol and the South West of England. Our annual Quality Report is one of the ways that we recognise success. For the second year running, UH Bristol was listed in the Dr Foster *Hospital Guide* as having lower than expected overall mortality: this means that the clinical services we provide are significantly safer and more effective than those provided by most NHS hospital trusts. The same Dr Foster report placed UH Bristol in the best five trusts for low mortality for patients who have suffered a stroke. Elsewhere, our rates of healthcare acquired infections are the best they have been since this data has been available – although every case of healthcare acquired infection is one too many and there is no room for complacency.

In last year's Quality Report, we set ourselves a large number of specific quality objectives – 16 in all. I am pleased to report that we met 10 of these objectives in full and partially met four more. There were however two areas where we did not achieve our goals, and we will remain focussed on these in 2012/13.

Twelve months ago, we said that 2011/12 would be a 'year of learning' for the Trust. I believe this report demonstrates how we have been learning from reported patient safety incidents, clinical outcome data, patient feedback and complaints. Every month, our Trust Board receives a report about the quality or our services which begins with a patient's story. Sometimes these stories are about things we have done well; sometimes they describe occasions when we have let patients down; but in every

case, the focus of Board discussion is on what we can learn to make things better for all our patients in the future. The work of the Board is now supported by a non-executive Quality and Outcomes Committee which has been established to monitor quality and performance, and to ensure that every member of staff who has contact with patients, or whose actions directly affect patient care, is motivated and enabled to deliver effective, safe and person-centred care. We have also established a new Quality Intelligence Group: this is a management group which has responsibility for monitoring external clinical benchmarking data (including outcomes of care) and initiating investigations if potential areas of concern are identified. Through this vigilant approach to reviewing data, we aim to detect potential issues as early as possible.

Through the work of the Membership Council and its various working groups, our governors continue to make a significant and valued contribution to our efforts to deliver clinical excellence. You will find a report from the governors, including their views on our performance in 2011/12, in an appendix to this Quality Report. A number of our governors are actively involved in carrying out patient surveys and interviews, providing invaluable insight to complement our core feedback systems. This year, more than 12,000 people gave us detailed feedback via a post-discharge survey about what it is like to be a patient at UH Bristol: the Patient Experience section of this report describes the key findings and some of our plans for improvement. I am encouraged by the fact that 98% of outpatients and 96% of inpatients say they would recommend the Trust to their friends and family.

As we go forward, in common with all NHS organisations, we face the challenge of making financial savings while at the same time improving the quality of our services. I want you to know that we are committed to a programme of change and service improvement to enhance quality, productivity and economic efficiency across the Trust and I look forward to telling you more about how our 'transforming care' programme is making a difference in future Quality Reports.

Finally, I would like to put on record my thanks to our external stakeholders for their input into this report. You can read their thoughts and feedback at the end of this document.

Robert Woolley
Chief Executive
18 May 2012

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Introduction

In every interaction we have with patients, there is an opportunity for learning, both from things that have gone well and those we wish were better. Throughout this report, you will find examples of how we have learned – from patient feedback, from complaints, from clinical incidents and from monitoring outcomes of care.

This is the fourth year we have produced an annual Quality Report. Quality Reports and Accounts are a requirement of the Department of Health and Monitor. All NHS Trusts are required to report on their progress in delivering safe and effective treatment – and to demonstrate that they have done this in a way which reflects a humanity of care.

This year's Quality Report follows the format we have used previously: discrete sections of the report deal with each key dimension of quality in turn, explaining how we performed against specific objectives we set ourselves for 2011/12 and a summary of other important developments during the year. You will also find here our objectives for Patient Safety, Patient Experience and Clinical Effectiveness for the year ahead. Our governors have debated, contributed to and ultimately approved, all our objectives; the objectives have also been presented in the public sessions of the Health Overview and Scrutiny Committees of our local authorities, and have been discussed in a facilitated workshop with our Local Involvement Networks.

The clinical themes within our Quality report are broadly similar to last year, with a focus on continuity for the purpose of transparency and to enable the reader to draw comparisons.

In February 2012, the Department of Health and Monitor announced a new set of quality indicators which will become mandatory content for Quality Accounts and Quality Reports in 2012/13, with an invitation to Trusts to consider including these indicators in 2011/12 reports. We have included all eight indicators – the table opposite lists them and explains where they can be found in this report.

Table 1

Mandatory indicator for 2012/13	Section of UH Bristol Quality Report	Page no.
Venous thromboembolism	Patient Safety	Page 14
Clostridium difficile	Patient Safety	Page 23
Rate of patient safety incidents and % resulting in severe harm or death	Patient Safety	Page 28
Responsiveness to inpatients' personal needs[1]	Patient Experience	Page 43
Percentage of staff who would recommend the provider	Patient Experience	Page 54
Summary Hospital-level Mortality Indicator	Clinical Effectiveness	Page 66
Patient Reported Outcome Measures	Clinical Effectiveness	Page 70
Emergency re-admissions within 28 days of discharge	Key national priorities	Page 74

[1] This is the national patient experience CQUIN.

Appendix A of this report contains a range of mandated content which the Trust is required to report on. This includes summary statements on clinical audit, research, data quality and our status with the Care Quality Commission.

Only an organisation which constantly strives to improve and learn from the experiences of its patients can truly call itself 'patient-centred'. We hope you will agree that this report demonstrates our progress towards that place.

Overview of quality objectives for 2011/12

Last year, we set ourselves 16 quality objectives: we fully achieved 10 of these and partially achieved four more. For the two objectives we did not meet, there is nonetheless evidence of progress to report.

In 2011/12 we chose significantly more objectives than in the previous year, and with more specific targets. Our decision to select a larger number of objectives reflected a desire to ensure that the priorities of patients, staff, governors, commissioners and other 'third parties' could be included, and to ensure that patient experience and clinical effectiveness objectives received sufficient focus alongside high-profile patient safety goals.

In the pages which follow, you will be able to read a detailed account of how we got on. Each objective has been assigned a 'traffic light' rating (**Red** = not met; **Amber** = partially met; **Green** = fully met) to give the reader an idea of the progress we have made. Table 2, below, provides an overview.

Table 2

	We wanted to…	How did we get on?
1	Meet our targets for participation in the NHS South West Quality and Safety Programme.	Red
2	Reduce hospital acquired thrombosis by improving levels of screening.	Green
3	Reduce medication errors.	Green
4	Reduce numbers of inpatient falls.	Amber

	We wanted to…	How did we get on?
5	Reduce the incidence of pressure ulcers.	Red
6	Continue to implement the findings of the Independent Inquiry into Histopathology Services in Bristol. Specifically to: • produce a joint plan with North Bristol NHS Trust for an integrated pathology service across Bristol; • finalise a review of histopathology multidisciplinary team meetings and implement agreed developments; • build upon work started in 2010/11 to involve patients and their carers to develop histopathology aspects of care pathways.	Green
7	Continue our core patient experience strategy and extend this into outpatient clinics.	Green
8	Create a range of opportunities for carers to provide feedback about their experience at UH Bristol, with a particular focus on carers of patients with dementia.	Green
9	Reduce patient-reported noise at night.	Green
10	Ensure patients are receiving the assistance they need to eat their meals.	Green
11	Review the provision of ward-based information.	Green
12	Develop new customer care training for our staff.	Green
13	See progress in one year survival rates for colorectal, breast and lung cancer.	Amber
14	Achieve improvements in Dr Foster ratings for stroke care. In particular, to establish a specialist stroke unit, with a target that at least 90% of patients who suffer a stroke spend at least 90% of their time in this unit.	Amber
15	Increase the proportion of spontaneous vaginal births.	Amber
16	Improve services for people with dementia.	Green

Patient Safety

Our 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. We were disappointed that we did not achieve the milestones we set ourselves in all the workstreams of the five-year NHS South West Quality and Safety Improvement Programme as described below, and will refocus and adjust our plans to enable us to achieve the overall objectives of the programme by 2014.

Report on our safety objectives for 2011/12

Objective 1

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

Why we chose this

The Trust has been participating in this regional patient safety programme for adult services since 2009. Working with partners from the Institute for Healthcare Improvement (Boston, USA), the programme aims to deliver sustainable improvement over a five-year period. The overall objectives to be achieved by October 2014 are that patient mortality will be reduced by 15% (as measured using

the Hospital Standardised Mortality Ratio) and adverse events will be reduced by 30% compared with the start of the programme in 2009. A 15% reduction in mortality rate (from a baseline HSMR of 86.83 to 73.81) means that approximately one further death will be avoided out of every 10 expected, which is challenging in a Trust with lower than average mortality rates at the start of the programme. There is further detail regarding adverse events and mortality later in this report.

Within the programme, there are five workstreams each focusing on a number of specific patient safety improvement measures. Each workstream contains a number of components (68 in total across the programme) against which improvement is measured.

1. Leadership workstream. The leadership of the Executive team is vital to improving patient safety across the Trust and this is enacted through Executive Director walk rounds in clinical areas to check aspects of patient safety and to listen and respond to concerns and challenges facing frontline staff in providing safer care. These walk rounds are followed up by monitoring completion of actions identified during the visit.

2. Peri-Operative workstream. This workstream focuses on providing safer care of patients before, during and after surgery and includes the use of the World Health Organisation Surgical Safety Checklist to prevent harm from, for example, wrong site surgery.

3. General Ward workstream. This workstream is challenging as it has the largest number of components (28) and improvements need to be spread across the greatest number of areas i.e. all adult general wards rather than being restricted to a specific specialty. Examples of components include: conducting safety briefings so that staff are clear at the start of each working day about which patients are at highest risk of harm; and implementing measures to identify deteriorating patients earlier and escalate to a more senior member of staff for review and action through clear structured communication.

4. Medicines workstream. Medication errors are recognised by the National Patient Safety Agency (NPSA) as one of the more common patient safety incidents in acute Trusts: this is also reflected in our own incident reports. This workstream focusses on reducing harm from anticoagulants and on ensuring, among other things, that medicines being taken by patients are reconciled with the correct prescription on admission.

5. Critical Care workstream. Patients receiving intensive care are among our most vulnerable due to the requirement for invasive treatment and monitoring and ventilatory support at a time when the body's natural defences are significantly compromised. A number of the components of this workstream focus on improving safety in these areas.

We said we would...

Achieve our target by reaching a milestone score of 3.5 out of a possible 5.0 on a scale of improvement defined for the programme.

To achieve a score of 3.5, we needed to achieve improvements in all five workstreams.

How did we do?

At the end of 2011/12, the Trust had achieved an overall score of 1.5 points out of a possible 5 on the programme's assessment scale, against a score of 3.5. Disappointingly, we have therefore not met our target. This was because we did not make the planned level of improvement in the majority of components in all five the workstreams.
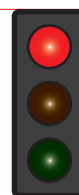
Milestones achieved 2011/12

1. Leadership workstream. The milestone was exceeded as we can demonstrate sustained improvement across the organisation for all components. We have completed at least six Executive Director-led walk rounds each month to proactively identify safety issues in clinical areas and engage Executive Directors in their resolution. Issues identified during these walk rounds have reached and sustained the target of at least 80% being completed within two months.

2. Peri-Operative workstream. The milestone was exceeded as we can demonstrate sustained improvement across all operating theatres for the majority of components and our plans are on track to reach our target for 2012/13. Examples of achievements include:

- 98%+ compliance (for a sustained period of at least three months) in all theatre settings for the use of the World Health Organisation Safety Checklist – this safety checklist is used within the theatre setting and is completed for each patient undergoing surgery.

- 95%+ compliance (for a sustained period of at least three months) with best practice guidance to reduce the incidence of the Surgical Site Infection following a surgical procedure.

Milestones underachieved 2011/12

1. General Ward workstream. This workstream underachieved because 10 of the 28 measures are still in the pilot phase and there has been difficulty in capturing data consistently and accurately. We have however demonstrated sustained improvement in a further 10 out of 28 components; for example we achieved 95%+ compliance in following best practice guidance for the insertion of Peripheral Vascular Catheters and the on-going care required after insertion on all adult wards, and we can demonstrate that a further eight measures have been spread across the organisation, but are not yet showing sustained improvement.

2. Medicines workstream. This workstream underachieved because we have not sufficiently progressed testing for patients with International Normalised Ratios (INRs)[2] above 6.0. We can show sustained improvement or spread across the Trust in the remaining components. An example of an improvement is the introduction of "green bags" by the Medicines Reconciliation Team working in partnership with Great Western Ambulance Service. The green bag is intended to act as a visual cue for the Ambulance Service and NHS staff to identify a patient's own drugs and re-use them in hospital, avoiding delay in essential therapy. It also ensures any medicine prescribed in the hospital setting corresponds to that which a patient was prescribed before admission.

3. Critical Care workstream. This workstream underachieved because there are four out of 22 components where we are unable to demonstrate sustained improvement, three of which relate to central and peripheral and venous catheter insertion and care, and one which relates to care of patients receiving supported ventilation.

[2] INR is a measure of blood clotting or how thin the blood is. An INR of around 1.0 is normal for someone who is not taking anticoagulants. Patients taking anticoagulants would aim for an INR of more than 1.0 depending on their condition, but an INR of 6.0 is too high.

However, an example of sustained improvement in 2011/12 is that we achieved 95%+ compliance in following best practice guidance for the insertion of central lines within the adult Critical Care Unit.

To address the underachievement in three of the workstreams we will refocus and adjust our plans to enable us to achieve the overall objectives of the programme by 2014. In particular, we will ensure strong leadership, engagement of all relevant professions, and robust data collection in order to demonstrate improvements based on data analysis.

For the Medicines and Critical Care workstreams, we need to keep going and build on the extensive work completed to date. For the General Ward workstream we will extend multi-professional engagement and will champion a monthly safety day to focus on patient safety improvements.

Objective 2

We wanted to reduce hospital acquired thrombosis by improving levels of screening.

Why we chose this

This was a continuation of an objective we set ourselves in 2010/11. Venous Thromboembolism (VTE) is a significant cause of mortality, long term disability and chronic ill health. It is estimated that there are 25,000 deaths from VTE each year in hospitals in England: reducing incidence of VTE is a national quality priority within the NHS Outcomes Framework.

We said we would...

Ensure that at least 90% of inpatients would be assessed for risk of developing a VTE.

This was a national CQUIN[3] target which we agreed with our commissioners.

[3] Commissioning for Quality and Innovation

How did we do?
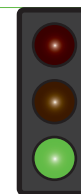
The Trust achieved the 90%+ target in every month during 2011/12. For the year as a whole, 97.4% of inpatients received a risk assessment. This compares with 82.7% in 2010/11.

With a full VTE risk assessment now integrated within the prescription chart, we have managed to sustain risk assessment compliance as documented above. It is used Trust-wide with the exceptions of day surgery, gynaecology and ante and postnatal admissions where speciality specific risk assessments have been agreed. The prescription chart also includes an area for documentation of re-assessment which has seen a recent increase in use which is encouraging. Where a patient is identified not to have been risk assessed, the VTE project nurses will raise this with the ward managers through weekly and monthly data reporting.

VTE prevention training continues for medical, nursing, midwifery and allied health professionals in-house and staff are also required to complete online training via the Kings Thrombosis Centre e-VTE tool. This tool provides a shorter and more focussed e-VTE programme and has been made available via the Trust's intranet site which makes it easier to access for busy ward staff. The Trust also continues to cover a basic understanding of VTE on the Foundation Programme for medical staff.

The VTE Project Nurse role was extended for a further year in April 2011 and increased to full time, allowing for additional audits looking at the appropriateness of thrombo-prophylaxis and accuracy of risk assessment completion. Regular smaller audits of appropriate thrombo-prophylaxis have shown compliance levels of above 90% Trust-wide and there will be a continued focus for the coming year to ensure that thrombo-prophylaxis administered reflects the quality of the risk assessments themselves.

Finally, we have also started to gather data relating to rates of actual hospital acquired thrombosis. We have initially done this through interrogation of the Picture Archiving and Communications System (PACS). In 2012/13, we will take steps to develop the accuracy of our reporting; we are also proposing to undertake a retrospective audit to identify any patterns in reported thromboses over recent years.

Objective 3

We wanted to reduce medication errors.

Why we chose this

This was a continuation of an objective we set ourselves in 2010/11. According to the National Patient Safety Agency's *Safety in Doses* report (2009), incidents involving medicines account for one in every 11 incidents reported nationally, and closer to one in seven incidents reported by our Trust. The vast majority (97%+) of such incidents at our Trust are of low harm, or no harm, but medication incidents have the potential for causing severe harm. The reduction of medication errors causing serious harm is a national quality priority within the NHS Outcomes Framework.

We said we would...

Reduce the proportion of medication incidents classified as 'moderate', 'major' or 'catastrophic' harm by 15%.

In 2010/11, of 1255 medication-related incidents reported, 42 were classified as moderate, major or catastrophic harm (3.35%). The CQUIN target agreed with our commissioners for 2011/12 was therefore that less than 2.84% of medication incidents should be classified as moderate, major or catastrophic harm.

How did we do?

For the year 2011/12, 1.61% (21 out of 1301) of medication-related incidents resulted in moderate, major or catastrophic harm. We therefore achieved our objective.

In 2011/12, there was one medication-related incident resulting in major harm and one incident that resulted in catastrophic harm. In the previous year, there was one medication incident resulting in major harm and none resulting in catastrophic harm.

During the past year, in order to achieve improvement, there have been regular monthly multidisciplinary reviews of reported incidents

and engagement with Trust Divisional patient safety leads. Divisions responded to issues raised and lessons learned were shared via the Medicine Governance Group. Medication safety bulletins have been produced and circulated among clinical staff, and improvements have been implemented to reduce the potential for patient harm. We have employed a safer medicines management co-ordinator to help us review, understand and learn from the medication incidents that occur within the Trust. We will continue to monitor the proportion of medication-related incidents that are classified as causing moderate, major or catastrophic harm and will remain proactive in ensuring that the proportion of incidents causing moderate harm or greater does not increase.

We have also focused on high risk areas of medication use in conjunction with the South West Quality and Safety Improvement Programme, implementing ongoing improvements in medicines reconciliation (getting medicines right when a patient is admitted to hospital) and anticoagulant prescribing. Alongside this work we implemented guidance from the National Patient Safety Agency and introduced a revised inpatient medication chart.

Looking ahead to 2012/13, we will continue to prioritise this indicator as the patient safety measure of the 'Transforming Care; Delivering Best Value' medicines workstream of the South West Quality and Safety Improvement Programme. To improve further, we are continuing to review and learn from all reported medication-related incidents, engaging on a multidisciplinary basis and cascading learning through the Trust. We will also be continuing to focus on avoidance of 'missed doses', medicines reconciliation and implementing improvements in transfer of care when patients are discharged.

Objective 4

We wanted to reduce numbers of inpatient falls.

Why we chose this

Patient falls are the most commonly reported safety incident in NHS inpatient setting and occur in all adult clinical areas. Falls in hospital lead to injury in about 30% of cases, with 1-5% leading to serious injury[4].

4 Healey, F. et al (2008) Falls in English and Welsh Hospitals in *Quality and Safety in Healthcare*;17: 6, 424–430

We said we would...

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 also agreed related CQUIN targets with our commissioners: one target relating to falls assessments for patients aged 65 years and over (95% to be completed in Quarters 3 and 4 of 2011/12); and another relating to numbers of falls in patients in this age group (10% reduction in Quarter 4 2011/12 compared with Quarter 2 2011/12).

How did we do?

The rate of reported patient falls for 2011/12 was 5.01 per 1,000 bed days, therefore achieving our overall objective. We achieved the CQUIN target for falls assessment (>95% measured in Quarters 3 and 4), however we did not achieve the target for reduced falls in patients aged 65 and over (317 falls in Quarter 4 against a target of 211).

The accuracy of our reporting of patient falls data in our 2010/11 Quality Report was criticised by our auditors. In 2011/12, we have therefore focussed on this area and are confident of the figures we are reporting. The total number of reported falls in 2011/12 was 1429 compared to 1345 in 2010/11. In 2011/12, 15 falls were recorded as serious incidents involving fractures sustained, the same number as in 2010/11.

In September 2011, the Trust launched "Being the Best", a 90-day project designed to focus all staff on reducing and preventing falls and pressure ulcers for all our patients. Weekly ward audits during this period demonstrated that falls risk assessments were being completed on all adult patients on admission. Falls care plans have been introduced where required / relevant actions include medication review and 'Intentional Rounding' (a formal checklist used by nursing staff to check patients every 1-2 hours).

Following evaluation of the initial 90-day project, it was agreed that the project team would continue meeting fortnightly until further notice. Validation of data and incident forms is undertaken monthly by Divisional patient safety leads and an appropriate clinician to ensure accurate data is reported within the Trust.

Objective 5

We wanted to reduce the incidence of pressure ulcers.

Why we chose this

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

We said we would...

Reduce the number of reported patients with pressure ulcers of grade 2 and above by 25%.

Our target was therefore to reduce the number of reported pressure ulcers to an average of no more than 6.51 per 10,000 patient bed days[5]. We agreed this target with our commissioners as part of the annual CQUIN scheme.

How did we do?

The number of patients identified as having pressure ulcers increased in 2011/12. 422 pressure sores (grade 2 and above) were reported, with 34 of these patients having the more severe category three and four ulcers. In total, this equated to 14.59 pressure ulcers per 10,000 bed days.

During 2011/12, we undertook a significant staff awareness and training programme[6] which led us to the conclusion that pressure ulcers had previously been under-reported and that our target for 2011/12 was therefore based on an under-estimation of pressure ulcer prevalence.

An independent survey carried out in October 2011 identified 39 patients with pressure ulcers acquired in the Trust (5.2% prevalence) compared to 63 patients in the previous equivalent survey in February 2011 (8.5% prevalence).
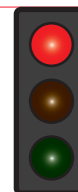
[5] This is how the pressure ulcer incidence is calculated in the NHS.

[6] This included on-line training and 'micro teaching' sessions. Micro teaching provides ward staff with succinct teaching on areas of concern - these sessions are well received by staff as training relates to directly to the patients in their clinical areas.

The October survey also showed improved practice in assessment of pressure ulcer risk and subsequent planning of care, turning protocols to ensure pressure is relieved for patients who cannot do this for themselves, and the correct use of pressure relieving mattresses and cushions.

Actions we have already taken to reduce the incidence of hospital acquired pressure ulcers include:

- A review of Trust policy to ensure this incorporated the latest national recommendations.

- Staff now identify and report on all category 1 pressure ulcers with the aim of preventing any further skin deterioration.

- Wards and departments identified as areas of concern through monitoring are actively supported by the Tissue Viability Team in changing practice where this is required.

In 2012/13, we will continue to focus on pressure ulcer prevention through our 'Being the Best' improvement programme, ensuring that all patients are checked regularly throughout the day and night, patients at risk of pressure ulcers are known to staff and the correct actions to prevent pressure ulcers is put in place.

Adoption of the NHS Patient Safety Thermometer in 2012/13 (see our Patient Safety objectives for the year ahead) should also enable us to report our pressure ulcer rates compared with other NHS Trusts in the future.

It should be noted that comprehensive national comparative data for pressure ulcers is not currently available. However, with the implementation of the NHS Safety Thermometer, we will for the first time be able to benchmark ourselves against hospitals across the country, and have the opportunity to learn from each other.

Objective 6

We said we would continue to implement the recommendations of the Independent Inquiry into Histopathology Services in Bristol.

Why we chose this

In our Quality Report for 2010/11, we gave an update on initial actions we had taken in response to the publication in December 2010 of the recommendations of an Independent Inquiry into Histopathology Services in Bristol into allegations of serious misdiagnosis in histopathology services at the Trust. The exhaustive Independent Inquiry found no evidence to suggest that the histopathology department at UH Bristol provides anything other than a safe service. However, we wanted make to make improvements in response to the recommendations of the Independent Inquiry and knew we needed commitment and leadership to sustain focus in order to make things better for patients. Therefore, as reported in 2010/11, one of the first priorities was the appointment of Dr Rob Pitcher as the clinical lead for histopathology for UH Bristol and North Bristol NHS Trust.

We said we would...

Produce a joint plan with North Bristol NHS Trust for an integrated pathology service across Bristol; finalise a review of multi-disciplinary team meetings and implement agreed developments; and build upon work begun in 2010/11 to involve patients and their carers to develop histopathology aspects of care pathways.

How did we do?

During 2011/12, we have implemented a comprehensive action plan in conjunction with North Bristol NHS Trust and NHS Bristol in response to the Inquiry recommendations. The progress of the action plan has been reported in both Trusts' Board papers throughout the year and to our governors, local Health Overview and Scrutiny Committees, NHS Bristol, the Care Quality Commission and Monitor. A summary of a few key areas of work covered by our histopathology action plan is provided below.

In 2011/12 the work, led by Dr Pitcher, has focussed on building on the foundations for a single integrated cellular pathology service for Bristol. This has included introducing new quality and governance arrangements for the service, reviewing workforce requirements, process redesign and increasing joint working across the city.
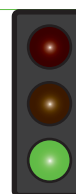
Since the Independent Inquiry report, two new consultant posts have been set up and five new consultants have been appointed into new or existing vacancies, including in the speciality areas of respiratory and paediatric pathology.

Within the last year, a review of the operation of Multidisciplinary Team meetings has taken place. Improvements have been made, working jointly with North Bristol NHS Trust, such as providing clearer information for patients about Multidisciplinary Team meetings and setting standards for attendance by contributing disciplines which exceed those required by the National Cancer Peer Review process. The operation of these meetings is subject to on-going audit which is reported internally as well as by exception to the Cancer Board.

We have also worked to better understand the expectations of our patients and the public in relation to tests and diagnoses through a range of patient and public involvement work such as focus groups and surveys, working with our commissioners, governors and Local Involvement Network. The results are being fed into the development of the integrated service and to commissioners and other providers as well as within UH Bristol to improve patients' experiences of care pathways.

In May 2011, the Care Quality Commission carried out a responsive review of our histopathology services and found that the Trust was meeting all the essential standards of quality and safety they reviewed. They made three recommendations to maintain the quality of our histopathology services, our responses to which are reflected in the progress made in key areas described above.

As the year drew to an end, the Independent Inquiry Panel returned to the Trust at our invitation to review progress in response to their recommendations. The panel visited the histopathology department and talked to patients, relatives and staff from both Trusts. The panel congratulated the Trust on achievements to date and they said that they had seen real evidence of a genuine commitment to implement their recommendations and evidence of real progress.

They recommended maintaining momentum of change and improvement with continued focus on the key areas in our action plan. These further recommendations will be incorporated into the development of the future single integrated service.

Review of patient safety 2011/12

This section explains how the Trust performed during 2011/12 in a number of other key areas relating to patient safety, which are in addition to the specific objectives that we identified.

Healthcare acquired infections

Last year, fewer patients acquired a healthcare associated infection in our Trust than in the previous year. In 2011/12, we achieved national targets for MRSA and *Clostridium difficile*: four cases of MRSA (two below our target and one less than last year) and 54 cases of *C. difficile* (10 below our target and 40 less than last year) were reported. The number of Meticillin sensitive *Staphylococcus aureus* (MSSA) bloodstream infections acquired in the Trust was 39, representing a 13.3% reduction on 2010/11, although this fell short of the 20% reduction target agreed with our commissioners.

The focus on preventing infections has remained a key priority for the Trust in 2011/12. We continue to train all our staff in infection prevention and control – 88% of our staff were compliant with initial or update training at the end of March 2012. Hand hygiene has remained a priority: regular auditing on wards has shown that hand cleaning takes place on 97.7% of occasions when it is needed (meeting our 95%+ target, as per 2010/11).

In March 2012, we changed the alcohol hand gel we use and as the bottle holders are designed to stop removal and accidental or deliberate spills and drinking, later in 2012 we will be re-installing gel bottles at the immediate entrances to wards and departments in response to requests from the public and visitors.

A review of Norovirus prevention carried out by the Health Protection Agency in 2011 and the relocation of wards from the Bristol Royal Infirmary Old Building has helped us to reduce the number of complete ward closures and patients affected by Norovirus. In the three months between January and March 2012, there were 10 full and seven partial ward closures where Norovirus was detected, with 49 patients confirmed to have the infection, compared to 123 patients in the previous year.

In 2012/13 we will maintain compliance to the Hygiene code and Care Quality Commission Outcome 8. We will meet our targets for reducing infections, in particular: no more than two MRSA cases; no more than 54 C. difficile cases; and no more than 29 MSSA cases. We plan to establish an in-house infection prevention and control master class training programme and to implement a programme for sharps injury prevention.

Nutritional care

National minimum standards of nutritional care are clearly laid out in the Care Quality Commission (CQC) *Essential standards for quality and safety* which all providers of health and social care in England should meet. At the initial point of registration with the CQC (from April 2010), the Trust self-declared non-compliance with the standard relating to meeting nutritional needs, known as 'Outcome 5'.

Throughout 2010/2011 the Trust demonstrated improvements in nutritional care. Protected mealtimes (where patients are protected from unnecessary interruptions during the lunchtime meal) were rolled out and adapted cutlery made available, however ward-based nutrition audit data demonstrated that further improvements were required in the completion of nutritional screening and nutritional care planning in order to declare compliance. These improvements were the subject of an internal action plan.

On 5 May 2011, the CQC conducted an unannounced nurse-led 'Dignity and Nutrition Inspection'. This included site visits to Ward 17 at the Bristol Royal Infirmary Queen's Building and Ward 23 at the Bristol Royal Infirmary Old Building. The Trust received a written formal report on 28 July 2011: the CQC noted that they had observed improvements in nutritional care, but that these improvements had not been sufficiently rapid or consistently applied. The CQC concluding that there were 'Moderate Concerns', noting that:

- While there was a space to record food likes and dislikes on nutrition care plans for those who were at risk of malnutrition, there was nowhere to record this information for patients who were not at risk.

- While a large number of staff had received informal teaching on nutrition, not all staff had received formal training on how to use the nutrition screening tool used by the Trust.

- Patients were not routinely offered the opportunity to wash their hands before a mealtime.

The Trust produced a 12-week recovery plan, detailing the measures to be taken in order to achieve compliance. These included:

- Fortnightly ward-based nutrition audits (increased from quarterly) with results fed back to the relevant Head of Nursing, matron and ward sister.

- Daily presence of Heads of Nursing and matrons on wards to follow up areas of non-compliance identified in the audits.

- Systematic peer review of nutrition practice to complement the fortnightly audits. This would be conducted by Heads of Nursing, matrons, members of the senior nursing team and governor representatives.

- The 'Quality in Care'[7] tool would be used in parallel with the peer reviews noted above.

- Over 80% of all nursing staff working with adult inpatients would complete the BAPEN nutritional e-learning tool.

The required improvements were observed and the Trust subsequently declared compliance with Outcome 5 to the CQC. The CQC visited the Trust again on 14 December 2011, this time visiting five wards: two at the Bristol Royal Hospital for Children and three wards at the Bristol Royal Infirmary. The CQC agreed that the Trust was compliant with the relevant regulations of the Health and Social Act: patients had reported they received the assistance required when eating meals, and they felt they could ask for additional food if they were hungry; the CQC also found that screening patients for risk of malnutrition had improved.

The following 'Minor Concerns' were identified in relation to ensuring continued compliance:

- Nutritional care plans were not always fully completed.

- The availability of religious and cultural menus was not always communicated to patients.

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[7] The Quality in Care tool provides assurance that nursing standards are being maintained based on observation of environment, documentation and patient experience. Wards are assessed against a range of benchmarks resulting in an automatically generated score. The tool has been adapted for all adult wards, paediatrics and maternity care.

Further steps were taken by the Trust in response, including a review of nutrition care plan paperwork and setting up an internal website page for staff to raise awareness of the availability of religious and cultural diets.

Ward-based nutrition audits continue to take place on a fortnightly basis. The latest available audit results (for March 2012) show that:

- protected mealtimes were observed (using observational audit) on 87% of adult wards and 100% of children's wards

- 88% of adults and 80% of children were being fully nutritionally screened within 24 hours of admission[8]

- 90% adult patients were given the opportunity to wash their hands before a meal

- 93% of adult patients had their food likes and dislikes recorded.

National Patient Safety Agency Alerts

UH Bristol, like all other NHS organisations, reports patient safety incidents to the National Patient Safety Agency (NPSA). The NPSA uses this information to develop advice for the NHS that can help to ensure the safety of patients: this advice is issued as 'alerts' to the NHS when patterns are identified.

At the end of 2010/11, we reported that we had seven NPSA alerts that were overdue for implementation; we also reported our plans to improve timeliness in implementing NPSA alerts as a result of an internal audit. We have since implemented a new protocol for managing NPSA alerts. During 2011/12, seven further NPSA alerts reached their due date for implementation and we completed the required actions for 12 alerts. At the end of the year, two alerts therefore remain which have breached their due date.

The first of these alerts (2011/RRR/001 Essential care after an inpatient fall) requires specialist equipment to be available to assist in safely moving patients who have sustained injuries subsequent to a fall.

[8] In previous Quality Reports, we have reported whether nutritional screening of adult patients had been attempted (94% for 2010/2011), not whether it was fully completed (88% in 2011/12, compared to 75% in 2010/11). The system in the Children's Hospital is slightly different: we audit whether patients have had a nutritional flow chart completed to ascertain whether further screening is needed (80% in most recent fortnightly audit, March 2012) and whether further nutritional screening has been completed if required (60% in same audit).

We have purchased all of the specialist equipment required and are awaiting the imminent delivery of a final few items, our specialist manual handling team is available to advise and assist in such manoeuvres, and we have the required protocols and a training plan in place. As soon as the final items of specialist equipment arrive, we will close alert.

The second of these alerts (SPN 14 "Right Patient, Right Blood") requires individual assessment of competency of the safety aspects in taking blood and administration of a blood transfusion. We are working towards achieving acceptable level of competency assessment compliance by August 2012 in order to consider closure of this alert.

Adverse Event Rate

In addition to routine analysis of reported patient safety incidents and near misses, the Trust has a proactive system in place for identifying adverse events, from which we can identify learning and implement risk reduction measures.The NHS South West Quality and Patient Safety Improvement Programme has a target to reduce adverse events by 30% over a five-year period from 44.95 per 1000 patient days to 31.74 (baseline taken as an average of the six months leading up to the start of the programme in October 2009).

In 2011/12, we have continued our monthly review of a sample of 20 adult inpatient case notes to look for adverse events relating to patient safety. This follows a standardised proforma (the Global Trigger Tool) used by the Trust's Patient Safety Team to identify potential harm events (called 'triggers') and is followed by a medical review of each case to determine: whether the trigger is linked to an adverse event for the patient; the nature of the adverse event; and the extent of harm sustained.

In 2010/11 we reported a sustained low adverse event rate. In 2011/12 we have secured engagement of additional doctors in participating in the monthly audits and have found this change in practice has led to variable reported adverse event rates throughout the year. During 2011/12 we have achieved an adverse event rate of below 31.74 month on month apart from in January and February 2012 when we saw an increase, which could be due to normal variation.

In 2012/13, we will continue to monitor our adverse event rate each month and plan to develop the process of case note review further to obtain a better proactive understanding of safety issues which are affecting our patients.

Rate of patient safety incidents and proportion resulting in severe harm or death

Based on the latest available data from the National Patient Safety Agency for the six-month period March to September 2011, the rate of patient safety incidents reported at UH Bristol is 6.66 per 100 admissions. Our incident reporting rate has shown a steady increase since 2009/10 and has also moved up the ranking with other acute teaching Trusts in our peer group and is currently within the top 50% as shown in Figure 1. Higher levels of reporting are generally indicative of an effective safety culture.

Figure 1
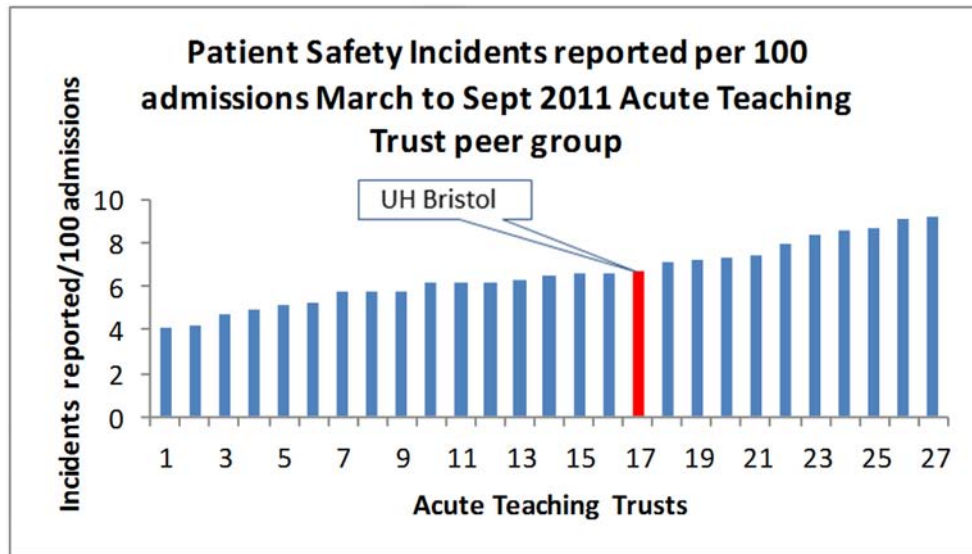
Source: National Patient Safety Agency.

The percentage of reported incidents resulting in severe harm is 1.1% and is ranked near the top of our peer group (see Figure 2). This equates to 47 incidents in the six-month period.

The NPSA advises caution when it comes to benchmarking levels of harm, as there can be differing assessments of levels of harm between Trusts. Where individual Trusts report no or very low levels of severe harm incidents, this should be considered in the light of their reporting culture.

When we look at the trend at UH Bristol, there has been an increase in reported severe harm incidents since 2009/10 which could be explained by a number of factors such as: overall increased incident reporting; increased reporting of pressure ulcers as incidents (a grade 4 pressure ulcer would be classed as a severe harm incident); or the quality of the data at the time of submission to the NPSA (shortly after the incident occurring and prior to completion of any investigation).

There will come a time when increases in reporting trends will plateau and we would expect to see a reduction in severe harm incidents.

Figure 2
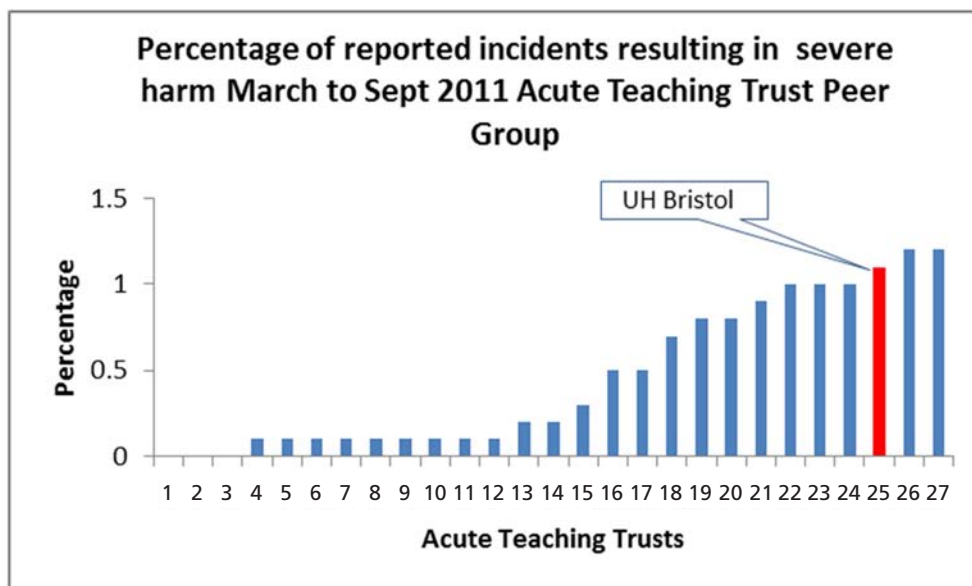
Percentage of reported incidents resulting in severe harm March to Sept 2011 Acute Teaching Trust Peer Group

Source: National Patient Safety Agency.

The percentage of reported incidents resulting in death is 0.1% and we are ranked near the bottom of our peer group (see Figure 3, page 30). This figure for UH Bristol represents three deaths in the six-month reporting period.

Incidents resulting in death or severe harm are subject to a thorough root cause analysis investigation to identify what happened, what we can learn, to put in place actions to reduce the risk of a repeat of the incident, and to share the learning across the organisation.

In 2011/12 we have strengthened our response to the most serious of incidents by introducing a new process whereby a panel is constituted, which may include an external expert, to review the broader organisational aspects of the incident and identify wider learning.

Figure 3

Percentage of reported incidents resulting in death March to Sept 2011 Acute Teaching Trust Peer Group
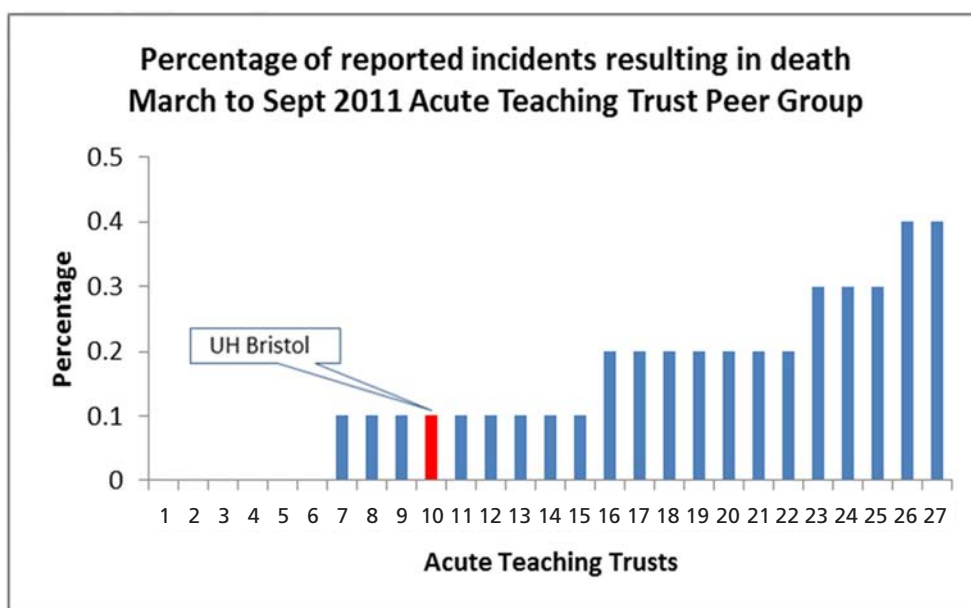
Source: National Patient Safety Agency.

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).

For 2011/12, the list of serious incidents which constitute a never event was expanded from eight incidents to 25.

Two never events occurred in UH Bristol in 2011/12. In the first case, a ward based patient had a chest drain inserted on the wrong side. It is normal practice for some chest drains to be inserted into patients while they are located in ward areas. The mistake was realised shortly afterwards and the drain was removed and a new one re-inserted on the correct side. The patient was informed of the error and came to minimal harm, but underwent an unnecessary procedure on the wrong side.

The Trust has fully implemented the World Health Organisation Surgical Safety Checklist (National Patient Safety Agency 2009) as required in its operating theatres and other areas designated to carry out interventional procedures. In response to this incident, a new chest drain insertion guideline has now been produced to be used across the Trust. This includes a checklist which requires the clinician to confirm the site on the patient's x-ray prior to chest drain insertion. This and other learning from this incident has been shared widely within the organisation and within NHS South West.

In the second case a patient was found to have an air embolism on post mortem. This is when a significant amount of air is inadvertently introduced into the vascular system usually via an intravenous cannula or similar device. At the time of writing (May 2012) this incident is under investigation. The patient's family have been informed of the incident.

Safeguarding

One of the fundamental responsibilities of providing healthcare services of the highest quality is that children and adults are protected while in our care. This is an important responsibility for every member of staff which is highlighted through mandatory safeguarding training. Safeguarding training also promotes the 'Think Family'[9] agenda and the need for a joined up approach to safeguarding, across both adult and children's services.

[9] Think Family is a Department for Children Schools and Families initiative for improving support for families at risk.

The Trust has in place robust safeguarding arrangements, which include clear lines of accountability, policies and procedures as well as experienced teams of safeguarding practitioners providing advice, support and supervision to a wide range of staff.

The Trust's safeguarding steering groups monitor activities, such as training compliance and audit data as well as reports submitted for Serious Case Review and the resulting action plans. External governance is through NHS Commissioning and Local Safeguarding Boards.

An annual safeguarding report detailing activity, for both children and adults, is produced by the Trust for internal and external scrutiny.

Patient Safety objectives for 2012/13

- We will continue to participate in the NHS South West Quality and Patient Safety Improvement Programme. The commitment we made in our Quality Strategy 2011-2014 is that in 2012/13 we will achieve the spread of all key changes relating to the programme in one to three (breadth) workstreams with at least 50% penetration (depth) into other applicable patient populations and areas.

  Through participation in the programme, we will continue to see improvements in key areas including:

  - Patient falls

  - Pressure ulcers

  - Medication errors

  - Hospital acquired thrombosis

- We will implement and develop local use of the NHS Patient Safety Thermometer (the Thermometer records data about patient falls, pressure ulcers, hospital acquired thrombosis and catheters with urinary tract infections, as well as other data determined by the Trust), focusing on the core elements, contributing to national benchmarking and learning from best practice.

- We will continue to embed high quality nutritional care across the Trust as part of the follow up to Care Quality Commission inspections in 2011.

- We will implement a proactive clinical audit programme for histopathology, building upon learning from the Independent Inquiry into Histopathology Services in Bristol into the Trust's histopathology services.

- We will seek reductions in recorded complications, misadventure[10] and re-admissions rates for gynaecological surgery.

These themes reflect a continuation of previous commitments, integration of new developments, learning from previous inquiries and inspections, and learning from internal scrutiny or patient safety data.

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

[10] Unintentional injury caused by medical error, for example an unintentional cut made during a procedure.
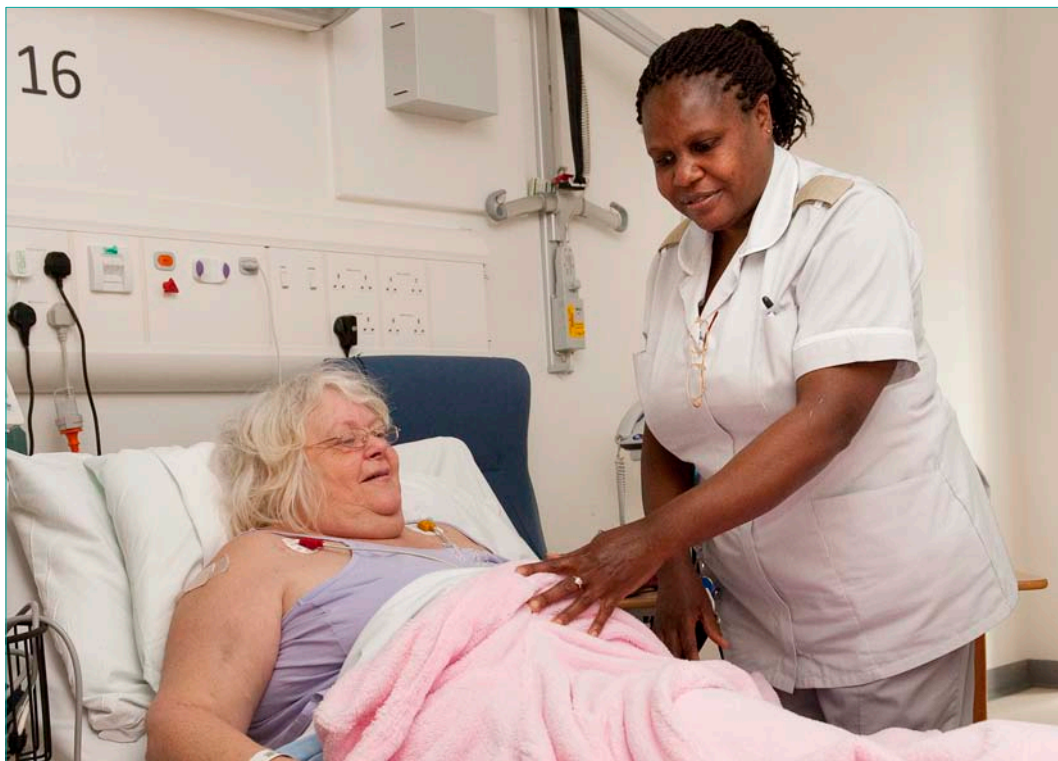
Patient Experience

Our 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 2011/12

Objective 7

We wanted to continue with our core methods of gathering and responding to inpatient feedback and extend these to outpatient clinics.

Why we chose this

To provide the highest quality care, we have to understand the experience of the people who use our services and learn from this. The majority of people who use our services do so as outpatients. We had established a very successful model for measuring patient feedback in inpatient settings and it was a logical development to extend this into outpatient clinics.

We said we would...

- Maintain our core inpatient feedback systems (surveys, comment cards, interviews, and qualitative activities).

- Introduce a robust outpatient survey.

- Extend the use of comment cards to outpatient clinics.

- Introduce a programme of on-site patient interviews.

- Carry out qualitative work (e.g. focus groups, mystery shopping) to gain a more in-depth understanding of outpatient services.

How did we do?

With the support of funding from the Above and Beyond charity (Trustees to the UH Bristol), we were able to achieve all the aspects of this objective. We continued our inpatient core methodologies and extended them into outpatients.

For the second year running, more than 10,000 inpatients have given us feedback about their experience of care. The feedback we received in 2010/11 enabled us to set an accurate baseline from which to measure our progress. Data from the survey throughout 2011/12 has enabled us to track progress with many of the patient experience objectives and targets described in this report.

In 2011/12, we also carried out a robust outpatient postal survey in which 2,250 outpatients (including parents of 0-11 year olds) took part. This has given us a detailed view of outpatient experience across the organisation, and provided a benchmark against which we can assess the impact of service improvement initiatives in 2012/13.

Comment cards and boxes have been purchased and are being installed in all outpatient clinics. We have held focus groups with patients about their experience of having tests and receiving the results in outpatients. The Trust's Youth Council has carried out 'mystery shopping' in outpatient areas and we have piloted the use of data from our governors' outpatient interview programme to provide clinic managers with rapid-time feedback.
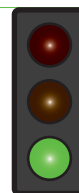
Objective 8

We wanted to create a range of opportunities for carers to provide feedback about their experience at UH Bristol, with a particular focus on carers of patients with dementia.

Why we chose this

Carers have a unique and valuable role to play in the provision of healthcare, particularly if the person they care for is in hospital. Carers are in effect our "expert partners in care".

Examples of what our patients told us in our monthly survey:

"[Staff] did not take on board my advice about my mum."

"My daughter has learning difficulties, I was pleased that staff listened to me with regards to managing her behaviour. Many thanks to all involved in her care."

We said we would...

- Ensure that there are processes in place for carers to tell us about their experience at the Trust and shape service delivery.

- Ensure that there are Trust systems and processes in place to support the role of carers as "expert partners in care".

- Ensure that carers have access to the information and support that they need about our Trust.

How did we do?

Engaging carers is an ongoing process which we remain firmly committed to as an organisation. A number of important initiatives were progressed during 2011/12 as follows:

A Carers Reference Group has been successfully established. The members of this group are carers. The group has played a key role in developing the new Carers' Charter, which has been a joint initiative between the Trust and North Bristol NHS Trust, setting out our commitment to carers and their role in the patient's care.

The Carers Reference Group provides a "carer's view" to the Trust on a range of relevant issues. We carried out an in-depth analysis of carer responses to our monthly inpatient postal survey which identified strong themes that have helped inform the work of the Trust's Carers Strategy Group (a management group which oversees developments in this area).

We piloted the introduction of a Dementia Carers Lay Reference Group, which comprised carers for people with dementia and acted as an advisory group to the Dementia Strategy Implementation Group. However, after three meetings the group decided that its objectives could be met by merging with the Trust's Carer's Reference Group.

In addition:

- We have developed an approach to interviewing carers about their experience at UH Bristol during home visits by the Occupational Therapy team – this is currently being piloted and if successful will become an established survey during 2012/13.

- The Trust took an active role in the Alzheimer Society, LINk and South West Dementia Partnership 'Living with Dementia' programme – specifically, the Trust took part in and helped facilitate workshops that explored both the carer's and patient's experience of acute care.

- We are currently developing a process whereby both the patient's carer and clinical staff will be able to record relevant information about the patient in a shared document.

- To help provide practical information and support, a carers' webpage is now available on the Trust internet site and a written leaflet for carers has been produced. We are also including a carers' page in our new *Welcome Guide*.

Objective 9

We wanted to achieve measurable reductions in the number of inpatients who are disturbed by noise at night from ward staff.

Why we chose this

This was a key issue raised by patients through our feedback systems.

Examples of what our patients told us in our monthly survey:

"It was impossible to sleep at night due to constant noises. Doors banging shut, telephones ringing and people walking through the ward."

We said we would...

Focus on reducing the amount of noise at night with new initiatives being carried out across the Trust during the year.

The CQUIN target agreed with our commissioners was a survey score of 81 points out of 100[11], measured in Quarter 3 of the financial year via out inpatient survey. This target represented a statistically significant improvement compared with the baseline score of 78 points.

How did we do?

We achieved a score of 82 points, therefore exceeding the CQUIN target agreed with our commissioners.

Ward staff played a key role in identifying improvement initiatives. For example, some areas purchased silent closing bins, while others worked closely with our Facilities department to reduce noise from equipment, doors, etc. We recognise that more needs to be done and so we have agreed to focus on this issue again during 2012/13, and are in the process of setting a new CQUIN target with our commissioners.

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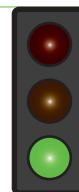
[11] Results were based on respondents aged 16+. Scores are derived from a weighting applied to each of the response options to a survey question (e.g. 'Yes, definitely' = 100; 'Yes, to some extent' = 50; 'No' = 0). This ensures that service improvement is measured across all possible responses (i.e. a change in the proportion moving from "no" to "yes, to some extent" is recognised, albeit at a lower rate that from "yes, to some extent" to "yes, definitely"). This follow the approach used in national patient surveys.

Figure 4
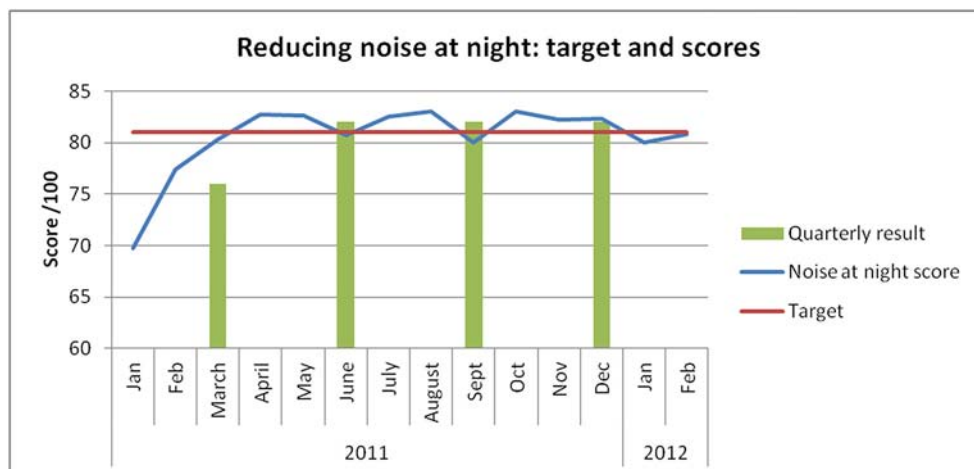
Reducing noise at night: target and scores

Source: UH Bristol monthly postal survey (patients aged 16 and over).
The CQUIN calculation was based on the aggregated Quarter 3 (October to December) result.

Objective 10

We wanted to ensure that patients are receiving the assistance they need to eat their meals.

Why we chose this

This was a key issue identified through our patient feedback systems. The Trust was also committed to improving nutritional care following CQC inspections.

We said we would...

Focus on ensuring that patients have the help they need to eat meals.

The CQUIN target agreed with our commissioners was a survey score of 76 points out of 100, measured in Quarter 3 of the financial year via our inpatient survey. This target represented a statistically significant improvement compared with the baseline score of 71 points.

How did we do?

We achieved a score of 81 points, therefore exceeding the CQUIN target agreed with our commissioners.

There was sustained operational focus on nutritional care throughout 2011/12. A team of volunteers has also been trained to go on to our wards to help patients during mealtimes. More information about how we have been improving nutritional care can be found on page 24 of this report.

Figure 5
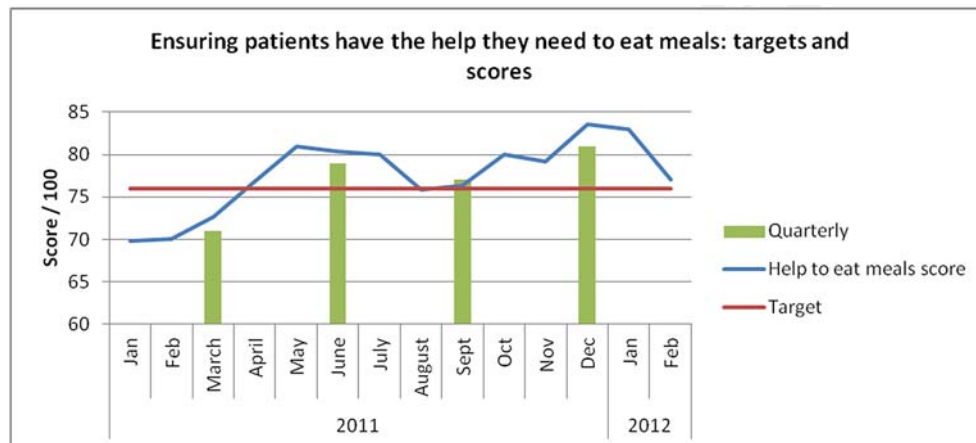
Ensuring patients have the help they need to eat meals: targets and scores

Source: UH Bristol monthly postal survey (patients aged 16 and over).
The CQUIN calculation was based on the aggregated Quarter 3 (October to December) result.

Objective 11

We wanted to review the provision of ward-based patient information, ensuring that this meets our patients' needs.

Why we chose this

Ensuring that patients receive clear information about the ward where they are staying is essential for a positive patient experience.

The Trust provides a huge range of literature (approximately 1,000 leaflets) providing patients with essential information about their clinical condition and treatment, however our previous external contract for the provision of generic 'bedside' information (the kind of information that would be helpful to anyone staying in one of our hospital beds) had expired and feedback from our patients was telling us that we needed to improve the quality of generic ward-based information.

Examples of what our patients told us in our monthly survey:

"It would be a vast improvement if staff informed patients of where to get food on arrival to the ward."

(Our new *Welcome Guide* will signpost patients to the food service information which is available to patients).

We said we would...

- Ask patients what information it is useful to be given about the ward they are staying on, and use this information to develop a new *'Welcome Guide'* for inpatients.

- Increase awareness of the ways that patients can raise concerns and tell us about their experience.

How did we do?

We carried out patient interviews to find out what patients thought about communication on our wards. A new *Welcome Guide* has been developed and will available on our wards from June 2012. We will be seeking early patient feedback about the *Welcome Guide* and will use this to fine-tune the design and content in future print runs. New posters have also been produced explaining how people can raise issues and give feedback – these are also in the process of being printed for distribution.

Objective 12

We wanted to develop new customer care training for staff in response to what our patients tell us matters to them.

Why we chose this

This objective was agreed with our governors, who expressed a strong desire to see the introduction of systematic customer care training for our staff.

We said we would...

Design and launch new customer care training, drawing on real patient stories, feedback and complaints to enable staff to understand the role of the Trust's values and expected behaviours in improving patient care.

How did we do?

A new 'immersion' and induction programme called *Living the Values* has been designed for all staff and starters, and has been successfully trialled. A customer care trainer is joining the Trust on secondment in April 2012, and the roll-out of training is due to commence in May.

Living the Values will provide training and opportunities for reflection for all staff about how their behaviour at work impacts on patient experience and on their colleagues.

The emphasis of the training is that *Living the Values* means respecting everyone, embracing change which results in improved patient care, recognising success and working together (communicating effectively) and demonstrating a positive and proactive attitude in everything we do.

These values are linked directly to the experience of patients, carers, relatives and other members of staff teams through the examination of complaints, compliments and feedback to see where our Values have been demonstrated effectively, resulting in improved care and experience for our service users and staff, and where improvements can be made.

Review of patient experience 2011/12

This section explains how the Trust performed during 2011/12 in a number of other key areas relating to patient experience, which are in addition to the specific objectives that we identified.

National Patient Experience CQUIN

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.

A national patient experience CQUIN measure was set for all NHS providers in 2011/12, based on the results of the annual National Inpatient Survey. The CQUIN consists of an aggregate score across five questions:

- Were you involved as much as you wanted to be in decisions about your care and treatment?

- Did you find someone on the hospital staff to talk to about your worries and fears?

- Were you given enough privacy when discussing your condition and treatment?

- Did a member of staff tell you about medication side effects to watch for when you went home?

- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

The Trust was set a target of achieving a score of between 72.4 and 74.4 points. Our score, measured using data from the National Inpatient Survey 2011, was 69.9. This compares with a score of 70.4 in 2011/12 (there is no material difference in these results when statistical margins of error are taken into account). Since March 2010, our Trust Board has been tracking the progress of this indicator using monthly data produced by our own inpatient survey.

We know from the analysis of the data that our own survey tends to produce slightly higher satisfaction scores than the National Inpatient Survey, however Figure 6 below indicates that among the natural data variation there is an upward trend in our score. We are committed to building on this promising progress 2012/13.

Figure 6

National CQUIN score, measured via UH Bristol's monthly survey, with target and trend lines, March 2010 - February 2012
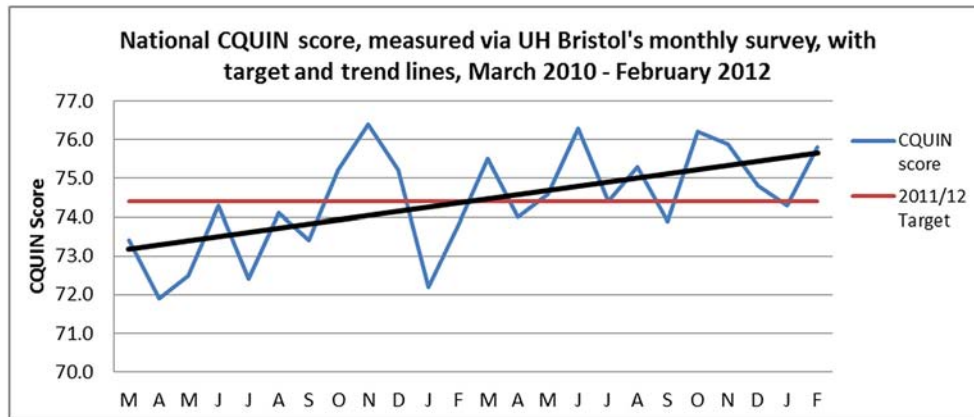
Source: UH Bristol Monthly inpatient survey; over 17,000 patients surveyed in the period shown.

Overall patient satisfaction

Examples of what our patients told us in our monthly survey:

"Every single person from healthcare assistant to consultant was kind, caring and compassionate. I was treated as a person not a condition, and should I have to go back in to hospital I would ask to go to the BRI."

"I was treated with dignity and respect at all times and it was a pleasant stay. All the staff worked very hard to make me comfortable and I am very grateful for the care I received."

"I would recommend your hospital to everybody I know."

Overall, patients of UH Bristol rate the service they received very highly. This is reflected in the proportion of patients who say that they would recommend the Trust to friends and family (see chart below). The Trust Board receives monthly data on the proportion of inpatients who would recommend us: if this figure should fall below an agreed level (91%), this would act as a warning sign that patient experience standards have fallen significantly and that we need to take action to address this. This has never happened to date.

Figure 7

Percentage of patients who would "definitely" or "probably" recommend the Trust to their friends and family (April 2011-February 2012)
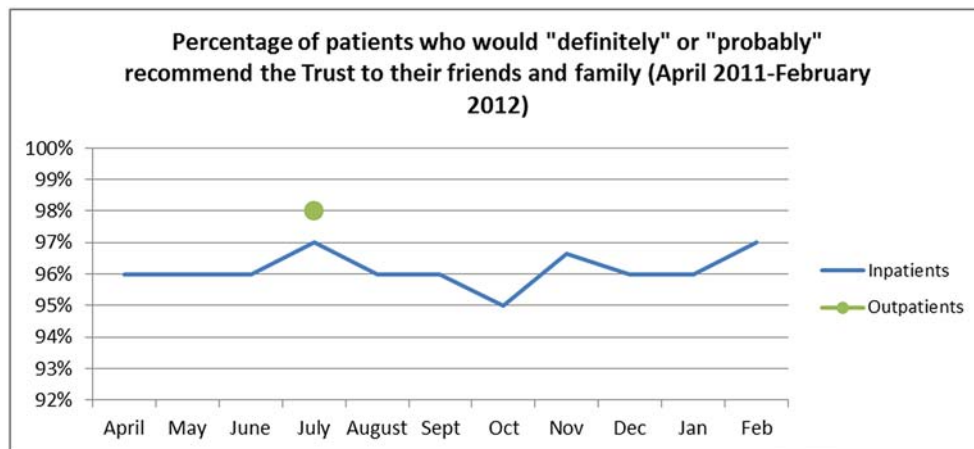
Source: Trust inpatient and outpatient surveys (or parents of 0-11 year olds). Our inpatient survey took place every month; our outpatient survey captured the views of patients seen in July 2011 only (this outpatient survey will be repeated twice in 2012).

Data from the Trust's surveys showed that 98% of outpatients and 96% of inpatients would "definitely" or "probably" recommend us based on their experience. Similarly, 96% of inpatients described their overall experience of care as "excellent", "very good" or "good".

Figure 8 (overleaf) provides a degree of assurance that this experience of care is shared across different ethnic groups (the differences in reported experience are not statistically significant), although we recognise that non-English speaking patients will be under-represented in this data.

A focus of our new *Patient Involvement and Engagement Strategy 2012-15* (see page 48) will be to carry out qualitative face-to-face engagement activities, with a particular focus on people who can't or don't access our main patient feedback systems.

We are also keen to develop our understanding of the experience of patients with protected characteristics as defined in the Equality Act 2010 (including for example, religion, disability and sexual orientation) and to develop our ongoing ability to monitor their experience through our core patient feedback channels.

Figure 8

% Rating their care at UH Bristol as excellent, very good, or good (by ethnic group)
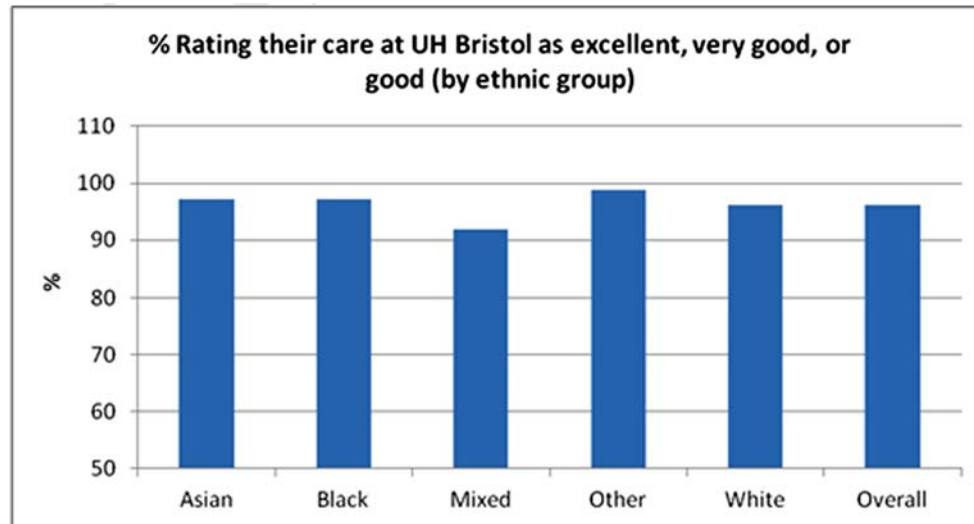
Source: UH Bristol monthly inpatient survey (April 2011 – January 2012).

Compliance with single sex accommodation

In November 2010, a change in national standards created an expectation that all NHS trusts eliminate mixed sex accommodation. The Trust was required to carry out a detailed assessment against this new, more stringent standard, with a view to making a formal declaration regarding compliance.

In last year's Quality Report we explained that the Trust Board had declared non-compliance with a number of issues around mixed sex accommodation. A significant amount of work was undertaken during 2011/12 and we are pleased to report that the Trust has declared compliance with the Government's requirement to eliminate mixed-sex accommodation. The declaration can be read on the Trust website and has been re-confirmed for 2012/13.

An expansion of beds in the Medical Assessment Unit has taken place to enable the Trust to manage operational pressures and so eliminate mixed sex accommodation completely. The Observation Unit is currently being upgraded: when it reopens, it will be fully single sex compliant (the current temporary location for the Observation Unit is also compliant). Figure 9 shows that patient-reported experience of mixed-sex accommodation at UH Bristol was similar to the national average as reported in the 2011 National Inpatient Survey.

Figure 9

Percentage of patients who stayed on a mixed sex ward when they were admitted to hospital

	2006	2007	2008	2009	2010	2011
UH Bristol	24%	34%	30%	13%	8%	10%
All English Trusts	25%	24%	24%	18%	14%	10%
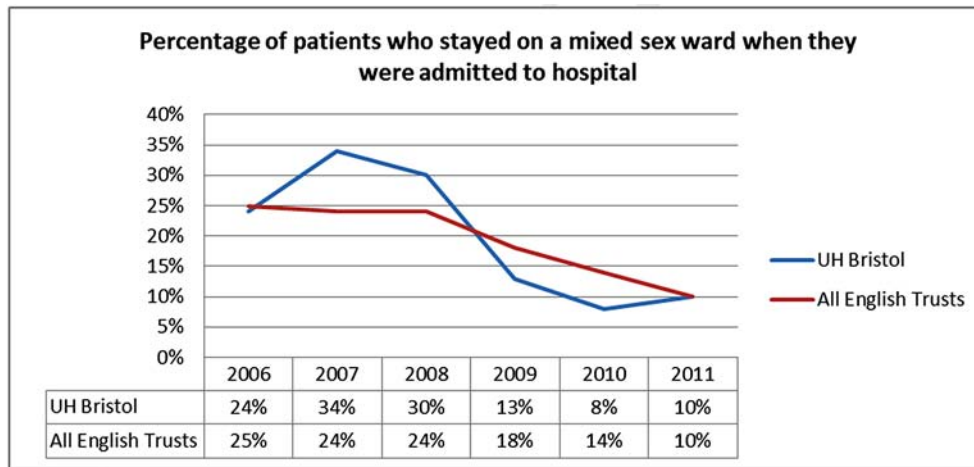
Source: National Inpatient Survey.

Linking patient feedback to service improvement

During 2011/12, we have continued to promote the use of patient feedback as a key service improvement tool for all staff. Ward-level survey data and comment cards are now publicly visible on the wards via a display board.

Patient survey ratings of each ward's cleanliness, overall patient satisfaction with care and privacy and dignity ratings are displayed along with a comparison of how the scores for that ward have changed over time and how they compare to the Trust as a whole.

The Trust's focus on collecting outpatient experience data during 2011/12 allowed us to identify key service improvement issues that patients feel are important.

In the main, these revolved around what could broadly be called 'administration and efficiency' issues, such as ensuring appointments are not cancelled, that it is easy to contact someone at the hospital for information if you need to, and that clinics run to time.

The issues we identified through patient feedback have now become key improvement objectives in a major Trust outpatient improvement project (the Productive Outpatient project). Furthermore, patient survey results will play a key role in assessing progress against these objectives. In other words, patients will have been involved both in the development of the objectives and the evaluation of them.

Developing a new strategy for Patient Experience and Involvement

The Trust's *Patient and Public Involvement Strategy 2010-12* led to the successful introduction of robust systems to capture patient experience and use this to drive service improvement. In March 2012, the Trust Board approved our new *Patient Experience and Involvement Strategy 2012-15*. The key aims of our new strategy are as follows:

1. To continue to refine our core patient experience tools; extending their use, prominence and influence.

2. To recognise that not all patients can or will respond to surveys and comment cards, and so ensure that we employ alternative methods to engage with these groups.

3. To develop a more systematic approach to our qualitative patient and public engagement methods, such as focus groups and interviews.

4. To use these qualitative methods as a springboard to developing a culture of genuine collaboration with patients and the public in service delivery and development.

Complaints

The Trust's Patient Support and Complaints Team is responsible for the management of our complaints and 'PALS'[12] functions and provides

another important source of information about the experience of patients and those who care for them.

The total number of complaints received by the Trust in 2011/2012 was 1465, averaging 122 per month. By comparison, the total number of complaints received in 2010/2011 was 1532, averaging 128 per month. This decrease in reported complaints is largely attributable to a significant reduction in reported complaints during February and March 2012, however in eight out of 12 months, our internal target of no more than 120 complaints was exceeded.

A monthly comparison between complaints received in 2010/2011 and 2011/2012 is shown in Figure 10.

Figure 10
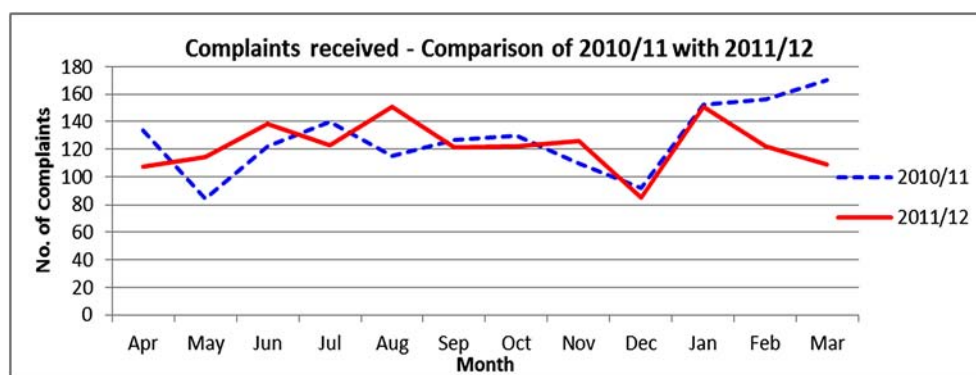
Source: UH Bristol Ulysses Safeguard system.

Each complaint we receive is categorised so that we can identify emerging patterns and learn lessons for the future. The three most common reasons why people complained to us in 2011/12 were as follows:

1. Clinical care provided to patients both from medical and nursing staff.

2. Attitude of staff (across all staff groups) and poor communication with patients.

3. Our appointment and admission systems (delay or cancellation of outpatient appointments and admission to the hospital for surgery).

Bristol Eye Hospital and the Bristol Royal Infirmary Trauma and Orthopaedic Department continue to be areas where we receive the highest number of complaints about delayed or cancelled appointments: these issues are being addressed through the 'transforming care' programme currently under way at the Trust.

In 2011/12, Urology and Lower and Upper Gastrointestinal services received the largest number of complaints about cancelled or delayed surgery.

Complaints regarding car parking and catering have decreased in the last 12 months, reflecting the improvements which have been made within these services.

During the year, our performance in managing patient complaints has not met the high standards we aspire to: 91.1% of complaints were resolved within the timescale agreed with the complainant, against an internal target of 98%.

Acknowledging the need to improve performance, the Trust commissioned an external review of the Patient Support and Complaints function, leading to the agreement of a detailed plan with our Divisions in October 2011. The plan has been directed at improving the efficiency of systems for managing complaints and performance in relation to both timeliness and quality of complaint responses.

We have been encouraged to see an improved performance in the last two months of 2011/12, both in terms of the number of complaints received (see Figure 10) and also timeliness of responses. The action plan, which includes a significant focus on learning and service improvement following complaints, was fully implemented by April 2012.

Training for frontline staff to resolve complaints within their own areas has taken place during 2011/12 and will be rolled out to more staff during 2012/2013.

Training has also been delivered to senior staff to improve the quality and timeliness of responses to written complaints – this will now become a regular training programme offered to staff across the Trust.

National Staff Survey 2011

As in previous years, as per the recommendations of the Department of Health, we are including in our Quality Report a range of indicators from the annual National Staff Survey which have a bearing on quality of care. Relevant results from the 2011/12 survey are presented below. Questionnaires were sent to a random sample of 813 staff across the Trust (this includes only staff employed directly by the Trust): 490 staff at UH Bristol took part in this survey, representing a response rate of 60% which is in the highest 20% of acute Trusts in England.

A key priority for the Trust is to ensure that our patients not only receive excellent clinical treatment but are treated respectfully and with dignity and compassion at every stage of their care. It is also vital for us to ensure that our staff are treated and treat each other with the same level of dignity and respect which we expect for our patients.

The Trust's 'Values' (respecting everyone, embracing change, recognising success and working together) are a guide to our staff about how they are expected to behave towards patients, relatives, carers, visitors and each other. The 'Values' are embedded in recruitment and staff induction and are clearly and regularly communicated.

Key ways we support staff include performance management, development and training, taking effective steps to tackle bullying and harassment, and improving our communications. The 2011 staff survey showed improvements against the previous year's survey results in the following areas:

- Staff receiving job-relevant training, learning or development (best 20%).

- Staff having an appraisal, which is well-structured, and a personal development plan.

- Staff experiencing harassment, bullying or abuse from other staff.

- Perceptions of effective action from employer towards violence and harassment (best 20%).

- Good communication between senior management and staff (best 20%).

Staff experience of discrimination

Despite improved scores in the areas of staff reporting that they had had equality and diversity training in the past 12 months and 92% of staff (better than national average) saying that they believed that the Trust provides equal opportunities for career progression or promotion, it was deeply concerning that 14% of respondents said that they had experienced discrimination at work in the last 12 months. This is an increase of 3% against the previous year's survey and is above (worse than) the national average.

Eight percent of respondents stated that they had experienced discrimination[13] at work from patients/service users, their relatives or other members of the public.

Eleven percent said that they had experienced discrimination at work from their manager/team leader/colleagues.

We are committed to taking action to improve the experience of our staff by reducing the incidence of discrimination at work. This issue will be addressed through training in Trust 'Values' for all staff, continuing equality and diversity training, use of clear signage to communicate to patients and visitors the expectation to treat staff appropriately and with respect, and through strengthened processes, procedures and policies to tackle harassment and bullying in the workplace.

Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

Seventy-four percent of staff agreed or strongly agreed with at least two of the following three statements:

- "I am able to do my job to a standard I am personally pleased with"

- "I am satisfied with the quality of care I give to patients/service users"

- "I am able to deliver the patient care I aspire to".

The Trust's score was average when compared with Trusts of a similar type and equated to a 2% decrease on our score last year.
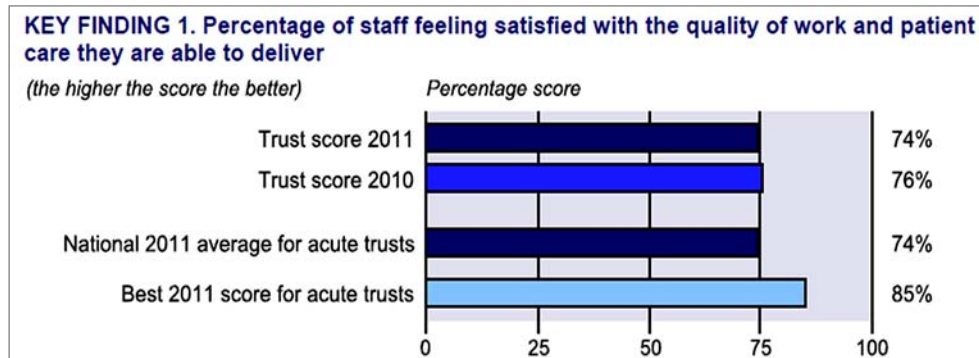
[13] On the basis of their ethnicity, gender, age, sexual orientation, disability, or for another reason.

Figure 11

KEY FINDING 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better)   *Percentage score*

Trust score 2011	74%
Trust score 2010	76%
National 2011 average for acute trusts	74%
Best 2011 score for acute trusts	85%

0   25   50   75   100

Source: 2011 NHS Staff Survey.

Percentage of staff agreeing that their role makes a difference to patients

Ninety-two percent of staff agreed that their role made a difference to patients/service users. This score was in the highest (best) 20% of NHS Trusts of a similar type, and was an identical response to the 2010 survey.

Figure 12
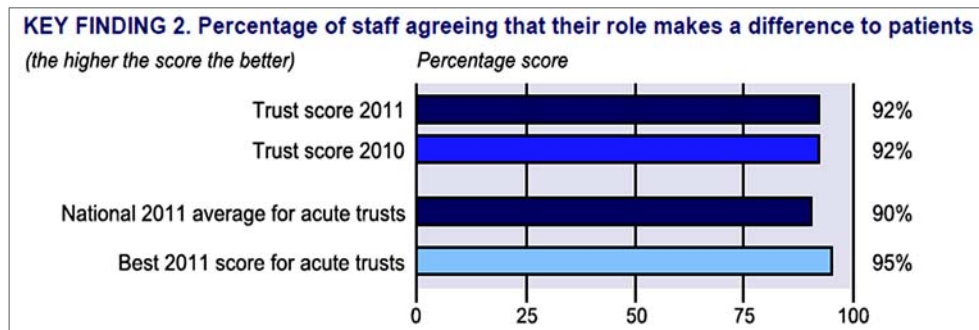
KEY FINDING 2. Percentage of staff agreeing that their role makes a difference to patients

(the higher the score the better)   *Percentage score*

Trust score 2011	92%
Trust score 2010	92%
National 2011 average for acute trusts	90%
Best 2011 score for acute trusts	95%

0   25   50   75   100

Source: 2011 NHS Staff Survey.

Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month

Thirty-nine percent of respondents said that they had *witnessed* potentially harmful errors, near misses or incidents the last month. This response rate is 5% higher than the national average of 34%, identical to the Trust's 2010 score, and in the worst 20% of acute Trusts.

Figure 13

KEY FINDING 20. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)   *Percentage score*

Trust score 2011	39%
Trust score 2010	39%
National 2011 average for acute trusts	34%
Best 2011 score for acute trusts	28%

0   25   50   75   100

The percentage of staff *reporting* errors, near misses or incidents witnessed in the last month had increased to 96% against the previous year's score of 94% but remained slightly lower than the national average for acute Trusts of just over 96%.

Figure 14

KEY FINDING 21. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)   *Percentage score*

Trust score 2011	96%
Trust score 2010	94%
National 2011 average for acute trusts	96%
Best 2011 score for acute trusts	100%

0   25   50   75   100

Staff recommendation of the Trust as a place to work or receive treatment

Staff were asked whether or not they thought care of patients and service users was the Trust's top priority.

Staff were also asked whether or not they would recommend the Trust to others as a place to work and whether they would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.

The Trust's score of 3.65 out of 5 was better than average when compared with Trusts of a similar type and a small decrease since 2010, when the Trust scored 3.68.

Figure 15

KEY FINDING 34. Staff recommendation of the Trust as a place to work or receive treatment

(the higher the score the better)   Scale summary score

Trust score 2011	3.65
Trust score 2010	3.68
National 2011 average for acute trusts	3.50
Best 2011 score for acute trusts	4.05

1   2   3   4   5

Unlikely to   Likely to
recommend   recommend
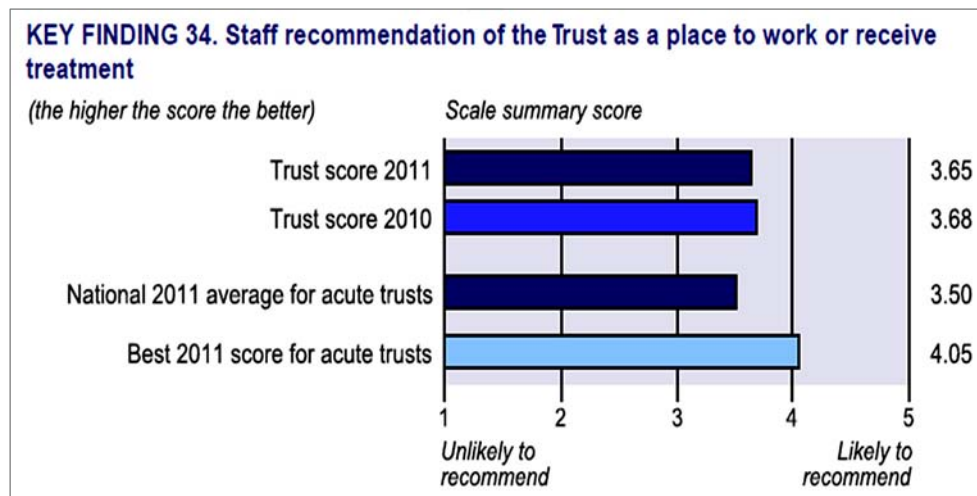
Source: 2011 NHS Staff Survey.

Staff engagement

The Trust's score of 3.70 was in the highest (best) 20% when compared with Trusts of a similar type.

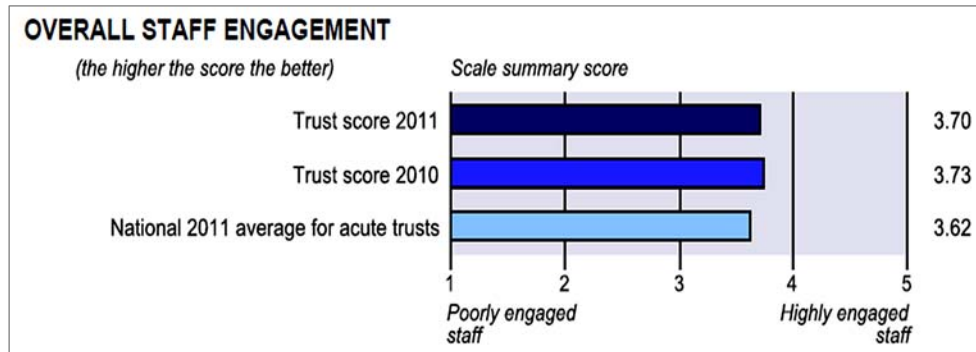This score is reached by analysing responses to questions in the areas:

• "Staff ability to contribute towards improvement at work"

• "Staff recommendation of the Trust as a place to work or receive treatment"

• "Staff motivation at work".

Figure 16

OVERALL STAFF ENGAGEMENT

(the higher the score the better)   Scale summary score

Trust score 2011	3.70
Trust score 2010	3.73
National 2011 average for acute trusts	3.62

1   2   3   4   5

Poorly engaged staff   *Highly engaged staff*

Source: 2011 NHS Staff Survey.

Patient Experience objectives for 2012/13

- We will implement the first year of our Patient Experience and Involvement Strategy for 2012-2015. As part of our work plan, this year we will focus on improving the experience of care among the following groups in particular:

  - Children

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

  - Patients with learning difficulties

  - Carers

  - Emergency patients

- We will reduce patient-reported noise at night.

- We will ensure that patients are treated with kindness and understanding.

- We will improve communication with patients: in particular about waiting times in clinic and making sure patients know who to speak to if they have worries or concerns.

- We will reduce numbers of reported complaints; and where people do complain, we will provide a full response as quickly as possible.

- We will improve the experience of our staff by reducing the incidence of discrimination at work both from patients/service users and from managers/team leaders/colleagues.

These themes reflect a continuation of previous commitments, learning from what our patients have told us matters to them, common themes arising from discussion with our clinical divisions and the views of our governors. The objective to ensure that patients are treated with kindness and understanding stems from an indicator in the National Maternity Survey which we monitor locally for maternity services but wish to extend across all services. At the request of our non-executive directors, we have also included an objective which is directed at improving the well-being of our staff.

The Director of Human Resources and Organisational Development will be responsible for achieving the staff objective relating to incidence of discrimination. Progress will be reported to the Human Resources Board and Industrial Relations Group.

For all the other objectives listed here, the Chief Nurse will be the responsible executive director. Progress will be monitored by the Trust's Clinical Quality Group and by the Quality and Outcomes Committee of the Board.

Clinical Effectiveness

Our 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 outcome. This commitment reflects our core Values of 'working together', 'embracing change' and 'recognising success'.

Report on our clinical effectiveness objectives for 2010/11

In addition to our overall goal to maintain low overall mortality ratings (see page 66), we set ourselves four specific clinical effectiveness objectives in 2011/12.

Objective 13

We wanted to see progress in one-year survival rates for colorectal, breast and lung cancer.

Why we chose this

Improving cancer survival is one of the key objectives of the NHS Outcomes Framework and an aspiration shared by the Trust.

We said we would...

- Improve our organisational knowledge of survival rates for colorectal, breast and lung cancer.

- Implement the recommendations of *Improving Outcomes: a strategy for cancer* (Department of Health, 2011).

- Review our respiratory Multi-disciplinary Teams (MDT) to improve outcomes for lung cancer patients.

How did we do?

Data we have received from the South West Public Health Observatory indicates that one-year survival for colorectal, breast and lung patients treated by the Trust is better than the national average for England. We are however taking a cautious approach to this new data and hence have assigned an amber rating to this objective. Our ongoing work to improve cancer treatment and care is fully aligned with the national cancer strategy.

Cancer survival data sits within the realms of public health – the data is complex and outcomes cannot be solely attributed to the Trust's clinical interventions.

During 2011/12, we have worked closely with the South West Public Health Observatory to establish baseline survival data for colorectal, breast and lung patients. To date, we have received one-year relative risk-adjusted survival data for patients diagnosed in the period 2007-2009.

Our baseline data is promising (consistently better than the national average).

We will continue to monitor these cancer outcomes year on year to understand changes in our performance relative to the rest of the NHS in England, and also relative to our own previous performance. We will also seek to widen the data we receive to include five-year survival statistics which may be more relevant measures depending upon the cancer type. Once we are confident in the data, our intention is to publish this in future Quality Reports.

The national *Improving Outcomes* cancer strategy underpins the strategic direction of the Trust's cancer services. To briefly address four of the key themes within the national strategy:

Information and choice

The Trust is doing a great deal of work on cancer data quality, focusing on completeness and accuracy. We are striving to improve our submissions to national audits and are working to implement the new Systemic Anti-Cancer Therapy dataset. We offer a good range of choices of treatment including those highlighted in the national strategy as not being available in some areas of the country.

Prevention and earlier diagnosis

We have actively planned to meet the increased demand associated with national campaigns for lung and bowel cancer, and also participated in a regional urological cancer campaign. The Trust offers direct access to GPs for all the test types mentioned in the national strategy. We have significantly improved our performance against waiting time standards in the last year and are working to maintain that.

Quality of life and patient experience

The Trust has been selected as a pilot site for Macmillan's 1:1 support workers. Many multi-disciplinary team (MDT) core members have attended Advanced Communication Skills training. UH Bristol is taking part in a pioneering project around survivorship for teenage and young adult cancer survivors (called 'On Target'). The Trust has also set up an aftercare MDT for childhood cancer survivors.

We have applied for funding to undertake research in self-reporting of symptoms via the internet post surgically. We have also put in place a comprehensive action plan in response to the results of the most recent National Cancer Survey.

Better treatment

We have introduced enhanced recovery[14] in many areas and are developing an acute oncology service that will help to reduce admissions and length of stay. We offer LAPCO[15] for relevant patients and robotic prostatectomy is undertaken at North Bristol NHS Trust (we send our patients there). We are working towards implementation of the chemotherapy dataset and continue to participate fully in peer review. Our radiotherapy services are highly rated and we have made full use of the cancer drugs fund. We participate fully in peer review and are working hard to improve our submissions to all national cancer audits. We have introduced an extensive MDT quality audit process to ensure the quality of our MDT meetings, as part of the histopathology review.

A recent audit of MDTs carried out by the Internal Audit department returned positive results with actions suggested which we are now implementing.

[14] Enhanced recovery, often referred to as rapid recovery, is a new, evidence-based model of care that creates fitter patients who recover faster from major surgery. It is the modern way for treating patients where day surgery is not appropriate.

[15] National Training Programme for Laparoscopic Colorectal Surgery.

Objective 14

We wanted to achieve improvements in Dr Foster ratings for stroke care. In particular, to establish a specialist stroke unit, with a target that at least 90% of patients who suffer a stroke spend at least 90% of their time in this unit.

Why we chose this

Improving the care of stroke patients is a national priority within the NHS Outcomes Framework. We know from research that treating stroke patients in dedicated stroke facilities is critical to their clinical outcome.

We said we would...

- Improve our Dr Foster ratings for stroke care.

- Establish a specialist stroke unit.

- Treat at least 90% of stroke patients on this unit for at least 90% of their time in hospital.

How did we do?

A dedicated stroke unit has been established in Ward 12 of the Bristol Royal Infirmary. The Trust featured prominently in the annual Dr Foster Hospital Guide, with one of the best stroke mortality rates in the NHS. However, we did not achieve our ambition that 90% of stroke patients should spend 90% of their time on the stroke unit.

The new stroke unit opened on 4 August 2011. Benefits have included:

- Daily consultant presence on ward and board round.

- Therapy gym in close proximity to the ward.

- Highly effective TIA (Transient Ischaemic Attack) clinic co-located and integrated within the ward.

- Provision of intravenous thrombolysis for patients assessed to be suitable as per commissioned hours (8am-11pm, Monday-Friday).

- Research team co-located with the acute ward to enable increasing numbers of acute and hyperacute patients entering Stroke Research Network portfolio adopted studies.

Our agreement with NHS Bristol for 2011/12 was that we would ensure that at least 80% of stroke patients should spend 90% of their time on the stroke unit. We achieved this target in nine out of 12 months: our overall performance for the year was 80.5%. However this means that we did not achieve our more stretching ambition that 90% of stroke patients should spend 90% of their time on the stroke unit[16].

We have worked hard to ensure that stroke beds are available for patients who have had a stroke, however this has not always been possible on a consistent basis (for example, due to winter norovirus).

In 2012/13, we will be seeking to improve our performance against the 90% target through targeted work to reduce discharge delays and enable patients to be discharged earlier in the day.

Some of the stroke indicators published by Dr Foster in 2011 differed from those published in 2010, limiting our ability to make direct comparisons, however the Trust's headline standardised mortality rate from stroke was 70.54 against an average of 100, placing UH Bristol in the top five Trusts nationally.

Objective 15

We wanted to increase the proportion of spontaneous vaginal births.

Why we chose this

Women and users of the service have expressed a wish for the maternity service to concentrate on reducing the number of caesarean sections and operative deliveries. A focus on normalising birth results in better quality, safer care for mothers and their babies, with an improved experience.

[16] This means that approximately 50 stroke patients did not spend at least 90% of their time on the stroke unit.

Increasing normal births and reducing caesarean section deliveries is associated with shorter (or no) hospital stays, fewer adverse incidents and admissions to neonatal units and better health outcomes for mothers.

We said we would...

Increase spontaneous vaginal births as a proportion of all births by 1% from a baseline of 63.4%, as measured in the final quarter of the year. This target was agreed with our commissioners through the CQUIN scheme.

How did we do?

For the year as a whole, the rate of spontaneous vaginal births was 63.31%.

In the final quarter of 2011/12 however, the rate of spontaneous vaginal births increased to 65.09%, and we therefore achieved the CQUIN target. The figure for the final month of the year was 66.67%.

During the year, a number of important steps were taken to move us towards our goal, which enabled us to achieve the related CQUIN:

- the maternity service set up a multi-disciplinary normal birth working party chaired by the practice development midwife;

- midwives are attending normal birth study days;

- the unit is developing the antenatal education given to women to prepare them better for birth and in particular the latent phase;

- posters have been displayed around the unit explaining the importance of normal birth and what women can do to try to achieve one e.g. use of water as pain relief, being as mobile as possible for as long as possible, having the appropriate fetal monitoring etc;

- and the service also purchased some telemetry fetal heart monitoring machines so that women requiring continuous monitoring could be mobile.

Objective 16

We want to improve services for people with dementia.

Why we chose this

The term dementia covers a range of progressive, terminal brain conditions which affects more than 73,000 people in the South West of England. This number is set to increase by 40% to 102,000 by 2021. There is increasing national recognition of the importance of ensuring the highest possible standards of assessment and care for patients with dementia in hospital.

We said we would...

- Implement our action plan in response to the NICE Quality Standard for Dementia.

- Deliver a range of specific actions relating to agreed standards of care for dementia care in the South West of England.

How did we do?

We have made significant progress in relation to the three statements in the NICE Quality Standard for Dementia which are of particular relevance to the Trust (1, 5 and 8). We have also made implemented a range of actions relating to the South West Standards (details below). In October 2011, the Trust received a very positive Dementia Peer review site visit.

Statement 1 of the NICE Quality Standard states that people with dementia should receive care from staff who have been appropriately trained in dementia care. The Trust has been working in collaboration with North Bristol NHS Trust to develop a mandatory dementia training matrix, together with a priority list of staff to be trained. The aim of this collaborative work is to ensure that people with dementia in Bristol receive care that is consistent across the city and not dependant on which hospitals they are admitted to. The training matrix was approved at the Joint Bristol Hospitals Dementia Strategy Group.

Level 1 training, 'An Hour to Remember' has already been delivered to a number of staff including newly identified Dementia Champions. A pilot has taken place looking at Level 2 e-learning dementia modules with very positive feedback; plans to roll this out are in place. The plan for 2012/13 is to rollout training to all members of staff identified in the matrix.

Statement 5 states that people with dementia, while they still have capacity, and their carer/s, will have discussed and made decisions about the use of: advance statements; advance decisions to refuse treatment; Lasting Power of Attorney; Preferred Priorities of Care. The Trust has appropriate policies and protocols in place to support these issues, which are also addressed via patient safety updates and corporate induction for all staff, plus Level 2 Safeguarding Adults training.

Statement 8 states that people with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health. The Trust fully meets this standard. As a result of an enlarged multidisciplinary team that supports both of the acute Trusts in Bristol, there is now increased access to the Older Adult Mental Health Team, including a Consultant Psychiatrist.

Progress in relation to the South West standards during 2011/12 has included the following key areas:

- 'This is Me' documentation has been systematically rolled out across the Trust with positive feedback about its benefits, which include greater understanding of patients' wishes about their treatment and care.

- A role description for 'Dementia Champions' has been agreed between UH Bristol and North Bristol NHS Trust. A joint training and awareness day was held in December 2011 with 60 participants attending, including carers and people with dementia. Additional champions are being recruited with a further joint champions' day planned for May 2012.

- A new policy has been approved to minimise ward moves for patients with dementia.

- Funding has been secured to introduce appropriate signage in communal areas used by patients with dementia.

- Special clocks and calendars have been purchased and installed on wards.

- A joint training plan and matrix has been agreed between the two Trusts and is being delivered. A dedicated dementia training lead will be appointed shortly as a fixed-term post, with the objective of developing a sustainable programme for the future[17].

Review of clinical effectiveness 2011/12

This section explains how the Trust performed during 2011/12 in a number of other key areas relating to clinical effectiveness, which are in addition to the specific objectives that we identified.

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

The Hospital Standardised Mortality Ratio is a calculation used to monitor death rates in hospitals. Based on a subset of diagnoses which give rise to 80% of in-hospital deaths, the HSMR is a broad measure covering the majority of hospital activity where risk of death is significant. As such, it is an effective screening tool for identifying where there may be problems with avoidable mortality.

HSMR is calculated using routinely collected Hospital Episode Statistics: this data is analysed by Imperial College London, who publish a benchmark mortality standard which Trusts can compare against. Data is available two months in arrears to allow for this benchmarking process to take place. The data is also scrutinised by the Care Quality Commission, who issue alerts to individual trusts if unexpectedly high mortality figures are detected.

It should be noted that the HSMR does not provide definitive answers: rather it poses questions which Trusts have a duty to investigate.

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[17] Training targets are due to be agreed at a meeting of the Trust's Dementia Steering Group in June 2012 and are likely to follow the recommendations of Dementia Professor Alistair Burns who advocates that 10% of staff should be dementia experts, 50% dementia trained and 95% dementia aware.

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. UH Bristol continues to have a very low overall HSMR and in 2011 was once again listed in the annual Dr Foster *Hospital Guide* as having 'lower than expected' HSMR. The Trust's latest HSMR (January 2012 data) is 69.6.

Figure 17
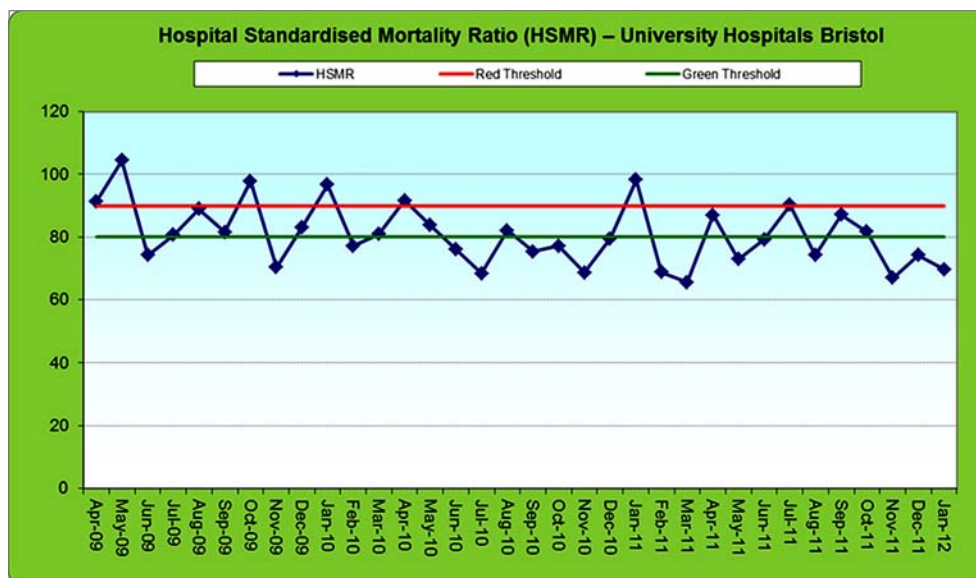
Source: Imperial College London – derived from HES data.
The upper (red) and lower (green) thresholds are set by the Trust.

The Trust's HSMR rose briefly to 90.2 in July 2011 – this was subsequently investigated via the Trust's Quality Intelligence Group and a coding error was identified whereby palliative care patients had been coded as unexpected deaths. Assurances were provided to the Board via its Quality and Outcomes Committee and the Trust has since appointed an expert clinical coder to avoid any similar recurrences in the future.

In 2011/12, a second headline mortality indicator, the Summary Hospital-Level Mortality Indicator, has become widely available to Trusts. Unlike HSMR, the dataset used to calculate SHMI includes all deaths in hospital, plus those deaths occurring within 30 days after discharge from hospital.

As per HSMR, the 'norm' is represented by a figure of 100, with scores of less than 100 representing better outcomes. The dataset for 2010/11, published in October 2012, gave UH Bristol a headline SHMI figure of 92, which is statistically 'lower than expected' at 99.8% confidence limits (red lines in Figure 18). Figure 18 below plots the Trust's SHMI score relative to all other acute, non-specialist Trusts in England.

Figure 18

Summary Hospital-Level Mortality Indicator (SHMI) 2010/11
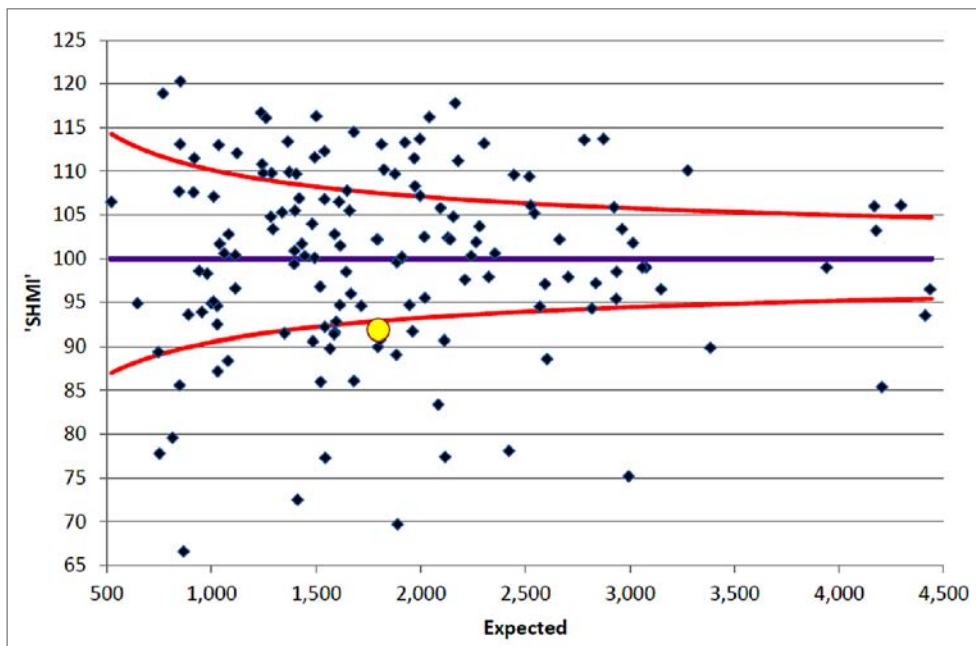
Source: Dr Foster intelligence. University Hospitals Bristol is represented by the large yellow dot on the graph. The x-axis 'Expected' represents the number of expected patient deaths based on statistical modelling.

Adult Cardiac Surgery Outcomes

The Trust has maintained a comprehensive cardiac surgery database for the past 15 years, enabling comparison of outcomes for patients undergoing adult cardiac surgery against national and international benchmarks.

Cardiac surgery outcomes at the Trust have been openly published since the 1990s: with rare exceptions, the Bristol Heart Institute's mortality figures have been better than the UK average for all procedures since data has been available.

In August 2011, a 14th year of comprehensive risk stratified outcomes data for the BRI adult cardiac surgical unit was successfully completed. The full published report can be viewed in detail on the Trust's website in the 'Key Publications' section at: www.uhbristol.nhs.uk.

This year, in response to previous comments from third parties and our auditors, our Quality Report includes preliminary benchmarked CCAD mortality data for the year 2011/12 (this data is generally available one year in arrears): the reader should note that this data has yet to be validated by the national CCAD team.

In 2011/12, the Bristol Heart Institute performed in excess of 1500 adult heart surgeries for the second year in succession. Figure 19 below shows a pattern of increasing levels of surgical activity, and a combined mortality rate which is below the national average.

Figure 19
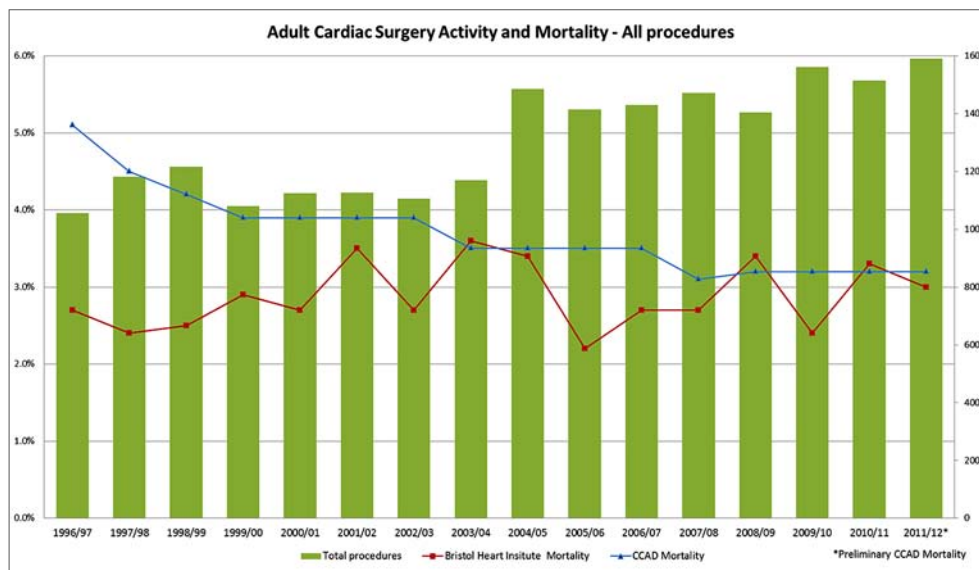
Source: Central Cardiac Audit Database / Patient Analysis Tracking System.

Patient Reported Outcome Measures (PROMs)

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 UH Bristol.

PROMs comprise questionnaires completed by patients before and after surgery to record their health status. Outcomes are measured in three ways: a tool called the 'EQ-5D index' asks patients questions about things like mobility, activities and pain levels; patients also rate their health on a scale of 0-100 using a 'visual analogue scale'; and finally (in the case of varicose veins) patients are asked questions about the specific condition for which they are having surgery.

Between April 2011 and September 2011 (the latest available data at the time of writing), there had been fewer than 30 patients treated by UH Bristol for varicose vein surgery. No modelled scores were therefore available from the Health and Social Care Information Centre due to the unreliability of the statistical models when presented with a small number of results.

Results for groin hernia surgery (see Figure 20) show that 64% of UH Bristol patients reported improvements in their quality of life, according to the EQ-5D index, following surgery. This compares favourably with a national rate of 52% and represents an improvement from the data we published last year.

In the previously reported period, April 2009 – July 2010, 47% of UH Bristol patients reported improvements in their quality of life according to the same index, compared with 50% nationally.

Results for individual Trusts should however be read with caution as the number of patients per Trust is relatively small with wide margins of statistical error associated with the data: for example, for the Groin Hernia EQ-5D index, of 7,553 patients in England who completed the PROM in this six-month period, only 33 were patients of UH Bristol.

Figure 20

Percentage of scores that improved for groin hernia surgery and scoring mechanism

National scores compared to University Hospitals Bristol: April 2011 - September 2011
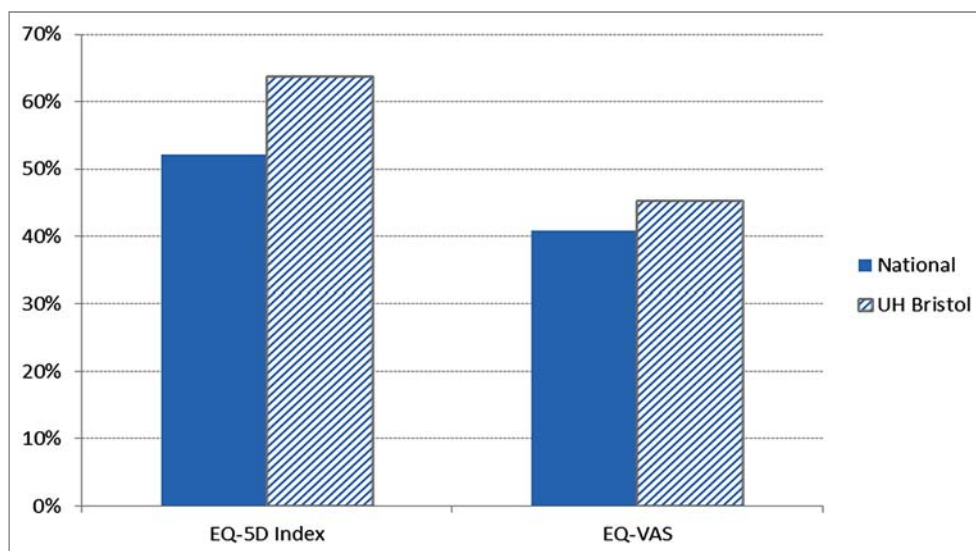
Source: Health and Social Care Information Centre

Clinical effectiveness objectives for 2012/13

- We will ensure that at least 90% of stroke patients are treated for at least 90% of the time on a dedicated stroke ward.

- We will develop our use of service-specific standardised mortality ratios to monitor clinical outcomes.

- We will continue to implement our dementia action plan.

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

- We will develop the use of enhanced recovery[18] for all surgical areas.

[18] Enhanced recovery, often referred to as rapid recovery, is a new, evidence-based model of care that creates fitter patients who recover faster from major surgery. It is the modern way for treating patients where day surgery is not appropriate.

- We will re-focus on ensuring compliance with published NICE guidance including targeted use of clinical audit.

These themes reflect a continuation of previous commitments and common themes arising from discussion with our Clinical Divisions. The objective relating to use of service-specific mortality ratios reflects our desire to enhance our ability to monitor high level indicators of clinical quality throughout the Trust.

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

Performance against key national priorities

Summary of performance against national access standards

The Trust's performance against the national access standards continued to improve in 2011/12. The improvements included meeting challenging target reductions in levels of MRSA (Meticillin Resistant Staphylococcus Aureus) bacteraemias and C. diff (Clostridium difficile) infections. Key national waiting time standards for the Accident and Emergency maximum wait within four hours (95% standard), cancer and 18-week Referral to Treatment Times (RTT) were also achieved for the year as a whole.

The consistency of performance across quarters also improved, although the Trust failed to achieve the 95% A&E four-hour standard in the fourth quarter of the year. All of the cancer standards were achieved in three quarters, with one standard (62-day wait for treatment for patients referred from a screening programme), not being achieved in Quarter 2. The 18-week RTT standards for admitted and non-admitted patients were achieved in each month of the year.

Year-on-year improvements were also seen in a number of other access standards, including the target time spent on a stroke unit, reperfusion times for patients suffering a heart attack (call to balloon times), last-minute cancelled operations and 28-day re-admissions. Although the Trust did not achieve the national standard for operations cancelled at the last minute for non-clinical reasons, significant reductions in levels of cancellations were achieved in the latter half of 2011/12. Improvements were also made in re-admitting a greater proportion of patients within 28 days of their procedure being cancelled, than in the previous year.

Full details of the Trust's performance in 2011/12 compared with 2010/11 are set out in the table overleaf, which shows the cumulative year-to-date performance. Further commentary regarding the 18-week RTT, A&E four hour, cancer, cancelled operations and other key targets is provided in Appendix B to this Quality Report.

Table 3 – Performance against national standards

National standard		
A&E maximum wait of four hours		
A&E time to initial assessment (minutes) 95th percentile within 15 minutes		
A&E time to treatment (minutes) median within 60 minutes		
A&E unplanned re-attendance within seven days		
A&E left without being seen		
MRSA bloodstream cases against trajectory		
C.diff infections against trajectory		
Cancer – 2-week wait (urgent GP referral)		
Cancer – 2-week wait (symptomatic breast cancer not initially suspected)		
Cancer – 31-day diagnosis to treatment (first treatment)		
Cancer – 31-day diagnosis to treatment (subsequent surgery)		
Cancer – 31-day diagnosis to treatment (subsequent drug therapy)		
Cancer – 31-day diagnosis to treatment (subsequent radiotherapy)		
Cancer – 62-day referral to treatment (urgent GP referral)		
Cancer – 62-day referral to treatment (screenings)		
Referral to treatment time admitted patients (95th percentile – 23 weeks)[19]		
Referral to treatment time non-admitted patients (95th percentile – 18 weeks)		
GUM* offer of appointment within 48 hours *Genito-urinary Medicine*		
Number of last minute cancelled operations		
28 day re-admissions		
Primary PCI – 150 minutes call to balloon time[20]		
Infant health – mothers initiating breastfeeding		
Stroke care – percentage of patients spending at least 90% of their time on a stroke unit		
Stroke care – high risk TIA patients starting treatment within 24 hours		
Adult patients who receive a Venous thrombo-embolism (VTE) risk assessment		

■ = Achieved for the year and each quarter

■ = Achieved for the year, but not each quarter

[19] New target came into effect in 2011/12 for the 95th percentile waiting times of 23 weeks for admitted and 18 weeks for non-admitted patients.

2010/11	2011/12 target	2011/12 to date	Notes
96.6%	98%	96.0%	Target met in three quarters in 2011/12 (not Q4)
	15 mins	26	Target met in three quarters in 2011/12 (not Q1)
	60 mins	20	
	< 5%	1.7%	
	< 5%	1.0%	
5	Trajectory	4	
94	Trajectory	54	
95.6%	93%	95.9%	Target met in every quarter in 2011/12
93.3%	93%	98.2%	Target met in every quarter in 2011/12
98.2%	96%	98.1%	Target met in every quarter in 2011/12
95.5%	94%	96.7%	Target met in every quarter in 2011/12
99.8%	98%	99.9%	Target met in every quarter in 2011/12
99.7%	94%	99.3%	Target met in every quarter in 2011/12
86.2%	85%	87.0%	Target met in every quarter in 2011/12
90.9%	90%	94.4%	Target met in three quarters in 2011/12 (not Q2)
/	23 weeks	22.0	Target met in every month in 2011/12
/	18 weeks	14.9	Target met in every month in 2011/12
100%	98%	100%	
1.31%	0.80%	0.87%	
91.0%	95%	93.3%	
80.4%	90%	84.0%	Target as per 09/10 Operating Framework
76.3%	76.3%	76.2%	
78.5%	80%	80.5%	Target met in three quarters in 2011/12 (not Q4)
66.1%	60%	64.4%	
82.7%	90%	97.4%	

🟥 = Not achieved for the year

⬛ = Target not in effect

[20] The Primary Percutaneous Coronary Intervention (PCI) standard for 2011/12 only applies to direct admissions to hospital. Target changed to 90% from 75% in 2010/11.

APPENDIX A -
Statements of assurance from the Board

1. Review of services

During 2011/12, University Hospitals Bristol NHS Foundation Trust provided clinical services in 65[21] specialties via five clinical divisions (i.e. Medicine; Surgery Head and Neck Services; Women's and Children's Services; Diagnostics and Therapy; and Specialised Services).

During 2011/12, the Trust Board has reviewed selected high-level quality indicators (e.g. infection control, HSMR) as part of monthly performance reporting. The data reviewed covered the three dimensions of quality i.e. patient safety, patient experience and clinical effectiveness. Sufficient data was available to provide assurance over the services provided by the Trust. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by University Hospitals Bristol NHS Foundation Trust services reviewed in 2011/12 therefore, in these terms, represents 100% of the total income generated from the provision of NHS services by the Trust for 2010/11.

2. Participation in clinical audits and national confidential enquiries

For the purpose of the Quality Account (Report), the National Clinical Audit Advisory Group (NCAAG) has published a list of national audits and confidential enquiries, participation in which is seen as a measure of quality of any Trust clinical audit programme. This list is not exhaustive, but rather aims to provide a baseline for Trusts in terms of number of percentage participation. The detail which follows relates to this list.

During 2011/12, 47 national clinical audits and four national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides.

During that period University Hospitals Bristol NHS Foundation Trust participated in 77% (36/47) national clinical audits and 100% (4/4) 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 2011/12 are as follows:

[21] 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.

Table 4

Title of audit	Eligible	Participated
Peri and Neonatal		
Neonatal intensive and special care (NNAP)	Yes	Yes
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	No
Paediatric asthma (British Thoracic Society)	Yes	Yes
Pain management (College of Emergency Medicine)	Yes	Yes
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	Yes	Yes
Paediatric intensive care (PICANet)	Yes	Yes
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	Yes	Yes
Diabetes (RCPCH National Paediatric Diabetes Audit)	Yes	Yes
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	No
Adult community acquired pneumonia (British Thoracic Society)	Yes	No
Non-invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	No
Pleural procedures (British Thoracic Society)	Yes	No
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Yes
Severe sepsis and septic shock (College of Emergency Medicine)	Yes	Yes
Adult critical care (ICNARC Case Mix Programme)	Yes	Yes
Potential donor audit (NHS Blood & Transplant)	Yes	Yes
Seizure Management (National Audit of Seizure Management)	Yes	No
Long term conditions		
Diabetes (National Diabetes Audit)	Yes	No
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes
Chronic pain (National Pain Audit)	Yes	Yes
Ulcerative colitis and Crohn's disease (National IBD Audit)	Yes	Yes
Parkinson's disease (National Parkinson's Audit)	Yes	Yes
COPD* (British Thoracic Society/European Audit)	Yes	Yes
Adult asthma (British Thoracic Society)	Yes	No
Bronchiectasis (British Thoracic Society)	Yes	No
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes
Elective surgery (National PROMs Programme)	Yes	Yes
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	No	N/A
Liver transplantation (NHSBT UK Transplant Registry)	No	N/A
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes
Carotid interventions (Carotid Intervention Audit)	Yes	Yes
CABG** and valvular surgery (Adult cardiac surgery audit)	Yes	Yes
Cardiovascular disease		
Acute Myocardial Infarction and other ACS (MINAP)	Yes	Yes
Heart failure (Heart Failure Audit)	Yes	Yes
Acute stroke (SINAP)	Yes	No
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes
Renal disease		
Renal replacement therapy (Renal Registry)	Yes	Yes
Renal transplantation (NHSBT UK Transplant Registry)	Yes	Yes

* COPD = Chronic obstructive pulmo-nary disease.
** CABG = Coronary artery bypass graft.

Title of audit	Eligible	Participated
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes
Head and neck cancer (DAHNO)	Yes	Yes
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	Yes
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	Yes
Severe trauma (Trauma Audit & Research Network)	Yes	No
Psychological conditions		
Prescribing in mental health services (POMH)	No	N/A
National Audit of Schizophrenia (NAS)	No	N/A
Blood transfusion		
Bedside transfusion (Comparative Audit of Blood Transfusion)	Yes	Yes
Medical use of blood (Comparative Audit of Blood Transfusion)	Yes	Yes
Health promotion		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	Yes*
End of life care		
Care of dying in hospital (NCDAH)	Yes	Yes*
National Confidential Enquires		
Perinatal mortality (formerly CEMACH)	Yes	Yes
Patient Outcome and Death (NCEPOD) - Cardiac Arrest Procedures	Yes	Yes
Patient Outcome and Death (NCEPOD) - Peri-operative Care	Yes	Yes
Patient Outcome and Death (NCEPOD) - Surgery in Children	Yes	Yes
Suicide and Homicide by People with Mental Illness	Yes	N/A

* Organisational aspects only

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

- British Thoracic Society audit programme – participation agreed for 2012/13, data entry for a number of audits is already under way.

- Seizure Management (National Audit of Seizure Management) – there are no indications that this national study has taken place and it is not part of the mandatory National Clinical Audit and Patient Outcome Programme.

- Severe trauma (Trauma Audit and Research Network) – participation for 2012/13 has been agreed as part of the Trust's designation as a Trauma Unit.

- National Diabetes Audit – limited resources within the Diabetes team have meant that the Trust has not participated. A way forward to enable future participation is under discussion.

- Acute stroke (SINAP) – the Avon, Gloucester, Wiltshire and Somerset Stroke Clinical Reference Group took a decision not to participate in the SINAP programme, instead focusing on developing its own local dataset (including a number of key clinical indicators not included in SINAP). The Trust has agreed to become a pilot site in 2012 for the Stroke Sentinel National Audit Programme (SSNAP).

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 2011/12 are listed below (and overleaf) 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.

Table 5

Title of audit	% Cases Submitted
Peri and Neonatal	
Neonatal intensive and special care (NNAP)	100% (703/703)
Children	
Paediatric asthma (British Thoracic Society)	100% (14/14)
Pain management (College of Emergency Medicine)	100% (50/50)
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	100% (60/60)
Paediatric intensive care (PICANet)	100% (686/686)
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	100% (614/614)
Diabetes (RCPCH National Paediatric Diabetes Audit)	100% (379/379)
Acute care	
Cardiac arrest (National Cardiac Arrest Audit)	60*
Severe sepsis and septic shock (College of Emergency Medicine)	100% (30/30)
Adult critical care (ICNARC Case Mix Programme)	
Potential donor audit (NHS Blood & Transplant)	100% (8/8)
Long term conditions	
Heavy menstrual bleeding (RCOG National Audit of HMB)	36% (64/180)
Ulcerative colitis and crohn's disease (National IBD Audit)	100% (40/40)
Parkinson's disease (National Parkinson's Audit)	100% (20/20)
COPD (British Thoracic Society/European Audit)	100% (25/25)
Elective procedures	
Hip, knee and ankle replacements (National Joint Registry)	30*
Elective surgery (National PROMs Programme)	74% (92/124)***
Coronary angioplasty (NICOR Adult cardiac interventions audit)	100% (1089/1089)
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	100% (120/120)
Carotid interventions (Carotid Intervention Audit)	100% (43/43)
CABG and valvular surgery (Adult cardiac surgery audit)	100% (1496/1496)
Cardiovascular disease	
Acute Myocardial Infarction and other ACS (MINAP)	866*
Heart failure (Heart Failure Audit)	157% (379/240)**
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	100% (312/312)

COPD = Chronic obstructive pulmonary disease.

CABG = Coronary artery bypass graft.

* Unable to establish baseline from HES data.

** Only 20 cases required per month according to the terms of the audit.

*** Provisional six month data (April - September) supplied by the NHS Information Centre.

Title of audit	% Cases Submitted
Renal disease	
Renal replacement therapy (Renal Registry)	100% (60/60)
Renal transplantation (NHSBT UK Transplant Registry)	100% (12/12)
Cancer	
Lung cancer (National Lung Cancer Audit)	94% (169/180)
Bowel cancer (National Bowel Cancer Audit Programme)	91% (167/182)
Head and neck cancer (DAHNO)	52*
Trauma	
Hip fracture (National Hip Fracture Database)	100% (347/347)
Blood transfusion	
Bedside transfusion (National Comparative Audit of Blood Transfusion)	100% (80/80)
Medical use of blood (National Comparative Audit of Blood Transfusion)	100% (40/40)
National Confidential Enquires	
Perinatal mortality (CEMACH)	
Patient Outcome and Death - Cardiac Arrest Procedures	100% (4/4)
Patient Outcome and Death - Peri-operative Care	100% (6/6)
Patient Outcome and Death - Surgery in Children	38% (8/21)

* Unable to establish baseline from HES data

** Only 20 cases required per month according to the terms of the audit

*** Provisional six month data (April - September) supplied by the NHS Information Centre

The reports of 10 national clinical audits were reviewed by the provider in 2011/12 and University Hospital Bristol NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National cancer audits

- The Somerset Cancer Register has recently been upgraded. The new version provides clearer indications of where to enter data and better reporting tools for monitoring and improving data quality.

  Guidance for inputting data (including outlining key mandatory fields) is in development.

- A demonstration on good practice in data entry by the Somerset Cancer Register team is planned for the Lung SSG (Site Specific Group) in 2012.

- The results of national audits will continue to be included within the national 'peer review process'; actions will be agreed within specific cancer group annual reports.

National Sentinel Audit of Stroke

- Continuous monthly audits have been instigated. These have demonstrated improvement across all 12 key indicators.

- The Trust has agreed to become a pilot site for the Stroke Sentinel National Audit Programme (SSNAP).

Neonatal intensive and special care (NNAP)

- A standard pathway regarding breastfeeding for premature babies being transferred from NICU to Ward 76 is to be developed. The process of support during breastfeeding will be examined further.

National Cardiac Arrest Audit (NCCA)

- Having not participated previously, the Trust will be using this data to help understand and benchmark current practice. Results/reports will be reviewed on a quarterly basis by the Trust's Transfusion Group.

Potential donor audit (NHS Blood and Transplant)

- Increased donor activity over the year has been acknowledged by the NHSBT who have re-categorised the Trust as a Level 1 hospital.

- The Trust aims to continue to achieve 100% identification and referral of all potential organ donors.

- An update of Trust documentation is planned, including the creation of hospital policy to incorporate NICE guidance.

- The introduction of a collaborative approach for consent for Donation after Circulatory Death (DCD) will be explored.

- Helping to ensuring that organ/tissue donation is offered to every family as part of their end of life care will continue through educational programmes. Teaching sessions for new doctors at the beginning of their rotations will be established.

- The presence of a Senior Nurse for Organ Donation will be established on Cardiac Intensive Care Unit.

National Hip Fracture Database

- During 2011/12, a specialist hip fracture nurse was appointed to streamline processes, improve patient care and improve data quality. Working closely with the Clinical Lead, this is a major development and is crucial to improving the service provided.

- Indicators around the proportion of hip fracture patients operated on within 36 hours, seen by an orthogeriatrician within 72 hours and achieving Best Practice Tariff continue to be monitored on a quarterly basis and reported as part of the Trust Board quality dashboard.

National Falls and Bone Health Audit

- A combined risk assessment, including cognitive function, has been introduced.

- Further amendments to the hip fracture clerking proforma are in progress.

National comparative re-audit of platelet transfusion

- Minor amendment to local guidelines will be made to explicitly specify that a platelet transfusion is not required routinely prior to bone marrow aspiration and biopsy; or as routine prophylaxis in stable patients with long term bone marrow failure.

The reports of 153 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2011/12; summary outcomes and actions reports were reviewed on a quarterly basis by the Clinical Audit Group. Summary details of the changes and benefits of these projects will be published within the 2011/12 Annual Report. This will be publicly available via the Trust website in July 2012.

3. Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by UH Bristol in the period 1 April 2010 to 31 March 2012 that were recruited during that period to participate in research approved by a research ethics committee was 8,846.

4. CQUIN framework (Commissioning for Quality and Innovation)

The amount of potential income in 2011/12 for quality improvement and innovation goals was £5.677 million, based on 2011/12 actual outturn (forecast). It is forecast that associated payment in 2011/12 will be in the order of £3.363 million (subject to finalisation of outturn). The final position has yet to be validated by commissioners (as of May 2012).

An explanation of the factors contributing to the failure to earn all of the potential CQUIN rewards is provided at the end of this section. A proportion of University Hospitals Bristol Foundation Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals Bristol Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The delivery of the CQUINs is overseen by the Trust's Clinical Quality Group. Further details of the agreed goals for 2011/12 and 2012/13 are available electronically at: www.uhbristol.nhs.uk/about-us/how-we-are-doing/.

The CQUIN goals were chosen to reflect both national and local priorities. Eighteen goals were agreed, including two nationally specified goals: Reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE); and improve responsiveness to personal needs of patients. The Trust has achieved nine of the 18 goals in full and three in part, as follows:

- VTE risk assessment

- Delivery of learning disabilities action plan

- Implementation of the end of life care tool

- Increase in the proportion of spontaneous vaginal deliveries

- Reduction in medication errors

- Reduction in Neonatal CONS (coagulase negative staphylococcal) infections

- Improved targeting of clotting factor prophylaxis for patients with severe haemophilia

- Reduced lengths of stay for patients undergoing two key procedures in Thoracic Surgery

- Smoking cessation – referrals to cessation service

- Improved patient experience (part – reduced noise at night and assistance at mealtimes – local goals)

- Improved outcomes for patients with dementia (part – mandatory training)

- Improved outcomes for patients with falls (part – falls assessments)

CQUINs which are not expected to be achieved include GP discharge summaries, improved cancer pathway efficiency and recording of cancer patient outcomes on databases, nutritional assessments, and improved utilisation of patient transport services, and a reduction in hospital acquired pressure ulcers.

A new electronic system for discharge letters was rolled out across the Trust during 2010/11, with work continuing to embed it in 2011/12; however, experience from other providers has shown that such systems can take a number of years to become fully embedded. While there was sustained progress during 2011/12, performance did not meet the level required to achieve the CQUIN. Our cancer related CQUINs were linked primarily to improvements in recording and while some progress was made during the year it did not meet the level required. Two of the indicators remain in place for 2012/13 including time to receiving antibiotics for patients with neutropenic fever and database recording compliance.

There has been an on-going concerted effort across the Trust to improve the nutritional care for patients. This has included a strong focus on the CQUIN with the number of patients receiving a nutritional assessment increasing significantly as the year has progressed. The CQUIN for 2011/12 was not quite achieved and will remain in place in 2012/13. The patient transport services CQUIN was always known to be challenging to deliver: the Trust had raised concerns about the likelihood of full delivery of this CQUIN at the outset as it did not have full confidence in the integrity of the booking data held outside our organisation, or the way that activity is allocated to hospital Trusts.

Performance did not reach the required levels to achieve the CQUIN despite measures implemented across the Trust to reduce the levels of aborted PTS journeys. There has been an improved awareness in the Trust regarding pressure ulcers, due in part to the Being the Best programme and the introduction of detailed processes for assurance over the accuracy of pressure ulcer data. As a result of this improved reporting, a reduction on 2010/11 pressure ulcer rates was achieved, but the CQUIN threshold was not met. This remains an area of focus for the Trust, and forms part of the NHS Safety Thermometer national CQUIN in 2012/13.

(Also see page 43 for information regarding the national Patient Experience CQUIN).

5. Care Quality Commission registration and reviews

University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered without compliance conditions'. The CQC has taken enforcement action against UH Bristol in 2011/12 in respect of Outcome 5 (meeting nutritional needs).

The Trust received a Dignity and Nutrition Inspection from the CQC on 5 May 2011. The Trust was found to be compliant with Outcome 1 (respecting and involving people who use services), however the CQC's judgement was that there were 'Moderate Concerns' in relation to Outcome 5 (meeting nutritional needs). Details of the CQC's concerns and actions taken by the Trust can be found on page 24 of this report. The Trust declared compliance to the CQC on 6 October 2011 and this position was subsequently supported by the CQC following a further inspection on 13 December 2011.

During the year 2011/12, the Trust was in the position of being self-declared as non-compliant with the following CQC Outcomes: 7 (Safeguarding people who use services from abuse), 11 (Safety, availability and suitability of equipment), 14 (Supporting staff) and 21 (Records).

The Trust declared non-compliance with Outcome 7 on 13 April 2011 because we recognised the need to improve the proportion of staff who had received appropriate levels of safeguarding training. We declared compliance to the CQC on 8 November 2011 having achieved our target of 80% compliance with all levels of training for safeguarding adults and child protection.

We declared non-compliance with Outcome 11 on 13 April 2011 in response to concerns we identified around equipment maintenance records and recorded staff training competencies. Concerns were addressed and we subsequently declared compliance on 21 December 2011.

We declared non-compliance with Outcome 14 at the point of registration with the CQC and although the reasons for this were addressed, we continued to declare non-compliance in 2011/12 to reflect our position on safeguarding training and also because we were not meeting our internal target for staff appraisal (at any time, 80% of staff should have had an appraisal within the previous 12 months). We declared compliance to the CQC on 8 November 2011 having achieved our targets.

We declared non-compliance with Outcome 21 at the point of registration with the CQC and although the reasons for this were addressed, we continued to declare non-compliance in 2011/12 because of concerns about the quality of clinical recordkeeping identified by the CQC and internally through audits. We declared compliance to the CQC on 21 December 2011 having implemented our recovery plan.

On 18, 19 and 27 May 2011, the CQC made planned visits to the Trust as part of a responsive review of histopathology services. The CQC found that the Trust was meeting all the essential standards of quality and safety they reviewed. Further detail can be found in the Patient Safety section of this report.

On 20 March 2012, a CQC inspection team carried out an unannounced inspection in relation to the Abortion Act. At the time of writing (April 2012), the CQC's report is awaited.

On 28 March 2012, the CQC carried out a planned registration inspection prior to the opening of the new South Bristol Community Hospital and the closure of the Bristol General Hospital. Clinical services subsequently commenced on 30 March 2011 following CQC approval.

The Trust has yet to receive a CQC Planned Review (now known as a Scheduled Inspection).

During 2011/12, the Trust received one Outlier Alert from the CQC. Outlier Alerts are triggered when data received by the CQC suggests that a healthcare provider's clinical performance (typically

mortality or complication rates following surgery) is found to be significantly different to that of other providers. An Alert does not draw conclusions – it is a prompt for the provider to make further investigations. On 4 August 2011, we received a maternity outlier alert for 'puerperal sepsis and other puerperal infections within 42 days of delivery'. On 31 August 2011, the Trust formally responded to the CQC advising that we had undertaken a detailed case note review of 30 women with a diagnosis of 'pyrexia of unknown origin following delivery', as per recommendations made by the CQC. An action plan was agreed with the CQC and implemented. Ongoing clinical quality performance across a range of indicators is monitored by the Trust's Quality Intelligence Group.

6. Data quality

University Hospitals Bristol NHS Foundation Trust is taking the following actions to improve data quality:

- Following an internal audit of data quality in 2010/11, in 2011/12 the Trust developed a new Data Quality Assurance Programme and Strategy.

- The Data Quality Assurance 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 follows up all issues with data quality and reports these to the Trust's Information Governance Management Group.

University Hospitals Bristol NHS Foundation Trust submitted records during 2011/12 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:

- 99.2% for admitted patient care;

- 99.7% for outpatient care; and

- 95.6% for accident and emergency care. (Improved scores on 2010/11 for all areas).

The percentage of records in the published data which included the patient's valid General Practice code was:

- 100% for admitted patient care;

- 100% for outpatient care; and

- 100% for accident and emergency care.

(This is the first time the Trust has achieved 100% in all areas)

Data source: NHS Information Centre, SUS Data Quality Dashboard, April 2011 – February 2012 as at Month 11 inclusion date.

UH Bristol's Information Governance Assessment Report score for 2011/12 was 69% with one requirement achieving level 3 (the highest level). The score was 65% in 2010/11. The Trust has run an extensive training programme in Information Governance which has included face-to-face sessions, an Information Governance booklet distributed to all staff and online training.

UH Bristol was subject to a Payment by Results clinical coding audit during the reporting period 2011/12 arranged by the Audit Commission. This external audit reviewed 200 sets of notes: 100 from General Medicine and a further 100 from a variety of specialties. The error rates reported were:

- Primary procedures coded incorrectly: 7%

- Primary diagnoses coded incorrectly: 14%

As this was a very small sample it is not possible to extrapolate from these findings to draw wider conclusions.

UH Bristol also commissioned an external company to provide an Information Governance Clinical Coding audit of 200 Finished Consultant Episodes. The audit focused on three areas of surgery: General surgery, Trauma and Orthopaedics, and Paediatric surgery.

- Primary procedures coded incorrectly: 8%

- Primary diagnoses coded incorrectly: 10%

APPENDIX B -
Additional information

Extended narrative about national access targets

18 weeks Referral to Treatment (RTT)

The Trust achieved an 18-week referral to treatment time (RTT) for more than 90% of admitted patients and 95% of patients not requiring an admission as part of their treatment, in every month in 2011/12. In addition, the Trust achieved the 95th percentile standards of 23 weeks and 18 weeks for admitted and non-admitted pathways respectively. In so doing, the Trust met the 18-week RTT standard in Monitor's 2011/12 Compliance Framework.

A&E four-hour maximum wait

The Trust achieved the four-hour maximum wait from arrival in an Emergency Department to discharge, admissions or transfer, for more than 95% of patients during the year, but failed to achieve the standard in the fourth quarter of the year. The reason for the failure to achieve the 95% standard was primarily due to a lack of ward beds to admit emergency patients to.

There was a significant increase in length of stay for emergency medical patients within the Bristol Royal Infirmary during Quarter 4, with an increase in delayed discharges (i.e. patients medically fit for discharge but needing support services, such as a care package, or placement in a residential home).

There was also a significant increase in the number of over 75 year olds attending the Bristol Royal Infirmary Emergency Department during Quarter 4, alongside an increase in the number of diagnostic investigations required.

Further analysis is being undertaken to understand whether this apparent increase in the patient acuity resulted in longer lengths of stay and a worsening of bed availability. A better understanding of these new patterns of demand for beds, combined with an ability to forecast further changes, will help to ensure the four-hour wait can be consistently achieved in the future.

Levels of *norovirus* within the community remained a challenge for the Trust, with wards having to be closed during two periods in the last quarter of the year, during which the 95% standard failed to be achieved. The Trust's improvement plans for 2012/13 will continue to focus on enhancements to emergency care pathways to reduce admissions and lengths of stay, and ways of improving the Trust's responsiveness to meet fluctuations in levels of emergency demand. Work is also continuing on the A&E quality of care indicators, and to understand what improvements need to be made to best serve our patients' needs.

Cancer

Further improvements were made in performance against the national cancer standards in 2011/12, building on the improvement work undertaken in the previous year. Across the year as a whole, every standard was achieved. The standards were also achieved in each quarter of the year, with the exception of Quarter 2, when the 62-day screening standard failed to be met. During the second quarter of the year there was a change to clinical practice within the breast cancer pathway. This involved patients undergoing a separate biopsy procedure. The change in practice was introduced to allow the type of treatment the patient needs to have to be more accurately defined and planned. However, this change also meant an increased demand for theatre slots and requirement for the clinical team to accommodate the biopsy procedure within a short space of time. As a result, three patients who would otherwise have been treated within the 62-day standard breached the national target. The 90% standard would have been achieved in Quarter 2 had these additional breaches not been incurred.

A significant improvement in performance was achieved against the two-week wait standard for symptomatic breast patients. During 2010/11, which was the first full year of this standard's introduction, the Trust initially struggled to consistently meet this standard. This was mainly due to the difficulties posed by having a relatively small team of consultants that provide this service. However, following a review of service capacity and subsequent changes to service provision, the two-week wait standard was routinely met in the latter part of 2010/11. Through the daily review of service capacity and demand, these improvements in performance were sustained in 2011/12, and the national standard was achieved, with a good margin, every quarter.

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

Cancelled operations

During 2011/12, the Trust cancelled 0.9% of operations on the day of the procedure for non-clinical reasons. This represents a significant improvement on 2010/11 when 1.3% of operations were cancelled on the day. At the end of the second quarter of the year, the Trust received a performance notice from NHS Bristol. A remedial action plan was agreed in response, with a target trajectory for improvements in performance. The actions taken included the establishment of a robust process for escalating potential cancellations of surgery to the divisional management teams, and regular reviews of the viability of the planned theatre lists.

The escalation process proved to be very effective in reducing the levels of cancellations by supporting bed managers and theatre staff in finding ways of avoiding the cancellation. This, in conjunction with the ongoing work to improve bed availability within the Bristol Royal Infirmary, helped the Trust to achieve the agreed improvement trajectory for reducing cancelled operations in full. The 0.8% national standard was achieved in March 2012 as planned, despite the challenges posed by the pressures of emergency admissions during a busy Quarter 4. There will be a continued focus on reducing levels of cancelled operations in 2012/13, to ensure improvements are sustained against this important indicator of both patient experience and service efficiency.

Being able to re-admit patients within 28 days of their operation being cancelled is very dependent upon the level of cancellation of operations at any point in time.

In line with the reduction in the number of cancelled operations, the Trust's performance against the 28-day re-admission standard improved to 93.3% during 2011/12. However, this was still just short of the national standard of 95%. In 2012/13 there will be further focus on the close management of 28-day re-admissions to try to ensure the 95% standard is achieved.

Other standards

Performance against the call to balloon times 150-minute reperfusion standard improved during 2011/12 compared with performance in 2010/11. The call to balloon time measures the time from the call for professional help for a suspected heart attack, through to the time when the reperfusion treatment commences (i.e. balloon inflation in the blood vessel).

Although there was an improvement in performance in 2011/12, the 90% national standard wasn't achieved. Two-thirds of the breaches of standard occurred out of hours (i.e. either overnight or at the weekend). Often, the delay in carrying out the procedure was due to another patient already being in the catheter laboratory having a reperfusion procedure. Also, in a significant proportion of cases the reason for the procedure not being carried out within 150 minutes was clinical (e.g. complex case, electrocardiograph (ECG) recorded in the ambulance was non-diagnostic, or the patient was having a cardiac arrest).

Despite not achieving the standard for the overall call to balloon times, the 90-minute standard for door to balloon times (i.e. arrival of the patient in the Bristol Heart Institute through to balloon inflation) was achieved, which shows that the internal waiting times were meeting the national standard.

In 2011/12 there was a slight deterioration in performance in the percentage of mothers initiating breastfeeding. In 2012/13 there will be a continued focus within the service to encourage mothers to breastfeed. But it is recognised that breastfeeding rates are highly dependent on patient choice.

Further details of performance against the other national standards can be found elsewhere in the Quality Report. This includes the Stroke and the VTE risk assessment standards, which can be found in the Clinical Effectiveness and Patient Safety sections of this report respectively.

Further information on the Trust's improvements in performance against the MRSA *(Meticillin Resistant Staphylococcus Aureus)* bacteraemias and *C.diff (Clostridium difficile)* infection targets can also be found in the Patient Safety section.

Board engagement with quality

Each month, the Trust Board receives a comprehensive report describing the quality of patient services. This report begins with a patient's story, some months describing where things have gone well, but on other occasions highlighting aspects of care where we have let patients down. The focus is always on organisational learning and the report acts as a reminder to the Board of whom the Trust exists to serve. Randomly selected patient comment cards are also displayed at every public Board meeting.

The monthly Board quality report includes a detailed Quality Dashboard covering the three core dimensions of quality. If performance fails to meet agreed targets, exception reports describe the relevant issues and the steps being taken by management to recover the position.

The Quality Dashboard continues to be a key tool for the Board to understand, scrutinise and challenge the quality of service provision and as such supports compliance with Monitor's Quality Governance Framework. During 2011/12, the Trust has developed equivalent quality dashboards at the level of our clinical divisions, enabling divisions to track performance against their own annual quality objectives[22].

At the beginning of 2011/12, following a technical review of Corporate Governance which was reported in last year's Quality Report, a new Quality and Outcomes Committee of the Board was established. This non-executive Committee focuses on significant quality themes which emerge during the year, providing in-depth scrutiny to support the Board to discharge its responsibilities for quality.

In recent months, the Quality and Outcomes Committee has, for example, reviewed detailed reports on: the experience of patients attending outpatient services; serious reported incidents; 30-day post-emergency discharge re-admissions to hospital; falls; pressure ulcers; stroke services; and dementia care.

The discussion between divisions and the Trust is two-way, so that common themes identified by divisions may also be elevated to become corporate objectives. This year, the inclusion of objectives for enhanced recovery and risk assessment of patients with specific needs are examples of this.

APPENDIX C –
Assurance statements from 'third parties'

Statement from the Membership Council of the University Hospitals Bristol NHS Foundation Trust

The Membership Council welcomes the opportunity to make comment on the Trust's Quality Report. The content is the result of extensive consultation, auditing and assurance processes under the leadership of the Chief Nurse and the Medical Director. It demonstrates the Trust's commitment to public accountability in pursuit of the achievement of the highest standards of care in patient safety, patient experience and clinical effectiveness for all users of its services.

During the year, the Trust has established a Quality and Outcomes Committee of non-executive directors to drive strategic quality assurance and improvement, a move that the Membership Council feels will enhance the objective of putting quality at the heart of everything the Trust does. The Trust also runs a set of care improvement programmes such as The Quality in Care Tool, Transforming Care (which is also a cost improvement programme) and "Being the Best". We are impressed by the Trust's determined and proactive approach to quality improvement at a time when financial pressures are high.

Governor involvement during 2011/12

The Trust's Membership Council (Council of Governors) has received regular reports from its governor working groups. One of these, the Quality Working Group meets every two months to progress issues placed before it by the Trust's membership, patient and carer representative groups, the Trust Board and executives and the public. Input from this working group is one of the main drivers for improvement and change when holding the Trust Board to account for its quality of care agenda. The governor group represents various constituency groups of members and has the full support of the Trust in facilitating access to service users at outpatient surgeries, attendance at executive walk rounds, presence on peer review teams and participation in PEAT (Patient Environment Action Team) NHS annual national surveys. Governors also exercise a level of scrutiny at Public Trust Board meetings where they attend as observers but are able to comment and question with the permission of the chair.

Format and readability

The Governors' Quality Working Group reviewed last year's report and recommended that it should be produced in the same format to achieve consistency and aid comparisons.

Comment on progress with the quality objectives in the Quality Report

Patient Safety

It is essential that the Trust is committed to learning from mistakes and that it has a policy of openness and honesty with patients and their families when things go wrong.

We share the disappointment on failure to meet all the targets specified as part of the NHS South West Quality and Safety programme but note that a plan to achieve the objectives by 2014 is being put in place.

Hospital acquired thrombosis prevention has been subject of sustained effort in our Trust for a number of years. We note the significant progress made with achievement of the inpatient VTE assessment target being exceeded and the setting up of an audit to accurately assess the rate of hospital acquired thrombosis.

There were mixed results from the objective of reducing inpatient falls with the overall objective achieved but a substantial increase in quarter 4 of falls in 65+ year old patients. The last quarter of the year has also shown up quality issues in other areas of patient safety compliance and we are asking the Trust about its position on bed availability pressures, staffing levels and budgetary controls. A similar situation exists with the objective of reduction in the incidence of hospital acquired pressure ulcers where the Trust failed to meet its target. We know that the Trust has responded with initiatives such as intentional rounding, "Being the Best", improved assessment processes and awareness training and we will be monitoring progress and resourcing.

The governor groups have had considerable involvement in issues resulting from criticism of the Trusts histopathology service and the subsequent Independent Inquiry. We have monitored progress on the Inquiry recommendations and are satisfied with the progress so far which has been based on an action plan shared with our histopathology service partners at North Bristol NHS Trust. We hope for full integration of services in 2013.

During the year, the Care Quality Commission gave their approval to the service improvements and the Trust invited the Inquiry panel back to review progress which again resulted in encouraging feedback.

The Trust has achieved its targets in the maintenance of the lowest ever levels of hospital acquired infections in the Trust. The Membership Council congratulates the Infection Control Team for their results in this discipline.

We have been encouraged by the steady progress the Trust has made in meeting the nutritional needs of patients. The Care Quality Commission has been monitoring the Trust's position in relation to Outcome 5 of the standard on a regular basis and there has been gradual but sustained improvement with good audit scores on protected mealtimes, nutritional screening, and recording systems. Coupled with this is the patient experience of help at mealtimes and it is encouraging to see the progress made in achieving the CQUIN target agreed with commissioners for mealtime assistance and to note a move towards a better co-ordinated approach to using trained volunteers.

We note that there have been delays in implementing National Patient Safety Agency alerts although actions are pending for compliance by August 2012. It is noted that the number of patient safety issues reported by the Trust has increased in part due to an increase in Grade 4 pressure ulcers.

Patient Experience

Our Trust has a comprehensive system for gathering patient and carer feedback which includes focus groups, surveys, comments cards and "mystery shopping". The Governors have a contributed to real time feedback in outpatient areas by interviewing outpatients while they wait and passing on their significant findings to clinic managers. The Trust has run a special project to improve communication with carers with particular emphasis on those who look after patients with dementia and this is a particularly welcome initiative.

Another welcome patient environment initiative is a project to reduce night time noise in wards. The Trust achieved its target reduction as agreed with the commissioners with the staff very much engaged in silencing measures. It is good to note that this work will continue in the coming year's programme.

Governors have noted the importance of comprehensive and accurate information for service users so the revision of the ward based patient information booklet and its introduction in the coming year is reassuring. Coupled with this we see that the concerns that governors and service users have raised in relation to staff communication attitudes or "customer care" has led to a Trust-wide training programme entitled *Living the Values* specifically based on the Trust value of Respecting Everyone.

The governors are able to draw on their experiences of contact with patients and relatives and can confirm that they usually indicate a high level of satisfaction with the care received and overall there was a decrease in the number of complaints. There are still issues relating to administration and efficiency in such areas as waiting time in outpatients, cancelled appointments and communication failures. We hope that the Productive Outpatient Project will address these failures.

The NHS is undergoing a period of dramatic change. Many of the changes impact on the staff through alterations in ways of working and improving efficiency at the same time as pushing to improve the quality of care. The Governors' Quality Working Group recognises the importance of staff engagement in this process and have, through the Membership Council, asked the Trust to concentrate on devising processes and systems which help to make their jobs easier. An example has been the drive to standardise and reduce paperwork systems. It is worth noting that the Non-Executive Directors of the Trust have asked that an objective of improving the well-being of staff be added to the coming year's list.

Clinical Effectiveness

Overall, we find that the Trust has been successful in meeting its chosen objectives for the year. There is encouraging data for one year survival rates in colorectal, breast and lung cancer patients being better than the national average and there have been significant improvements in meeting waiting time targets. We did not achieve our stretch target of 90% of stroke patients spending 90% of their time on a stroke unit but we do have one of the best stroke mortality rates, placing us in the top five Trusts.

The drive towards increasing the proportion of vaginal births as opposed to Caesarean section has been motivated by the need to reduce adverse incidents, facilitate better health outcomes and consequently, reduced length of stay in hospital.

We note that the Trust achieved its Commissioning for Quality and Innovation target for the year.

A great deal of effort has been channelled into improvements in dementia care as this area of medicine is going to face increasing demand in the years to come. We are aware that there are national priorities in dementia care so the Trust should be well placed to deal with future challenges. The Hospital Standardised Mortality Ratio is used as a general guide to clinical effectiveness and safety in healthcare and we are pleased to see that the Trust's ratio is consistently below national average.

Performance against national priorities

There is a good record of achievement here with most waiting time targets being met during the year. This is somewhat overshadowed by the fourth quarter of the year when the emergency four hour target was exceeded together with other quality measures such as incidence of inpatient falls and pressure ulcers.

We know that this quarter carries an annual risk of underachievement in some standards due to ward closures, staff sickness and a higher level of activity. We make the comment that there should be greater attention paid to planning for this period of the year to ensure that it is sufficiently resourced and that we should not take the view that it is a problem for all Trusts and therefore acceptable.

Summary

We commend this report for its transparency and thoroughness and believe that it is an accurate representation of the Trust's position on quality issues. We think that substantial progress has been achieved during the year but would like to see more attention paid to demand management in the fourth quarter in the year to come. We recognise that managing demand depends to some extent on our healthcare partners providing the infrastructure to enable us to achieve our targets and this is especially the case with patients waiting to be discharged to community healthcare providers.

17 May 2012

Statement from Bristol Local Involvement Network

Bristol LINk welcomes the opportunity to comment on the draft Quality Report prepared by University Hospital Bristol. The LINk notes with satisfaction the record of progress being made by UH Bristol in to seeking to provide a clean, safe and recuperative environment for patients. Bristol LINk also acknowledges a positive and constructive working relationship between the LINk and the Trust, and also the willingness of the Trust to discuss issues raised by LINk's participants, as illustrated by the LINk's work plan.

With regards to the overall tone of the Trust's Quality Report, LINk congratulates the Trust on the openness and honesty of the Report, as reflected also in the discussions about the Quality Report, which have already taken place. Improvements have clearly been made and recorded, for example in infection control, but the areas where the Trust considers they have not been so successful are equally detailed, including the identification of future strategies to improve performance in those areas.

The issues that have concerned the LINk over the past year are mainly falls, dementia, stroke services, infection control, and nutrition and hydration.

The incidences of falls by patients while in hospital, particularly involving elderly patients is an issue, which is of considerable concern to both the Link Acute Hospitals and Older People's Working Groups. Falls in more senior patient can be difficult to control and to anticipate due to frailty, levels of confusion, mental capacity and mobility. Therefore, while the LINk is disappointed that the Trust feels that it did not achieve its target, we are pleased that, in acknowledging this, the Trust has responded by identifying and in some cases already implementing strategies and measures designed to produce better outcomes in the short term and also in the next year.

LINk hopes that these measures, such as falls care plans, medication review and 'Intentional Rounding' will also help to improve the prevention of pressure ulcers in this age group of patients. Acknowledging that serious falls can result in significant injury, we note that a dedicated hip fracture nurse has been appointed and we hope that this step will yield at least in part the improvement, for which the Trust is aiming.

The LINk is aware that the incidence of pressure ulcers is taken very seriously and that nursing staff are being held to a higher bar of accountability, with ward sisters given overall clinical leadership and reporting to the Chief Nurse in cases where Stage 3 and 4 pressure ulcers have occurred.

Dementia is another area of concern for the LINk, particularly with the number of sufferers projected to increase in the foreseeable future. The LINk takes cognizance of the work currently under way in ensuring staff are trained appropriately in the care of dementia patients, and in collaborating with North Bristol NHS Trust, to ensure that care is consistent across Bristol.

With regards to training it would be helpful if the number of staff trained at each level could be given and the program of training for the coming year given the modest nature of level 1 training. In addition, the LINk notes that the Trust takes into consideration the wishes, needs and dignity of dementia patients, while they have the ability to express themselves, as to their future care and treatment.

While we note that the Trust meets the standard for accessing the service that specializes in the diagnosis and management of dementia and older people's mental health, LINk considers that the appointment of a dedicated dementia training lead will enhance the future provision of care.

Bristol LINk is pleased that the Trust has established a dedicated stroke unit within the BRI, but notes that they did not achieve their ambition that at least 90% of patients should spend 90% of their time there. LINk hopes that improved and more efficient management of beds will bring about a rapid improvement in achieving this target, although we would not like to see this measure put at risk the safe discharge of patients back into the community.

With respect to the infection control measures now in place within the Trust, LINk Bristol is very pleased to see that the Trust has more than met the targets set for the incidences of both MRSA and C. diff, with an improving result for MSSA. LINk notes that attention has been given to improving training and regular auditing to prioritise hand hygiene. LINk is pleased to note that in response to patients and visitors, improvements are being made to the provision, installation and location of alcohol gel.

In the case of Norovirus, the LINk is aware that outbreaks have an impact on the management of wards, admissions, cancelled operations and finances. With the likelihood that, as shown by the previous year, this infection shows no signs of diminishing in the near future, we feel that this is something hospital Trusts cannot deal with on their own and more strenuous efforts should made by the appropriate agencies to control it in the community as a supplementary measure.

With regard to nutrition, the issues brought out in the LINk's Nutrition and Hydration Report, submitted in April 2011, were (a) high nutritional standard, particularly to the older patient if they were in danger of malnourishment, (b) the importance of recognizing how important mealtimes are to the care of the patient, (c) offering help to eat where necessary, and (d) making sure that appropriate food was available to the different ethnic communities within the Bristol area.

The above issues were largely confirmed by the CQC visit in May 2011 and, as a result the Trust produced a plan to improve the nutrition audits on the wards and to ensure that all relevant staff received training to use the nutrition screening tool. The LINk was, therefore, disappointed to learn that, at the subsequent CQC visit in December 2011, it was found that nutritional care plans were still not always completed and the ready availability of religious and cultural menus was still not always communicated to patients. However, note has been taken of the fact that further steps have been taken to improve paperwork and staff awareness, and the LINk hopes that this will result in more satisfactory results.

Finally, LINk would like to comment on a number of issues in addition to those listed above. Firstly there is the issue of the targets in the NHS South West Quality and Safety Improvement Programme, where the Trust have stated that they did not achieve in 2010/11 those targets, i.e. Workstreams in General Wards, Medicines and Clinical Care. These areas are all of potential harm to patients and the LINk hopes that measures that will be in place, with sound leadership and engagement for 2011/12, which will produce the results that the Trust aims for and that this will be reflected in next year's Quality Report. Secondly members of the LINk had the opportunity during a workshop to discuss ways in which the statistical information given in the report could be improved and presented to a lay audience, in particular that when percentages are given absolute numbers should be also given in brackets.

The LINk noted that discharge and planning has not been included in this year's Quality Report. LINk has already commenced work in this area and will be continuing in the coming year and looks forward to commenting on this in next year's Quality Report. Bristol LINk very much appreciated the workshop with UH Bristol and particularly the information shared and explained further by the Chief Nurse the Assistant Director for Audit and Assurance and the Public Involvement Project Lead.

21 May 2012

Statement from South Gloucestershire Local Involvement Network

South Gloucestershire LINk welcomes the opportunity to comment on the draft Quality Report prepared by University Hospital Bristol. South Gloucestershire LINk notes the record of progress being made by UH Bristol in to seeking to provide a hygienic, safe and recuperative environment for patients.

South Gloucestershire LINk hope that this coming year will see a stronger relationship built between UH Bristol and the LINk working group on Health Services.

The LINk noted that discharge and planning has not been included in this year's Quality Report. The Joint Bristol and South Gloucestershire LINk has already commenced work in this area and will be continuing in the coming year and looks forward to commenting on this in next year's Quality Report. South Gloucestershire LINk appreciated the workshop with UH Bristol and particularly the information shared and explained further by the Chief Nurse, the Assistant Director for Audit and Assurance and the Public Involvement Project Lead.

21 May 2012

Statement from South Gloucestershire Health Scrutiny Select Committee

The Committee was pleased to welcome UH Bristol's Medical Director, Dr Sean O'Kelly and the Assistant Director for Audit and Assurance, Chris Swonnell to a meeting on 18 April 2012 to present the key themes of the Trust's draft Quality Report for 2011-12.

The Trust's full draft Quality Report was emailed to members on 26 April.

After the presentation there was a helpful Question and Answer session. The main topics of discussion were as follows:

- There was a discussion about patient reported support at mealtimes and a feeling that the target of 76 was not that high. In response it was explained that there was clear evidence in national research that subjective patient-reported measures were difficult to achieve. At the time the target was agreed between the Trust and NHS Bristol, the target of 76 was felt to be stretching but achievable, based on the previous year's data. The Select Committee was reassured that as part of focused work on the target, the Trust had introduced a team of volunteers whom provided support at mealtimes.

- The Trust provided some information on its complaints procedure and the Committee was satisfied that there is a robust system in place for addressing complaints. The Trust uses complaints as learning opportunities and it carries out an annual survey of all people who have complained during the year to gauge their satisfaction.

- The Trust was commended on its dementia action plan.

- In relation to recent articles in the national press about patients being discharged from hospital at night, the Trust representatives said that they were not aware of this being an issue at UH Bristol.

- The Trust provided a summary of its performance against last year's objectives, which included a Patient Safety Objective to "Implement the histopathology action plan". The Trust put a 'tick' against this objective and highlighted it as 'green'. The Committee felt that this gave the wrong impression because whilst a lot of work in the Action Plan had been completed, some actions were ongoing. It was suggested, therefore, that it would be more accurate to have some text against the objective explaining this.

In addition to the presentation on 26 April during 2011-12 the Committee undertook a specific piece of scrutiny on the outcome of the Independent Inquiry into Histopathology Services in Bristol and the implementation of the histopathology action plan by UH Bristol and the North Bristol NHS Trust.

The item was added to the Committee's work programme following issues raised in a public submission, and the subsequent meeting was carefully planned to ensure that the NHS provided a comprehensive report. The meeting went smoothly and enabled a full and frank exchange of views in a public setting, followed by detailed questioning by members of the Committee. As a result of this in February 2012 the Committee submitted eight recommendations to the hospital Trusts, and agreed to undertake follow up work with the Bristol Health and Adult Social Care Scrutiny Commission, which was already receiving regular reports on the Action Plan.

The first meeting with the Bristol Commission took place at the end of April 2012, and it ran smoothly and was well attended. The hospital Trusts provided a detailed response to the Committee's recommendations, explained how they were implementing the Action Plan and answered members' questions. A further meeting will be held in a few months' time.

Statement from Bristol City Council Health and Adult Social Care Scrutiny Commission

At its meeting on 16 April 2012, the Scrutiny Commission heard a presentation from UH Bristol officers on the key themes in the draft UH Bristol Quality Report for 2011/12, and proposed objectives for 2012/13. Members subsequently received the full Quality Report document by email.

At the meeting, questions were asked about staff training around patient care and patient experience; the systems in place for dealing with pressure ulcers; and clarification around stroke care. The Commission requested a separate briefing on Stroke Services across Bristol.

Members were in general agreement with the priorities and objectives identified by the Trust and had no specific comments or concerns about the information provided.

Statement from NHS Bristol, North Somerset and South Gloucestershire Primary Care Trust

NHS Bristol, North Somerset and South Gloucestershire have reviewed the NHS University Hospitals Bristol NHS Foundation Trust Quality

Report document for 2011–2012 and believes that it provides a fair reflection of the work of the Trust and includes the mandatory elements required.

We have reviewed the data presented and are satisfied that this gives an overall accurate account and analysis of the quality of services. This is in line with the data supplied by University Hospitals Bristol NHS Foundation Trust for 2011/12 which is reviewed as part of their performance under the contract during the year.

We continue to work with the Trust to ensure that patient safety, data accuracy and information governance at all levels remains a key priority.

The account identifies significant progress in relation to:

- The sustained reduction of HCAI; MRSA and clostridium difficile levels

- Achieving all cancer wait targets for 2011-12

- Achieved the 18 week referral to treatment wait times for both admitted and non-admitted patients for every month in 2011-12

We will continue to work closely with University Hospitals Bristol NHS Foundation Trust to implement the joint action plan for Bristol that was produced in December 2010 following an Independent Inquiry into Histopathology Services in Bristol to improve cancer care.

NHS Bristol, North Somerset and South Gloucestershire will continue to work with University Hospitals Bristol NHS Foundation Trust to raise the profile for quality improvement.

The ongoing engagement of clinicians close working with primary care will remain crucial in monitoring standards and improving services for local people.

The Trust is commended for its ongoing work with the South West Quality and Safety Improvement Programme.

This Quality Report follows the Quality Accounts toolkit framework.

Part 1 Statement on quality from Chief Executive, senior employee, stating document is accurate	Statement, signed by CEO and senior clinical staff provided stating report content is accurate
Part 2 Information Provided on Priorities for improvement	For 2012-13: 17 priorities for improvement defined, have set clear goals and have provided evidence of how these will be monitored and measured
8 Mandatory Quality Measures	Compliant
Review of Services	Compliant: 16 key priorities for 2011/12, and 10 were achieved
Participation in Clinical Audits	Compliant
National Audit	Compliant
Participation in Clinical Research	Compliant
CQUINs (commissioning for quality Improvement scheme)	Compliant
Care Quality Commission	Compliant
Data Quality	Compliant
Information Governance Toolkit	Compliant

Deborah Evans

Deborah Evans   Date: 14 May 2012

Chief Executive

NHS Bristol

APPENDIX D –
Statement of Directors' Responsibilities

2011/12 Statement of Directors' Responsibilities in respect of the Quality Report

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

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

- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual;*

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2011 to May 2012;

  - Papers relating to Quality reported to the Board over the period April 2011 to May 2012;

  - Feedback from the commissioners dated 14/05/2012

  - Feedback from governors dated 17/05/2012;

  - Feedback from Bristol LINk dated 21/05/2012;

  - Feedback from South Gloucestershire LINk dated 21/05/2012;

  - The Trust's complaints data as reported to the Board for the period April 2011 to March 2012.

  - The 2010 National Inpatient Survey published 24/04/2012;

- The 2010 National Staff Survey published 23/03/2012;

- The Head of Internal Audit's annual opinion over the Trust's control environment dated 22/05/2012;

- Care Quality Commission quality and risk profile dated 02/04/2012;

- 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, and is subject to appropriate scrutiny and review; and

- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/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

29 May 2012

Robert Woolley, Chief Executive

29 May 2012

APPENDIX E –
External audit opinion

Independent Assurance Report to the Membership Council of University Hospitals Bristol NHS Foundation Trust on the Annual Quality Report

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

I have been engaged by the Board 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 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

• MRSA (Methicillin-resistant Staphylococcus aureus).

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

I refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that:

• the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*

- the Quality Report is not consistent in all material respects with the sources specified in *Monitor's Detailed Guidance for External Assurance on Quality Reports 2011/12* ; and

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

I read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I became aware of any material omissions.

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

- Board minutes for the period April 2011 to March 2012;

- Papers relating to quality reported to the Board over the period April 2011 to April 2012;

- Feedback from Bristol Health and Adult Social Care Scrutiny Commission dated 15 May 2012;

- Feedback from NHS Bristol, North Somerset and South Gloucestershire Primary Care Trust dated 14 May 2012;

- Feedback from LINks dated 21/05/2012;

- The national patient survey dated 24 April 2012;

- The national staff survey dated 23 March 2012;

- Care Quality Commission quality and risk profiles dated 2 April 2012;

- The Head of Internal Audit's annual opinion over the Trust's control environment dated 22/05/2012; and

- Any other information included in our review.

I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). My responsibilities do not extend to any other information.

I am in compliance with the applicable independence and competency requirements of the Association of Chartered Certified Accountants (ACCA) Code of Ethics and Conduct. My team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Governors of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Board of Governors in reporting University Hospitals Bristol NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Board of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Board of Governors as a body and University Hospitals Bristol NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

- Making enquiries of management;

- Testing key management controls;

- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and

- Reading the documents listed above.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

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

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

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*

- the Quality Report is not consistent in all material respects with the sources specified in *Monitor's Detailed Guidance for External Assurance on Quality Reports 2011/12* ; and

- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

Wayne Rickard

Officer of the Audit Commission

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June 2012

University Hospitals Bristol NHS Foundation Trust

Quality Report 2011/2012