Royal United Hospital Bath NHS
NHS Trust

Royal United Hospital Bath NHS Trust
Quality Accounts 2009/10

United in Excellence

Foreword

This is the first set of Quality Accounts for the Royal United Hospital Bath NHS Trust (RUH), produced in line with national requirements. It is intended that they provide a realistic assessment of the quality of care provided by the RUH during 2009/10.

The content and format of these Accounts are laid down in the NHS (Quality Accounts) Regulations 2010[1] which came into force on 1st April 2010. As a provider of healthcare, we are required to present certain information which has been nationally determined, in the form of statements. These statements are specified in the above regulations. There are seven such statements and we have highlighted them in a **purple** box as they appear in the relevant sections of the Accounts.

We provided the following local organistions and groups with the opportunity to comment on these Accounts:

The South West Strategic Health Authority (NHS South West)
NHS Bath & North East Somerset
NHS Wiltshire
NHS Somerset
Bath & North East Somerset Council's Healthier Communities and Older People Overview and Scrutiny Committee
Wiltshire County Council's Health and Adult Social Care Select Committee.
Local Involvement Networks (LINk).

Their comments, where made, can be found in Chapter 5.

We encourage our staff, patients, public and healthcare partners to look at these Quality Accounts to understand what we are doing well and where improvements in services are required. These Accounts outline our priorities for improvement in the coming year (2010/11) and we welcome comment on and involvement in determining future priorities for improvement.

1 www.opsi.gov.uk/si/si2010/uksi_20100279_en_1

Contents

Chapter One 5

Chief Executive's Statement 6

Chapter Two 9

Our current status and priorities for improvement in 2010/11 10
Our Priorities 11

Priority One: to further reduce our healthcare associated infection rate 12
Priority Two: to deliver same sex accomodation 14
Priority Three: To reduce the risk of deep vein thrombosis and venous thromboembolism 17
Priority Four: To reduce the number of hospital acquired pressure ulcers 18

Chapter Three 21

Review of quality performance in 2009/10 22

Patient Safety 23
Clinical Effectiveness 26
Patient Experience 30

Chapter Four 43

Participation in clinical research and development 44

Chapter Five 53

What others say about us 54

Chapter Six 57

Data Quality 58
Clinical Coding 60

Mr and Mrs M said, “Well done RUH!”
“I was delighted to see the RUH in Bath on the national news showing the huge improvements in care and cleanliness over the last two years. I was an inpatient several times in 2004; on these occasions I was very unhappy about the unhygienic conditions and the low quality of care.

“However more recently I have been hospitalised and what an improvement! The wards were clean and bright, the care was superb and morale was noticeably boosted.

“In August my mother-in-law was diagnosed with terminal lung cancer and was admitted for palliative care in the Respiratory unit. As she was too ill to move to Dorothy House, the palliative care team joined the ward team from the RUH to discuss the best approach for her. Mum could not say enough for the care she received. No matter when we visited, she looked clean, comfortable and totally well cared for. We now have a general hospital to be proud of. If you should be unlucky enough to be a patient it is one of the best hospitals to be in. Thank you so much from us to all the staff responsible for these huge improvements.”

Chapter One

Chief Executive's Statement

We want you, our patients, to have confidence that you are in the best hands when you are being cared for by us. We want our staff to provide the highest levels of care and treat you as an individual, with dignity and respect. We want you to know that the quality of the care we provide is of the utmost importance to us.

The Board of the RUH has made a public commitment to promote quality as its first priority and we demonstrate this in a number of ways. For example, the safety and experiences of our patients are routinely discussed as the first item at public Trust Board meetings. Our clinicians are asked to attend Trust Board meetings to present on issues of patient safety and experience and are encouraged to raise any concerns that they may have so that improvements can be made. On wards and in clinics, patients provide real time comment on the care they are receiving. This feedback goes to the Board in a report and supports our drive to improve quality.

The Francis Report[2] examined the systemic failures which allowed high death rates and poor standards of care at the Mid Staffordshire NHS Foundation Trust to continue unchecked for several years. One of the Report's many recommendations was that 'all NHS Trusts and Foundation Trusts, responsible for the provision of hospital services should review their standards, governance and performance in the light of this report.' The RUH Trust Board reviewed all our controls and assurances and went on to further strengthen data analysis and accountability in several key areas such as mortality rates, staffing levels and the standards of nursing care. We have also increased the nature and level of assurance obtained on clinical data and clinical governance by members of our Clinical Governance Assurance Committee, which in turn reports to the Trust Board. The Trust Board also seeks to take learning from elsewhere in the NHS.

2 The Francis Report is the The Mid Staffordshire NHS Foundation Trust Inquiry published in February 2010.

During 2009/10 the RUH achieved the following improvements in the quality of care offered to patients:

1. The numbers of patients with MRSA or Clostridium ***difficile*** (C***.difficile)*** infection continued to reduce. The RUH was set targets by NHS South West of less than 19 MRSA bacteraemias and less than 127 cases of hospital associated ***C. difficile***. Actual performance for the year was 17 patients with MRSA bacteraemia and 113 cases of hospital associated ***C. difficile*** infection.
2. The RUH spent over £600,000 making changes to ward areas in order to improve privacy and dignity for patients. This was achieved by offering separate washing and lavatory facilities for men and women. All wards now provide single sex bathrooms and lavatories.
3. By working as part of a regional patient safety improvement programme - NHS South West Quality and Patient Safety Improvement Programme - the RUH spent time better understanding the risks to which patients are exposed whilst receiving care. As part of this work, sets of patients' medical records were chosen at random to be examined for evidence of potential harm. 'Harm' in this context covered a broad range of circumstances from merely the potential for harm to occur (even though it did not), to minor issues with no long term effect right through to major events with significant on-going consequences. By undertaking a number of such reviews every month it was possible to see patterns of risk in how care was provided and to make changes that reduced or removed such risks. Through this process of enquiry and learning, care for patients at RUH continues to improve.

These Quality Accounts demonstrate the continuing improvements we are making in the quality of care we deliver at the RUH and they review progress made in the year 2009/10.

As Chief Executive I am pleased to confirm that the information contained within this report is, to the best of my knowledge, accurate and that it has been reviewed and approved by the Trust Board at its meeting in June 2010.

James Scott
Chief Executive

Mr D, from Trowbridge, said "Thank you and your team of admin staff, nurses and doctors for treatment I received during the time I spent at the RUH in November. I must praise everybody involved.

On arrival at the day surgery I was treated with courtesy and efficiency. The nurse introduced herself and explained clearly what the procedure would be and that she was there to support me before and after my operation. The surgeon and the anaesthetist were both very professional. I felt I was in safe hands, a comforting thought."

Chapter Two

Our current status and priorities for improvement in 2010/11

Over the past year, we have made significant progress in a number of areas which we believe demonstrates our commitment to make quality this hospital's priority and embed high standards in all we do.

The National Survey of Adult Inpatients in the NHS for 2009 placed the RUH in the best performing 20% of Trusts in several areas of care and treatment including nurses' hand hygiene, involving patients in decisions about their care and providing information for patients in the Emergency Department about their condition. Year on year, our incidence of healthcare associated infections has fallen.

In 2009 we achieved a score of 'good' for our Use of Resources and retained the score of 'good' for Quality of Care in the Care Quality Commission's (CQC) performance ratings, the Annual Health Check. In 2007 our scores had been 'weak' 'weak' and this improvement placed us among only 13 acute trusts in the country to be rated as 'most improving' by the CQC in 2009.However the CQC also highlighted areas where we needed to make improvements. Against nationally set targets, we under-achieved in the number of people waiting 4 hours or more to be seen in the Emergency Department, delays in transfer of care and cancelled operations. We acknowledge that 2009/10 has been a very challenging year for the RUH and we expect this may be reflected in the year's CQC performance ratings due to be published in October 2010. We also failed to meet the national priority for the type of care we offer to people who have had a stroke. We have made significant progress during 2009-10 to ensure we do meet these targets in future.

There was an unannounced hygiene inspection of the hospital by assessors from the CQC during November 2009. This followed an inspection earlier in the year, following which a number of actions had been requested to ensure we met, in full, the Hygiene Code. The assessors reported that they had found no breaches of the Hygiene Code at the time of the second inspection.

During 2010 nursing staff at the RUH will be working to new national guidance on Nursing Specific Indicators. In 2009, the NHS Information Centre for Health and Social Care collated 'indicators for quality improvement', to underpin quality improvement policy initiatives such as Quality Accounts. They include five that make explicit reference to nursing such as nursing staff not talking in front of a patient as if they weren't there, giving patients information they could understand and patients having confidence and trust in the nurses treating them.[3]

During 2010/11 matrons at the RUH will ensure that the quality of nursing care is closely monitored, in particular in areas such as pressure ulcer care, preventing falls and the prevention of urinary tract infections.

In 2009, the RUH published a Strategic Direction for the next four years. This document makes clear our ambition:

To be a national exemplar for the NHS through dedicated staff, working together, to give every patient excellent care

3 Source: The NHS Information Centre for Health and Social Care (2009)

Our Priorities

Excellent care is defined as being safe, effective and personal. The key strategic objectives in relation to the quality of care we offer at the RUH are:

- Reducing infections associated with coming into hospital
- Improving communication with patients – telephone, face to face and written
- Improving patient safety
- Working with patients in managing their care and their expectations from treatment
- Improving the environment for care.

These improvement priorities for 2010/11 have been agreed through a series of discussions and consultations with our clinicians, our commissioners, healthcare partners and from patient feedback. Making progress in them will also demonstrate progress in patient safety, patient experience and clinical effectiveness – the three domains of quality care identified in Lord Darzi's report for the NHS, High Quality Care for All. (June 2008)

If we can successfully deliver the improvements in each of these priorities over the coming year, we will also achieve a reduction in the amount of time our patients spend in the hospital. Our catchment area has an older population and many of our patients have complex care needs once they have been discharged from hospital. This can lead to delays in discharge. We will be working harder and with our health and social care partners, to help ensure patients are discharged at the right time and to the most appropraite environment for them. We need to ensure we maintain the flow of patients through the hospital. At the RUH up to 200 people a day attend our Emergency Department. Whilst not all of these will need admitting, there is always a constant demand for our services. By better managing the way people go home, we can work on creating capacity for emergency admissions.

Priority One: to further reduce our healthcare associated infection rate

Reducing healthcare associated infections such as MRSA and C.*difficile* is a key priority and our goal is to ensure that not a single preventable infection is allowed to develop at our hospital. We take the control of infection very seriously and are taking forward a number of actions as a result of our involvement in the South West Quality and Patient Safety Improvement Programme.

Our aim for 2010/11
To further reduce our healthcare associated infection rates to:

MRSA bacteraemia: no more than 5 cases this year [4]
C.difficile: no more than 63 cases this year, a reduction of 50% on last year

Our current status
We have consistently reduced the number of MRSA bacteraemias and C.*difficile* infections and aim to continue to do so.

	2007/08	08/09	09/10	10/11 (target)
MRSA bacteraemia	35	26	17	5
C.*difficile*	301	248	113	63

What are we doing to reduce infection rates?

- In April 2009 we started screening all patients for MRSA before admission for planned procedures and from April 2011 all patients coming to the hospital, whether for a planned operation or as an emergency, will be screened automatically.
- We have opened a new Central Pre-Operative Assessment unit where we test patients well in advance of their operation. About one in three of us carry SA (Staphylococcus aureus) bacteria in our nose or on the surface of our skin[5], and people can be 'colonised' with the antibiotic resistant strain MRSA, without ever being infected. However, to reduce their risk of the bacteraemia entering an open wound we screen patients before their operations. If they screen MRSA positive we ask their GP to start a simple washing and lotion treatment five days before they are due to come in to hospital.
- We undertake infection control audits quarterly. These include audits of hand hygiene, use of personal protective equipment, and ensuring that intravascular catheters (those inserted into veins) and those inserted into the bladder (urinary) are kept infection free.
- We undertake monthly auditing of hand hygiene compliance and have a rigorous performance management process in place.
- Infection Control reports go directly to our Trust Board every quarter and our performance is closely monitored at the highest level.

4 The procedure for recording MRSA bacteraemias has changed and only patients who develop MRSA bacteraemia 48 hours post admission will be counted in our figures. All other cases will be attributed to the patient's Primary Care Trust. The recording of Clostridium ***difficile*** cases remains the same.

5 NHS Choices www.nhs.uk/chq/Pages/1280.aspx?CategoryID=71&SubCategoryID=71

Priority Two: to deliver same sex accomodation

Virtually eliminating same sex accommodation remains one of our key priorities and our goal is to ensure that we provide every patient with same sex accommodation, because it helps to safeguard privacy and dignity when patients are often at their most vulnerable.

Our aim for 2010/11

That all patients who are admitted to our hospital share the room where they sleep only with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex should happen only by exception based on clinical need (for example where patients need specialist equipment such as in Critical Care).

Our current status

Focused work throughout 2009/10 has resulted in demonstrable improvements to the patient environment, changes in staff culture and new processes to support the delivery of same sex accommodation. A significant investment programme to upgrade bathroom facilities was undertaken on six wards. We were required to have met the national standard of virtually eliminating mixed sex accommodation by 31st March 2010. However, data collected from patients in December 2009, January 2010 and February 2010 showed that 45% of patients stated they shared sleeping areas with members of the opposite sex when they were first admitted, primarily on our Medical Assessment Unit (MAU). Whilst we had some difficulties in meeting this standard during the winter, we are now back on track and delivering the standard required.[6]

What are we doing to improve our provision of same sex accommodation?

- A strategic delivery plan has been devised to ensure compliance with same sex accommodation standards on our MAU.
- Progress reports go directly to our Trust Board every month and our performance is closely monitored to ensure we are fully compliant with same sex accommodation standards.
- Any breach or failure to comply with providing same sex accommodation is analysed to look at the causes and the time and actions taken to resolve it.
- Contingency plans have been developed on how to maintain same sex accommodation at times of high service demand and pressures, including when wards are closed due to viral outbreaks.
- We have established one female-only ward in our Older Peoples Unit and one female-only ward on our Orthopaedic Trauma Unit.
- We will explore the opportunities for creating capacity and same sex wards within existing areas. Same sex accommodation will be assured in all new or refurbishment building work that takes place.
- Plans are in place to put a Matron in charge of Privacy and Dignity work, who will also chair the new Privacy and Dignity Advisory Committee.
- We will continue to measure how changes have improved the patient experience by undertaking Trust-wide audits and using the Patient Experience Tracker (PET) devices, as well as taking part in nationally required local surveys of patients' experience.
- We will be reviewing our hospital gowns in the coming year to ensure they better protect privacy and promote dignity for our patients.

6 As of 31st May 2010 we declared compliance.

Comments from audits of patients on MAU include "Don't mind at all. I've been married for 51 years so I know what a man is", "Prefer not to share but understand it's not always possible", "I didn't mind as long as there are curtains. To be honest, when you're sick you don't mind", and "They (ladies) might mind but I don't." We have significantly improved the information we give to patients when they come to MAU regarding our same sex accommodation pledges and we display our commitments clearly.

Priority Three: To reduce the risk of deep vein thrombosis and venous thromboembolism

Blood clots that develop in a vein are also known as venous thrombosis. Deep Vein Thrombosis (DVT) usually occurs in a larger vein that runs through the muscles of the calf and the thigh. It can cause pain and swelling in the leg and may lead to complications such as pulmonary embolism. This is when a piece of blood clot breaks off into the bloodstream and blocks one of the blood vessels in the lungs. DVT and pulmonary embolism together are known as venous thromboembolism (VTE).

The Department of Health has made the prevention of DVT a priority across the NHS. All patients admitted to hospital should be assessed for their risk of developing a blood clot and, if necessary, given preventative treatment. This recommendation was made by the National Institute for Health and Clinical Excellence (NICE) in January 2010.[7]

Our aim for 2010/11

At least 70% of patients to be risk assessed for prevention of VTE on admission to hospital
100% of patients to be given written information on hospital acquired VTE at the pre-operative assessment clinic or during their inpatient stay
100% of patients who are considered at risk of developing VTE to be offered prophylaxis (preventative drug treatment or therapy)

Our current status

Prevention of hospital acquired VTE is one of the key workstreams of our Patient Safety Improvement Programme. Since July 2009, the RUH has been assessing those patients identified as being most at risk. 33% of patients thought to be at risk had a completed risk assessment undertaken and 86% received the appropriate prophylaxis (preventative) treatment.

What we are doing to reduce the risk of VTE?

- Since January 2010, all patients admitted to the RUH are assessed for their risk of developing DVT or pulmonary embolus during their hospital admission. If they are considered to be at risk, they will be treated with either compression stockings or a drug known as an anticoagulant. which prevents the clot forming
- A weekly audit of five patients per ward/speciality across the RUH takes place with results fed back to individual wards/consultants and to our commissioning PCTs.
- 'Prevention of VTE' is now part of induction for junior doctors and is part of mandatory training for all clinical staff. An e-learning package (eVTE) is now available and the directive is for all clinical staff to complete this by the end of the year.
- A working group has been set up to streamline the prevention of VTE across the local health network.
- An awareness day to increase patient and public awareness of hospital acquired VTE is planned during the summer of 2010, whilst information on hospital acquired VTE is planned to be on the RUH website with links to the latest national clinical guidelines.
- We are working closely with our local healthcare partners to ensure a consistent approach across the community.

7 To read the NICE report in full, go to www.nice.org.uk/nicemedia/live/12695/47920/47920.pdf

Priority Four: To reduce the number of hospital acquired pressure ulcers

Most pressure ulcers, or bed sores, are an avoidable complication of care and we have a zero-tolerance approach to hospital acquired pressure ulcers. People who are unable to move some or all of their body due to illness, paralysis or advanced age often develop pressure ulcers which are graded from 1 (least serious) to grade 4 (most serious). At their most serious they can destroy fat, muscle and nerves and become infected. An audit carried out in December 2009 at the RUH showed that there has been a reduction in the number of grade 2, 3 and 4 pressure ulcers from a rate of 11% in 2007 to 7% in 2009; the number of grade 1 pressure ulcers remained constant.

Our aim

To reduce the number of hospital acquired pressure ulcers at Grade 3 and 4 by 50%

To reduce the number of hospital acquired pressure ulcers at Grade 2 by 20%

Our current status

Pressure ulcers are a widespread and often underestimated health problem and as of 31 March 2010 there was no nationally set way of measuring and recording the incidence of pressure ulcers or of comparing the incidence levels between hospitals. During 2010 the Department of Health will be implementing a new way of calculating the incidence of pressure ulcers within organisations.

In the UK it is estimated that between 4% and 25% of patients admitted to hospital will develop a pressure ulcer [8]. An internal audit at the RUH in 2009 showed that 6.5% of inpatients had developed a pressure ulcer. In total, we had approximately 40,000 inpatients at the RUH during 2009/10 of whom 744 (1.86%) had a pressure ulcer. However, not all of these pressure ulcers were acquired in the RUH. Our audit revealed that approximately 60% of patients had an ulcer when they were admitted and the remaining 40% developed in the RUH.

8 Bennett et al 2004

Even with the best possible medical and nursing care, pressure ulcers can be difficult to prevent in particularly vulnerable people and it is known that 70% of pressure ulcers develop in those who are aged 70 or older.

What are we doing to reduce the number of patients acquiring pressure ulcers and treating those patients admitted with pressure ulcers?

- We investigate every grade 3 and 4 pressure ulcers if they are acquired at the RUH, with every patient being seen by a specialist nurse called a Tissue Viability Nurse. A Serious Untoward Incident investigation is completed for all Grade 4 RUH acquired pressure ulcers (a total of three for year 2009/10). We also complete a root cause analysis for every patient with a grade 3, RUH acquired pressure ulcer.
- We are introducing a new pressure-ulcer prevention tool 'PRIMED', a simple tool to help staff deliver more effective pressure-relieving care, and have revised our pressure ulcer reporting form and database to promote more accurate reporting.
- 2010/11 sees the launch of a new patient information leaflet for any patient at risk of developing, or with an existing, pressure ulcer.
- We are holding a Pressure Ulcer Awareness Week in 2010, called 'Let's reduce the Pressure' to raise awareness of the wide range of evidence-based resources for the prevention and management of pressure ulcers and training provided by the Tissue Viability service.
- We provide high-specification pressure relieving mattresses and cushions for the prevention and management of pressure ulcers. We have over 20 different wound dressings available and we are currently reviewing the method of which dressings we use and how to ensure they are both clinically and cost-effective.

Kate Purser, Tissue Viability Nurse Specialist says: "When skin becomes damaged the remaining wound takes time to heal. Whilst many heal naturally in time, choosing the right dressing for each wound can make all the difference to ensure patients have the best chance of healing as quickly, and as pain free, as possible. We have a range of dressings that are clinically effective and can be tailored to an individual's need.

Mrs Y from Bath, has been receiving treatment for a pressure ulcer for the last three years and recently began using honey dressings. She says: "I felt I wasn't getting anywhere, and the pain made it hard to sleep. After trying a new dressing I'm optimistic about the future. I'm able to sleep without sleeping tablets and for the first time new skin is forming over my ulcer. I'm very, very pleased, these dressings just seem to work for me and I'd recommend the treatment to anyone."

Chapter Three

Review of quality performance in 2009/10

"We can only be sure to improve what we can actually measure"
Lord Darzi, High Quality Care for All, June 2008

In this section of the Quality Accounts, we are looking back at 2009/10 and explaining how we have evaluated or measured the quality of the care we provided. We also show which standards of measurement are set nationally and which we determined at a hospital level. Where data was readily accessible, we identified our performance in 2009/10 and either established a target for improvement or have planned to undertake additional work in 2010/11 in order to fully understand how improvements can be made.

Where data is not readily accessible, we will be putting systems in place to rectify this in order for us to measure our performance and determine how it can be improved.

The first of the 7 regulatory statements is within this section. The purpose of this statement is to show we have considered quality of care across all the services we deliver, rather than focusing on one or two for inclusion in these Accounts. Indicators of health, performance, quality and efficiency give us a valuable insight into how we are delivering care. The data we have reviewed covers the three domains of quality care; patient safety, patient experience and clinical effectiveness.

Statement 1

During 2009/10 the Royal United Hospital Bath NHS Trust provided and sub-contracted 7 types[1] of NHS services via three clinical divisions, Medical, Surgical and Specialty. During 2009/10 the Royal United Hospital NHS Trust has reviewed data available to them on the quality of care using hospital wide performance information such as the Hospital Standardised Mortality Rate (HSMR) and has undertaken further indepth review of clinical care within a number of areas including:

- Monthly case note review of 20 patient records to identify harm events (things that happened or were not acted upon that may have caused harm to the patient, including such things as delay in recovery time)
- Trust wide monitoring of healthcare associated infections such as MRSA and C difficile and full investigations of causes of such infections
- Identification, reporting and investigation of grade 3 and 4 hospital acquired pressure ulcers
- Participation in national audits in the areas of cardiac care, stroke care, joint replacement surgery, fractured hip surgery.

The income generated by the Royal United Hospital Bath NHS Trust, in relation to thises services, represents 100% of the total income generated from the provision of NHS services by the Royal United Hospital Bath NHS Trust for 2009/10.

1 The Health and Social Care Act 2008 lays down a number of 'activities' (types of services provided) which are regulated by the CQC. The CQC will register providers, like the RUH, to carry out the regulated activities if providers show that they are meeting essential standards of quality and safety. The 7 types of activity that, as a Trust we have been registered by the CQC to carry out are:

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Management of supply of blood and blood derived products
Nursing care
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury.

Patient Safety

Patient safety is paramount in all that we do at the RUH. We have been involved in patient safety improvement programmes over a number of years including the Patient Safety First campaign and the Leading Improvement in Patient Safety programme. In September 2009 the RUH became part of the South West SHA's Quality and Patient Safety Improvement programme.

The Patient Safety Improvement programme aims to make healthcare in the South West of England safer. This initiative enables us to improve safety for our patients and to become respected leaders for others to learn from. The Patient Safety Improvement programme builds on the work we have already completed in improving patient safety and was the new way of managing our progress in 2009/10. We developed five workstreams to guide all we do in improving patient safety and which allowed clinicians, nurses, ward staff to become directly involved in leading such improvements. Workstreams included:

- Leadership: executive patient safety visits / embedding a safety culture
- General Ward: deteriorating patient / infection prevention and control / reducing pressure ulcers / safety briefings / preventing falls
- Perioperative[9] care management: prevention of surgical infection / perioperative cardiac protection for high risk patients / safer surgery checklist
- Medicines Management: anticoagulant use / venous thromboembolism (VTE) / high risk medication / reconciliation of patients' medication lists
- Critical Care Management: complications from mechanic ventilation / central lines[10] / infection prevention and control.

9 Assessing a patient's fitness for surgery.
10 A small, flexible tube inserted into the large vein above the heart, through which access to the blood stream can be made.

Learning from incidents
As a Trust, we recognise the importance of reporting all types of incidents and accidents as an integral part of how we identify and manage risk. This is why we have made incident reporting and the timeliness of investigations into Serious Untoward Incidents, under the National Patient Safety Agency (NPSA) National Reporting Framework, one of our key quality indicators, as shown in the table on page 26.
We are committed to improving the quality of care to patients, and the safety of staff and members of the public, through the consistent monitoring and review of incidents that result, or had the potential to result, in injury, damage or other loss. In June 2009 we revised our policy and procedures around incident reporting and made the process for reporting incidents or near misses much more simple. To read our policy in full, please go to http://www.ruh.nhs.uk/about/policies/index.asp?menu_id=9. We also provide staff with feedback on the incidents they report.

The Trust approach to incident management is standardised to ensure that learning from incidents is an integral part of our culture and achieves the following objectives:

- analysis of trends which may identify the further need for intervention
- to improve patient and staff safety by addressing systematic errors
- to promote a culture of accountability without 'blame'.

We learned that we can meet these objectives by promoting a positive and non-punitive approach towards incident reporting, so long as there is no flagrant disregard of the Trust Policies, fraud or gross isconduct.
In October 2009, the NPSA said that the RUH encouraged staff to report incidents and that we had an 'open culture' for reporting. The number of incidents whereby a patient suffered severe harm was less than 1% of the total number of

Mr C from Malmesbury wrote "I am writing to tell you of the wonderful treatment I received at your hospital. Because of negative media reporting of the NHS, I had a 'terror' of having to go in to hospital.

I came to the RUH scared and in acute pain. In the Emergency Department the kindness and speed I was seen by doctors was exceptionally good. On to MAU and the cleanliness, care, empathy, friendliness astounded me. Was this the NHS I kept reading about? This was the opposite of everything I'd been told. In Victoria ward everyone was kind, caring, patient and professional. The hand washing and floors and cleaning sparkled - very impressive. I am now telling everyone - don't be afraid to go to Bath. What a great hospital you have and wonderful staff."

incidents reported. Compared to similar sized health organisations, the RUH showed it had a strong culture for being open about reporting incidents or concerns. The majority of patient safety incidents reported during 2009/10 were classed as 'low harm', meaning that a patient may have required some extra monitoring or minor treatment, such as dressing a graze or wound after stumbling. For a full breakdown of the number and profile of incidents reported by Trusts, visit www.npsa.nhs.uk

Safeguarding Adults and Children

In law[11], we have a duty to safeguard and promote the well-being of children, young people and vulnerable adults. The Department for Children, Schools and Families updated its guidance on working together to safeguard children in March 2010 and this will influence future plans for safeguarding children for organisations like the RUH. During 2010, the CQC is setting essential standards of quality and safety, including the requirements for safeguarding from abuse, people who use our services. The RUH was required to make a declaration against these standards in January 2010 and our registration was accepted with no conditions applied. The full declaration can be found on our website, www.ruh.nhs.uk

An internal audit in 2009 highlighted some gaps in staff knowledge about child protection procedures, particularly what to do if they suspected abuse. To combat that, we have totally revised the training and increased the numbers of staff being trained
All of our employees have a responsibility to safeguard children and young people from harm and job profiles have been amended to reflect that duty. Key staff have management responsibility for safeguarding children and young people. All staff must be familiar with and adhere to the Trust's child protection procedures and guidelines in conjunction with the Local Safeguarding Children's Board (LSCB). The LSCB is a local partnership organisation whose members co-operate to protect and promote the welfare of children. We are represented on all our local Boards.

"No Secrets" is mandatory guidance issued under the Local Authority and Social Services Act 2007. It says that all agencies working with vulnerable adults living within a local authority boundary must work together to protect them from abuse. The RUH is part of Bath and North East Somerset and Wiltshire Safeguarding Adults Group, which brings together specialists from medicine, social care, the council and the police.

The hospital also has its own Safeguarding Adults Group which was originally established in 2008 and presents regular reports to the Trust Board. The group continues to raise awareness amongst staff within the RUH to enable them to recognise and report abuse and to understand their roles in the Safeguarding Adults procedures. The ownership and responsibility for the safeguarding committees for both adults and children rests with the Trust's Director of Nursing.

11 Children Act 1989 and the Children Act 2004. The Safeguarding Vulnerable Groups Act 2006.

Clinical Effectiveness

Clinical effectiveness is a measure of the extent to which a particular intervention, or treatment, works. We need to look at whether the treatment itself is successful but also many additional factors such as whether the treatment is appropriate, whether it is nationally recognised and whether it represents value for money.

To this end we make sure clinical effectiveness is embedded in our culture across the hospital, from ward level to Trust Board, to make sure we do the right thing, for the right patient, at the right time and that we get it right first time.

We have undertaken a range of quality improvement activities and initiatives to ensure the care we provide is clinically effective including:

- evidence, guidelines and standards to identify and implement best practice; these include implementing the latest NICE[12] guidelines and learning from world-wide best practice
- quality improvement tools, (such as clinical audit, evaluation, rapid cycle improvement) to review and improve treatments and services based on
- the views of patients, service users and staff
- evidence from incidents, near-misses, clinical risks and risk analysis
- outcomes from treatments or services.
- identifying areas of care that need further research
- developing information systems to assess current practice and provide evidence of improvement
- assessing whether services/treatments are cost effective.

We have identified three primary indicators for Clinical Effectiveness in the table on page 26.

We also have a number of national targets to comply with, which provide a measure of our clinical effectiveness. The time a person spends in our Emergency Department waiting for treatment or to be admitted is one of these nationally set targets. Patients attending the Emergency Department at the RUH should be admitted, discharged or transferred within four hours of arrival. The national standard for achievement of this goal is 98% of patients. During 2009/10 the RUH and local minor injury centres together achieved a standard of 97.7% which is much the same as that achieved for 2008/09. The performance of the Emergency Department alone was 95.1%. Again this is the same level of performance as in 2008/09; however, performance deteriorated more severely during the last three months of the year when there was a period of very cold weather and a high level of norovirus (diarrhoea and vomiting) in the community. We are planning to achieve the 98% standard for our emergency patients in 2010/11 (a 3% improvement).

Patients needing to be admitted to receive a planned (elective) procedure should be treated within 18 weeks of referral by their GP. This becomes a patient right as part of the NHS Constitution from 1 April 2010 and is one our quality indicators for 2010/11. The national standard for achievement of this goal is 90% of patients as some patients will have clinical needs which mean it is not possible to meet this timescale and some patients will choose to wait longer for their treatment. During 2009/10 the RUH consistently met this standard until October 2009; however, from that date the proportion of patients cared for within 18 weeks of referral deteriorated on a month on month basis and in March 2010 only 67% of patients were treated within 18 weeks. The full year performance was 85%. As for the emergency care standard, some of this deterioration was linked to pressures on hospital beds during the winter period. We have a recovery plan in place which will deliver the expected national standard by June 2010.

12 National Institute for Clinical Excellence

RUH-determined quality domains and indicators

Quality domains & indicators	2009/10 actual[1]	2010/11 targets[2]
Patient Safety		
VTE: Risk assessments on all eligible patients Patients who require prophylaxis (preventative treatment) receiving it	Not available - recording of target in development	70% 100% (national target 90%)
Incident reporting: Timeliness of investigations into Serious Untoward Incidents (NPSA National Reporting Framework)	Information not required	< 45 days
Clinical effectiveness		
Length of stay: Reduce the average length of stay for both elective (planned) and non-elective (unplanned) patients	Elective: 4.1 days Non-elective: 6.2 days	Elective: 3.6 days Non- elective: 5.6 days
Pressure ulcers: Reduce the number of hospital acquired pressure ulcers at Grade 3 and 4 Reduce the number of hospital acquired pressure ulcers at Grade 2	49 pressure ulcers 286 pressure ulcers	by 50% from baseline by 20% from baseline
Stroke care Number of patients spending 90% of time in a dedicated stroke unit	23.9%	80%
Patient Experience [3]		
Cleanliness: Inpatient Survey, Outpatient Survey Patient Experience Tracker (PET) question: 'Is the ward clean?'	Inpatient 91% Outpatient orthopaedic: 89% chemotherapy day case: 99%	Inpatient 90% Outpatient 90% PET 90%
Treated with Dignity & Respect: Inpatient Survey Outpatient survey PET question 'Are you being treated with dignity and respect?	Inpatient 96% Outpatient chemotherapy day case only: 100%	Inpatient 90% Outpatient 90% PET 90%
Information given to patients: Inpatient survey Outpatient survey PET question 'Are you being kept well informed?'	Inpatient: 92% Outpatient 90%	Inpatient 90% Outpatient 90% PET 90%

1. Actual refers to the score actually achieved by the RUH.
2. Target is the minimum score or level of achievement the RUH is expected to reach.
3. Patient Experience indicators are monitored on a quarterly basis by the Trust Board.

Nationally-determined targets

Category	2009/10 Target	2009/10 Actual	2010/11 Target
18 week referral to treatment waiting times – admitted patients	90%	85%	90%
18 week referral to treatment waiting times – non-admitted patients	95%	97.5%	95%
A&E waiting times	98%	97.7%	98%
Access to genito-urinary medicine (GUM) clinics	98%	100%	98%
Cancer diagnosis to treatment waiting times – 31 days (first treatment)	96%	98.4%	96%
Cancer diagnosis to treatment waiting times – 31 days (subsequent surgery treatment)	94%	94.7%	94%
Cancer diagnosis to treatment waiting times – 31 days (subsequent drug treatment)	98%	97.4%	98%
Cancer urgent referral to first outpatient appointment waiting times – 2 weeks (urgent GP referral)	93%	93.8%	93%
Cancer urgent referral to first outpatient appointment waiting times – 2 weeks (urgent referral breast symptoms)	93%	99.2%	93%
Cancer urgent referral to treatment waiting times – 62 days (GP referral)	85%	87.6%	85%
Cancer urgent referral to treatment waiting times – 62 days (national screening service)	90%	96.2%	90%
Cancer urgent referral to treatment waiting times – 62 days (consultant referral)	90%	78.6%	90%
Cancelled operations – cancelled on or after the day of admission for non-clinical reasons	0.8%	1.7%	0.8%
Cancelled operations – rebooking of cancelled operations within 28 days	5%	15.6%	5%
Clostridium ***difficile*** infections	174	113	63
MRSA Bacteraemias	19	17	7
Delayed transfers of care	3.5%	3.3%	3.5%
Ethnic coding data quality	85%	89.4%	85%
Inpatients waiting longer than the 26 week standard	0.03%	0%	n/a
Outpatients waiting longer than the 13 week standard	0.03%	0%	n/a
Quality of stroke care	60%	25.5%	80%
Rapid access chest pain clinic waiting times	98%	100%	98%
Reperfusion[4] waiting times – thrombolysis[5] within 60 mins	68%	50%	68%
Reperfusion waiting times – primary PCT within 150 mins	75%	100%	75%
Revascularisation[6] waiting times	0.1%	0.12%	0.1%

4. Reperfusion - the restoration of blood flow to an organ or tissue that has had its blood supply cut off, for instance after a heart attack
5 Thrombolysis is the process of breaking up and dissolving blood clots using drug therapy.
6 Revascularisation - this describes procedures which improve the blood flow to the heart through either Coronary Artery Bypass Surgery (CABS) or Percutaneous Transluminal Coronary Angioplasty (PCTA).

Patient Experience

The Trust places a great deal of emphasis on the views and feedback of patients; it is only with this feedback that we can identify areas for improvement, recognise where things are going well and share this good practice across the Trust, and truly understand more about what is important to our patients.

There are a number of national patient surveys that take place regularly, including those independently commissioned by the CQC, the Adult Inpatient Survey and the Adult Outpatient Survey. Both surveys are national and not only give results on a wide range of questions for each hospital, but also benchmark against other Trusts, showing patient experience across the country.

The 2009 results for both surveys show steady improvement in the general experience of patients and put our hospital in the top 20% of all NHS Trusts in many areas, including treating patients with dignity and respect.

Outpatient Survey
Between March and May 2009, 483 of our patients responded to the survey, which was a 57% response rate and above the national average of 53%.

Compared with the last national Outpatient Survey in 2004, the question responses showed we have significantly improved on waiting times for appointments, not making changes to appointments, cleanliness of the department, comprehensiveness of the information provided and ensuring patients receive copies of letters sent between GPs and hospital doctors. We were in the top 20% of all Trusts on 18 of the 48 questions asked of 163 Trusts. We scored poorly in one area; that of patients believing they were not made fully aware of what would happen during their appointment. We will be addressing this issue during 2010/11.

Inpatient Survey
Between June and August 2009 a questionnaire was sent to people who had been inpatients at 73 Trusts in England. 473 of our patients responded, which was a 57% response rate and above the 52% national average.
The survey showed us we had improved on the 2008 results in five main areas; the 4 hour wait in the Emergency Department, discharge letters being sent to GPs, sharing sleeping areas or sharing a bath or shower facility with a member of the opposite sex and nurses washing hands.

We decided to make both the Inpatient and Outpatient surveys part of our Quality Indicators and identified three areas which we understood to be of great importance to our patients. These are highlighted in the table on page 26 and included cleanliness, patients being treated with dignity and respect and the quality and comprehensiveness of information that we gave to patients.

Together with these national surveys, we also carry out a wide range of local surveys, from ward questionnaires asking about patient's experience of same sex accommodation, to health improvement questionnaires aimed to raise awareness of heath related issues such as skin cancer.

Ms H from Trowbridge said “In February I spent three weeks and two days in the RUH after fracturing my wrist and other complications developing. Recently I have spent four weeks in the RUH with pneumonia and heart problems.

The care and kindness I received was second to none. Nothing was too much trouble for anybody from the consultants, doctors, nurses, porters and domestic staff. The hospital is spotlessly clean and the food good (one complaint, too much). Also, on every occasion that the ambulance was called the paramedics were extremely kind and very efficient and very prompt.

We were the first Trust in the South West to use instant, electronic patient feedback with the Patient Experience Tracker (PET). The PET is a wipe clean, handheld device for use by our patients. It allows us to ask patients five questions of our choice with a simple press button response. The questions were agreed through patient consultation. A total of 6,865 patients have given their feedback on their experience at the RUH using the PET from January 2009 to the end of December 2009. The results are shared with the public through posters in the wards where they are used, with the Patient Experience Group and monitored regularly through Trust and Management Board reports.

The PET has also been extremely useful in the last year in allowing us to monitor whether we are getting it right for patients by treating them with dignity and respect and by delivering same sex accommodation.

Example of questions used on the PET for wards:

- Is the ward clean
- Are the staff kind and friendly?
- Do the staff work together as a team?
- Are you being kept well informed?
- Are you being treated with dignity and respect?

Examples of improvement to services because of the PET include:

- More toys and games provided in the Children's Centre
- Making sure patients in the Orthopaedic Outpatient Clinic are updated more regularly if there are delays to clinic times
- The cleaning team get direct feedback, and are able to act on, patient perceptions of cleanliness.

For patients or carers who want to raise concerns about services or the care they have received, our Patient Advice and Liaison Service will assist in the first instance. We also have a Complaints Department and we provide leaflets, in several languages, about how to complain as well as 'easy to read' versions.

RUH Pharmacy Robot in action

Quality Management Systems
The use of local and national indicators as a measure, or evaluation of our quality of care, is very important. But there are other ways we use to measure the quality of our care. For example, at each Management Board and Trust Board, members review performance scorecards. These show at a Divisional, as well as Trust operational level, how we are performing in certain areas.

On the Trust wide scorecard, there are 47 separate indictors, ranging from the 4 hour wait in the Emergency Department to diagnostic waiting times, staff sickness levels, the number of operations cancelled on or after the day of admission, through to how long it takes our call centre staff to answer the telephone and the percentage of patients who can access our genitourinary clinic within 48 hours of contacting the service.

There are also national measures such as the registration of the Trust by the CQC and the Commissioning for Quality and Innovation payment framework (CQUIN) There is more information about both of these measures in **Chapter Four: Participation in Clinical Research and Development.**

We also participate in national clinical audits. In simple terms, this means looking at the practices of our clinicians and identifying areas where improvements are needed, both locally and when measured against similar organisations or services.

Participation in Clinical Audits
Clinical audit is an essential component of clinical effectiveness and ensures that current practice, patient care and services are working well and according to evidence based national guidelines. By looking at results we can target where further improvements are required, in order to improve the quality of care that patients experience.

In this section you will see the second of the 7 regulatory statements we have to include. In this statement we are saying that by presenting data on our level of participation in clinical audits, we are demonstrating that we monitor quality in an ongoing and systematic manner at Board level. The RUH carries out a Trust-wide clinical audit programme which includes national, regional and local audits. Our audit programme includes audits required by the CQC, the National Patient Safety Agency and the Department of Health. Individual specialties also carry out clinical audit projects specific to their areas of work.

Statement 2
During 2009/10, 30 national clinical audits and 5 national confidential enquiries covered NHS services that the RUH provides. During that period the RUH participated in 83% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in. Participation in clinical audits by clinical teams and individual clinicians is a means of monitoring and improving their practice.
The national clinical audits and national confidential enquiries that the RUH participated in, and for which data collection was completed during 2009/10 are listed in the chart below/right/left 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.

National Confidential Enquiries

NCEPOD[7] – Eligible Studies	RUH Participated (✓ / ✗)	No of cases submitted as % of no of cases required by NCEPOD
Parenteral Nutrition study Elective and Emergency	✓	100%
Surgery in the Elderly study	✓	100%
Cosmetic Surgery study	✓	100%
Surgery in Children study	✓	100%
Peri-operative Care study	✓	82%

Clinical Audit - Continuous data collection with no planned end date

National Clinical Audits – Eligible	RUH Participated (✓ / ✗)	Continuous – all patients No of cases submitted as % of no of cases required
National Neonatal Audit Programme (NNAP) : Neonatal care	✓	100%
Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme Data (CMPD): adult critical care units critical care units	✓	100%
National Elective Surgery PROMs: four operations	✓	Hernia - 18.1% Hip - 28.9% Knee - 39.0% Varicose vein - 31.7% Percentages calculated from number of patient questionnaire responses, April 09-Nov 09
Adult cardiac interventions: coronary angioplasty	✓	100%
National Joint Register (NJR): Hip and knee replacements	✓	87%
National Lung Cancer Audit (NLCA): Lung cancer	✓	Data available April 2010
National Bowel Cancer Audit Programme (NBOCAP): Bowel cancer	✓	86%
Audit Head and Neck Oncology (DAHNO): Head and neck cancer	✓	Data available April 2010
Myocardial Infarction National Audit Programme (MINAP) (including ambulance care): Acute Myocardial Infarction (AMI) and other Acute Cardiac Syndromes (ACI)	✓	100%
Heart failure audit	✓	70%
Effective use of Percutaneous Coronary Interventions (PCI) for inpatients at the Royal United Hospital Bath (BCIS)	✓	100%
Effective Pacing of patients at the Royal United Hospital Bath (BPEG)	✓	100%
National Audit of Cardiac Rehabilitation	✓	100%
National Carotid Interventions Audit	✓	86%

National Clinical Audits – Eligible	RUH Participated (✓ / ×)	Continuous – all patients No of cases submitted as % of no of cases required
NHS blood & transplant: potential donor audit	✓	93%
National Hip Fracture Database: Hip fracture	✓	93%
Trauma Audit and Research Network (TARN): severe trauma	×	Did not participate
NDA: National diabetes audit	×	Unable to participate due to IT technicalities
Adult cardiac surgery: CABG and valvular surgery	N/A	do not perform adult cardiac surgery
Pulmonary hypertension audit	×	data collected by the Royal Free Hospital.

Intermittent Clinical audit

National Clinical Audits – Eligible	RUH Participated (✓ / ×)	Intermittent Samples of patients - No of cases submitted as % of no of cases required
National sentinel stroke audit	✓	Further organisational audit to be undertaken 2010 – 80 case notes to be audited. To be included in 2010/11 Quality Accounts
National audit of dementia: dementia care	✓	Audit commenced March 2010 – 40 case notes to be audited. To be included in 2010/11 Quality Accounts
National falls and bone health audit	✓	46%
National comparative audit of blood transfusion: Bedside Transfusion Re-audit	✓	100%
British Thoracic Society: BTS guidelines for emergency oxygen use in adult patients	✓	100%
College of emergency medicine: pain in children; asthma, fracture	✓	100%
National Health Promotion in Hospitals Audit	✓	100%

One – off clinical audit with no plan to repeat in the future

National Clinical Audits – Eligible	RUH Participated (✓ / ×)	One off – all patients
National Mastectomy and breast reduction Audit	✓	85%
National Oesophago-gastric cancer audit	✓	98%
Royal College of Physicians continence care audit	✓	Data completed March 2010. To be included in 2010/11 Accounts

7 National Confidential Enquiry into Patient Outcome and Death. For more detail, go to www.ncepod.org.uk

The reports of 25 national clinical audits were reviewed by the RUH in 2009/2010 and we intend to take the following actions to improve the quality of healthcare provided:

A National Health Promotion audit was undertaken to provide hospitals with information on the extent to which ideas for a healthy lifestyle are promoted to their patients. The results of the audit raised issues concerning the assessment and documentation of patients' health promotion needs. To address this issue, health promotion training was introduced to specific wards to improve and increase the referral system between the RUH and the community health promotion support post-discharge. Additional resources were provided such as information and leaflets for patients, and pocket guides for nursing staff. Nursing documentation has been amended to provide evidence that patients' lifestyle has been recorded and any actions taken are documented. The effectiveness of these actions will be re-audited in June and December 2010 to monitor ongoing compliance.

The RUH took part in the National Comparative Audit of Blood Transfusion. This audit was carried out to determine if Trusts complied with the British Committee for Standards in Haematology (BCSH) guidelines for the administration of blood at the patient's bedside. This audit looked at safety issues concerning patient identification prior to, and during, blood transfusion episodes. The audit results showed the RUH compared favourably with the national results. Areas for improvement that were highlighted were the recording of observations during and after a blood transfusion. New observations charts were introduced at the end of 2009 and teaching sessions highlighted the importance of the recording of observations during transfusions.

In November 2009, a report by the NCEPOD was published following a review in 2007 of the care of patients who died in hospital within four days of admission. There were fourteen recommendations within the report, of which the RUH complied with nine – the remaining five recommendations are almost met, with short timescales planned to achieve compliance. Examples of actions to be implemented are the revision of the RUH anaesthetic chart to have a section that allows the recording of anaesthetic information given to patients and to include a space to record the grade of the doctor anaesthetising the patient. The surgical acute admission document will allow the recording of the name and location of the supervisory consultant.

Healthy Hospitals Project

Improving health at the heart of the community

NHS Bath and North East Somerset are working together with the Royal United Hospital to create a referral system that encourages patients to think about their health.

If you are interested in making a positive step then be sure you make the most of this opportunity and ask your nurse about being referred.

The Healthy Hospital Project

The Healthy Hospital Project aims to look at individual's lifestyles and how overall health may be improved by making some small changes to the way we live our lives.

During your recent time in hospital you should have been encouraged by a member of staff to look at your lifestyle and see if there is anything you can do to make a positive change. We don't expect you to do this alone and so we have put together a whole programme of services which may help you.

Health promotion messages included in 'Having a General Anaesthetic' patient information leaflet.

The reports of 58 local clinical audits were reviewed by the RUH in 2009/2010 and we intend to take the following actions to improve the quality of healthcare provided:

Is intravenous vancomycin being used appropriately in adult patients at the RUH?
Actions: This audit was carried out following a Department of Health report regarding antibiotic use. The audit aimed to establish whether intravenous vancomycin (injecting the antibiotic, vancomycin into a vein) was being used effectively at the RUH. The results showed that intravenous vancomycin was prescribed appropriately in 94% of cases. However the audit also showed that there appeared to be confusion about appropriate antibiotic prescribing in patients with renal (kidney) impairment. New guidelines for vancomycin and gentamicin (an antibiotic) have been produced which include more information on dose adjustments and monitoring in renal failure. Teaching has also been provided for ward pharmacists and junior doctors on induction as well as sessions for nursing staff on various wards. A re-audit is planned for May 2010 to monitor the implementation of the new guidelines.

The Post Anaesthesia Care Unit (PACU)
Actions: PACU undertook an audit to review the service provided to children on the unit. This audit of 10 standards of care highlighted that parents and children were 100% satisfied with nine out of the ten of them. There was 95% satisfaction on the tenth standard - that of nursing staff introducing themselves to parents and children upon arival at the Unit. The majority of written comments were positive and these results were fed back to staff on the Children's Centre and PACU.

Timeliness of radiotherapy outpatient appointments
Actions: The National Cancer Plan aims to reduce waiting times for patients referred for treatment. An increase of patients has resulted in a busy schedule in the Radiotherapy Department. Patients should be seen within 30 minutes of their appointment time. The aim of this audit was to ensure that patients attending for radiotherapy are seen in a timely manner. The audit has demonstrated that 95% of patients with Radiotherapy appointments are being seen within 30 minutes of their appointment. The results have been disseminated to staff in Radiotherapy and also presented at the Oncology/Haematology Audit half-day in September 2009. This audit will be repeated over a longer timeframe in June 2010 to ensure that patients are still being seen within the Department of Health recommended timescale.

Monitoring of quality is ongoing and reports of local and national audits are reviewed via the clinical governance structure at the RUH. The Clinical Governance committee acts as a sub-group to the Trust Board. However the implementation of a Quality Board in 2010, will ensure that the national audit programme, audit reports and implementation of action plans from all audits will inform the quality of practice throughout the RUH.

Timeliness and accuracy of patient discharge summaries

Actions: The National Health Service Litigation Authority (NHSLA) is the body that provides NHS organisations with insurance cover. The NHSLA needs to be satisfied that Trusts have measures in place which will reduce clinical risk and therefore lessen the chances of a claim being made in the first place. These standards examine many areas of clinical risk management, one of them being health care records including discharge arrangements for a patient. In December 2009, we carried out an audit of our patient records to ensure they were being completed accurately and effectively. A sample of 133 patient notes were reviewed and found that, on the whole, their discharge summaries were being completed correctly. There were 25 standards for information that should be present on a discharge summary. Ther equired information was present in 80% or more of the discharge summaries that were reviewed for 17 of the standards. The areas were compliance need improving include:

- instructions on wound management
- medication dose
- frequency of medication.

It was also unclear whether the patient was given a copy of their discharge summary. This audit has been presented at the RUH Medical Records User Group and actions are being taken forward. A meeting was held in April 2010 with key hospital staff to review how patient records are dealt with across the RUH.

In March 2010 a female patient attended X-ray department to have a barium enema procedure carried out during which two male staff were present. The patient confirmed that whilst the service they received was very good they would have preferred a female chaperone to be present; they wanted to know what the radiology procedure regarding chaperones was.

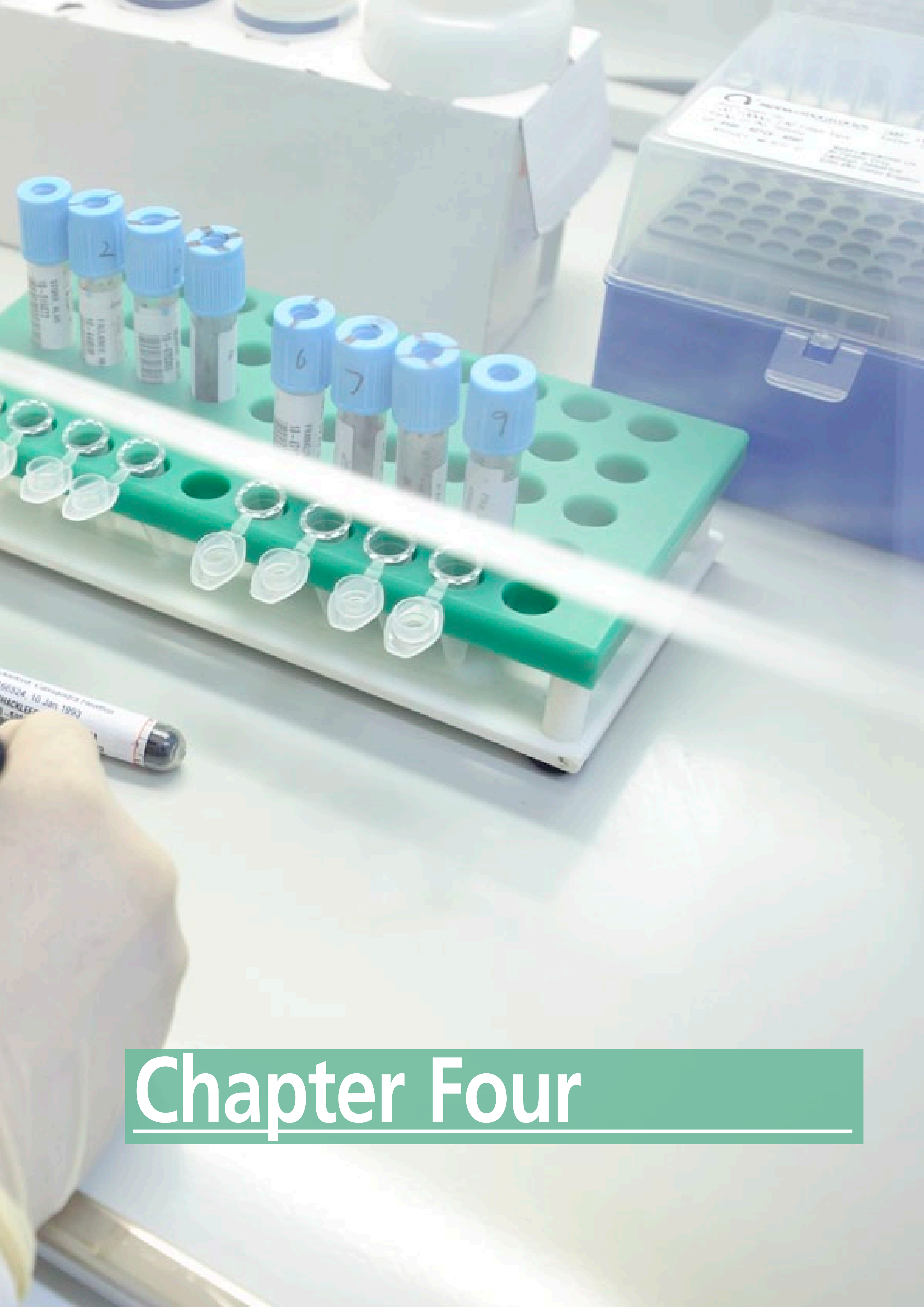
The Patient Advice and Liaison Service staff telephoned the patient to listen to her concerns and proposals. It was agreed that PALS staff would contact the radiology department to find a resolution. The department now provides patients with information on chaperone arrangements.

ROYAL UNITED HOSPITAL NORTH
Pay on Exit
Pay
Station
Inside Main
Entrance

Senior Research Sister at the RUH Christine Cox says: "Clinical trials are particularly important now, when research is producing many new drugs and treatments. Trials may test these new treatments against, or in addition to, standard care, to see which are most effective. A trial may also look at reducing the amount of treatment that patients receive to reduce side effects.

"Some large scale trials need thousands of patients to take part and so will run over several years and the results may take a few more years to gather, but it is only by doing this that we can be sure that we are offering patients care that has a solid evidence base to it. All care that is currently used as standard has come about as a result of previous clinical trials."

Ms G, a patient from Bath says: "I've had a lot to do with the RUH over the years and when considering being involved in a clinical trial, my first thoughts were that this was a way to pay something back. Nothing would move forward unless people volunteer for these things and though I may not necessarily benefit, other patients will in the future, and that's another good reason to take part."



Chapter Four

Participation in clinical research and development

All of the research we carry out has the same goal; to improve the quality of care we give and therefore improve a patient's experience.

Most of the research carried out is funded by the National Institute of Health Research (NIHR), but research councils, charities and the commercial sector provide funds as well. The NIHR provided £828,000 last year. The research is carried out by a wider range of suitably qualified staff, comprising medical staff, nurses, psychologists, scientists and allied health professionals. Around 10% of our staff are involved in research.

A snapshot of current research includes:

- Evaluation of new airway devices for anaesthesia. Better devices could mean that patients can be intubated easier (putting an artificial airway down a patient's windpipe) so that the anaesthetic process will improve for the patient. This hospital has anaesthetists who are internationally recognised for their work in this area.
- Evaluating new drugs for Intensive Therapy Unit (ITU) which could improve the experience and survival rates of patients with acute respiratory distress syndrome. This is one of many projects carried out in the ITU in this hospital, and the unit is nationally recognised for its innovative research.
- An innovation radiation measurement system that could make the introduction of new radiotherapy methods (cancer treatment) possible, which could give better, safer radiotherapy. This is funded by a prestigious New and Improving Applications of Technology (NEAT) grant.
- Poor eyesight in stroke survivors. This is a trial to understand this group of patients and how to optimise their subsequent treatment. This is one of many stroke related research projects.
- Evaluating and finding better drugs that will improve the experience and care of patients with Parkinson's disease. There are many projects like this which aim to find better drug treatments for a wider variety of patients.
- Carrying out an extensive evaluation of cardiac output (heart function) monitors to make patient care safer and more effective in our Emergency Department. Proper equipment evaluation is carried out in many areas, and this is just one example.

As part of our new research strategy we have prioritised research support funding for the following medical areas: Oncology, Diabetes, Stroke, Intensive Care and Paediatrics. We are now funding six specialised research staff in the William Budd Oncology department and can now undertake clinical trials covering a much wider range of cancers with obvious benefits to patients including the opportunity to have access to new and potentially more effective therapies and drugs.

We are fortunate to host the Cochrane Library for Gynaelogical Cancer. The Library organises systematic reviews of clinical trials in order to determine the most clinically effective treatments and drugs for particular cancers. The information gained is used by outside bodies such as the National Institute for Clinical Excellence (NICE) who recommend the most effective treatments and drugs to the NHS as a whole.

The third of the 7 regulatory statements is in this section. The purpose of this statement is to declare our commitment to taking part in clinical research as a way of improving the quality of care we offer and making a contribution to wider health improvement.

Statement 3
The number of patients receiving NHS services provided or sub-contracted by the Royal United Hospital Bath NHS Trust in the period 2009/2010 that were recruited during that period to participate in research approved by a research ethics committee was 332.

A patient undergoes an angiography

There are also many developmental projects going on in the hospital, which are outside the scope of Clinical Research and therefore not registered with a research ethics committee, but are important examples of improved patient care and experience. Below are just four examples which have been very successful in the past year.

Pharmacy Robot

The RUH has successfully installed a state-of-the-art robot to help dispense drugs in the hospital's busy pharmacy.

The robot selects the required drugs at a speed of one item every 6 to 12 seconds from its own internal shelves using advanced computer technology. Pharmacy staff still order the medication and generate the labels from their computers, but drugs are picked and placed in a spiral chute by the robot, arriving at the dispenser's workstation in a matter of seconds. Pharmacy staff then check against the prescription to ensure the right medicines, dose and expiration date goes to the ward. The robot also helps to reduce waste by monitoring expiry dates - when drugs are delivered the packages will be scanned into the robot and stored so that the older stock is used first. In practice, a robot dispenses prescriptions faster and more accurately than humans and enables pharmacies to directly free up staff to have a more patient focused role. The RUH robot picks between 1500 and 1700 items a day mainly for dispensing but also for ward stock. During 2009/10 a pilot study was started on two wards to improve the reduction of waste at ward level. At the end of March 2010, there was an average of 50% reduction in waste products as a direct result of using the robots.

Getting medicines right at the start of the hospital journey is crucial to good patient care and speed of recovery. National targets say that all patients admitted to hospital should have their medications checked within 24 hours of admission to hospital. The pharmacy department has been able to release more time for pharmacy technicians to expand this programme.

Productive Ward

Research carried out by the NHS Institute for Innovation and Improvement found that ward nurses in acute settings spend an average of just 40% of their time on direct patient care. This is supported by research carried out by Nursing Times in 2007[13], which showed that nearly three in four ward nurses said that they did not spend enough time on direct patient care, and 90% of those polled said that patient care suffered as a result.

In 2007 the Institute launched a programme that aimed to combat this. Designed by nurses, for nurses, the 'Releasing Time to Care: Productive Ward' programme was launched following a pilot at four hospital Trusts across the country. Productive Ward provides tools and guidance to help nurses make changes to their physical environment and working processes that will improve quality of care and improve safety standards. The approach analyses the main tasks taking place on a ward, such as medication rounds and meal rounds, and then 'redesigns' these to ensure they are patient-focused and easier for staff.

The power of the Productive Ward is that change is initiated from frontline staff as they become enthused and empowered by seeing the impact that they can have. By increasing direct care time we hope to:

- Improve the patient experience
- Reduce length of stay
- Reduce infections
- Reduce complaints / increase compliments
- Improve the job satisfaction of staff, thus reducing absenteeism and turnover.

13 the full report can be found at www.institute.nhs.uk/productive ward

The RUH was an early implementer of Productive Ward when the programme was released in 2008. Since then the amount of time spent by nurses at the bedside has increased on all our wards by varying amounts; The most significant change saw the time spent by nurses in direct patient care increase to over 70%.

Surgical Safety Checklist

There is evidence suggesting that implementing a systematic process of checks, briefing and debriefing can reduce safety incidents in operating theatres by up to one third. The World Health Organisation (WHO) has developed a simple reminder procedure known as the Surgical Safety Checklist. The tool brings together best practice about safety checks in theatres and can be adapted to accommodate additional local requirements. It ensures that all equipment is avaialble, that all staff understand the procedure to be undertaken and are able to raise any concerns.

There is a check or 'pause' immediately before the patient is anaesthetised (Sign In) and then another immediately before surgery starts (Time Out). This is a check of patient identity and site of surgery as well as a check that everything is ready. There is then a final check at the end of the operation (Sign Out). There have always been checks in theatres, but the concept of every patient having this surgery checklist immediately before interventions is to ensure that checks occur for all of the things, on all of the patients, all of the time.

At the RUH we were already beginning to implement this tool when, in February 2009, the NPSA issued a directive that all hospitals must be using WHO checklist by February 2010. The checklist can be adapted for local use so we continued to develop the RUH checklist over the following months. We made minor changes to increase reliability of its use and used champions in a few theatres to do this. Since September 2009 we have been using our current checklist which also incorporates a preoperative briefing, which was essential to ensure all correct equipment is available and that the whole team is aware of all the issues with each patient. This is also very important for increasing team work and improving the safety culture in theatres. In September the checklist was used in day surgery theatres, then gradually rolled out to the other theatres, so that since October 2009 we have been using it in all theatres. We audit use of the checklist by random note review every week and we are more than 95% compliant. Also since February 2010 its use has been recorded on ORSOS (the theatre IT system) and a run chart has been produced to show monthly compliance. From these figures we are 96% compliant for all patients going through theatres at RUH and are therefore compliant with the NPSA directive.

Both these figures are sent to the South West SHA each month as part of the South West Quality and Patient Safety Improvement Programme. The run charts are also displayed in theatres. Obstetric patients required slightly different safety checks so we adapted the checklist for obstetric patients and are now currently using this for all obstetric cases, both planned and emergency.

Reduction of radiation exposure to babies receiving X-rays on the Neonatal Intensive Care Unit

The babies in our Neonatal Intensive Care Unit (NICU) need a range of treatments and therapies during the days or weeks they spend with us. One such diagnostic treatment is an X-ray. Whilst it is important the X-ray image is sufficient for the radiologist to diagnose a potential problem, it is vital that the dose of radiation the baby receives during the X-ray process is as low and as safe as possible. We know that infants, because they are still developing, are at greater risk of the harm associated with radiation exposure. To perform X-rays on such tiny babies as those in our neonatal unit requires a significant amount of handling, which in turn, can affect their stability.

During 2009/10, a team of specialists from the RUH undertook research to see if the amount of radiation a premature baby was exposed to could be reduced without compromising the quality of the exposed image. This was a joint project involving medical physicists, radiologists, and paediatricians from NICU. Their premise was that the dose of radiation being received by these babies could be reduced without any reduction in quality of the exposed films, or adverse impact on clinical effectiveness. This would enable the continuance of good medical care but improve the safety of the procedure for the babies.

Over a period of a few months the radiation doses being used on our premature babies was gradually reduced. The clinicians on NICU were not told which X-rays were being exposed at the reduced dosage. They looked at each X-ray on merit and commented on whether the quality was adequate to give the appropriate level of clinical information requested. The X-rays were further quality assured by consultant radiologists. The result at the end of the project time frame was that the target dose was achieved with no discernible reduction in image quality. The dose of radiation given to a baby receiving an X-ray reduced by an average of 33%; more specifically, it was reduced by 40% in our most vulnerable, small and immature babies and 26% in the largest babies.

This project is an excellent example of how teams from different disciplines can work together to improve quality of care and patient safety in an organised and comprehensively evaluated way.

162
46
PHILIPS

Major J H from Wells wrote “I wanted to express my gratitude and appreciation for the treatment I was given at the RUH. I have had little recent experience of life in hospitals, but, like so many people, have been infected by the constant flood of critical media commentaries. I was therefore uncertain as to what I should expect. I am delighted to say that from the moment of my arrival on Philip Yeoman ward, my reception and the atmosphere of the establishment totally reassured me.

“Advice, enquiries and explanations were readily answered; the subsequent move, including handover procedures on route to the operating theatre could not have been bettered by even the most efficient airline crews. All I had to do was relax. I fully appreciated what a marvellous team, or teams, were looking after us. Care appeared to be seamless and with available staff almost interchangeable. Individuals were clearly dedicated and highly motivating and always encouraging. I would like to offer my thanks for all your efforts.”

Commissioning for Quality and Innovation (CQUIN) payment framework
The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of healthcare providers' income conditional on their quality and innovation. Its aim is to support the vision set out in Lord Darzi's report for the NHS, ***High Quality Care for All*** where quality is the organising principle. This payment framework was launched in April 2009 and helps ensure quality is part of the discussions between those health organisations commissioning services and those providing them. The RUH is commissioned to provide health services and treatments primarily by three local Primary Care Trusts, NHS Bath and North East Somerset, NHS Wiltshire and NHS Somerset. During 2009/10 the CQUIN framework was not used in our local contracts for services.

Statement 4
Whilst we are committed to improving quality and fully support the framework's aims, the Royal United Hospital Bath NHS Trust income in 2009/10 operating year was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

This was because the Trust established a variation to its 2008/09 contract which gave a set financial sum for the year without the risks of fines or the benefits of additional payments for quality. This was in order to manage financial risks across the health community within which the Trust works.

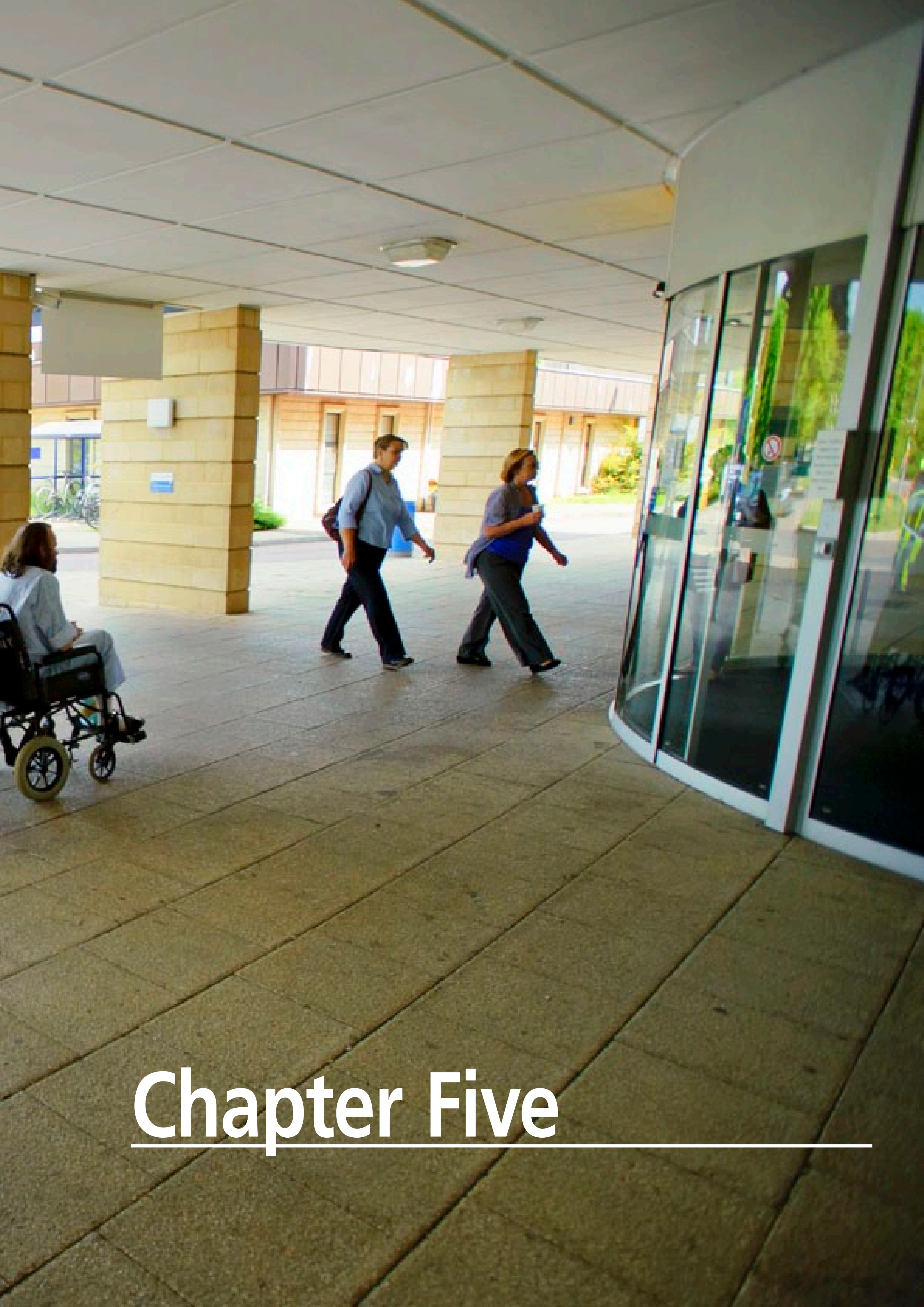
Care Quality Commission Registration
The CQC was established by the Health and Social Care Act 2008 to regulate the quality of health and social

care and look after the interests of people detained under the Mental Health Act. In April 2009 the CQC took over the work of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. The RUH has registered with the CQC and declared full compliance with the nine compliance criteria detailed in the Code of Practice for the Prevention and Control of Healthcare Associated Infections.

During 2009/10 the RUH assesed its performance against all 43 Standards for Better Health and was able to declare full compliance at an interim assessment in November 2009 and full year compliance in March 2010

Statement 5
The Royal United Hospital Bath NHS Trust is required to register with the Care Quality Commission and its current registration status is 'registration without conditions'. The Care Quality Commission has not taken enforcement action against the RUH during 2009/10.

Statement 5a
The Royal United Hospital Bath NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2009-10; an unannounced hygiene code inspection. The Care Quality Commission raised no concerns.



Chapter Five

What others say about us

These Accounts have been compiled to be an honest and accessible review of the standards of our quality of care over the past year and of our commitment to continue to make improvements for the benefit of our patients. Powers have been granted within the Quality Accounts section of the Health Act 2009 giving the CQC and the South West SHA a role in asking for errors and omissions identified within published Accounts, to be corrected.

As a Trust we are required to send a copy of the completed accounts to the Secretary of State for Health. Before that, Trust Board members had the opportunity to comment on a draft and we were also required to send copies to our local Primary Care Trusts, council Healthier Communities and Older People Overview and Scrutiny Committees and local patient involvement groups such as LINkS. They were given up to three weeks to read the Accounts and forward comment as they saw fit. Here is a summary of the points raised from all organisations, other than that of NHS Bath and North East Somerset. We are required to publish in full, their 500 word response.

Bath & North East Somerset Council's Healthier Communities and Older People Overview and Scrutiny Committees (OSCs) and Wiltshire County Council's Health and Adult Social Care Select Committee.
Bath & North East Somerset co-ordinated this response on behalf of both committees.

Wiltshire Health and Adult Social Care Select Committee have chosen not to comment this year. Bath and North East Somerset Council Healthier Communities and Older Peoples Panel have made the following comments:

The content of the Quality Account itself broadly reflects the Panel's discussions with the RUH over the last year.

The Panel has been made aware during the year that there have been some sustained difficulties with meeting waiting time targets in A&E, and look to the RUH and NHS Bath and North East Somerset to continue to work to address this. The RUH is consistently very good at engaging positively with the Panel to keep members updated on issues and developments. There is mutual respect between the Panel and the RUH, and the RUH is notably very responsive to requests for information, as well as taking the initiative to maintain an open and constructive dialogue. The Panel look forward to continuing its positive relationship with the RUH over the coming year.

Bath and North East Somerset LINk - Response to Royal United Bath's Quality Account 2009-10

It is to be applauded that great improvements in the provision of single-sex wards have been made.
The LINk also welcomes the training in mental health being assisted by the Trowbridge Alzheimer's Society and the Avon and Wiltshire Mental Health Partnership, which is provided for nurses working with elderly patients, particularly those with a dementia.

There has been an acknowledged improvement in food provision, and work is in hand to meet the dietary needs of ethnic minorities of all nationalities.

Considerable work is in progress to help patients of all ages who have a learning disability.

There are still concerns around the planning of discharges. On some occasions elderly people are discharged home leading to problems for family and friends. The achievement of getting the right result for young children with significantly lower doses of radiation is of very great benefit.

The Wiltshire and Swindon Users Network (Wiltshire LINk) did not make any comment.

Bath & North East Somerset Council

NHS
Bath and North East Somerset

Working together for health & wellbeing

NHS Bath and North East Somerset (B&NES) has taken the opportunity to review the Quality Account prepared by the Royal United Hospital NHS Trust (RUH) for 2009/10. It is our view that the account is comprehensive and accurate.

In a shared vision to maintain and continually improve the quality of services, NHS B&NES and the RUH have worked in collaboration to establish a comprehensive quality framework that includes nationally mandated quality indicators alongside locally agreed quality improvement targets. The National NHS Contract and Commissioning for Quality and Innovation (CQUIN) scheme provide further support for ensuring robust quality measures are in place.

There are robust arrangements in place with RUH to agree, monitor and review the quality of services, covering the key quality domains of safety, effectiveness and experience of care. This is managed through the Clinical Quality Review Group (QRG) that meets monthly, with representation from senior clinicians and managers from both the RUH and NHS B&NES (including GP colleagues), to review, monitor and provide assurance in relation to quality of care. In addition to the QRG there are a number of community wide groups where quality improvement, assurance, learning and development take place .The RUH is actively involved in these groups.

Through the quality framework for 2009/10 the RUH have improved the safety, effectiveness and patient experience of their services across a wide range of key areas; these are described in this Quality Account. NHS B&NES have also received assurance throughout the year from the RUH in relation to key quality issues, both where performance has improved and where it occasionally fell below expectations with remedial action plans put in place and learning shared across the organisation and the health community.

NHS B&NES has welcomed the opportunity to attend the RUH Clinical Governance Committee and the Infection Prevention and Control Committee. Additionally NHS B&NES has agreed with the RUH to undertake both planned and unplanned site visits to observe and review key quality indicators. These activities facilitate triangulation of information and assurances in relation to quality issues across the Trust.

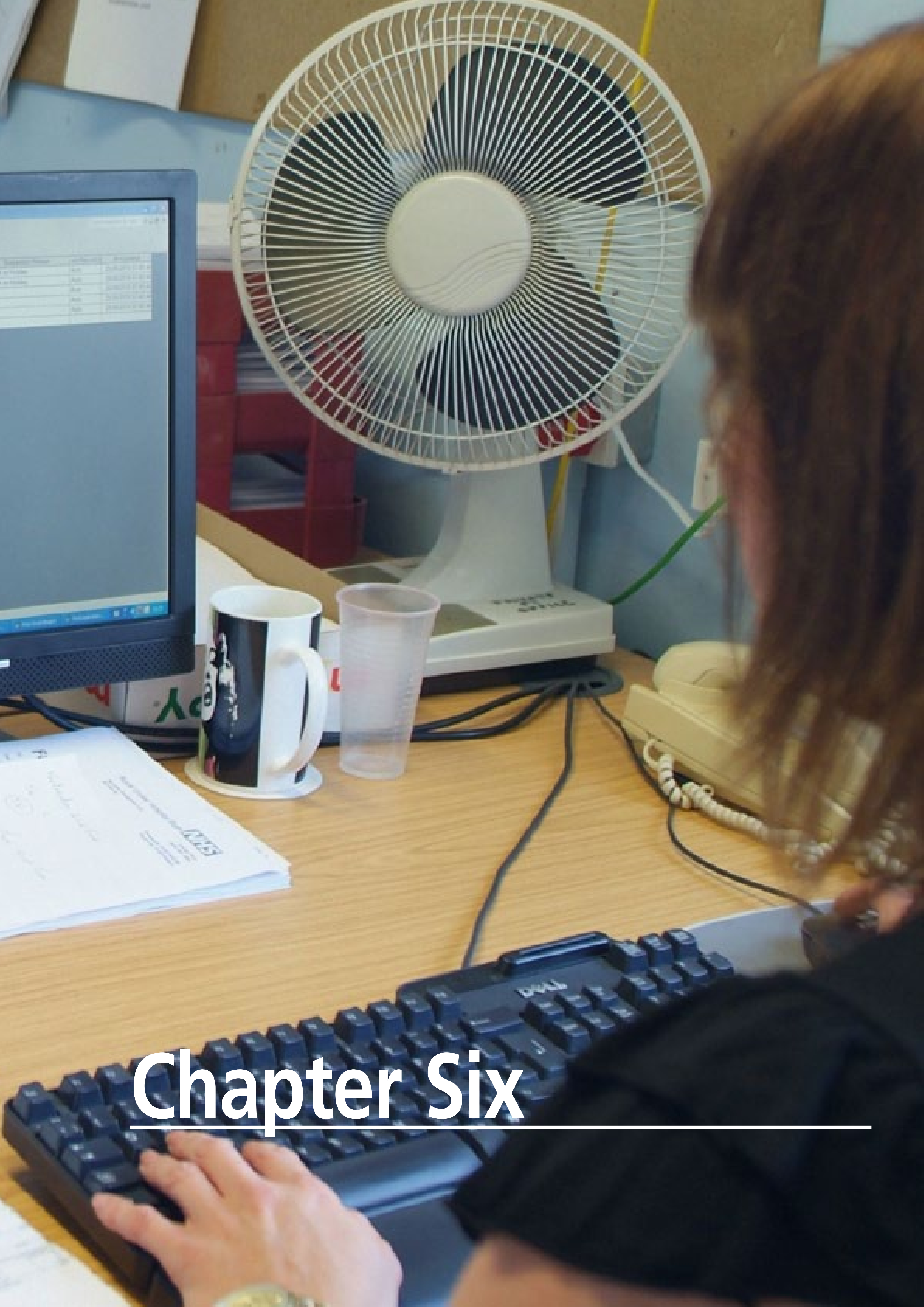
The priorities for 2010/11 have been developed in partnership and NHS B&NES endorse the proposals set out in the Quality Account.

NHS B&NES can confirm that we consider that the Quality Account contains accurate information in relation to the quality of services they provide to the residents of B&NES and beyond.

Malcolm Hanney
Chair

Janet Rowse
Acting Chief Executive

Making Bath and North East Somerset an *even* better place to live, work and visit



Chapter Six

Data Quality

The quality of the information and data we collect about patients and how we keep those records is an extremely important element of patient care. If our data quality and records management is good, we are better able to provide more organised and appropriate patient care.

Every acute hospital, like the RUH, has a computerised patient administration system (PAS) which enables us to register and record each test, diagnosis or procedure which a patient has. These are called 'episodes of patient care'. The majority of information about care received by our patients continues to be paper records. How we keep that information secure is governed by the Data Protection Act 1998.

On arrival at the RUH, whether as a planned or emergency admission, patients will be registered on the hospital's PAS system. At this point every effort will be made to ensure the identity of a patient is confirmed. Every night all new registrations are collated and forwarded in a safe electronic format to the NHS central care record service (known as the SPINE) in order to allocate or validate a patient's NHS number.

We also have to submit the records of patient registrations to the Secondary Uses Service. This is a national service, designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

The NHS Information Centre for health and social care is establishing a single, secure data environment for the whole of the NHS. The Secondary Uses Service provides a consistent environment for the management and linkage of data, allowing better comparison of data across the care sector, together with associated analysis and reporting tools.

In 2009/10, the RUH sent a total of 347,672 patient registrations to the NHS and within that there were 2,942 duplicate registrations. The data we submit also has to show how many of the registrations we made included a valid patient's NHS number.

The sixth of the 7 regulatory statements can be found in this section on data quality. The contents confirm that we submit data to the Secondary Uses Service and the percentages listed are an indication of the quality of the information we provide.

Statement 6
The RUH submitted records during 2009/10 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, taken from the NHS Information Centre Data Quality Dashboard for the period April 2009 to January 2010:

- which included the patient's valid NHS number was:
99% for admitted patient care;
99.5% for out patient care; and
92.6% for accident and emergency care.

- which included the patient's valid General medical Practice Code was:
100% for admitted patient care;
100% for out patient care; and
100% for accident and emergency care.

The RUH score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 70%.

The score for Information Quality and Records Management assessed using the Information Governance Toolkit, referred to in Statement 6, is an indicator of the overall measure of the quality of our data systems, standards and processes. The Toolkit is an online system that enables organisations to measure their performance against elements of law and policy from which information governance standards are derived. It encompasses legal requirements, central guidance and best practice in information handling, including:

- The common law duty of confidentiality
- Data Protection Act 1998
- Information Security
- Information Quality
- Records Management
- Freedom of Information Act 2000.

Whilst a key focus of information governance is the use of information about service users, it applies to information and information processing in its broadest sense and underpins both clinical and corporate governance. Further information about the Information Governance Toolkit can be found at www .igt.connectingforhealth.nhs.uk.

Our staff work hard to ensure we correctly identify all our patients and minimise the risks of confusion or errors concerning a patient's identity. During 2009/10, the RUH recorded 11 incident reports under misidentification but without nay harm to patients. **Our target for 20010/11 is to have no such incidents.** Our methods to reduce incidents of duplicate registrations include:

- Identifying and monitoring the staff responsible for creating duplicate registrations, feeding back monthly to managers
- Retraining any member of staff who repeatedly creates duplicate registrations
- Closely monitoring any department where there is an unusually high level of duplicate registrations, discussing why problems occur and encourage good practice.

Details of a patient's General Practitioner (GP) are added to the hospital's patient care records system as part of the registration process. All local, and a significant number of GPs in North and West Wiltshire, North Somerset and South Gloucestershire are on the hospital's care records system and this can be searched when a patient is registered by the RUH. All the relevant information relating to the GP is contained within this file and once selected, the GP's name is then stored as the patient's registered doctor within the community. This then enables the process of payment by the PCT to be more straightforward. The PCT responsible for the registered GP of a patient is billed for the cost of that patient's care. In the absence of a GP the PCT is identified by the post code in a patient's registered home address. Therefore, it is essential we accurately record both elements – the GP and the postcode - as this is the data used by the hospital to obtain the funding for a patient's care.

The RUH Information Governance Strategy is delivered through an action plan which looks to improve the way that information is handled and managed within the Trust. We have modelled our plan according to the requirements of the NHS Information Governance Toolkit and national legislation, polices and directives.

The Information Governance Toolkit comprises 62 requirements covering the following initiatives:

- Information Governance Management
- Confidentiality and Data Protection
- Information Security
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance.

Clinical Coding

The RUH is required to annually assess its compliance against the requirements, scoring each between Level 0 (low) to Level 3 (high). These scores are then brought together and an overall percentage score is given to each Trust. The RUH score was assessed to have improved from 68% (Amber) in 2008/09 to 80% (Green) in 2009/10. Our target for 2010/11 is 84%, which would mean we comply with all 62 requirements.

This assessment is published on the Connecting For Health website, (www.connectingforhealth.nhs.uk) at the end of each financial year. The assessment is subsequently viewed by the CQC and may be subject to external audit.

Clinical Coding

Clinical coding is the process by which a patient's diagnosis and treatment, is translated into standard recognised codes. The accuracy of this coding is an essential indicator of the accuracy of the patient records. The purpose of these codes or classifications is to allow the systematic recording and analysis of data on death rates and the relative frequency of the occurrence of a disease in different countries or areas at different times.

The codes, using the International Statistical Classification of Disease and Related Health Problems (ICD), the Office of Population Censuses and Surveys and surgical operations and procedures (OPCS) manuals, translate diagnoses of diseases, surgery and medical procedures from words into alphanumeric codes. This permits easy storage, retrieval and analysis of the data. Each diagnosis, procedure or operation is called an 'episode'.

At the RUH, the Clinical Coding Department codes between 65,000 and 75,000 finished consultant episodes per year. These episodes are also given a code relating to how much they cost. The RUH is funded by our local PCTs to provide patient care for the populations they serve and the code provides a means of categorising the treatment of patients in order to monitor and evaluate the use of resources.

Payment by Results (PbR) is the name given to the system of reimbursement for providers of healthcare. PbR predicts a single price or tariff for a given episode of care in hospital by creating a Healthcare Resource Group code (HRG) that is based on the clinical coding data; a HRG code is assigned to every patient's episode of care in hospital.

Each year a number of patient episodes - treatments or procedures in different clinical areas - are chosen by the Audit Commission and checked or audited for accuracy. Auditors use the medical records or case notes as their source document. Clinical coding errors can occur through poor documentation, lack of availability of case notes, poorly written doctor's records and of course, human error. An example of a clinical coding error could be that a patient, Mr. Jones, is admitted for a cataract operation. Their doctor writes in their notes that Mr. Jones has a cataract, which is clinical code H25.9. Mr. Jones actually has a senile cataract which should be coded as H25.1.

During 2009/10, four specialties at the RUH were audited for clinical coding errors as follows.

- General Medicine 100 episodes
- Ophthalmology 100 episodes
- Gynaecology 70 episodes
- Hand surgery 30 episodes.

The tables opposite shows the coding errors for the year 2009/10 based on the episodes audited:

GENERAL MEDICINE	Total from episodes audited	Incorrect		Total incorrect	% incorrect
		Coder error	Non coder error		
Primary diagnosis	102	14	1	15	14.7
Secondary diagnosis	251	67	0	67	26.7
Primary procedure	61	0	0	0	0.0
Secondary procedure	59	1	4	5	8.5
Overall	473	82	5	87	18.4

OPHTHALMOLOGY	Total from episodes audited	Incorrect		Total incorrect	% incorrect
		Coder error	Non coder error		
Primary diagnosis	100	24	0	24	24.0
Secondary diagnosis	176	106	1	107	60.8
Primary procedure	98	2	0	2	2.0
Secondary procedure	169	7	0	7	4.1
Overall	543	139	1	140	25.8

GYNAECOLOGY	Total from episodes audited	Incorrect		Total incorrect	% incorrect
		Coder error	Non coder error		
Primary diagnosis	70	16	1	17	24.3
Secondary diagnosis	35	4	1	5	14.3
Primary procedure	69	10	0	10	14.5
Secondary procedure	100	11	0	11	11.0
Overall	274	41	2	43	15.7

MINOR HAND PROCEDURES for non trauma	Total from episodes audited	Incorrect		Total incorrect	% incorrect
		Coder error	Non coder error		
Primary diagnosis	30	1	0	1	3.3
Secondary diagnosis	22	17	1	18	81.8
Primary procedure	29	1	0	1	3.4
Secondary procedure	34	2	2	4	11.8
Overall	115	21	3	24	20.9

Primary diagnosis describes the main condition a patient is being treated for.
Secondary diagnosis describes other significant conditions that are relevant to a patient's stay in hospital – for example, diabetes, epilepsy, cardiac disease.
Primary procedure describes the main operation or procedure being carried out
Secondary procedures are other operations/procedures carried out at the same time or during a patient's stay at the RUH

The RUH is striving to improve the accuracy and quality of clinical coding. Regular refresher training courses, internal audits, data quality workshops and Consultant seminars all help improve the clinical coder's knowledge of coding. Clinical Coding staff are expected to sit the clinical coding accreditation examination after three year's experience.

In the seventh and final of the regulatory statements, we are providing information about how many errors were identified when samples of our clinical coding were audited.

Statement 7
The RUH was subject to the Payment by Results clinical coding audit during the reporting period July - September 2009 (2nd quarter) by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

General Medicine 18.4%
Ophthalmology 25.8%
Gynaecology 15.7%
Minor Hand Surgery for non Trauma Category 2 without complications 20.9%

Moving Forward

The Department of Health intends to evaluate the first year's publication of Quality Accounts in order to draw lessons from that experience to inform the next set of regulations. One area of interest, highlighted in the responses to the consultation, is to look at identifying what core data the majority of providers such as the RUH are including in their Quality Accounts. This would then provide a starting point for increasing the content set by the Department of Health in the regulations.

The National Institute for Clinical Excellence (NICE) has started to develop independent standards clarifying what high quality care looks like for specific services across the three dimensions of quality: clinical effectiveness, patient safety and patient experience. Once developed, quality standards will become a useful resource for Quality Accounts. Further information regarding NICE Quality Standards can be found at: www.nice.org.uk

Locally, we will continue to review our quality agenda and ensure that the quality improvement plans we have committed to in the coming year are undertaken. This year the time frame for the production of our, Quality Accounts has been very short and has not allowed us to engage with our staff, patients and healthcare partners as much as we would have liked regarding the contents. However, we are committed to developing a much wider and prolonged engagement process for next year.

Quality Accounts are annual and as an organisation, we want our staff, patients and visitors, as well as our health care partners to see consistency year on year. We want to demonstrate the progress made on the plans and commitment made to improving quality on an annual basis, providing information on the quality journey we are on.

The Quality Accounts, together with the Annual Accounts will be published on our website, www.ruh.nhs.uk and that of NHS Choices, www.nhschoices.nhs.uk from 30th June 2010. Notices will also be placed within the hospital after this date informing our patients, visitors and staff where and how they can obtain a printed copy of the Quality Accounts. We will also provide them in alternative formats and languages upon request.

We would welcome comments and suggestions, both on these Accounts and what you would like to be considered for inclusion in next year's. This can be done by emailing qualityaccounts@ruh.nhs.uk or by writing to:

The Communications Department (Quality Accounts)
Royal United Hospital Bath NHS Trust
Combe Park
Bath BA1 3NG

If you would like to know more, or to comment on our plans, please write to the Chairman Brian Stables or Chief Executive James Scott at:
Royal United Hospital NHS Trust
Combe Park
BATH
BA1 3NG
Telephone: 01225 824033
E-mail: qualityaccounts@ruh.nhs.uk

Website: www.ruh.nhs.uk

We value your opinion

We want to make sure future Accounts give you all the information you need on our services, so please tell us if you think we could improve.
E-mail: qualityacounts@ruh.nhs.uk

Write to:
Communications Department (Quality Accounts)
Royal United Hospital Bath NHS Trust
Combe Park
Bath BA1 3NG

Are we talking your language?

If you need this document in another format, including large print, please contact PALS (Patient Advice and Liaison Service)
Tel: 01225 825656
E-mail: pals@ruh.nhs.uk

Se você gostaria desta informação em seu idioma, por favor nos contate em 01225 825656.

如果你希望这一信息在你的语言,请联系我们关于1225 825656。

Jeśli chcesz tę informację w twoim języku, prosimy o kontakt z 01225 825656.

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