



Quality Accounts 2011/12

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Foreword

These Quality Accounts for the Royal United Hospital Bath NHS Trust have been 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 2011-12.

As a provider of healthcare, we are required to present certain information which has been nationally determined, in the form of mandatory statements.

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 2012/13 and we welcome comment on, and involvement in, determining future priorities for improvement.

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CHAPTER ONE

Chief Executive's Statement

These Quality Accounts provide the opportunity for the Royal United Hospital Bath NHS Trust to report on our future plans for improving safety, quality, and patient and carer experience and to provide information about our current performance.

Our guiding principles at the RUH are to provide clean, safe, professional and compassionate care where every patient matters.

In November 2011, the hospital was subject to an unannounced planned visit by the Care Quality Commission. Inspectors visited a number of wards and outpatient areas, speaking with patients, carers, visitors and staff members. We were very proud of the feedback and achieved a high level of compliance which demonstrates our continued commitment to improving quality. The full report can be found on the Care Quality Commission website at www.cqc.org.uk

There is, of course, absolutely no room for complacency and I know that staff are aware of how and where we need to do better. We know we can improve how we respond to our patients and carers and have invested in a new system for recording patient experience called Meridian. This will allow us to gather information from inpatients, outpatients and carers about their visit to our hospital. Our goal is that 100% of patients, carers and staff would recommend us to their family and friends – only by doing this and monitoring, reviewing and improving what we do, can we truly achieve a quality service which meets our patients' needs.

Involving our local community has continued to be an important part of our preparation to become an NHS Foundation Trust. Our 'Caring for You' events have provided an opportunity for our public and staff to learn more about the RUH. We hope to hear the outcome of our application to become an NHS Foundation Trust this financial year.

The Board takes pride in the many examples of improvements in quality and safety outlined in this report, such as the treatment of patients with hip fracture and caring for patients who have suffered a stroke. Focusing on these groups of patients has resulted in better clinical outcomes for our patients.

We continue to invest in our Estates and IT systems. The building of the new neonatal intensive care unit - The Dyson Centre for Neonatal Care - was completed this year, and it provides state-of-the-art facilities for premature and sick babies and purpose-built accommodation for their parents.

The hospital underwent the successful implementation of a new computerised patient administration system, Millennium. The flexibility, commitment and understanding of both staff and patients helped make the RUH's deployment of Millennium one of the smoothest yet.

I am grateful to those who have contributed to the content of this year's Quality Accounts and to the Overview and Scrutiny Committees, Primary Care Trusts and Local Involvement Networks who have worked with us to ensure that these Accounts accurately reflect the work that we have undertaken this year. Their views are reflected in Chapter Five.

As Chief Executive I am pleased to confirm that the information contained in these Quality Accounts is, to the best of my knowledge, accurate.

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

James Scott
Chief Executive

Director of Nursing's Statement

We continue in our total commitment to reduce healthcare associated infections and are very pleased with the low incidence of patients having an infection in their blood stream (bacteraemia) caused by MRSA after admission to our hospital - just one case this year. The number of patients suffering diarrhoeal illnesses caused by *Clostridium difficile* has also continued to fall markedly. This year has seen our second successive year in achieving our locally-agreed targets for both of these superbugs, and we have surpassed national expectations as a clean and infection-free hospital.

Excellent progress has been made with our Enhanced Recovery pathway. This programme significantly improves each patient's speed of recovery following surgery. Patients are actively involved in their preparation for surgery which also helps to reduce their natural anxieties about experiencing major surgery. The surgical techniques (smaller incisions and the use of epidural anaesthetic) enable patients to return to normal living much sooner following their surgery. We have been nationally recognised for making the most progress in the South of England, and all of our colorectal patients and some orthopaedic patients are now being cared for in this way. We have received excellent feedback and we are aiming for all elective patients to be part of the Enhanced Recovery pathway.

This is some of the feedback we have received:

"Brilliant, can't think of anything you could have done better"

"Most impressed with the whole experience, thank you. Feeling so well nine days post bowel surgery, going to a ball tonight."

"Care in hospital amazing, so helpful, very comforting, nothing was too much trouble"

"Absolutely thrilled with how things went, everything good, faultless care"

"Experience was really good, enjoyed myself so much I was disappointed to be sent home. Nice to see familiar faces and know the routine"

In March 2012 I was particularly proud to be invited to the Nurse of the Year Awards to support Senior Charge Nurse Simon Andrews and Junior Sister Lisa Brown who were both nominated for their dedication and commitment to improving the care and treatment of their patients on one of our orthopaedic wards. I am delighted that Simon won the 'Charge Nurse of the Year' award, and Lisa was awarded the 'Royal College of Nursing Professional Forums General Award' for her innovative role in reducing pressure ulcers.



Francesca Thompson
Director of Nursing

Joint Statement by the Medical Director and Associate Medical Director for Quality Improvement

We feel proud of the quality improvements made at the RUH over the past year and hope that you see these reflected in these Quality Accounts.

As a Trust, we have made a real commitment to continuing quality improvement for our patients by opening the 'Qulturum', a quality improvement centre, one of the first of its kind in the country.

This centre brings together teams such as patient safety, patient experience, quality improvement and audit, so that we can work together as effectively as possible to improve patient care and experience throughout the hospital.

The Qulturum provides a hub where we can continue some of our collaborative work such as that performed with staff to reduce infections and pressure ulcers.

Some of the innovative ideas generated from these collaborative groups have not only been effective in reducing harm, but have also been nationally recognised – such as the 'Think Pink' campaign celebrated in our Junior Sister Lisa Brown's recognition in the Nurse of the Year awards.

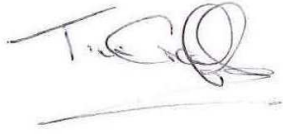
We have won research grants to develop quality care for our patients. A major grant from the Health Foundation will help us ensure that patients with Parkinson's Disease receive their medication on time; however the aim of this Safer Clinical Systems programme is also to learn how we make medication delivery more timely and effective for all our patients.

We are also very active in driving care improvements for patients undergoing emergency surgery. We have speeded up time to the operating theatre for our patients with broken hips and ensured that their care is now managed by both a surgeon and a specialist in the care of older people. In the next year we will continue our improvement for patients with hip fractures but we also have research grants to study how we improve our care for patients undergoing emergency bowel surgery. We are particularly interested in the problems faced by elderly patients undergoing emergency surgery, and how we ensure their best possible outcome.

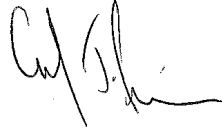
The RUH is one of only a few UK hospitals involved in an international programme called The Dr Foster Global Comparators, a study in which top European, American and British hospitals share learning with each other to improve patient care.

Despite all this focus on improving outcomes, we never forget we are caring for real people who each have different needs. This year in particular, we have listened to feedback and made a number of 'reasonable adjustments' to the way we offer care so as to minimise the impact that being in hospital has on our patients' lives. We feel we have achieved so much in the past year, but are aware that there is much more we can do.

We hope these accounts demonstrate that everyone at the RUH is committed to striving for continuous quality improvement to deliver safe, effective and personal care to all our patients.

Handwritten signature of Dr. Tim Craft in black ink, featuring a stylized 'T' and 'C'.

Dr Tim Craft
Medical Director

Handwritten signature of Dr. Carol Peden in black ink, appearing as 'C. Peden'.

Dr Carol Peden
Associate Medical Director for Quality Improvement

CHAPTER TWO

Our current status and priorities for improvement in 2012/13

During 2011/12 we made significant progress in a number of areas demonstrating our commitment to improve the quality of patient care. Our priorities continue to focus on patient experience, patient safety and clinical effectiveness.

For 2012/13, we have identified five priorities which we believe our patients and the local community will benefit from.

These are:

- to further reduce our healthcare associated infection rates
- to improve the pathway of care for patients with Chronic Obstructive Pulmonary Disease
- promoting organisational learning
- improving urinary continence care
- improving the experience of patients at the end of their life.

Priority One – to further reduce our healthcare associated infection rates

Good infection prevention and control is essential to ensure that our patients receive safe and effective care. It is our priority to ensure that effective prevention and control is used as a part of everyday practice and consistently applied by all staff. By achieving this we can continue to reduce healthcare associated infections (HCAIs) such as Methicillin Resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*. We have continued to reduce our infection rates through a number of initiatives and have remained below the national targets as set by the Department of Health.

Why have we chosen this as a priority?

Our focus on infections continues as a priority from previous years, however this year we have broadened the priority to include increased surveillance in post-operative infections.

Reducing our HCAI rates is our number one priority as this ensures a culture of continuous quality improvement and minimises risk to patients. This will also lead to increased patient safety and a reduction in unnecessary pain and suffering. Reducing the incidents of HCAIs can also lead to financial savings and the ability to use the saved funding elsewhere.

Our aims for 2012/13 are:

- to enhance isolation facilities by upgrading side rooms and adding doors to bays where possible
- to publicise infection prevention and control through the availability of information leaflets and posters at hospital entrances and on our website
- to launch infection prevention initiatives such as hand hygiene awareness and a dedicated infection control week

- to launch a *Clostridium difficile* 'Think Tank' involving staff working in direct contact with patients and increase awareness of reducing incidence of the infection
- to increase the surveillance of surgical site infections beyond the procedures that are covered by the mandatory programme.

Priority Two – to improve the pathway of care for patients with Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a common and debilitating chronic disease. Patients experience progressively worsening breathlessness over many years, interspersed with 'exacerbations' during which they suffer an acute deterioration in their symptoms resulting in frequent admissions to hospital. The Government has recognised the need to improve standards and has produced a national 'Outcomes Strategy' for implementation throughout the country.

Why have we chosen this as a priority?

Locally we have around 500 admissions per year for COPD exacerbations. Audits have shown that around 40% of our patients are readmitted within three months of discharge.

Our aims for 2012/13

In recent years we have started a number of initiatives to improve standards – these have focused on integrating primary and secondary care services so that patients can be managed proactively and potentially avoid admission to hospital. Our aim is to further develop the service so that patients can be discharged early and both patients and their carers are adequately supported in the community.

Our areas of focus are:

- patients on Non-Invasive Ventilation (NIV) for COPD exacerbations should be cared for on the Respiratory Ward within 24 hours of the use of NIV
- emergency oxygen should be prescribed and appropriately administered for patients with COPD
- improving patient education through the use of patient information leaflets, inhaler training guides, appointments for smoking cessation/pulmonary rehabilitation
- improving communication with primary care when patients leave hospital to prevent unnecessary re-admission
- recognising the importance of special nutritional needs for this group of patients by ensuring nutrition screening is undertaken and patients with a low body mass index receive dietetic input or nutritional supplements during their stay.

Priority Three – Promoting Organisational Learning

We are committed to promoting organisational learning by ensuring that the lessons learnt from incidents and complaints are effectively communicated to all members of staff at all levels of the organisation. We will actively use the feedback from patients and carers to improve the quality of care we provide. The RUH has created a quality improvement centre, the Qulturum, which brings together in one physical location patient safety, clinical effectiveness, patient experience, risk management, practice development and complaints and litigation teams. Information collated from the Qulturum will help identify areas improvement.

Why have we chosen this as a priority?

All hospitals have incident reporting systems, complaints departments and collect patient experience surveys. However, it is well recognised that not all of this information is fed back to staff in the most effective manner to enable learning to occur. The Qulturum allows us to collate information from patient experience, complaints and incidents. We aim to study this information, develop improvement themes and learn how we most effectively feed back to frontline teams so they can learn and improve patient care.

This is supported by the Department of Health's Duty of Candour policy which requires providers to be transparent in admitting mistakes and promoting a culture of openness. We recognise that we can improve our understanding and learning from error by focusing on a number of interventions.

Our aims for 2012/13

- to use our improvement forum to identify trends and themes from complaints and incidents so that the quality of patient care and patient experience can be improved. Having identified the key themes the forum will work to change practice where appropriate. This will be achieved by incorporating the learning into existing training e.g. junior doctor training and the re-launching of UTOPIA – Urgent Treatment of Patients in Adversity – training which will reflect clinical priorities and will be more accessible to staff
- identify resources to identify and train 'champions' who will incorporate 'human factors' knowledge and skills into existing training programmes and into the ways teams work
- develop joint working with other Trusts to share learning and best practice
- to use the information from the 'Meridian' patient feedback devices to better understand the views and experiences from our patients and carers
- to continue to use 'patient stories' both at Trust Board and for staff learning events (our 'See it My Way' programme).

Priority Four – Improving Urinary Continence Care

A one day 'snap shot' community-wide audit was undertaken in February 2012 and showed that 19% of patients had a catheter in place, 16% of whom had a urinary tract infection.

Why have we chosen this as a priority?

We recognise the physical and emotional suffering for our patients who suffer from urinary incontinence. Forty-five per cent of the adult population have urinary continence problems compared with diabetes (32%), and hypertension (28%).

Research in an acute hospital found that 25% of catheters were unnecessary and 60% of urinary tract infections were as a direct result of catheter insertion¹. Good continence care maintains health and wellbeing, improves dignity, reduces the likelihood of skin problems potentially leading to pressure ulcers and therefore improves the quality of life for our patients.

Our aims for 2012/13

As part of the existing patient safety programme, we aim for a 50% reduction of catheter associated infections by 2013.

We have a well-established multi-disciplinary Continence Group which this year aims to:

- minimise the loss of dignity for patients by reviewing the use of continence products
- review patient information regarding incontinence associated dermatitis and catheter associated urinary tract infections
- raise awareness for staff around the issues relating to continence – increase the use of teaching for ward staff through the introduction of 'continence ambassadors' and holding a Trust-wide Continence Awareness workshop
- work with our community partners to ensure continuity of care for patients with long-term catheters by developing a patient-held catheter passport as part of a research project in association with the University of the West of England
- continue to monitor the number of urinary catheters in place and the number of patients with a catheter urinary tract infection
- launch new skin cleansing products which will help to maintain the skin of patients who suffer from incontinence
- apply for a research grant to help improve the skin condition of patients with incontinence as this is known to increase the risk of pressure ulcers
- improve the recording of urine output on vital sign charts.

¹ Rothfeld et al (2010), A program to limit urinary catheter use in an acute care hospital. Am J Infect Control 38(7):578-571

Priority Five – Improving the experience of patients at the end of their life

Improving end of life provision in acute hospitals is crucial as more than half of all deaths take place within this setting.

Why have we chosen this as a priority?

We recognise that we can improve the quality of care for patients at the end of their life and provide greater support to staff in managing the emotional difficulties that they face in caring for the dying. We will continue to work with clinical staff in the early identification of patients nearing the end of their life. This will ensure that decisions made by patients and their families are shared with relevant staff as the end of their life approaches. For some patients who wish to die at home, we will endeavour to facilitate this.

The needs of carers while they are in hospital at this time have been recognised as an area for improvement – this includes practical information, emotional and spiritual support and providing a comforting, environment.

Our aims for 2012/13

The End of Life Group, chaired by the Director of Nursing, is responsible for implementing the improvements we have identified and those recommended in the Department of Health National End of Life Care Programme 'The Route to Success'. Our aims are to:

- maximise the potential of the End of Life register – this is the sharing of information of patients' end of life care needs between the community and the hospital
- respect patient and family wishes to die at home by developing a plan to enable this to happen
- identify the needs of family and staff – such as quiet rooms, signposting for support, facilities for relatives and carers
- provide end of life education and support for staff
- provide practical information for bereaved relatives and carers
- ensure a sensitive design of the new mortuary and increased availability for relatives and carers at weekends.

MANDATORY STATEMENTS

Mandatory statement 1

During 2011/12 the Royal United Hospital Bath NHS Trust provided and sub-contracted seven types² of NHS services via two clinical divisions, Medicine and Surgery.

During 2011/12 the Royal United Hospital Bath NHS Trust has reviewed the data available on the quality of care using hospital-wide performance information such as the Hospital Standardised Mortality Rate (HSMR) and has undertaken further in-depth 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)
- Trust-wide monitoring of healthcare associated infections such as MRSA and *Clostridium 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, and fractured hip surgery
- monitoring of the completion of Venous Thromboembolism (VTE) risk assessment
- commitment to eliminating mixed sex accommodation unless clinically indicated.

The income generated by the Royal United Hospital Bath NHS Trust, in relation to these services, represents 100% of the total income generated from the provision of NHS services by the Royal United Hospital Bath NHS Trust for 2011/12.

² The Health and Social Care Act 2008 lays down a number of 'activities' (types of services provided) which are regulated by the Care Quality Commission (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 seven 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.

Mandatory Statement 2

See Page 30 – Participation in Audit.

Mandatory Statement 3

The number of patients receiving NHS services provided or sub-contracted by the RUH in 2011-2012 that were recruited during that period to participate in research approved by a research ethics committee was 930.

Mandatory Statement 4

A proportion of Royal United Hospital Bath's income in 2011-12 was conditional on achieving quality improvement and innovation goals agreed between Royal United Hospital Bath and our co-ordinating commissioner, on behalf of all associates with which we entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2011-12 are available electronically at http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

Mandatory Statement 5

The RUH is required to register with the Care Quality Commission and its current registration status is 'registration without conditions'. The RUH has no conditions on registration.

The CQC has not taken enforcement action against the RUH during 2011-12. In January 2012 the RUH participated in the joint CQC/Ofsted inspection for safeguarding children. The outcome of the assessment for health was inadequate and as such the RUH is currently working towards completion of a whole community action plan.

The RUH has not participated in any special reviews or investigations by the CQC during the reporting period.

Mandatory Statement 6

The RUH submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data, taken from the NHS Information Centre Data Quality Dashboard for the period April 2011 to December 2011:

- which included the patient's valid NHS number was:
 - 99.2% for admitted patient care
 - 99.5% for outpatient care
 - 94.3% for accident and emergency care

- which included the patient's valid General Medical Practice Code was:
 - 99.9% for admitted patient care
 - 100% for outpatient care
 - 100% for accident and emergency care.

Mandatory Statement 7

The RUH score for 2011/12 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 81%.

Mandatory Statement 8

The RUH was not subject to the Payment by Results clinical coding audit during 2011-2012 by the Audit Commission.

CHAPTER THREE

Review of quality performance in 2011/12

2011/12 Priority One – to further reduce our healthcare associated infection rates

What we said we would do last year

We said we would reduce our healthcare associated infection rates to no more than three cases of MRSA bacteraemia and no more than 51 cases of *Clostridium difficile*.

What we have done

Our involvement with the South West Quality and Patient Safety Improvement Programme continued with monitoring of new measures to reduce urinary catheter associated infections.

The number of MRSA bacteraemias and *Clostridium difficile* infections continued to reduce over the year:

	07/08	08/09	09/10	10/11	11/12	12/13 target
MRSA bacteraemia	35*	26*	17*	2	1	No more than 1
<i>Clostridium difficile</i>	301 ^o	248 ^o	113	51	46	Less than 31

* These figures included bacteraemias occurring pre and post 48 hours of admission. From April 2010 only bacteraemias occurring 48 hours or more after admission are attributed to the Trust.

^o These figures include cases occurring both pre- and post- 72 hours of admission. From April 2009 only *Clostridium difficile* infections occurring 72 hours after admission were attributed to the Trust.

MRSA screening

All relevant elective and non-elective admitted patients are screened for MRSA. Patients who are found to be colonised are treated to prevent them from acquiring more severe systemic infection. Where possible, these patients are nursed in side rooms to prevent the spread of infection. Compliance with the MRSA screening standard is audited quarterly by the Infection Prevention and Control Team (IPCT) and results are reported back directly to the matrons and senior sisters.

Learning from healthcare associated infection incidents

Root cause analysis investigations are carried out for MRSA, Methicillin-sensitive *Staphylococcus aureus* (MSSA) and *E.coli* bacteraemia cases and also for Trust-apportioned cases of *Clostridium difficile*. These investigations are carried out through collaboration with senior clinicians and members of the IPCT and are used to identify where practices can be improved or highlight examples of good practice.

Collaborative improvement programme

Our second *Clostridium difficile* improvement collaborative was held during 2011/12. The staff involved worked together to reduce rates of *Clostridium difficile*

on their wards by applying simple improvement measures that they could spread across the ward. Implementing these measures has empowered staff to take ownership for events that occur within their departments and through dedicated teamwork they have demonstrated that infections can be reduced by keeping a focus on their individual improvement programmes.

Maintaining standards

We continue to monitor compliance against the Department of Health Saving Lives audit programme. Each ward and department is responsible for auditing compliance with hand hygiene, peripheral venous cannula care and urinary catheter care. The Critical Care Unit carries out additional audits against the ventilated and central venous access standards. Results are monitored through the weekly Infection Control Taskforce and the monthly Saving Lives Audit Committee. All admission wards are visited daily by the IPCT to identify isolation requirements and report back any issues.

2011/12 Priority Two – to further reduce hospital acquired pressure ulcers

Tissue viability is the nurse-led speciality that focuses on the prevention and management of people with wounds including pressure ulcers, more commonly known as bed sores. Pressure ulcers are given categories from 1 (least serious) to 4 (most serious).

What we said we would do last year

We said we would continue our work to reduce the number of hospital-acquired pressure ulcers, by recording, reporting and monitoring every patient with a pressure ulcer and investigating all hospital-acquired category 3 and 4 pressure ulcers.

What we have done

Following the introduction of a number of interventions, we have continued to reduce the occurrence of hospital-acquired pressure ulcers. We set ourselves a target to reduce category 3 and 4 pressure ulcers by 50% each year between 2010-2012. In 2010-2011 we reduced category 3 and 4 pressure ulcers by 67% and in 2011-2012, we have further reduced by another 41%, thereby exceeding our target. We also reduced RUH-acquired category 2 pressure ulcers by 20% during 2011-2012.

During the year, all wards were supplied with new pressure-relieving devices that protect the heels – one of the three most common areas for patients to develop a pressure ulcer. This intervention was supported by a 'Healthy Heels' week which aimed to improve awareness of pressure ulcer prevention, particularly preventing pressure ulcers on the heels. The week involved staff competitions, and the provision of education and information taken to the wards and displayed in public areas within the hospital.

Four wards were invited to become involved in a pressure ulcer working group to create innovative approaches to improve pressure ulcer prevention and management. One of the ideas included the award-winning 'Think Pink' campaign, which changed certain aspects of documentation to the colour pink to highlight

pressure ulcer prevention. Pink clock faces above the patient's chair and bed were used to indicate to staff how long a patient had been sitting in a chair and when they need to be assisted back to bed. In recent months the Trust has also introduced 'comfort rounds' which involves a new way of recording the regular re-positioning and skin checking of vulnerable patients.

The Tissue Viability Team supported 'National Honey Week' by holding another successful event to promote the importance of holistic wound assessment and the appropriate use of specialist dressings for pressure ulcers such as Manuka Honey dressings.

We recognise the link that can exist between the development of significant pressure ulcers and the possible neglect in a person's care. The team assess every patient with a confirmed category 3 or 4 pressure ulcer against the safeguarding adults standards to ensure that vulnerable patients are protected.

Although the prevention of pressure ulcers is not a priority in the Quality Accounts this year, in 2012/13 the team will continue to focus on pressure ulcer avoidance by promoting pressure ulcer prevention and raise awareness of the importance of a healthy diet and keeping the skin dry. We are also applying for a research grant to help to identify innovative ways to improve the skin condition of patients with incontinence as this is known to increase the risk of pressure ulcers. New skin barrier products will be evaluated to ensure the highest quality care is provided.

We will also continue to:

- work to reduce the number of hospital-acquired pressure ulcers
- record, report and monitor every patient with a pressure ulcer
- investigate all hospital-acquired category 3 and 4 pressure ulcers
- assess patients with a category 3 or 4 pressure ulcer against the Safeguarding Adults framework
- provide a Tissue Viability Nurse assessment of all patients with category 3 or 4 pressure ulcers and raise these as serious incidents
- contribute to the use of the safety thermometer which is used to measure 'harm free care'. This tool is used to collect data nationally on a number of identified harms including pressure ulcers. This will involve all patients being audited on one day every month to identify pressure ulcer prevalence. For the first time ever, this will allow for benchmarking of data with other Trusts.

2011/12 Priority Three – to make improvements for services especially for patients with dementia, learning disabilities and Parkinson's Disease

What we said we would do last year

We said we would make improvements for services, especially for patients with dementia, learning disabilities, and Parkinson's Disease – tailoring our services to meet their specific needs.

What we have done for patients with dementia

Nearly a quarter of adult hospital beds are occupied by people who have dementia, so it is vital that their specific care needs are understood. Working with the

Alzheimer's Society and Avon and Wiltshire Mental Health Partnership, we developed an improvement plan for the care of these patients. A peer review in October 2011 highlighted areas of excellent practice, and good progress with implementation of the plan.

"The review team was impressed by the welcoming environment of the hospital in particular the art work and clean and spacious common areas."

Central to this is a ward charter mark scheme, externally assessed by the Alzheimer's Society, to demonstrate that wards have reached a high standard of care for patients with dementia. It is the first such scheme in the UK and provides a gold standard for staff to ensure care for people with dementia on all adult wards is the very best it can be. Part of the assessment includes how we ensure our dementia patients are well nourished and are drinking enough and how we assist them in finding their way around the ward. We are proud that a number of wards have already achieved the Silver award, and Midford Ward has become the first to reach Gold. By the end of 2012 all wards will be assessed under the scheme.

In the last year 98% of all staff (both clinical and non-clinical) working on our older people's wards have completed specific dementia care training.

We have benefited from charitable monies to improve the environment. The Alzheimer's Society has developed a volunteer befriending scheme at the RUH, whereby patients with dementia can engage with trained individuals to reduce boredom and agitation levels on our wards.

It is widely recognised that active participation in musical activities can act as a form of social inclusion, therefore reducing loneliness and anxiety. Regular interaction through activities can have a lasting effect and can build relationships between staff, patients and visitors; enhancing the community within the hospital. The RUH's Soundbite Music Programme brings a varied line-up of music including live musical performances with musicians from Live Music Now, funded by the Joyce Fletcher Charitable Trust. Our musician in residence, Rosanna Campbell, leads workshops and activities such as music workshops, creative writing sessions, reminiscence workshops, musical performances and storytelling.

We are conscious, too, of the important role of carers, and we wish to engage with them around aspects of ward care and how they can be more involved. For example, we have been working with B&NES Carer's Centre to develop a Carer's Resource Pack which is available for every medical emergency admission. Carers can provide us with background information and wishes of their loved ones, as well as discussing how much involvement they would like during the hospital stay.

What we have done for patients with learning disabilities

We have continued to work closely with community partners during 2011/12. The number of 'easy read' information leaflets has increased and these are available for patients coming into hospital as an emergency, an outpatient or for planned surgery. These have been published on our intranet for staff to access and are also available on our external website for people to access prior to coming into hospital.

We have included making reasonable adjustments where needed; for example, outpatient department staff are aware of the patient's needs before they arrive in the unit and are able to alter appointment times to meet the needs of the patient; day surgery staff are aware of their patient's needs beforehand and are allocated a side room. Carers who know the patient well are able to support them throughout their stay so that the patient has a better continuity of care. The sister for quality improvement for learning disabilities and mental health has met patients coming in for appointments so that information can be given in an appropriate way to ensure liaison/correct care can be continued within the community.

Further information leaflets are being developed to include information regarding general anaesthetic and infection control. A pictorial menu has also been developed and is now being trialled. We are developing our carer's policy, and focusing on carer's wellbeing. We have support from the carer's centre at the RUH and staff are able to make referrals and utilise this service to maximum benefit for patients.

What we have done for patients with Parkinson's Disease

Approximately 900 people are living locally with Parkinson's Disease and, of these, up to 20 patients are admitted to the RUH each month. These patients are at particular risk when they are admitted to a hospital environment. The management of their medications can be complex and it is important that they receive the correct dose at the correct time in order to avoid complications and a longer hospital stay.

At the beginning of 2011, a Parkinson's Disease Quality Care Group was established and various events such as the Parkinson's Disease Awareness Day and 'See it my Way – living with Parkinson's Disease' were held. The group's initial work involved improving the experience for these patients and their carers when visiting the hospital. This resulted in an increase of awareness by the nurses of the importance of patients with Parkinson's Disease receiving their medication on time; for example, some wards are using timers and alarm clocks to remind them to ensure this crucial medication is not delayed or missed. We have identified one of the Older People's Unit wards as a specialist ward for Parkinson's Disease and it is regarded as the ward for expert advice and support for staff on other wards.

To support this work, we successfully applied for funding from The Health Foundation Trust as part of their Safer Clinical Systems programme. We were one of only eight trusts selected out of 49 across the country to be involved in the project. This funding is for a two year project to improve the safety of the medication pathway for patients with Parkinson's Disease. Since the project was launched in October, the team has established relationships with our community healthcare providers and patient representatives to assess the current patient experience and to identify the risk factors within the system in order to plan the areas of improvement. Our aim is to share learning from this project to improve the way we manage medicines for all patients.

2011/12 Priority Four – to improve outcomes for older patients who require surgery for a hip fracture

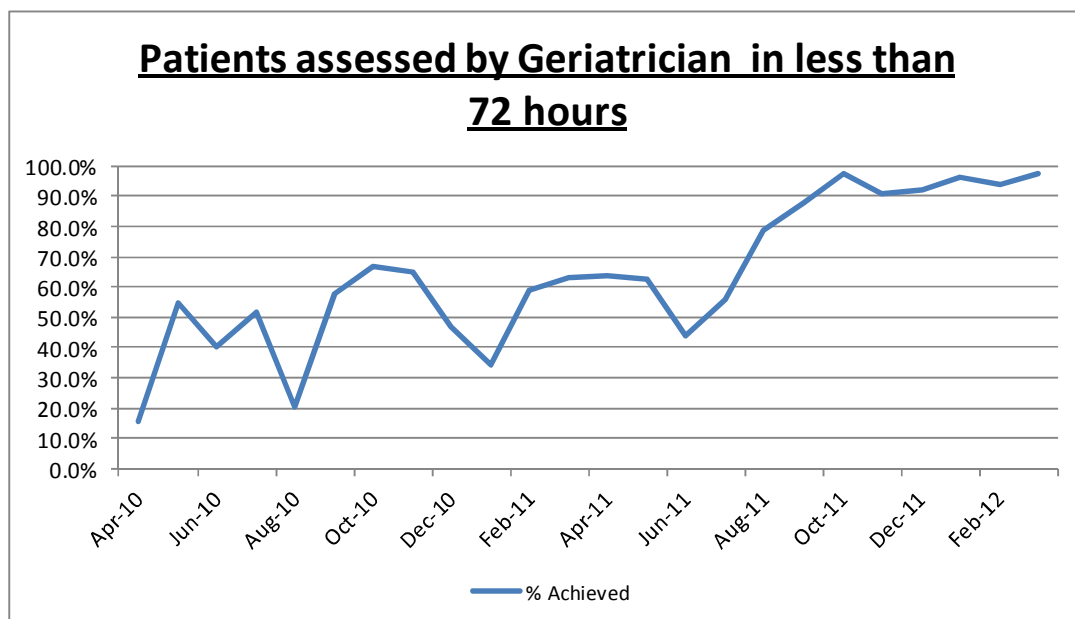
Around 520-550 patients per year come to hospital having suffered a fractured hip (neck of femur). The majority of these patients are among the most elderly and the frailest patients we admit. It is widely recognised that patients recover from surgery quicker and go home sooner if they have their operation within 36 hours of admission.

What we said we would do last year

We said we would improve the quality of care received by patients with fractured neck of femur, by standardising the pathway of care across the health community. We said we would improve the timeliness to theatre as this leads to a better outcome, and we said we would reduce the length of time that patients spend in hospital so that they can return quickly to their previous lifestyle.

What we have done

We improved access to theatre by increasing the availability of theatres for patients who had suffered a fractured neck of femur. We opened a new, 20-bed hip fracture unit and recruited an additional orthogeriatrician to join a new team of geriatric medicine specialists working alongside the orthopaedic surgeons providing day-to-day care on the unit. This has resulted in more patients being assessed by a geriatrician in less than 72 hours (see Graph 1 below).

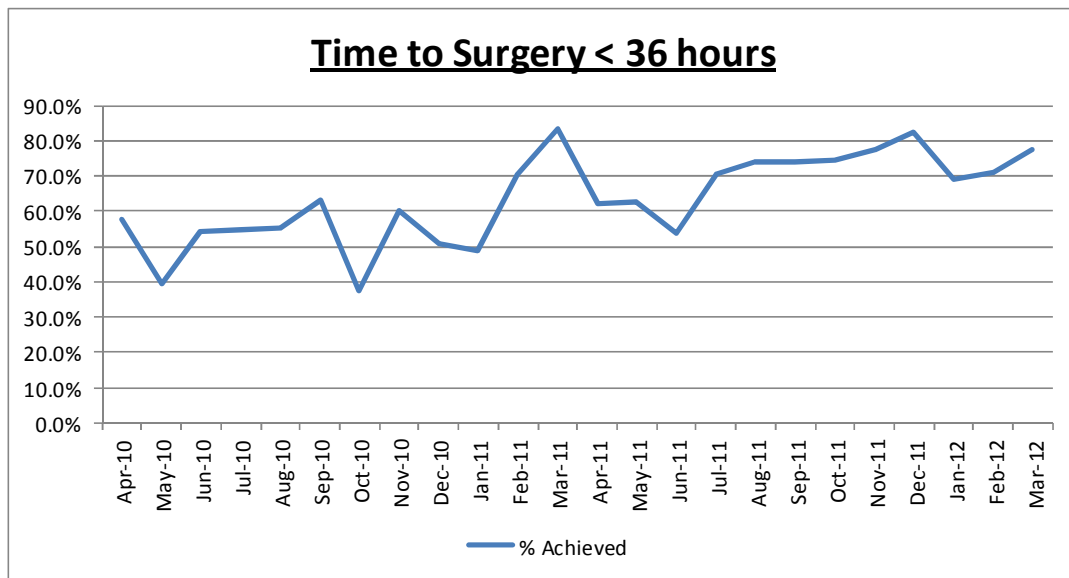


Graph 1

While the orthopaedic team provides the surgery and post-surgical reviews, other medical conditions are treated at the same time and rehabilitation is considered from the patient's admission. Patients are now operated on more quickly following their admission, reducing the amount of time they need to stay in hospital. At the beginning of 2011, around half of patients received their operation, where necessary, within 36 hours of admission (see Graph 2). At the end of the third

quarter of the year 82% of patients received their operation within 36 hours of admission. Our aspiration of 95% was unrealistic since a number of patients who have suffered a fractured hip will not be fit enough for an operation. We have therefore amended our target in line with national guidance (more than 80%).

We have also worked to provide relatives with a dedicated time slot to talk to a doctor about the patient’s care.



Graph 2

2011/12 Priority Five – to improve care for patients who have suffered a stroke

We admit around 60 patients a month with acute stroke and now have a well-established pathway for direct admission to the Acute Stroke Unit from the Emergency Department.

We are very proud that we were recognised by the Dr Foster hospital guide for the significant improvements in patient outcome following a stroke. We were one of only 11 hospitals cited in the guide for having better than expected outcomes for stroke patients. There are five measures against which hospitals are assessed – ten of these 11 hospitals scored better than expected for two of these five measures. We were the only hospital who scored better than expected in three of the five categories. This gave us the best results for outcome following stroke in the entire country according to Dr Foster.

Health Minister Simon Burns visited us in August 2011 and was shown the pathway a patient who had suffered a stroke would take through the hospital. The Minister commended our work in allowing patients to be discharged sooner and continuing their rehabilitation at home.

What we said we would do last year

We said we would improve the care for patients who have suffered a stroke, and be more consistent in achieving national targets. We also said we would work to meet the accelerated stroke target of achieving 80% of patients spending 90% of their inpatient stay on the Acute Stroke Unit, meet the radiology target of 50% of patients receiving a scan within one hour, and sustain 80% of patients assessed for trans ischaemic attack (TIA) within 24 hours of presenting with symptoms.

What we have done

We are continuing to work towards achieving our target of 80% of patients spending 90% of their inpatient stay on the Acute Stroke Unit and achieving radiology scan times, and we are currently reviewing the patient pathway to the unit. We are also planning to pilot a 'direct to scan' pathway with Great Western Ambulance Service for potential thrombolysis patients – where the paramedic will take them directly to the scanner from the ambulance.

Plans are in place to appoint a third stroke consultant to enable a daily high risk TIA clinic to continue over the weekend. This will also allow for a daily specialist consultant ward round on the Acute Stroke Unit at weekends.

In 2012-13 we intend to introduce occupational therapy, physiotherapy and speech and language therapy seven days a week so that patients will receive rehabilitation at the weekends.

One patient praised the hospital's standard of care after returning home just four days after suffering a stroke: "I felt like I'd had a lucky escape. The care I received at hospital was amazing and I couldn't believe how quickly I was going home."

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.

We also have a number of national targets to comply with, which provide a measure of our clinical effectiveness. The following tables show our performance against our own quality domains and indicators, and also our performance against nationally-determined targets, along with targets for 2012/13.

RUH-determined quality domains and indicators

Quality domains & indicators	2011/12 Targets	2011/12 actual performance	2012/13 targets
Patient Safety			
Venous Thromboembolism: Risk assessments on all eligible patients Patients who require prophylaxis receive it Incident reporting and root cause analysis	90% 100% 75% in Quarter 3	97.6% 75% in Quarter 3 75% in Quarter 3	90%* 100% 100%
Incident reporting Timeliness of investigations into Serious Untoward Incidents (National Patient Safety Agency National Reporting Framework)	45 days for level one incidents, 60 days for level two incidents	68.4 days	45 days for level one incidents, 60 days for level two incidents
Clinical effectiveness			
Average length of stay (whole hospital)	4.5 days	4.9 days	Specialty specific average length of stay targets to be agreed
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	12 251	10 251	7 (25% reduction) 201 (20% reduction)
End of Life Care: Staff Training	78.4%	78.4%	75%*
To improve outcomes for patients with dementia: Staff training Dementia screening Dementia risk assessment Referral for specialist diagnosis	No targets set No targets set No targets set No targets set	No targets set No targets set No targets set No targets set	30% 90% 90% 90%
Weekend Discharges: Working towards a seven day working week	16.2%	16.2%	19%
Fractured neck of femur - % of patients to theatre within 36 hours	70.7%	70.7%	80%
Day Surgery Rates	No target set	70.5%	80%
Outpatient letters to GPs within 2 weeks of attendance	No target set	N/A	75%

Patient Experience			
Learning Disabilities: Appropriate use of MCA, best interest decision making and consent forms	No target set	No target set	95%
Cleanliness Patient Experience Tracker (PET) question: 'Is the ward clean?'	92% April – December 2011	92% April – December 2011	To be confirmed
Treated with Dignity & Respect PET tracker 'Are you being treated with dignity and respect?'	93% April- December 2011	93% April- December 2011	To be confirmed
Information given to patients PET tracker 'Are you being kept well informed?'	97% April- December 2011	97% April- December 2011	To be confirmed

* Our performance in 2011/12 was above the target set for that year and also exceeds the target set for 2012/13. We will strive to perform over and above our performance last year.

Nationally-determined targets

	2011/12 National target	2011/12 Target	Y/E Actual 2011/12	2012/13 Target
Assessed by Acute Trust performance (ATPF) and Monitor 2012/13	% patients treated in A&E within 4 hours	95%	95.7%	95%
	Number of MRSA Bacteraemias (Post 48 hours)	3	1	1
	Number of Clostridium <i>difficile</i> infections (Post 72 hours)	59	46	31
	RTT admitted -18 weeks from GP referral to hospital treatment (in all specialties 2012/13)	90%	86.1%	90%
	RTT non-admitted - 18 weeks from GP referral to hospital treatment (in all specialties 2012/13)	95%	96.2%	95%
	RTT – open pathways in 18 weeks	New measure 2012/13	New measure 2012/13	92%
	Diagnostic tests - maximum wait of 6 weeks	100%	99.7%	<1%
	Cancer urgent referral to first outpatient appointment – 2 weeks	93%	94%	93%
	Cancer urgent referral to first outpatient appointment – 2 weeks (breast symptoms)	93%	99.2%	93%
	Cancer diagnosis to treatment – 31 days (subsequent surgery)	94%	96.1%	94%
	Cancer diagnosis to treatment – 31 days (subsequent drug treatment)	98%	99.7%	98%
	Cancer diagnosis to treatment – 31 days (subsequent radiotherapy)	94%	97.7%	94%
	Cancer diagnosis to treatment all cancers – 31 days	96%	99.7%	96%
	Cancer urgent referral to treatment – 62 days (Screening)	90%	95.7%	90%
	Cancer urgent referral to treatment all cancers– 62 days (includes GP and hospital specialist)	85%	N/A	85%
	Delayed transfers of care	3.5%	5.5%	3.5%
	Number of Mixed Sex Accommodation breaches	ATPF measure 2012/13	ATPF measure 2012/13	0.0%
	Venous thromboembolisation % screened	ATPF measure 2012/13	95.7%	90%

	2011/12 National target	2011/12 Target	2011/12 Actual	2012/13 Target
Other nationally determined indicators 2012/13	Patients offered date within 48 hours of contacting Genitourinary Medicine clinic	98%	100%	100%
	Patients seen within 2 weeks for rapid access chest pain	98%	100%	98%
	Hip fractures operated on within 36 hours	80%	72.9%	80%
	Primary angioplasties - % under 150 mins	70%	100%	70%
	Higher risk trans ischaemic attack (TIA) treated within 24 hours	60%	60.7%	60%
	% people spending 90% time on stroke unit	80%	71.4%	80%
	% cancellations not re-booked within 28 days	5%	0%	5%
No longer measured as part of ATPF or Monitor	RTT admitted -18 weeks from GP referral to hospital treatment	90%	86.1%	Removed
	RTT non-admitted - 18 weeks from GP referral to hospital treatment	95%	96.2%	Removed
	95th percentile - admitted pathways	23 weeks	24.1 weeks	Removed
	95th percentile - non-admitted pathways	18.3 weeks	17 weeks	Removed
	95th percentile - incomplete pathways	28 weeks	27.9 weeks	Removed
	% patients treated in A&E and MIU within 4 hours	n/a	96.4%	Weekly SITREP Reporting
	A&E re-attendance rate	5%	0.9%	
	A&E – 95 th percentile time to treatment	4 hours	3hours 9 minutes	
	A&E Left Without Being Seen rate	5%	0.8%	
	A&E Time to assess – 95 th percentile	15 minutes	11 minutes	
	A&E median time to treat	1 hour	1hour 3 mins	
	Patients waiting >3 months for revascularisation	0.1%	0%	

Mandatory statement 2: Participation in Audit

During 2011-2012, 41 national clinical audits and two national confidential enquiries covered NHS services that we provide.

During this period we participated in 76% of the national clinical audits and 100% of the national confidential enquiries we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2011-2012 are as follows:

NCEPOD	Participation	% cases submitted
Bariatric Surgery (Note: this study is still current and data has not been finalised)	Yes	100%
Cardiac Arrest Procedures	Yes	100%
Peri-operative care study	Yes	100%
Surgery in children study	Yes	100%

The national clinical audits and national confidential enquiries that we participated in, and for which data collection was completed during 2011-2012, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit	Participation	% cases submitted
Peri- and neonatal		
Neonatal intensive and special care (NNAP)	Yes	100% (PARCAR 2010)
Children		
Paediatric pneumonia (British Thoracic Society)	No	N/A
Paediatric asthma (British Thoracic Society)	No	N/A
Pain management (College of Emergency Medicine)	Yes	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	75%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	100%

Acute Care		
Emergency use of oxygen (British Thoracic Society)	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	No	N/A
Non-invasive ventilation - adults (British Thoracic Society)	Yes	Last submission Feb-March 2011. Next submission Feb-March 2012.
Pleural procedures (British Thoracic Society)	Yes	100%
Cardiac arrest (National Cardiac Arrest Audit)	Yes	100%
Severe sepsis and septic shock (College of Emergency Medicine)	Yes	100%
Adult critical care (ICNARC CMPD)	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	100%
Seizure management (National Audit of Seizure Management)	Yes	100%
Long term conditions		
Diabetes (The National Diabetes Inpatient Audit)	Yes	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	55 cases – 9.4%
Chronic pain (National Pain Audit)	No	N/A
Ulcerative colitis & Crohn's disease (UK IBD Audit)	No	N/A
Parkinson's Disease (National Parkinson's Audit)	Yes	100%
Adult asthma (British Thoracic Society)	No	N/A
Bronchiectasis (British Thoracic Society)	No	N/A
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	91%

Elective surgery (National PROMS Programme): four operations	Yes	Overall – 69.5% Hernia – 46.3% Hip – 76.1% Knee – 78.4% Varicose vein – 38.5% Percentages based on Part 1 patient questionnaires returned (Source: HES Online: April 11-Dec-11)
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	31% - full report delayed until end April 2012
Carotid interventions (Carotid Intervention Audit)	Yes	88%
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%
Heart failure (Heart Failure Audit)	No	Local audit undertaken to address local issues. Results available in May 2012.
Acute stroke (SINAP)	Yes	100%
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Yes	100%
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	117% (2011 Report – 199 cases reported against an expected 170)
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	95.2% (237 cases)
Head & neck cancer (DAHNO)	Yes	Data currently unavailable
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	78% (2010 Report)

Trauma		
Hip fracture (National Hip Fracture Database)	Yes	97%
Severe trauma (Trauma Audit & Research Network)	Yes	100%
Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	100%
Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	100%
Health Promotion		
Risk factors (National Health Promotion in Hospitals Audit)	No audit undertaken by NHPHA this year	N/A
End of life		
Care of dying in hospital (NCDAH)	No	N/A

The reports of national clinical audits were reviewed by the provider in 2011-2012 and the RUH intends to take the following actions to improve the quality of healthcare provided:

National Audit of Dementia

The National Audit of Dementia worked with acute inpatient services to review the delivery of care which impacted on people with dementia admitted to hospital. Since the audit report was published we have worked extensively with the South West Partnership to ensure that significant improvements are made to dementia services within the RUH and across the region as a whole. This has resulted in us receiving a very positive peer review site assessment and showed a high level of commitment to improving care for people with dementia.

Key initiatives, such as the Dementia Ward Charter Mark, were seen as exemplary practice. Excellent progress was noted around the nutrition and hydration work being carried out and also the use of the 'Forget Me Not' symbol, which identifies patients with Dementia. The Emergency Department and Medical Admissions Unit were considered to have a real understanding and focus on admitting to the 'right place' to avoid moves between clinical settings. The welcoming environment provided by the art work and the 'Befrienders' Scheme' being piloted on Combe Ward, were both seen as excellent ongoing initiatives.

Areas identified as opportunities for improvement included the need to embed further the use of the 'This is me' document, which provides professionals with information about the person with dementia as an individual. It was suggested by

the review team that an increased use of day rooms for meal times would encourage socialisation and interaction and that the introduction of coloured toilet seats and grab rails could be considered on some wards to compliment the work already carried out with pictorial signage.

Overall the review team were impressed by very energetic and enthusiastic staff and the level of good leadership at both clinical and board level.

National Audit of Falls and Bone Health in Older People

The results of the National Audit of Falls and Bone Health in Older People aged 65 and over, examined clinical care delivered to individuals who had fallen and fractured a bone. In nine out of the 12 key indicators we achieved higher results than the national overall findings.

Since the audit report was published in April 2011 we have seen further improvements to the quality of care given to patients who present with fractures, resulting from a fall. Specialist geriatricians took over the post-operative care of patients with hip fractures in August 2011. There are now three dedicated orthogeriatric bays on Forrester Brown ward.

We expect to see continued improvements in the quality of patient care following implementation of these actions.

National Comparative Re-audit of Bedside Transfusion

This audit reviewed whether the British Committee for Standards in Haematology for the administration of blood are being followed at the bedside. In six out of seven of the standards, we have either improved or maintained our good practice, scoring 100% in four standards and more than 95% in two standards. Near 100% compliance was achieved for 19 out of the 21 standards. The two standards identified for improvement are regarding the recording of the temperature and pulse 15 minutes or less after the transfusion has started. The audit results were fed back to all wards. Teaching and training sessions continue to emphasise to staff the importance of 15 minute observations. The Blood Component Transfusion Care Plan will also be amended to include clearer prompts for staff to document observations after the transfusion has started.

Myocardial Ischaemia National Audit Project (MINAP)

The active participation in the MINAP national audit, and the positive results generated monthly for the ambulance reperfusion reports, have demonstrated an ongoing requirement for primary angioplasties and the services of a Cath Lab at the RUH. The opening of a new state-of-the-art bi-plane Cath Lab means patients are benefiting from the use of cutting edge digital imaging technology to treat cardiovascular conditions. The Cardiology team continue to be encouraged by the results being produced from MINAP, which show we are performing to high standard for a number of measures including delivering primary angioplasty within 150 minutes of calling for help. Additionally, a review group has been set up in-house to look at breaches of the 'call to needle' and 'door to needle' times with a view to further improving these figures in 2012/13.

CQUIN Stroke Performance Targets

The Commissioning for Quality and Innovation (CQUIN) standards for stroke require us to meet four specific measures, reported on a quarterly basis – for example, patients being required to have swallowing tests (where appropriate) within four hours. The commitment of the Acute Stroke Unit in addressing issues of quality has seen these figures gradually improve on a quarterly basis in 2011/12, with the third quarter of the year demonstrating full compliance for all four standards – nutrition plans, referral to community services within three days of diagnosis, assessment/management by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission, and documented multi-disciplinary goals agreed within five days of admission.

The reports of 54 local clinical audits were reviewed by the provider in 2011-2012 and we intend to take the following actions to improve the quality of healthcare provided:

Re-audit on the cleanliness of commodes

Audits on the cleanliness of commodes are carried out on a weekly basis by wards and departments to ensure that sustained high standards of cleanliness are maintained for commodes. Commode audits are also carried out on a quarterly basis by the Infection Prevention and Control Team to ensure that commodes are being appropriately cleaned and the right equipment is available. The last audit completed in January 2012 showed that the correct equipment was available and commodes were being appropriately cleaned.

Paediatric Outpatient Did Not Attend Audit

This audit was carried out to check that safeguarding concerns are appropriately managed for children that do not attend outpatient appointments.

For children identified as being category 'amber' (where it is thought that the child's health might suffer if a consultation did not go ahead but the risks are not thought to be immediate) all standards were appropriately followed including a letter to the GP and parents stating a new appointment letter would be sent.

For those children identified as being category 'green' (where there were no known safeguarding concerns), a letter had been sent to the family about the missed appointment for 93% of cases audited. However, it was identified that the secretaries did not always indicate on the letters written to parents that a copy was sent to the GP. A request was also not always sent to the GP to check that the address of the patient was correct.

The audit report has been disseminated to key staff and secretaries informed of the requirement to check the patient address in the letters sent out to GPs.

Urinary Catheter Prevalence Audit

As part of our participation in the NHS South West Quality and Patient Safety Improvement Programme in association with the Institute for Healthcare Improvement we are required to reduce catheter associated urinary tract infections by 50% by 2013. This audit was carried out to measure the number of patients with urinary catheters in situ and those being treated for urinary tract infection (UTI). It

was also carried out on behalf of Bath and North East Somerset community provider service.

An audit in February 2011 identified that 18% of patients had a urinary catheter in situ. Of those patients with a urinary catheter, 27% had a UTI. The reason for insertion and date of insertion was documented in the majority of cases. Catheters in situ were also found to still be required. Further improvement is required for the use of care plans with a care plan started for 75% of patients.

Our continence group agreed an action plan to address any areas of non-compliance. These were incorporated into the work plan of the group. Changes in implemented practice have included the introduction of a new care plan for patients with a urinary catheter. The new care plan requires re-evaluation by the clinical team responsible for the patient at day three and day seven from the insertion date. At day seven, a doctor and nurse must sign the care plan to indicate a re-assessment has been made for the need for continued use of the urinary catheter.

CHAPTER FOUR

Participation in clinical research and development

Research and Development is a core activity within the NHS and benefits the RUH in many ways. It helps attract high quality staff and improves the quality of care by introducing new clinical techniques.

We are actively involved in a range of research projects throughout the Trust with over 27 disciplines represented in our research base. Areas of particular research focus are in cancer, diabetics and endocrinology, paediatrics, stroke and elderly care and anaesthesia and critical care. We have over 220 active projects on our database and we are now one of the most successful research-active District General Hospitals in the region, and in the top five of research-active District General Hospitals in the country. We were recently commended by the Western Comprehensive Local Research Network for being one of the best performers in the region for recruiting patients into cancer research studies.

The total amount of external grants to us averages around £1 million per year. The drugs, equipment and clinical sessions that otherwise would be bought by us, benefit research and non-research patients alike.

Stroke

Patients are helping our research nurses find out more about the causes and treatment of stroke. This allows them access to new and innovative treatments. For example, some patients are involved in a prevention study which compares a medication called pioglitazone with a dummy tablet (placebo) to find out if it lowers the risk of stroke and heart attack. One patient involved in the clinical trial said: "I didn't want another stroke. I didn't want anyone else to go through what I had been through, so my motivation was high. The trials are beneficial for other patients in the future, and hopefully for me too."

Dermatology

Major work in the department of dermatology and in collaboration with colleagues at the University of Bath looked at the treatment of acne, examining how the condition affects the quality of life and how it contributed to depression. A study concluded that 'treatment of acne improves quality of life' and could not find evidence of 'mood deterioration' in patients prescribed isotretinoin.

Oncology

The Oncology department has the highest number of research projects in the hospital and has doubled the number of patients recruited to be involved in cancer research studies. The result of this outstanding research activity has meant that we have been recognised as being the best recruiter for cancer research projects in the South West and in the top 10 in the UK.

Paediatrics

A grant was received from the Dyson Foundation for the Neonatal Intensive Care Unit research project. This project represents a unique opportunity to study the effects of a sustainable, purpose-built NICU on the complete medical, social,

operational and psychological environment. The research is needed to show if, and how, the NICU new build has made any difference to patient care. The results could indicate how patient care could be further improved in the new unit and pave the way for other healthcare improvement initiatives in the wider health community.

CHAPTER FIVE

What others say about us

This document has been amended taking into consideration comments from stakeholders who were given an opportunity to comment on a draft version of our Quality Accounts. We thank them for their input.

Response from Bath and North East Somerset Local Involvement Network

Chapter One

The LINK is pleased to endorse the statements of the Chief Executive and Director of Nursing.

Chapter Two

The five priorities chosen for 2012-13 seem to cover a wide perspective that should be able to easily show the progress in next year's Quality Accounts.

Priority One – we agree with the priority to reduce healthcare associated infections in the coming year, but question whether this will be possible without increased staffing.

Priority Two – the 40% readmission rate within three months of discharge for Chronic Obstructive Pulmonary Disease seems rather high, although we recognise that the readmission rate is always high (around 30%+) for hospital treatment of this condition. It is appropriate that the Trust should target this rate for improvement. We urge the Trust to pay particular attention to the monitoring of communication between Trust clinicians and primary care. We have reports that there can still be unacceptable delays in GPs receiving discharge letters.

Priority Three – the LINK feels that the Learning from Patient Experience priority is a valuable and appropriate one, and is an effective way of improving standards and enhancing the patient experience in the coming year. We think that leadership and example by senior staff, managers and directors are crucial to the success of these efforts. We agree with the Picker Institute's findings, and think that a priority reflecting this will be useful.

Although the RUH has patient groups and a Privacy, Respect and Dignity Group, the LINK knows from feedback from our community that there is still a philosophical hurdle to get over regarding staff understanding of patients' needs as a whole. One member of the LINK very recently had a very good experience in terms of clinical treatment, but a not-so-good care experience. The observation made to us had two components; (i) staff being negative about other staff and patients in the hearing of other patients; and (ii) the fact that when this patient was initially taken to a ward for admission, there was a complete lack of interaction and communication with the patient and carer from a number of nursing staff present on the ward, and no communication as to what was going to happen to the patient, and how they would be cared for and by whom. We totally understand that the attitude shown by staff within various departments is a reflection of their superiors' attitude and approach to patients, and that therefore some areas within the Trust are exemplary, whilst others see patient care as a less important accompaniment to clinical care. We feel that there are issues here relating to leadership skills and leading and supporting by example.

Priority Five - We applaud the concern shown in this priority for relatives and carers in end-of-life treatment. The needs of the patient are most important, but those of families and carers cannot be forgotten, and it can be attention to this that uprates care from “good” to “excellent”. It is good to see recognition of the needs of carers for practical information, and the importance of having staff around to help families and carers at weekends. We have heard the stroke unit operates to a very high standard in the area of end-of-life care and commend this highly.

Mandatory Statement 1 – the elimination of inappropriate mixed sex accommodation was a target for 2010-11. We feel that there should be a firm commitment and timescale to achieve this.

Mandatory Statement 4 – we note that the registration of the RUH with the Care Quality Commission is unqualified, and commend the Trust for this. We also note that there have been no special reviews or investigations at the Trust by the CQC.

Chapter Three

Priority One – we note the measures that the Trust has been taking in screening patients for MRSA on admission, and through root-cause analysis of infection incidents. It has made significant achievements in respect of healthcare associated infection rates during the year, and that has comfortably exceeded its targets for the reduction of MRSA and *Clostridium difficile* infection during the year. We look forward to hearing that it is meeting its challenging targets for 2012-13.

Priority Three – the LINK commends the Trust’s achievements in the care of patients with dementia, learning disabilities, and Parkinson’s Disease. However, we urge the Trust to keep under review the adequacy of staffing capacity in this area.

Priority Four – the opening of a new 20-bed hip fracture unit and employment of an additional orthogeriatrician should mean better care and outcomes for these older patients. The attention to providing information for relatives is also welcomed.

General comment

Recent observations indicate that there should be additional nursing staff in some areas. Despite the increase in patient numbers, it appears that staffing levels remain the same. This cannot be right, as it also means more risk for patients and for the Trust. We acknowledge the dedication and expertise of all staff while working under severe pressure.

Summary of comments from Bath and North East Somerset Council’s Wellbeing Policy Development and Scrutiny Panel

“We believe that the priorities set by the RUH match those of the public. There is clear evidence of patient involvement throughout the Quality Accounts. We are glad that the need to reduce healthcare associated infections has been kept as the number one priority as this will continue to improve patient safety.

We hope that the RUH continues to set ambitious targets to maintain the low MRSA rate and further reduce the instances of *Clostridium difficile* by installing more isolation wards and continued commitment to training and information provision. With regard to monitoring the use of catheters, this must be closely connected to awareness raising amongst staff to ensure they are responsive and sensitive to patients using continence products to maintain patient dignity and avoid emotional suffering.”

Full response from NHS Bath and North East Somerset

**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 (RUH) for 2011/12. It is our view that the account is comprehensive and accurate.

In a joint vision to maintain and continually improve the quality of services, NHS B&NES and the Royal United Hospital (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 provides further support for ensuring robust quality measures are in place. The RUH has demonstrated areas of improvements to patient experience through their patient experience reports via the 'see it my way' events which are patient or carers' stories, in-house feedback reports, complaints and PALs. Despite these efforts their performance in the National Inpatient Survey has fallen below the out-turn for the previous year. NHS B&NES carried out quality assurance visits to a number of wards and departments at the RUH and as part of this process we interviewed patients. We have received good feedback from patients at these visits. We regularly receive reports on patient experience at the Clinical Outcomes and Quality Assurance Group (QO& QAG) and are impressed with the number of initiatives the RUH has underway to seek to improve the patient experience. Other CQUIN schemes agreed in 11-12 related to length of stay, dementia, stroke care, reducing the number of patients who are at the end of their life and who die in hospital, and management of venous thrombo-embolus (VTE). Improvements were made in all areas apart from the Inpatient Survey but final confirmation of results is awaited.

There are 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 Outcomes and Quality Assurance Group (QO& QAG) 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. Areas for improvement are identified and agreed within the QO& QAG process and action plans are monitored until improvements are achieved. In addition to the QO& QAG, 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 2011/12 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. Examples of areas where the PCT has raised concern are: children's safeguarding, adult safeguarding, learning from serious incidents and discharge summaries.

During 2011/12 NHS B&NES has carried out a number of quality assurance visits at the RUH. The purpose of the visits is to observe and review key quality indicators. These activities facilitate triangulation of information and assurances in relation to quality issues across the Trust. As a result of the quality assurance visits, recommendations are made to providers.

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NHS B&NES endorse the priorities for 2012/13 set out in the Quality Account. We believe these to be representative for the patient population and services provided by RUH. We are pleased that the indicators chosen for 12/13 encompass both an improvement in clinical outcomes and in patient experience.

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.



Ed Macalister-Smith
CEO NHS B&NES and Wiltshire PCT Cluster

If you would like to know more, or to comment on our existing reports,
please write to:

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We value your opinion

We want to make sure future Quality Accounts give you all the information
you need on our services, so please tell us if you think we could improve.

Email: qualityaccounts@ruh.nhs.uk

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