

# Quality Accounts 2012/13

Healthcare you can Trust



# Foreword

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These Quality Accounts for the Royal United Hospital Bath NHS Trust (RUH) 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 2012/13.

The content and format of these Accounts are laid down in the NHS (Quality Accounts) Regulations 2010 which came into force on 1 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 mandatory statements are specified in the above regulations.

We have highlighted these in [blue boxes](#) as they appear in the Accounts.

We provided relevant local organisations and groups with the opportunity to comment on these Accounts. 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 (2013/14) and we welcome comment on, and involvement in, determining future priorities for improvement.

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# Chapter One

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## Chief Executive's Statement

We see a growing number of patients every year and our aim is to treat each of them as an individual; to understand what they are going through and to fulfil their expectations of compassionate care in a clean, safe, comfortable and friendly hospital.

Central to this has to be our staff. Their skill, dedication and hard work is at the centre of everything we do to ensure that every patient matters. Our values – to provide clean, safe, professional and compassionate care – define the way we work.

The last year has seen significant pressure upon the whole local health community, a situation mirrored up and down the country. At the RUH we cared for 73,168 emergency attendances and performed 17,284 operations during the last year, both day case and inpatient.

We have noticed an increase in the number of patients whose discharge from hospital has been delayed while waiting for home or community arrangements to be put in place. It is our absolute focus in the coming months to improve the flow of patients through our hospital so patients are looked after in the most appropriate place and we are working closely with our community partners to achieve this.

We received two inspections from the Care Quality Commission during 2012/13. The first took place in November 2012, when the Trust was found to be compliant with the essential outcomes. A second responsive visit in February 2013 to the Day Surgery Unit and Older People's wards found the Trust to be non-compliant with four outcomes – one a minor concern relating to privacy and dignity in our day case unit and the other outcomes

where moderate concerns were identified relating to our discharge arrangements during peak levels of activity in February 2013. We have improvement plans in place to enable the Board to declare full compliance. It is anticipated that this will be achieved during the summer. The CQC outcome reports are available on its website at [www.cqc.org.uk](http://www.cqc.org.uk)

Despite the pressures on the hospital we are proud of the progress we have made in a number of areas last year including the ongoing work towards becoming a beacon hospital for dementia care. We were awarded a major grant for dementia research and were delighted that a dementia peer review undertaken at the Trust in January 2013 found that we are a 'Dementia Friendly' hospital where caring for patients with dementia is embedded amongst all staff groups. The review group commended the Trust's clinical leadership and the Dementia Charter Mark, which recognises wards for their levels of expertise and adjustments to care for dementia patients. We were pleased to be able to explain more about the Charter Mark and work we are doing to improve dementia care to Professor Alistair Burns, the national clinical director for dementia, when he visited us in October 2012.

The hospital's Stroke Research Team has been highly commended in the Team of the Year category of the National Institute for Health Research's awards, in recognition of their success in embedding a research culture into day-to-day clinical care. All patients admitted to the Acute Stroke Unit are screened for their suitability for inclusion in studies. Our research studies look into various aspects of the care and treatment of this group of patients including improving recovery and

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preventing further strokes, as well as looking for possible genetic causes.

Our Estates & Facilities team had a successful year with their efforts to make our Trust greener and more sustainable. The Dyson Centre for Neonatal Care won several awards from the Royal Institution of British Architects and achieved an 'Excellent' rating under BREEAM, the Building Research Establishment and Assessment Method. BREEAM is the leading design and assessment method for sustainable buildings. The team also won the Energy Efficiency section of the Health Service Journal Efficiency Awards and collected a 'Green Apple' award at the Houses of Parliament.

We continue to invest in our estate and in May 2012 we were delighted to open our new, purpose-built Dermatology Unit. The new department has meant that we can treat a greater number of patients in a light, spacious and welcoming environment. This year, we look forward to the completion of the new Pathology laboratory and mortuary building, while planning for our state-of-the-art Cancer Centre.

We remain focused on becoming an NHS Foundation Trust, and this year held our first ever elections for our Council of Governors. The Council is operating in shadow form until we are approved as an NHS Foundation Trust by Monitor. Our membership continues to grow and our popular 'Caring for You' events continue to provide an opportunity for members to find out more about the work we do.

I am grateful to those who have contributed to the content of this year's Quality Accounts and to those who have worked with us to

ensure that they 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.



James Scott  
Chief Executive

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# Joint Statement by the Medical Director, Acting Director for Quality Improvement

We continue with our total commitment to improving patient safety, outcomes for patients, and the experience of patients and their families. Central to this is ensuring that we continue to invest in and value our staff in order to help them to deliver the best possible patient care.

This year has seen a number of major challenges to the NHS including very high bed occupancy across all acute hospitals and the concerns raised about compassionate patient care in the Francis Report. Whilst acknowledging that we are facing capacity pressures along with all surrounding hospitals, we continue to maintain a focus on patient safety and quality.

The publication of the Francis Report in February 2013 into the events at Mid-Staffordshire hospital has led the NHS to reflect on how well it is delivering care in a compassionate, safe way. The ward sisters, matrons, nursing and therapy teams at the RUH have been involved in a number of initiatives in the last year to further improve the delivery of fundamental care for patients. Comfort rounds have been introduced on all the wards to ensure that vulnerable and high risk patients are regularly checked to make sure they are comfortable, free from pain, that their toileting needs are met and they have access to a drink and/or a snack.

We were pleased to see our work on our 'See it my Way' events, which use patient stories to inspire and motivate our staff, referred to in the Department of Health's response to the Mid Staffs Public Inquiry, 'Patients first and foremost', as an example of excellent practice. You can read more about these events on Page 19. In addition we were the only acute hospital in England to be asked to

present our work on safety and quality to an expert group including the Medical Director of the NHS, considering the future of the NHS post the Francis Report.

We continue to develop quality improvement for our patients in the 'Qulturum', one of the first centres of its kind in the country which 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. This year we have continued our collaborative work to reduce infections and pressure ulcers and our active input to the regional patient safety programme. This programme has seen a seven per cent reduction in the number of deaths in hospitals in the South West of England over its first two years. We are very proud to have been awarded charge of the programme of patient safety work in the South West. We were also finalists in the National Patient Safety awards last summer for our work using structured case-note reviews to improve patient care.

We continue to be awarded research grants to develop quality care for our patients. Our work on ensuring that patients with Parkinson's Disease receive their medication on time has expanded, with the aim of ensuring medication delivery is more timely and effective for all our patients. This is supported by a major grant from the Health Foundation and was featured in the Health Service Journal in January 2013.

We have been awarded two 'Shine' grants from the Health Foundation. These are to develop new ideas in healthcare. One award is to develop innovative ways to deliver safety messages to staff and patients using

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## Director of Nursing, and Assistant Medical Director

multi-media approaches. This work will draw on the successful arts programme already running in the hospital. The other grant is shared with three other hospitals including the Royal Surrey County Hospital NHS Foundation Trust, and is testing improved pathways for patients undergoing emergency surgery. Should this be successful, it will form the basis of a programme to be rolled out across the UK.

The majority of our patients are elderly and we are continuously striving to improve their care. Improvements in care for our patients with broken hips, including ensuring they are managed by both a surgeon and a specialist in the care of older people, has seen us become one of the top hospitals in the country for this procedure in the past year. Our outcomes are now in the best 2.5% in the UK. Despite all this focus on improving outcomes, we never forget we are caring for real people, each of whom has different needs. This year we have faced the challenges of delivering safe, person-centred care whilst coping with an ever increasing emergency workload. We feel we have achieved a lot in the past year, but are aware

that there is much more to do.

We hope these accounts continue to demonstrate that everyone at the RUH is committed to delivering personalised safe care to all our patients, while striving for quality improvement and new ways to make our care better.

We are proud that Sue Leathers (Matron for Older People's Services) was shortlisted to the last eight nationally as Nurse of the Year for her dedication and commitment to the care of patients who have had a stroke and older people. Anne Plaskitt (Senior Nurse for Quality Improvement) was awarded the Chief Executive's Patient Safety Award for developing electronic nursing risk assessments.



Dr Tim Craft  
Medical Director



Mary Lewis  
Acting Director of Nursing



Dr Carol Peden, Associate Medical  
Director for Quality Improvement

# Chapter Two

## Our current status and priorities for improvement in 2013/14

During 2012/13 we made significant progress in a number of areas demonstrating our commitment to improve the quality of patient care. You can read more about the progress we made on Pages 14-23.

This year we have identified three quality priorities for improvement in 2013/14. We decided on these priorities through a process of consultation with our staff and NHS Foundation Trust members. As in previous years, they continue to focus on patient experience, patient safety and clinical effectiveness.

Our priorities for 2013/14 are:

- to further reduce our healthcare associated infection rates, with a focus on sepsis
- to promote organisational learning
- to improve the experience of patients at the end of their life, and to support their carers.

These priorities were among the five priorities we identified in our Quality Accounts last year, but we have decided to continue with them in order to make further improvement.

Our other priorities last year were improving care for patients with continence problems and improving the care of patients with Chronic Obstructive Pulmonary Disease. Although these areas of work remain important to the organisation there has been improvement in both these areas and they have not been identified as key priorities for 2013/14, although we will of course continue to improve in these areas.



*Improving the safe management of cannulae, the small tubes sometimes placed in the vein to administer medicine, is one of our priorities this year*



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# Priority One – to further reduce our healthcare associated infection rates with a focus on sepsis

We know that good infection prevention and control is essential to make sure that our patients receive safe and effective care. We aim to ensure that effective infection prevention and control is used as part of everyday practice and consistently applied by all staff. In this way, we can protect patients against healthcare associated infections (HCAIs).

Targets have been in place for several years for a reduction in the number of cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridium difficile. Improvements continue to be made and we have demonstrated this by year-on-year reductions. Data is also gathered and reported to the Health Protection Agency on bacteraemias caused by Methicillin-sensitive Staphylococcus aureus (MSSA) and Escherichia coli (E coli).

## Why have we chosen this as a priority?

We recognise the distressing effect on patients and their families/carers of acquiring an infection during their hospital stay and therefore reducing HCAIs remains one of our key priorities.

This year we have broadened the scope of this priority to include increased monitoring of post-operative infections and the management of patients with sepsis. Sepsis, otherwise known as 'septicaemia' or 'blood poisoning' is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. Early recognition and prompt treatment of sepsis is imperative.

The delivery of six interventions, known as the Sepsis Six, is completed by clinical staff during the patient's stay. When performed within one hour following recognition of sepsis, the Sepsis Six can save lives and evidence has shown that the chances of an individual dying from sepsis can be halved.

## Our aims for 2013/14:

- to increase the surveillance of surgical site infections
- to focus on increasing and enhancing our isolation facilities
- to work collaboratively with our partners in the community to develop a community-wide Clostridium difficile pathway
- to continue to improve the safe management of peripheral venous cannulae (the small tube sometimes placed in the vein to administer medication) and urinary catheters
- to implement the Sepsis Six tasks.

### The Sepsis Six Tasks

1. Give high flow oxygen
2. Take blood cultures
3. Give intravenous antibiotics
4. Start intravenous fluid resuscitation
5. Check haemoglobin and lactate blood levels
6. Monitor accurate hourly urine output

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## Priority Two – to promote organisational learning

How can we learn from incidents of harm to reduce the risk of them happening again?

This is a concern for hospital trusts nationwide, and at the RUH we are committed to creating an environment where staff have confidence in the process of reporting incidents and have a desire to share learning from these events.

We are also committed to being open and transparent with patients and their families when care has fallen below their expectations of us, and below the expectations of care we would expect to provide.

### **Why have we chosen this as a priority?**

We recognise that more can be done to feed back to staff in an effective manner the learning we gain from incidents and complaints.

This year we have seen an increase in the number of complaints received. We believe that this is primarily a result of the increased pressures on the hospital from emergency admissions which has resulted in the cancellation of planned admission dates for patients undergoing surgery.

We want to learn from the feedback our patients provide about the quality of care we give so that we can continually improve.

Being open with patients and their carers when things go wrong, and promoting a culture of openness is supported by the Department of Health's Duty of Candour.

We recognise that we need to keep improving how we learn from incidents and share this learning across the organisation.

We will continue in the year ahead to develop further ways of making sure we take every opportunity to listen to what patients, carers and the public tell us, to act on this and to feedback to both patients and staff about what we have done. This work will include reviewing how we respond to both complaints and compliments received across the Trust.

### **Our aims for 2013/14**

- to use the funding awarded by the Health Foundation 'Shine' project to improve the communication of feedback from reported incidents using innovative multimedia strategies such as animation, art, short video clips, social media, staff stories and safety bulletins that will engage and interest healthcare staff. It is intended that this will indirectly create a safer environment for patients
- to actively improve the reporting process and encourage a 'no blame' culture and prevent reoccurrence of incidents and learning from successful outcomes
- to provide resources to train 'champions' who will incorporate specific skills into existing training programmes to recognise the way teams work
- to use the information from the Meridian patient feedback system and the 'Friends and Family' questionnaire to better understand the views and experiences of our patients

## The Friends and Family Test



We have begun asking all patients aged 16 and over who either stay at least one night on one of our wards, or who visit our Emergency Department but are not admitted to fill in one of our 'Tell us what you think' cards.

These cards ask: 'How likely are you to recommend our Ward/Emergency Department to friends and family if they needed similar care or treatment?' Respondents can choose from Extremely likely, Likely, Neither likely nor unlikely, Unlikely, Extremely Unlikely, or Don't know. The question is being asked as part of the national Friends and Family Test which will allow patients to see the same information for all hospitals.

and carers and make improvements where necessary

- to review our complaints and compliments process to ensure we are taking on feedback and sharing this learning

- to continue to use 'patient stories' at Trust

Board meetings and for staff learning events (our 'See it My Way' programme).

We have also held our first ever staff story event which was a unique opportunity for staff to share their experience of the fire in our Intensive Care Unit in November 2011.

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## Priority Three – to improve the experience of patients at the end of their life and to support their carers

Improving end of life care in acute hospitals is essential as more than half of all deaths take place in hospital.

This priority aims to ensure that patients nearing the end of life and their families have the opportunity to have their needs met because the clinicians have identified that they are nearing the end of life, have communicated this to the patient and family, and have allowed them to be involved in appropriate decision-making.

### 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 at this time. This will ensure that decisions made by patients and their families are shared with relevant staff as the end of the patient's life approaches. For those patients who wish to die at home, we will endeavour to support them as much as we can.

### Our aims for 2013/14

Our End of Life Group is responsible for implementing the improvements identified, together with those recommended in the Department of Health National End of Life Care Programme 'The Route to Success'. We will ensure that practical information, emotional and spiritual support and a comforting and supportive environment is also offered to carers and families at this difficult time.

This year we aim to:

- train all relevant staff to access and use the Electronic Palliative Care Co-ordination system (previously called the End of Life Care Register). This is a register that holds information that patients and families have requested regarding their end of life care. This enables healthcare professionals from the RUH and the community to share information about patients nearing the end of their life, helping to improve care delivery and co-ordination
- re-locate the Patient Affairs team, which cares for the immediate needs of families following the death of a loved one, closer to our new mortuary
- identify the specific needs of patients who are approaching the end of their life and support them to manage the uncertainty that can exist at this time
- work with the health community to improve discharges and communication about appropriate future admissions
- use the results of a Care after Death Audit, which is one of the ways we collect feedback from families about the care of their loved one in the last few days of their lives, to improve our service.

## Mandatory Statement 1

During 2012/13 the Royal United Hospital Bath NHS Trust provided and sub-contracted seven types of NHS services via two clinical divisions, Medicine and Surgery.

During 2012/13 the Royal United Hospital NHS Trust has reviewed the data available on the quality of care using hospital-wide performance information such as the Hospital Standardised Mortality Rate 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 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 2012/13.

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, such as 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.

# Chapter Three - Review of Quality

## 2012/13 Priority One: to further reduce our health

Reducing healthcare associated infections continues to be a key priority for all the clinical teams and we are pleased that, although challenging, we have sustained the ongoing fall in the number of patients suffering a diarrhoeal illness caused by *Clostridium difficile* and we were able to meet the challenging target again this year.

We are disappointed to have had four cases of patients with an infection in their blood stream (bacteraemia) caused by MRSA after admission to hospital this year; two of these cases occurred when the hospital was under significant pressure in March 2013.



### What we have done

We have improved our isolation facilities. In order to provide a safe environment for patients suffering from infectious illnesses, doors were installed at the entrance to the bays on Parry Ward. This allows for small sections of the ward to be isolated and reduces the spread of infections such as influenza or diarrhoea and vomiting.

The below tables show the incidence of MRSA bacteraemia and *Clostridium difficile* since 2009, and our targets for 2013/14.

	09/10	10/11	11/12	12/13	13/14 target
MRSA bacteraemia	17*	2	1	4	1
<i>Clostridium difficile</i>	113	51	46	30	29

\* This figure 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.

# Quality Performance in 2012/13

## Healthcare associated infection rates

We continue to review our temporary isolation facilities and are currently investigating further isolation initiatives to increase our ability to provide an appropriate environment for this group of patients.

We have publicised infection prevention and control advice. Patient information leaflets for the most common healthcare associated infections are now available. These leaflets provide advice on how patients and carers can help to prevent the spread of infection and explain appropriate treatment.

We have launched infection prevention and control initiatives Trust-wide. In conjunction with the World Health Organisation Hand Hygiene Week, the Infection Prevention and Control Team organised an awareness campaign for patients, staff and visitors to demonstrate the importance of effective handwashing.

A second event focused on visiting wards to educate staff on how to interpret the results of the new Clostridium difficile test.

We held a Clostridium difficile Think Tank in April 2012. This was a collaborative event focusing on further reduction of the incidence of Clostridium difficile infection across the Trust. As a result of the event a number of new initiatives were launched, including the 'Spring Clean' initiative which involved the de-cluttering of wards.

We have increased surveillance of surgical site infections. A surgical site infection occurs when micro-organisms get into the part of the body that has been operated on and multiply in the tissues. We have continued to take part in the mandatory surveillance of surgical site infections for patients

undergoing hip and knee replacement surgery.

In addition, patients undergoing surgery for fractured neck of femur are now included in this surveillance programme. The monitoring of these types of procedures will ensure patients are closely monitored following their operation and prompt action taken if an infection is identified.



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## 2012/13 Priority Two: to improve the pathway of Pulmonary Disease

We have around 500 admissions per year for exacerbations of Chronic Obstructive Pulmonary Disease (COPD), a common and debilitating chronic disease.

Patients experience worsening breathlessness over many years, interspersed with exacerbations which frequently result in admissions to hospital.

### What we have done

There has been closer collaboration between the Respiratory ward, Medical Assessment Unit and the bed management team to improve the placement of patients on Non-Invasive Ventilation (NIV) to the Respiratory ward within 24 hours of the use of NIV.

Furthermore, an education programme has been rolled out for middle grade doctors working in the Emergency Department, Intensive Care Unit and Medical Assessment Unit to improve the standards of care that patients requiring NIV receive.

The use of oxygen is very closely observed with monitoring to ensure that oxygen is being turned up at the appropriate time and also turned back down again. This recognises that oxygen is a drug and close observation is essential as too much oxygen can be detrimental to the well-being of the patient.

On our Respiratory ward, patients are particularly sensitive to the use of oxygen and so need to be very closely observed. We therefore undertake audits of patients on this ward to monitor the use of oxygen and ensure that patients' saturation levels are within the target range.



Oxygen is now included on all drug charts as a prescribed medication.

We have worked to improve our patient education through the use of patient information leaflets, inhaler training guides, appointments for smoking cessation/ pulmonary rehabilitation.

Patient leaflets providing information about COPD, recovering from an exacerbation and the benefits of exercise in chronic lung disease have been developed. The team has



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## care for patients with Chronic Obstructive

also developed inhaler training leaflets to ensure every patient discharged from the ward is taught and assessed on the use of their inhalers.

We have increased the number of patients referred to the Healthy Lifestyle Service for smoking cessation. We have seen immediate results in this area - in the eight weeks following training of three RUH staff by Sirona Care and Health, referrals into the Healthy Lifestyle Service went up by 200%. This was due to the efforts of all of the staff on the respiratory ward and, in particular, three members of staff who trained as Level 2 Stop Smoking Advisors.

Patients are asked about their lifestyle and if they would like help to change, they are referred to the Healthy Lifestyle Service. This could be for support to stop smoking, get more active or to eat more healthily. The trained advisors on the ward provide extra support for patients while they are still in hospital.

This is part of a new initiative, which has been referred to as 'the COPD discharge bundle' and is a way of asking patients suffering from chronic obstructive pulmonary disease early on what help they will need when they leave hospital, rather than waiting until they are about to leave. It aims to improve the quality of care and patient experience and minimise the risk of them being readmitted to hospital.

The discharge checklist prompts staff to ensure that patients have been offered smoking cessation, referral to pulmonary rehabilitation and that satisfactory use of

inhalers is understood and demonstrated.

The checklist also ensures GP practices are informed promptly when patients are discharged with a diagnosis of COPD and that a follow up appointment with the community practice nurse is made within two weeks of the patient going home.

Regular audits have been carried out to monitor current practice to ensure this group of patients has their specific nutritional needs met.

We recognise 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.

There is ongoing work within the Trust to ensure adequate nutrition for vulnerable groups of patients such as these.

### Mandatory Statement 3

The number of patients receiving NHS services provided or sub-contracted by the RUH in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 1,066.

## 2012/13 Priority Three: to promote organisational

Promoting organisational learning remains one of our key priorities this year, however we carried out a significant amount of work in this area in 2012/13.

### What we have done

We have developed a training programme to ensure all staff are competent to use our incident reporting system, and a Risk and Patient Safety web page has been developed for staff to access information and guidance. Urgent Treatment of Patients in Adversity training has been incorporated in the clinical nurse skills training and it is planned to be included within the healthcare assistant induction programme.

We have upgraded the system our staff use to report incidents and given it a fresh

new look. This has been widely publicised internally and staff have been encouraged to attend training sessions to ensure that if they ever witnessed an incident, they would know how to report it.

We have developed training for junior doctors and human factor awareness training for surgeons and anaesthetists has taken place. Human factors is a discipline which studies people's behaviour in relation to their work with the goal of optimising their performance to enhance patient safety.

Clinical human factors are all the non-technical factors that impact on patient care in medicine. Human factors have enormous breadth including human behaviour, interactions between professionals, design of equipment, systems and environment.

The impact of human factors is enormous. Awareness of, and attention to, the negative aspects of clinical human factors improves patient care.

Learning from other trusts in the South West region was undertaken and elements of good practice were identified in order to develop our incident reporting strategy.

The Meridian real-time patient and carer feedback system was implemented in March 2012 on nine inpatient wards and outpatient areas as pilot sites within the RUH. Questions



***Ann Clywd MP visited the RUH as part of a review she is carrying out into the way the NHS handles complaints. The visit gave us the opportunity to explain the importance we place on learning from patient feedback.***

## See it my way

Our 'See it my way' patient story programme continues to go from strength to strength, using patient stories to inspire and motivate staff. This year we have heard patient, carer and staff stories from the following areas: dying matters, living with breathlessness, living with bladder problems, and being deaf.



*Talking with one of our Deaf guests at a See it my Way event via a British Sign Language interpreter*

Feedback from these events has been extremely positive and inspiring, and has resulted in improvements to patient experience.

In the Department of Health's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry 'Patients first and foremost' the work of our patient experience team and the 'See it my Way' events pioneered at the RUH are featured in the first chapter of the report as an example of excellent practice. The document describes our events as a "powerful way of using patient stories to inspire and motivate staff".

were chosen following a consultation process with patients, carers and staff. Feedback is given via tablet devices and the RUH public website and allows staff working in the areas where it is used to understand how patients experience care on the wards or clinic.

We use this feedback to identify areas that require improvement. For example, some patients reported that the quality of the soup was poor and as a result we have made changes to the soup and are now able to monitor what patients think of this change.

Patient or carer stories are heard at every

monthly Trust Board meeting. Staff present the story and are able to highlight to the Trust Board areas that may require improvement. Previous stories have included a patient who experienced the enhanced recovery pathway, and that of a frequently attending patient and his wife in the Emergency Department.

See it my Way events, and Trust Board stories, have enabled us to build up a substantial library of patient, carer and staff stories which we have permission to share within the RUH at learning events.

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## 2012/13 Priority Four: Improving Urinary Continence Care

As part of the existing patient safety programme, we wanted to achieve a 50% reduction in urinary catheter associated infections between 2011 and 2013. For patients with a catheter in place, in February 2011 27% patients had a urinary tract infection (UTI) compared to 15% in February 2012 and 14% in February 2013. We have achieved a 48% reduction in catheter associated infections, and continue to monitor the number of urinary catheters in place and the number of patients with a catheter urinary tract infection.

### What we have done

We have worked to raise awareness among staff about the issues relating to continence, which has included increasing the use of teaching for ward staff through the introduction of 'continence ambassadors' and holding a continence awareness workshop.

We also held a 'See it my Way' event – 'Living with bladder problems' – where staff listened to stories told by patients on their experience of living with incontinence. One of the Continence team nurses also shared her story about her experiences of looking after patients with catheters and her motivation to improve our service in this area. For patients suffering incontinence, we have introduced a new skin wipe which minimises the likelihood of incontinence-associated skin sores, which can be a painful experience for patients.

New catheter care plans have been implemented that alert staff caring for patients with a urinary catheter to undertake a daily review to assess whether the catheter is still required. We monitor the number of patients with a urinary catheter and the

number of catheter-associated infections by undertaking a monthly 'snapshot' audit each month.

We have developed a patient information leaflet on 'how to care for your catheter' and continue to 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 Bath's Research Design Service. Expertise has also been supplied by University of West of England researchers.

We have been told by patients and know from community nursing staff that we are not providing adequate information for the patient who is discharged with a catheter in place, and we know that many patients leave hospital without fully understanding why they had a catheter fitted in the first place, and many struggle with learning to live with having a catheter.

The passport will enable us to provide more information to the patient when they leave the hospital, and to our partners in the community who will continue to care for the patient. A discharge nurse will complete a section on the passport with the patient, and the patient will take the passport with them when they leave, putting them in charge. The community nurse will see from the passport why the patient has the catheter in place, when it can come out (if it can), and when it needs changing. The passport will focus on the psychological elements of care as well as the physical and practical aspects as evidence tells us that this is often the missing piece of the jigsaw. We hope to implement the passport later this year.

#### **Mandatory Statement 4**

A proportion of the Royal United Hospital's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between the RUH and any person or body it entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

#### **Mandatory Statement 5**

The RUH is required to register with the Care Quality Commission (CQC) 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 2012/13.

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

The CQC visited the RUH in November 2012 to inspect surgical areas and assessed the Trust as being fully compliant.

The CQC made an unannounced visit to the RUH in February 2013 and inspected the Day Surgery Unit and Older People's wards.

The CQC found that the RUH was not compliant with the four essential standards that were assessed and that compliance action was needed to meet the regulations.

The RUH has submitted a report to the CQC detailing the actions to be taken to ensure the Trust is compliant with the essential standards.

#### **Mandatory Statement 6**

The RUH submitted records during 2012/13 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:  
99.7% for admitted patient care  
99.8% for outpatient care; and  
98.8% for accident and emergency care

- Which included the patient's valid General Medical Practice Code was:  
100% for admitted patient care  
99.2% for outpatient care; and  
100% for accident and emergency care

#### **Mandatory Statement 7**

The RUH Information Governance Assessment Report score for 2012/13 was 89% but was graded unsatisfactory due to one of the 45 requirements only achieving level 1, rather than the required level 2.

# 2012/13 Priority Five – Improving the experience of patients at the end of their life

We are working towards developing staff to be better able to identify when a patient is nearing the end of their life. Once this has been established, staff document this in the patient's notes, discuss the plan with the patient, if they are able to, and their family. Staff then follow a clear pathway once the patient is identified as approaching end of life care.

## What we have done

We have worked to maximise the potential of the Electronic Palliative Care Co-ordination system (formerly known as the End of Life register) for BANES and Wiltshire and are working to make it more accessible for staff, enabling the sharing of information about

## Helping make hospital visits more comfortable

We know that families can spend long periods of time in hospital, including overnight, and receive good support from nursing staff.

To complement this we have supported the use of comfort boxes, which hold small items for use by a patient's family when they need to spend many hours at the bedside or overnight.

The Medical Assessment Unit and Respiratory ward and a further nine wards have received comfort boxes funded by The Palliative Care Charitable Fund.

The box contains the kind of things which may help during a long visit to the hospital – such as tea, coffee, hot chocolate, mugs, biscuits, toothbrushes, wet wipes, and ear plugs.

We have also promoted the role of the chaplaincy team and our volunteers in providing support for patients and families.



patients' end of life care needs between the community and the hospital. A separate register for Somerset will be used once staff are trained. The database provides information such as the patients' wishes and what consent has been given, and this is accessible to the wider health community.

Understanding and navigating the often complex discharge process is difficult. Discharge packs have been developed and are currently being promoted. We will continue to work with the Discharge Liaison Team to improve the discharge of patients who are approaching the end of their lives.

Plans are in place to include end of life care training when new staff are appointed as part of their induction. We have also been able to second a member of nursing staff with experience in end of life care to provide support and education for ward and department staff. In addition we have strengthened the role of the end of life care ambassadors, who are nurses and healthcare assistants, who work on each ward and act as a link between the Palliative Care team and the ward staff.

Our End of Life Care Facilitator has been involved in the design for the new mortuary, working to ensure that it is sensitively designed with the needs of bereaved relatives and families in mind, and has the right ambience to it.

There is a website for the public regarding the care of the dying, and our staff intranet site has been revised and will be further developed and promoted to ensure it provides the information that staff need.

## Mandatory Statement 8

The RUH was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The aim of the Payment by Results programme is to provide assurance that the Healthcare Resource Group (HRG) used as the basis for charging commissioners has been correctly calculated. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

### Specialty – General Medicine

Primary diagnoses Incorrect (5%)  
Secondary diagnoses Incorrect (8.3%)  
Primary Procedures Incorrect (13%)  
Secondary Procedures Incorrect (13.6%)

### Specialty – Pain

Primary diagnoses Incorrect (55%)  
Secondary diagnoses Incorrect (57.8%)  
Primary Procedures Incorrect (2%)  
Secondary Procedures Incorrect (33%)

In spite of a high proportion of incorrect diagnoses in Pain specialty, in its 2012/13 audit, the Royal United Hospital Bath Trust achieved a low spell error rate. These incorrect diagnoses were categorised as non-coder errors, and had arisen because of a lack of diagnosis information which resulted in a high and incorrect use of the code for diagnosis 'pain unspecified'. Although a generic code for 'pain' was used, the use of this code did not affect the HRG allocation.

# 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 a separate table giving our targets for 2013/14.

## RUH Quality domains and indicators

RUH Quality domains & indicators	2012/13 target	2012/13 actual	Commentary
<b>Patient Safety</b>			
Venous thromboembolism (VTE) - Risk assessments on all eligible patients	90%	95%	
VTE - Patients who require prophylaxis receive it	100%	81%	Progress continues to be made and this is part of CQUIN for 2013/14.
VTE - Root Cause Analysis (RCA) of Hospital Acquired VTE	100%	60% in Q3	The RCA process is currently being revised to improve timeliness and clarify clinical ownership with a view to improving performance against the target.
Timeliness of investigations into Serious Untoward Incidents	45 days	45 days	
Percentage of patient safety incidents resulting in severe harm or death	N/A	0.71%	These incidents are also measured locally using harm events per 1,000 bed days on the integrated balance scorecard. (RUH actual performance = 15 against a target of less than 30)



RUH Quality domains & indicators	2012/13 target	2012/13 actual	Commentary
<b>Clinical Effectiveness</b>			
Reduce the average length of stay for both elective (planned) and non-elective (unplanned) patients. Specific CQUIN length of stay targets were agreed for non-elective for specialties as below			Overall non-elective length of stay has increased due to the emergency care system pressures. The Trust has established various projects, the combination of which will help to deliver the 2013/14 target of Adult non-elective length of stay of 6.8 days from the 2012/13 baseline of 7.2 days.
1 Respiratory (days)	11.14	12.43	
2 Cardiology (days)	7.22	12.06	
3 Geriatrics (days)	13.62	14.97	
4 Endocrinology (days)	11.81	9.83	
5 Gastroenterology (days)	9.96	12.75	
Reduce the number of hospital acquired pressure ulcers at Grade 3 & 4 (25% reduction on 2011/12)	7	17	The number of hospital acquired pressure ulcers can be partly attributed to a 60% increase in referrals and a temporary reduction in the tissue viability nurse service. A lead tissue viability nurse has been appointed.
Reduce the number of hospital acquired pressure ulcers at Grade 2 (25% reduction on 2011-12)	201	259	See above comment.
End Of Life Staff Training	75%	65%	We have now embedded this training into our staff induction programme so expect this to increase in 2013/14
Dementia Staff training	30%	72%	
Dementia screening	90%	N/A	These measures were introduced at the end of 2012. An audit is to be undertaken to assess compliance.
Dementia risk assessment	90%	N/A	See above comment.
Dementia referral for specialist diagnosis	90%	N/A	See above comment.

<b>RUH Quality domains &amp; indicators</b>	<b>2012/13 target</b>	<b>2012/13 actual</b>	<b>Commentary</b>
Weekend discharges - Working towards a seven day working week	19%	16.70%	The Trust has now pulled all discharge actions into a Green to Go project which is being led by the Head of Therapies. This project was significantly affected by the pressure seen on the whole system last year for Emergency and Urgent Care.
Fractured neck of femur - % of patients to theatre within 36 hours	80%	84.40%	
Day Surgery Rates - Renamed to "Increase Day Surgery and Outpatient Procedures - BADS" (British Association of Day Surgery)	80.5%	85%	
Outpatient Letters to GPs within 2 weeks of attendance	75%	87%	Current reporting structures only allow performance monitoring of typing completion from typing request.
Total readmission rate within 30 days	5.4%	6.7%	This is a steep trajectory. The avoidable readmissions that the RUH can influence is significantly smaller.
Patients readmitted within 28 days	N/A	0-14 years = 2.6%. Over 15 years = 12.5%.	To monitor performance the Trust applies a 30 day readmission methodology which is used for national billing purposes.
<b>Patient Experience</b>			
Learning Disabilities: Appropriate use of MCA, best interest decision making and consent forms	95%	100%	
National Inpatient Survey question: 'In your opinion, how clean is the hospital room or ward you are in?'	90%	97.90%	This question will be replaced by the Friends and Family Test (FFT) national measure next year.
National Inpatient Survey question: 'On the whole, are the staff kind and friendly?'	90%	99.60%	This question will be replaced by the FFT national measure next year.
National Inpatient Survey question: 'Were you involved as much as you wanted to be in decisions about your care and treatment?'	90%	90.30%	This question will be replaced by the FFT national measure next year.

# Performance against national targets 2012/13

National targets	2012/13 Target	2012/13 Actual	Commentary
<b>Assessed by Acute Trust Performance Framework (ATPF) and Monitor Governance Indicators</b>			
% patients treated in A&E within 4 hours	95%	91.90%	
Number of MRSA Bacteraemias (Post 48 hours)	1	4	Each MRSA bacteraemia is investigated fully. An improvement plan is in place to address the shortcomings
Number of Clostridium difficile infections (Post 72 hours)	31	30	
Referral to Treatment (RTT) admitted -18 weeks from GP referral to hospital treatment (in all specialties 2012/13)	90%	92.60%	
RTT non-admitted - 18 weeks from GP referral to hospital treatment (in all specialties 2012/13)	95%	97.20%	
RTT – open pathways in 18 weeks	92%	92.40%	
Diagnostic tests - maximum wait of 6 weeks	<1%	0.30%	
Cancer urgent referral to first outpatient appointment – 2 weeks	93%	94.80%	
Cancer urgent referral to first outpatient appointment – 2 weeks (breast symptoms)	93%	98.80%	
Cancer diagnosis to treatment – 31 days (subsequent surgery)	94%	99.10%	
Cancer diagnosis to treatment – 31 days (subsequent drug treatment)	98%	100.00%	
Cancer diagnosis to treatment – 31 days (subsequent radiotherapy)	94%	98.30%	

National targets	2012/13 Target	2012/13 Actual	Commentary
Cancer diagnosis to treatment all cancers – 31 days	96%	99.70%	
Cancer urgent referral to treatment – 62 days (screening)	90%	99.20%	
Cancer urgent referral to treatment all cancers– 62 days (includes GP and hospital specialist)	85%	92.60%	
Delayed transfers of care	3.50%	1.78%	
Number of Mixed Sex Accommodation breaches	0%	0.09%	This represents a very small number of patients where extreme pressures meant that, on rare occasions, patients shared a ward area with members of the opposite sex. In these circumstances, individual care, privacy and dignity is paramount.
Venous thromboembolisation % screened	90%	95.30%	
<b>Other nationally determined indicators 2012/13</b>			
Patients offered date within 48 hours of contacting Genitourinary Medicine clinic	100%	100%	
Patients seen within 2 weeks for rapid access chest pain	98%	99.80%	
Hip fractures operated on within 36 hours	80%	84.40%	
Primary angioplasties - % under 150 mins of call to emergency services	70%	77.50%	
Higher risk trans ischaemic attack (TIA) treated within 24 hours	60%	51.00%	TIA performance improved with the full implementation of a 7 day TIA high risk clinic in May 2013 and appointment of 2 new stroke consultants.
% people spending 90% time on stroke unit	80%	69.19%	7 day working will support recovery of this target
% cancellations not re-booked within 28 days	5%	3.10%	

<b>National Acute Trust Performance Framework (ATPF) Targets</b>	<b>2013/14 Target</b>
% patients treated in A&E within 4 hours	95%
Number of MRSA Bacteraemias (Post 48 hours)	1
Number of Clostridium difficile infections (Post 72 hours)	29
RTT admitted -18 weeks from GP referral to hospital treatment (in all specialties 2012/13)	90%
RTT non-admitted - 18 weeks from GP referral to hospital treatment (in all specialties 2012/13)	95%
RTT – open pathways in 18 weeks	92%
Diagnostic tests - maximum wait of 6 weeks	1%
Cancer urgent referral to first outpatient appointment – 2 weeks	93%
Cancer urgent referral to first outpatient appointment – 2 weeks (breast symptoms)	93%
Cancer diagnosis to treatment – 31 days (subsequent surgery)	94%
Cancer diagnosis to treatment – 31 days (subsequent drug treatment)	98%
Cancer diagnosis to treatment – 31 days (subsequent radiotherapy)	94%
Cancer diagnosis to treatment all cancers – 31 days	96%
Cancer urgent referral to treatment – 62 days (screening)	90%
Cancer urgent referral to treatment all cancers– 62 days (includes GP and hospital specialist)	85%
Delayed transfers of care	3.50%
Number of Mixed Sex Accommodation breaches	0%
Venous thromboembolisation % screened	90%
<b>National CQUIN Targets</b>	
FFT - Compliance with phased expansion	Fully compliant
FFT - Increase patient response rate	20% or greater
FFT - Improved Performance on the Staff FFT	Greater than 60%
NHS Safety Thermometer - Reduction in the prevalence of hospital acquired (new) pressure ulcers	1%
Dementia - Find, Assess, Investigate and Refer pathway	90%
Dementia - Clinical Leadership	Compliant
Dementia - Supporting Carers	Compliant
VTE - Risk Assessment and Root Cause Analysis	95% for risk assessment

<b>Local Priority Targets</b>	
End Of Life Care	To improve identification and management of patients who are reaching the end of life, with specific focus on ensuring appropriate conversations are had with all relevant parties, via the implementation of the End of Life Care prognostic and pathway framework. To have implemented the pathway on 6 keys wards by the end of Q3 (December 2013).
Promoting Organisational Learning	Increasing the rate of reporting of patient safety incidents by staff
Infections & Sepsis 6	Reliable implementation of the Sepsis 6 tasks (see Page 9) in the Emergency Department by October 2013, and in the Surgical Admissions Unit and Medical Assessment Unit by December 2013

## Mandatory Statement 2 – Participation in audit

During 2012/13, 38 national clinical audits and 4 national confidential enquiries covered NHS services that the Royal United Hospital Bath NHS Trust provides.

During that period the Royal United Hospital participated in 89% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the RUH participated in, and for which data collection was completed during 2012/13 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.

<b>NCEPOD</b>	<b>Participation?</b>	<b>% cases submitted</b>
Alcohol Related Liver Disease	Yes	100%
Subarachnoid Haemorrhage	Yes	100%
Bariatric Surgery	Yes	100%
Cardiac Arrest	Yes	100%

<b>National Clinical Audits</b>	<b>Participation?</b>	<b>% cases submitted</b>
<b>Acute</b>		
Adult community acquired pneumonia (British Thoracic Society)	Yes	Not yet available
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
Emergency use of oxygen (British Thoracic Society)	Yes	100%
National Joint Registry	Yes	699 procedures submitted
Non-invasive ventilation - adults (British Thoracic Society)	Yes	Not yet available
Renal colic (College of Emergency Medicine)	Yes	100%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	81% (November 2012 – March 2013)
<b>Blood and Transplant</b>		
National Comparative Audit of Blood Transfusion programme	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	100%

<b>National Clinical Audits</b>	<b>Participation?</b>	<b>% cases submitted</b>
<b>Cancer</b>		
Bowel cancer	Yes	100%
Head and neck oncology	Yes	100%
Lung cancer	Yes	100%
Oesophago-gastric cancer	Yes	Not yet available
<b>Heart</b>		
Acute coronary syndrome or Acute myocardial infarction	Yes	90%
Cardiac arrhythmia	Yes	100%
Coronary angioplasty	Yes	100%
Heart failure	Yes	100%
National Cardiac Arrest Audit	Yes	98%
<b>Long term conditions</b>		
Adult asthma (British Thoracic Society)	No	Local asthma audit planned
Bronchiectasis (British Thoracic Society)	No	N/A
Diabetes (Adult), includes National Diabetes Inpatient Audit	Yes	100%
Diabetes (Paediatric)	Yes	100%
Inflammatory bowel disease	Yes	N/A (data collection started January 2013 – still open)
National Review of Asthma Deaths	Yes	100%
Pain database	No	N/A
<b>Older People</b>		
Carotid interventions audit	Yes	100%
Fractured neck of femur	Yes	100%
Hip fracture database	Yes	100%
National audit of dementia	Yes	100%
Parkinson's Disease (National Parkinson's Audit)	Yes	Awaiting response from Parkinson's UK
Sentinel Stroke National Audit Programme	Yes	N/A (Officially launched 1 April 2013. RUH is submitting data)
<b>Other</b>		
Elective surgery (National PROMs Programme)	Yes	100% offered questionnaires to complete



National Clinical Audits	Participation?	% cases submitted
<b>Women's &amp; Children's Health</b>		
Child health programme	Yes	100%
Epilepsy 12 audit	Yes	100% (Round 1, October 2011)
Neonatal intensive and special care	Yes	100%
Paediatric asthma (British Thoracic Society)	Yes	90%
Paediatric fever (College of Emergency Medicine)	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Yes	Data collection closes 31 March 2013

The reports of 15 clinical audits were reviewed by the provider in 2012/13. The following are examples of actions that the RUH has implemented or intends to take to improve the quality of healthcare provided.

#### Heart Failure

The RUH was above the national average for drug treatment on discharge from hospital for patients with a primary/secondary diagnosis of Left Ventricular Systolic Dysfunction and for all heart patients receiving an In-Patient Echocardiogram.

There is a need to look in more detail at the effectiveness of the Heart Failure Pathway and readmissions within 30 days. The RUH is currently planning a two-part audit to look at the performance of the Heart Failure Pathway compared to relevant NICE guidance. The second part of the audit plans to look at reasons for readmissions within 30 days and post-discharge heart failure support within the wider community.

#### Paediatric National Diabetes Audit 2010-11

The audit measures the percentage of infants, children and young people with

diabetes who are receiving the key standards of care which include Glycated Haemoglobin A1c (HbA1c), Body Mass Index (BMI), blood pressure, urinary albumin, blood creatinine, cholesterol, eye screening and foot examination. HbA1c is recommended as the best indicator of long term diabetes control.

The RUH recorded all care standards for 52.1% of patients. This compares favourably with the national results. 96% of RUH infants, children and young people had their HbA1c recorded compared to 92.1% of patients nationally. 12.5% of RUH infants, children and young people achieved the target for HbA1c, slightly lower than the national average of 15.8%.

The RUH is revising the annual review proforma to ensure all care standards are completed. The team can refer direct to the retinal screening service if necessary (previously relying on referral by GP). Increased Paediatric Diabetes Specialist Nurses and dietetic time has already allowed the team to be more pro-active rather than reactive. A local audit has shown that the percentage of patients who achieved the

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target for HbA1c has improved to 16.1%. The Trust is working towards being much closer to the best units with year on year improvements. Best units achieve 30% or more whilst the poorer performing Trusts achieve less than 5%.

### **Epilepsy 12 audit (Childhood Epilepsy)**

The audit results showed that the RUH is on the whole better than the national average for Epilepsy 12 performance indicators for investigations, management and outcomes. Improvement is required for children with epilepsy being seen by appropriate professionals with expertise in epilepsy. Children with convulsive seizures did not always receive an electrocardiogram within one year.

In Bath, a business case is being discussed with community paediatrics for a specialist nurse.

To improve history taking and ECGs there is already an intranet guideline but further changes will need to be made and trainee doctors made aware of these changes.

A re-audit was carried out by the RUH in November 2012 which showed an improvement for input by a consultant paediatrician with expertise in epilepsies.

### **Emergency use of oxygen (British Thoracic Society)**

The RUH has slightly improved on a number of parameters. Prescribing has improved (60% in 2012 compared to 47.2% in 2011) and remains better than national figures. Administration of oxygen by nursing staff has improved (61.9% of patients within the target range in 2012 compared to 51.9% in 2011). There remain a significant number of patients who receive too much oxygen (18.5%) or too little oxygen (22.2%).

The audit was carried out just days after

the new prescription charts were rolled out, and it is expected that performance will further improve over the next few months as staff become aware of how to use the new prescription charts.

A rolling prospective audit is being carried out on the Respiratory ward which will help improve nursing administration of oxygen. Results of the audit will be presented at the Respiratory departmental meeting to help improve staff knowledge and awareness.

### **2011: National clinical audit of HIV testing and new diagnoses**

HIV testing is already routinely recommended in the sexual health clinic, antenatal clinics, TB service and drug dependency units. It remains selective in hepatitis clinics, termination of pregnancy service, the Emergency Department, Medical Assessment Unit, medical out-patients and in general practice.

The prevalence of HIV in this area is below that which would trigger recommendation of routine screening for all new GP registrations and all hospital admissions (Emergency Department, Medical Assessment Unit).

However, BANES has the highest rate of late diagnosis in the South West and this needs to be addressed. Continued education of clinicians about HIV testing to move away from the risk factor approach and to focus on a clinical indicator approach in which presence or absence of risk factors is irrelevant is required.

The sexual health team in partnership with the public health team has formed an HIV working group to tackle the issue of late diagnosis and to encourage increased HIV testing in non-specialty settings, especially primary care.

Following a questionnaire to GPs about

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possible barriers to testing and how they felt we could help address these, a number of initiatives were put in place. An 'open house' at the sexual health department was held on World AIDS Day to which all BANES primary care clinicians were invited. This included educational talks and the opportunity to have informal discussions with the team.

A further GP education day was held at Dorothy House and was well attended. Flow charts detailing how to order HIV tests and how to manage results, both positive and negative, were designed and made available through the RUH web. ICE, a system used by GPs to order clinical tests, was adjusted to make the HIV test request far easier to locate and use and the HIV test was added as a 'pop-up' to a variety of pick lists for indicator conditions.

There was an overall 24% increase in HIV testing through non-specialist sites in the first six months of 2012 compared to 2011. This work is ongoing with more GP education meetings planned in 2013.

### **Local audits**

The reports of 54 local clinical audits were reviewed by the Trust in 2012-2013 and the following are examples of actions that the RUH has implemented or intends to take to improve the quality of healthcare provided. Further details of local audits undertaken during 2012-2013 will be included in the Trust's Annual Clinical Audit Report.

#### **Child Protection Knowledge Audit**

This reviewed staff knowledge of child protection processes in line with the requirements of the Care Quality Commission's essential standards of quality and safety and the RUH Child Protection Policy. The audit found that current child protection knowledge and training amongst RUH staff who have regular contact with

children, young people and their families was acceptable. Staff demonstrated an awareness of child protection issues and the majority are able to act accordingly should they have concerns about a child's safety and wellbeing. Attendance at training continues to be monitored through the Safeguarding Children Committee with target trajectories for attendance at training. Self-assessments of knowledge are also now undertaken following staff attending level 1 training. Results for March 2013 show that staff feel more confident about raising a safeguarding alert, identifying risks of abuse and categories of abuse following training.

#### **Time to giving Post-operative Mitomycin C, audit and re-audit**

Mitomycin C is used to reduce the number of reoccurrences of bladder cancer, it has been shown to be most effective if given within six hours. Initial audit showed that only 11% of patients were discharged on the day of their Transurethral Resection of Bladder Tumour (TURBT), and that only 8% of patients were administered mitomycin C within six hours of their TURBT procedure. A change in practice was introduced so that mitomycin C could be administered in theatre. A re-audit was then carried out which showed that 46% of patients were discharged on the day of their TURBT and that 100% of patients who met the criteria for mitomycin C received it within 6 hours of their TURBT procedure. The biggest benefit of giving mitomycin C early is the significant improvement we have made to same day discharges.

#### **Do Not Attempt Cardiopulmonary Resuscitation (DNAR) Audit - evaluation of combined Resuscitation Decision and Ceiling of Treatment proforma pilot**

A previous audit, completed in December 2011, highlighted areas for improvement around documenting decisions of whether to attempt to resuscitate people. In response to this and national recommendations from

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the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) 2012 report, a “do not attempt resuscitation” (DNAR) working group was established as a sub-group of the Resuscitation Committee. A Ceiling of Treatment (COT) form had been previously developed and trialled in the Older People’s wards. It had been well received and aided communication across disciplines and during out of hours; however, feedback had highlighted the desire for a combined DNAR and ceiling of treatment form.

A combined proforma was developed using multidisciplinary input that included a legal opinion and piloted on two wards. A re-audit was undertaken that showed that documentation of the reason for the DNAR decision and discussion with the patient and/or relatives has improved considerably since it was last audited but this area still needs further work. Further education is planned for medical staff.

The DNAR/COT form has also been amended to improve clarity around the reason for the DNAR decision. The audit results were fed back to staff through the Resuscitation Committee and Operational Governance Committee.

The audit will be repeated in July 2013.

# Chapter Four

## Participation in research and development

We are very fortunate to have our own researchers and scientists on site, who investigate new techniques and treatments that will benefit our patients and improve patient care. R&D benefits the RUH in many ways – it helps attract high quality staff, improves quality of care and the patient's experience, brings in new clinical techniques and otherwise unavailable treatments and attracts patients by making the RUH the hospital of choice for both our patients and their GPs. R&D provides grant income, and many extra clinical resources such as drugs, equipment, and clinical sessions which are often over and above what is normally provided by the NHS.

The RUH has 227 active projects on the approved research database, and is one of the most active and successful research district general hospitals in the region, and is in the top 10 of research-active medium sized acute trusts in the UK. Last year we saw an increase in patient recruitment in clinical trials of 30%, one of the highest levels in the region. About 10% of staff are involved in research, including medical staff, nurses, psychologists, scientists and allied health professionals. Our most active research areas are cancer, diabetics and endocrinology, paediatrics, stroke and elderly care, and emergency medicine. This year we have seen an increasing number of research projects in surgery and cardiology.

Research is funded from a number of sources: commercial and pharmaceuticals, National Institute of Healthcare Research NHS funding, research councils and medical charities. External funding is around £1.5 million per year. There are a minority of research projects that are not externally funded, but carried out in staff members' own time.

There are many examples of research carried out in the RUH such as:

The Oncology department works in close collaboration with the University of Bath and has the highest number of research projects in the hospital (30%) and aims to involve as many patients as possible in clinical trials, giving them state of the art care. It has recently doubled the number of patients recruited to be involved in cancer research studies and as a result has been recognised as the best recruiter for cancer research projects in the South West and in the top 10 in the UK.

Patients are helping our stroke research nurses find out more about the causes and treatment of stroke. This allows them access to new and innovative treatments. The stroke department has been so successful in their research that they were awarded the RUH Research Award for 2012.

In Ophthalmology, one project is a study of vision treatment following stroke when loss of vision to one side can be common. This leads to problems including bumping into objects and difficulty with reading. This study aims to find out if plastic prisms on glasses or a visual search/training is better at helping with loss of vision. Prism glasses could provide an effective therapy vastly improving quality of life for stroke patients with vision loss.

Diabetes is one of the most challenging health problems in the 21st Century, known to affect over 2 million people in the UK alone. The Diabetes and Lipids Research Team is currently working on 12 portfolio studies, with more being set up, and in 2012 contributed to 24% of all patients recruited into research at the RUH. Our aim is to provide high quality, patient focused research, and contribute to the overall positive patient experience.

# Chapter Five - What others say

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## Statement from Bath and North East Somerset Clinical Commissioning Group



**Bath and North East Somerset  
Clinical Commissioning Group**

Bath and North East Somerset Clinical Commissioning Group (CCG), on behalf of our predecessor organisation NHS BaNES, has taken the opportunity to review the Quality Account prepared by the Royal United Hospital Bath (RUH) for 2012/13.

We are very pleased that the RUH has been working closely with NHS BaNES and the CCG in its shadow form through 2012/13 to maintain and continue to improve the quality of its commissioned services. The RUH has also been cooperative in building new clinical and managerial relationships with the CCG in preparation for the transfer of commissioning on 1st April 2013.

The RUH together with many other Acute Trusts across England and Wales has faced significant pressure during the winter and the early part of 2013. This has had an impact on a number of important indicators. However, the RUH has taken positive steps to ensure that patient safety and experience of care is maintained and has engaged with Commissioners and the public to ensure the on-going delivery of high quality services.

There are robust arrangements in place with the RUH to agree, monitor and review the key quality domains of safety, effectiveness and patient experience. The CCG and the associate commissioners meet with the Trust on a monthly basis to seek assurance in relation to key quality issues both where quality and safety has improved and where on occasion matters fall below expectations to ensure remedial plans are put in place and learning shared.

The CCG was concerned with the performance of the RUH in relation to both reducing Health Care Associated Infections (HCAI) and the staff survey results published in March 2013, particularly in relation to reported staff concerns that they do not always receive feedback and learning on incidents. The CCG is therefore pleased that the priorities for 2013/14 have been developed in partnership and BaNES CCG endorse the proposals set out in the Quality Account.

BaNES CCG can confirm that we consider that the Quality Account contains accurate information in relation to the quality of services that the RUH provides to the residents of Bath and North East Somerset and beyond.

Over the next year the CCG would like to see the RUH develop its Quality Account to include further information on the following:

- Evidence of outcome measures over time
- National benchmarking to evidence to the public where the RUH stands against others
- How audit activity is used to improve outcomes
- Further information on how the Commissioning for Quality and Innovation (CQUIN) schemes have impacted on the quality of services provided. These schemes for 2013/14 include important areas such as end of life care and continence care.

**Dr Simon Douglass  
Clinical Accountable Officer  
BaNES CCG**

## Healthwatch B&NES

Our Quality Accounts was sent to Healthwatch B&NES for comment. However, being a newly-formed organisation, Healthwatch B&NES did not feel in a position to comment. Healthwatch B&NES intends to provide a comprehensive response to our Quality Accounts next year.

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# Independent Auditors' Limited Assurance Report to the Directors of the Royal United Hospital Bath NHS Trust on the Annual Quality Account

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Royal United Hospital Bath NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

## Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death; and
- Percentage of patients readmitted within 28 days.

We refer to these two indicators collectively as "the indicators".

## Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;



- 
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 (“the Guidance”); and
  - the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 27/06/2013;
- feedback from Local Healthwatch dated 28/05/2013;
- the latest national inpatient survey dated February 2013;
- the latest national staff survey dated 2012;
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated May 2013;
- the annual governance statement dated 29/05/2013;
- Care Quality Commission quality and risk profiles dated March 2013;
- the results of the Payment by Results coding review dated May 2013; and
- the Care Quality Commission inspection reports dated November 2012 and March 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively “the documents”). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Royal United Hospital Bath NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Royal United Hospital Bath NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

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## **Assurance work performed**

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

## **Limitations**

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

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

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Royal United Hospital Bath NHS Trust.

## **Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

- 
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.



John Golding

Senior Statutory Auditor

*For and on behalf of Grant Thornton UK LLP*

Grant Thornton UK LLP  
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55-61 Victoria Street  
BRISTOL  
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28 June 2013

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:

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### **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: [RUHCommunications@nhs.net](mailto:RUHCommunications@nhs.net)

Write to:

Head of Quality  
Royal United Hospital Bath NHS Trust  
Combe Park  
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If you need this document in another format, including large print, please contact the Communications Department Tel: 01225 826230

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