RUH

Royal United Hospital Bath NHS
NHS Trust

Quality Accounts
2010/11




Healthcare you can Trust

Foreword

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 2010-11.

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 statements are specified in the above regulations.

We have highlighted these in blue boxes as they appear in tthe Accounts.

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

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

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

We encourage our staff, patients, public and healthcare partners to look at these Quality Accounts to understand what we are doing well and where improvements in services are required. These Accounts outline our priorities for improvement in the coming year (2011/12) and we welcome comment on, and involvement in, determining future priorities for improvement

Contents

Chapter One

Chief Executive's Statement

Patient safety continues to be at the heart of everything that we do, and our Trust board is committed to continuing to improve the quality of our services. The RUH is a member of the NHS South West Quality and Patient Safety Improvement Programme and we are working to ensure that the patient safety culture is widely embedded in our day to day activities.

We recognise that our reputation will be dependent upon a robust quality improvement programme, which is why we have made 'Improving Quality' one of the five pillars of the Trust's corporate strategy. Our goal is to become an organisation in which every member understands their role in delivering a quality service and works to that goal every day.

2010/11 was a very successful year for us. Although the Government has reduced the target of treating 98% of Emergency Department patients within four hours, to 95%, we have continued to work to the original standard which we achieved for the first time ever last year. This means 98% of our 66,000 emergency attendances were seen, assessed, treated, and discharged or admitted within four hours or less.

We achieved this despite challenging operational issues such as the impact of an increase in swine flu cases, particularly to our Intensive Therapy Unit in January this year. National data and targets around quality also show that care for critically ill patients in our Intensive Therapy Unit, is among the best in England and Wales.

We have also improved the time it takes to transfer the care of patients brought in by ambulance crews to our Emergency Department team. Along with seeing emergency patients quicker, and caring for those most seriously ill even better, I am confident that a number of key projects will see significant improvements to the care we provide to patients.

Our new, state-of-the-art cardiac catheterisation lab provides primary angioplasty for patients suffering a heart attack. This procedure involves inserting a balloon catheter into the blocked artery that causes a heart attack. Locally, primary angioplasty has replaced the use of clot-busting drugs (thrombolysis) as the frontline treatment for patients suffering a heart attack.

In 2011/12 we will complete work on the building of our new pioneering, sustainable Neonatal Intensive Care Unit (NICU) aimed at producing the best outcome for every premature and sick baby. Our NICU is the first home for one in every ten babies born in our area.

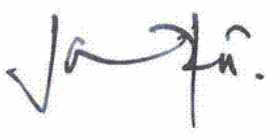
We will also improve our correspondence with patients, with the installation of our new patient administration computer system, Millennium.

The priorities for quality improvement set out in these Quality Accounts have been chosen to reflect our goals to improve patient safety, clinical effectiveness and the patient experience.

Our staff work incredibly hard to ensure the delivery of high quality care for our patients, their families and their carers and I thank them for the dedication and expertise that they have shown. Building a better relationship with our local community will be a focus for 2011/12 as we apply to become an NHS Foundation Trust, and honour our pledge to provide 'healthcare you can Trust'.

I am grateful to those who have provided the content for 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.



James Scott
Chief Executive

Director of Nursing and Medical Director's Statement

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

We both have a seat on the hospital's Trust Board and as such have an excellent opportunity to influence strategy, debate, and discussions held with regard to patient care and quality.

If we had to single out any one area, we would particularly wish to celebrate our fantastic achievements in the reduction of healthcare associated infections. The incidence of patients having an infection in their blood stream (bacteraemia) caused by MRSA after admission to our hospital has reduced dramatically. Similarly, the number of patients suffering diarrhoeal illnesses caused by Clostridium difficile has also fallen markedly. These infection rates mean that the RUH is among the best hospitals in the country in terms of safety from infection. Details of the numbers of cases can be found on page 27.

We have so much planned for the forthcoming years and pledge our continued commitment to ensuring the RUH provides healthcare you can Trust.

Francesca Thompson
Director of Nursing

Tim Craft
Medical Director

Chapter Two

Our current status and priorities for 2010/11

During 2010/11 we made significant progress in a number of areas, demonstrating our commitment to improving the quality of care we offer.

The three domains of quality that our priorities are based upon are patient experience, patient safety, and clinical effectiveness.

For 2011/12 we have identified five priorities which reflect our continued commitment to delivering the best possible care for our patients.

These are:

- to further reduce our healthcare associated infection rates
- to further reduce hospital-acquired pressure ulcers (bed sores)
- to make improvements to services especially for patients with dementia, learning disabilities and Parkinson's Disease
- to improve outcomes for older patients who require surgery for a hip fracture
- to improve care for patients who have suffered a stroke.

Two of these priorities, focusing on pressure ulcers and hospital associated infections, were areas that we also identified last year. Details about our progress on last year's priorities can be found in Chapter Three.

Priority One:
to further reduce our healthcare associated infection rates

We continue to make excellent progress in reducing infections and this year remain below the targets for MRSA and Clostridium difficile set by the Strategic Health Authority (SHA).

We take prevention and control of infection very seriously and aim to ensure that no preventable infections are allowed to develop as we recognise the devastating effects that these infections have on the recovery of our patients. Reducing healthcare associated infections such as MRSA and Clostridium difficile will continue to be one of our key priorities in 2011/12.

Our aim for 2011/12

To further reduce our healthcare associated infection rates to:

- MRSA bacteraemias: no more than 3 cases this year
- Clostridium difficile infections: no more than 51 cases this year.

From 1 January 2011, all Trusts are required to undertake mandatory surveillance of all Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemia for the Department of Health and Health Protection Agency.

Our current status

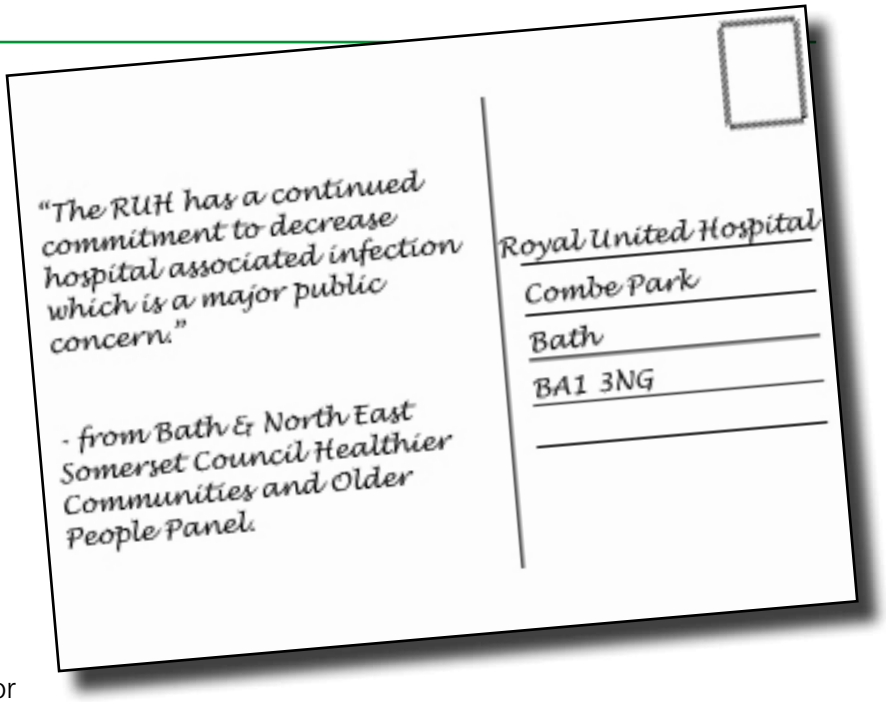
We have continued to consistently reduce the number of MRSA bacteraemias and Clostridium difficile

Coloured notices show the cleaning regime needed for particular areas

infections and aim to continue to do so.

What are we doing to reduce infection rates?

We have a number of initiatives planned to ensure that our infection rates continue to reduce.



These include:

- Collaborative working on Clostridium difficile: groups of staff from different wards are getting together to share their ideas and good practice with the aim of reducing Clostridium difficile infections. One of the clinical areas involved in our first collaborative working initiative on Clostridium difficile, the Acute Stroke Unit, has not had a single case for more than a year.
- Embarking upon a programme looking at reducing urinary tract infections in patients with catheters, with the aim of reducing these cases by 50% by 2013.

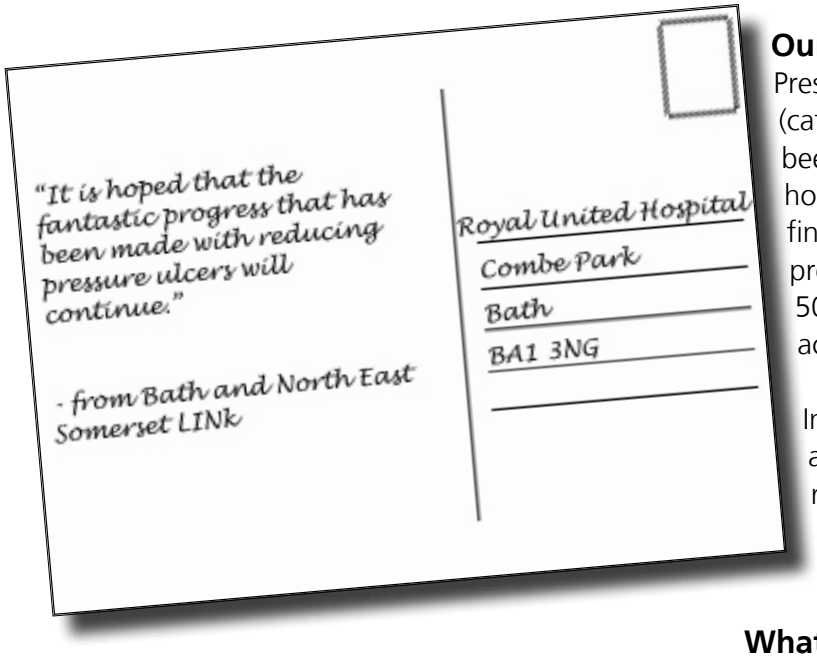
In February 2011, the Trust was visited by the Strategic Health Authority to review our management of norovirus, sometimes called the 'winter vomiting bug', and feed back on practice and lessons learnt.

The report from the visit demonstrated that the RUH and our whole health community has developed a culture shift from believing that norovirus is inevitable to one of it being something to be eradicated promptly. The visit also found that a focus by staff at every level in the hospital, together with improved communication between the RUH and the local health community, had made a significant difference to reducing outbreaks of norovirus.

Practical improvements have been implemented such as the development of a bed cleaning checklist, a greater focus on hand hygiene for patients, visitors and staff and de-cluttering of ward areas to allow for more thorough cleaning. During the year three films, available on the Trust website, warning our patients and the public about the devastating effects of bringing norovirus into a hospital were launched as a joint venture between the Communications teams in the RUH and the primary care trust, NHS Bath and North East Somerset.

To continue to protect patients and staff from viruses that may be brought into the hospital, a Visitor's Charter has been developed and is on display at the hospital. Visitors are asked to respect the charter by avoiding coming to the hospital when they are unwell.

Priority Two:
to further reduce hospital-acquired pressure ulcers



Our current status

Pressure ulcers are graded from least serious (category 1) to most serious (category 4). We have been actively working towards the reduction of hospital-acquired pressure ulcers and in the last financial year have reduced category 3 and 4 pressure ulcers by 67%, exceeding our target of 50%. We have also significantly improved the accuracy of pressure ulcer reporting.

In May 2011 we were pleased that health analysts Dr Foster gave us a low risk score regarding pressure ulcers.

Pressure ulcers, more commonly known as bed-sores, are considered an avoidable complication of care. They are distressing to patients and may prolong the time that a patient spends in hospital. Although we made progress in this area last year (see page 24 for full details), we recognise there is more to do. We know that the prevention and treatment of pressure ulcers is a significant concern to patients and it is for this reason that we will continue to make this a Trust priority for 2011/12.

Our aim for 2011/12

We will continue our work to reduce the number of hospital-acquired pressure ulcers. We will record, report and monitor every patient with a pressure ulcer and investigate all hospital-acquired category 3 and 4 pressure ulcers.

What are we doing to 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. This is a relatively new speciality and in the RUH this service provides expert knowledge and leadership in the following areas:

- assessment and treatment of people with complex needs
- comprehensive training programme
- clinical audit to monitor and improve standards particularly in relation to pressure ulcers
- development and promotion of evidence-based resources for the prevention and management of pressure ulcers
- an active and effective Tissue Viability link nurse network
- equipment provision.

In 2011/12 we will:
• supply all wards with a new heel pressure-relieving device, such as the one seen here in the photograph
• hold a 'Healthy Heels' week which will help to focus attention on heel pressure ulcers
• commence a 'Pressure Ulcer Collaborative' where we will work with individual wards on specific projects to reduce hospital-acquired pressure ulcers
• use National Honey Week to promote awareness of our range of antibacterial honey wound dressings
• develop 'Comfort Rounds' to help ensure patients have their skin checked and are re-positioned at regular intervals
• use the new Department of Health audit tool to monitor the number of hospital-acquired pressure ulcers.

We will also continue to:
• assess patients with category 3 and 4 pressure ulcers against the Safeguarding Adults framework. The RUH has its own Safeguarding Adults Group which raises awareness among staff of their role in recognising and reporting abuse.
• Investigate all hospital-acquired category 3 and 4 pressure ulcers
• provide a Tissue Viability Nurse assessment of all patients with category 3 and 4 pressure ulcers
• use Tissue Viability nurses to raise awareness of the need for good nutrition and hydration as there is evidence that this helps to prevent pressure ulcers.

Priority Three:
to make improvements for services especially for patients with

The RUH is committed to improving the outcomes for those who are most vulnerable in our community, such as those with dementia, learning disabilities, and Parkinson's Disease. If we are getting it right for the most vulnerable people that we care for, then we can be confident in the way we serve the whole hospital community. We will work with our partners in primary care to improve the integration of our services.

The Health Service Ombudsman's report 'Care and Compassion?' (February 2011) demonstrates that the NHS needs to improve the care given to older people, ensuring that we respect their dignity and respond to their needs with care and compassion. This is why the RUH has decided that improvements to the experiences for these groups will be a priority for next year.

Our aim for 2011/12

To make improvements for services especially for patients with dementia, learning disabilities and Parkinson's Disease - tailoring our services to meet their specific needs.

What are we doing to help patients with dementia?

While patients with dementia may have been admitted to the RUH for reasons other than their condition, their dementia can make their time spent in hospital more distressing.

In recognition of this, the RUH, together with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and other partners such as Alzheimer's Support, has been leading the implementation of the National Dementia Strategy to improve the experience of patients in hospital.

We run a Charter Mark standard scheme for dementia care, where wards can apply for a Charter Mark which covers four main areas of care: respecting and caring for people with dementia, the ward environment, meeting nutritional needs and suitability of staffing. We also placed a strong focus on training for our staff, with the opportunity to book onto a three-hour interactive training session run by the Mental Health Liaison Team at AWP, exploring all areas of dementia and how to care for people with mental health problems.

Staff visited wards to share information and raise awareness

A South West Expert Reference Group has been established to assess the standards in dementia care

dementia, learning disabilities and Parkinson's Disease

about Parkinson's Disease

in the South West and support Trusts in responding to areas that require improvement and the findings of a national audit.

Our action plan to address areas for improvement during 2011/12 focuses on the following areas:

- respect, dignity, and appropriate care
- agreed assessment, admission, discharge processes and needs specific care plans
- access to a specialist mental health liaison service
- providing a dementia friendly environment
- maintaining a healthy diet
- promoting the contribution of volunteers
- improving quality of care at the end of life
- appropriate training and workforce development.

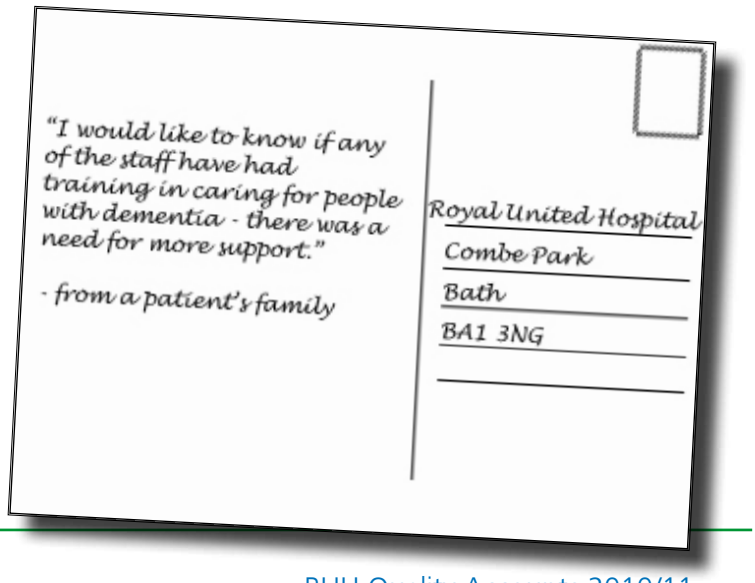
We also plan to run an event called 'See it my way – living with dementia', which will involve patients and their carers telling the story of their experience directly to RUH staff.

What are we doing to help patients with learning disabilities?

Several national reports, including the MENCAP report 'Death by Indifference' have identified that patients with a learning disability, often receive poor hospital services.

In recognition that patients with learning disabilities have specific needs, we have been working in partnership with community organisations to improve the service for these patients at the RUH for the last three years.

A Confidential Inquiry into deaths of patients with a learning disability began on 1 June 2010 in several NHS Trusts in the South West, including the RUH. Learning from this inquiry is fed back to staff and actions required are included in the RUH Action



Plan for People with a Learning Disability.

In its first year the Inquiry, which will continue until March 2013, found that people with learning disabilities are three times more likely than the general population to die before the age of 50.

A peer review of services for people with learning disabilities took place in 2010 in all acute trusts in the South West, organised by the South West Strategic Health Authority and the RUH review took place in October 2010. The RUH was benchmarked as seventh out of all 18 Trusts for quality of patient experience for people with a learning disability.

In January 2011, we appointed to a new post of sister for Quality Improvement for people with learning disability and mental illness. The postholder has worked with the Head of Patient Experience and partner organisations to compile an action plan for people with learning disabilities to address the recommendations from the review.

During the review process, areas of innovative or best practice at the RUH were identified by the review team. A summary of these can be found at www.swacutehospitalreview4ld.org.uk

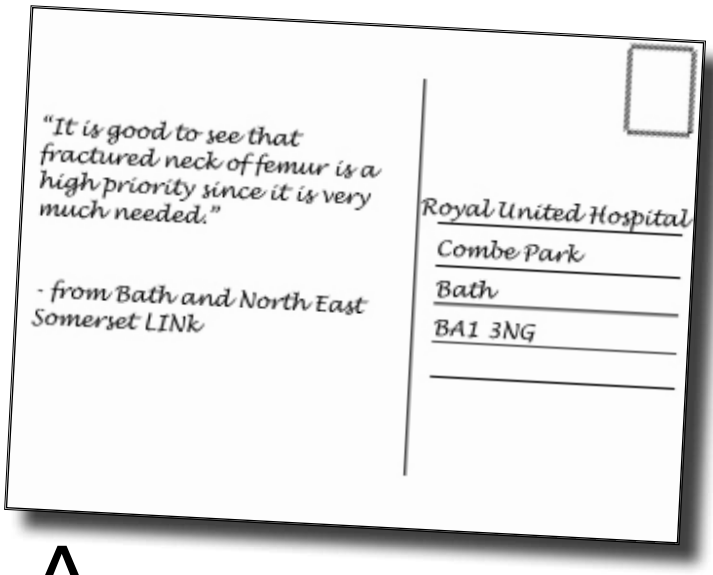
In 2011/12 we will:
- implement reasonable adjustment by staff - making allowances for the special needs of patients
- provide more easy read versions of relevant patient information
- place a greater focus on the dietary needs for these patients with the introduction of pictorial menus and protected mealtimes
- work closely with carers as equal partners
- work closely with community services.

What are we doing to help 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. The condition is progressive and results in problems which often require hospital admission, in particular falls, chest infections and delirium. Patients with Parkinson's Disease are at particular risk when admitted to a hospital environment. The management of their medications can be complex and it is particularly important that they receive the correct dose at the right time in order to avoid secondary complications and a longer hospital stay.

We recognise that we do not always get it right for these patients and in 2011 we will:
- improve the quality of inpatient care and the patient experience
- improve discharge planning and reduce readmissions
- reduce length of stay
- ensure medication is given on time and introduce 'get it on time' stickers for drug charts
- establish a Parkinson's Disease Quality Care Group, focusing on improving patient care
- improve the patient pathway – with better communication between the Emergency Department and the patient's Parkinson's Disease consultant, and the community specialist nurses
- identify a ward as a specialist Parkinson's Disease area
- hold a Parkinson's Disease Awareness day to launch the Parkinson's Disease Quality Care strategy
- work closely with carers and branch members of the charity, Parkinson's UK to improve services for patients with Parkinson's Disease.

Priority Four: to improve outcomes for older patients who require surgery for a hip fracture



Around 10 patients per week come to our hospital having suffered a fractured hip or, more specifically, neck of femur. Some of these patients are amongst the most elderly and frailest of the patients we admit. However not all patients are frail, and a large number are still living independently and this injury presents a potentially catastrophic decline in their health and lifestyle.

For a Trust our size, we see a relatively large number of patients with a fractured neck of femur and, as the population ages, particularly in the South West, this number will only increase. For this reason we have chosen this group of patients as a priority for 2011/12.

Our aim for 2011/12

We aim to improve the quality of care received by patients with fractured neck of femur. We will do this by standardising the pathway of care across the health community; improving the timeliness to theatre as this leads to a better outcome; and reducing the length of time that patients spend in hospital so that they can return quickly to their previous lifestyle.

Our current status

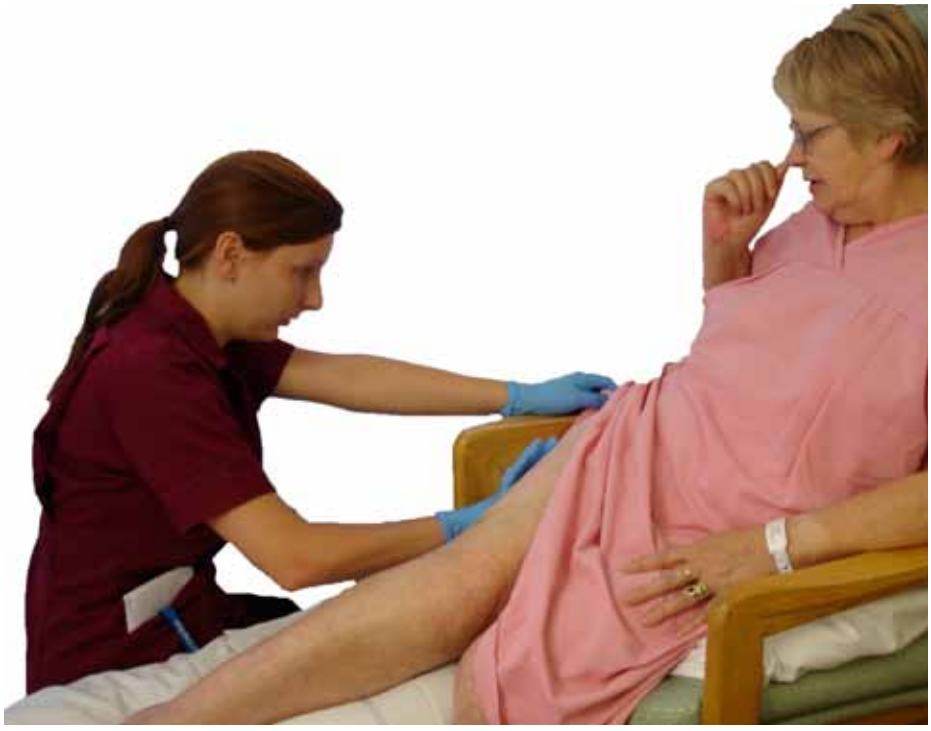
Currently, approximately 50% of patients get to theatre within 36 hours of admission with a fractured neck of femur. Although we are making gradual progress in this area, we recognise there is a lot more we can do for this group of patients as delay to surgery can have a significant impact upon outcome.

It is for this reason that we have chosen improving outcomes for patients with fractured neck of femur as one of our priorities for 2011/12.

What are we doing to improve outcomes for patients with fractured neck of femur?

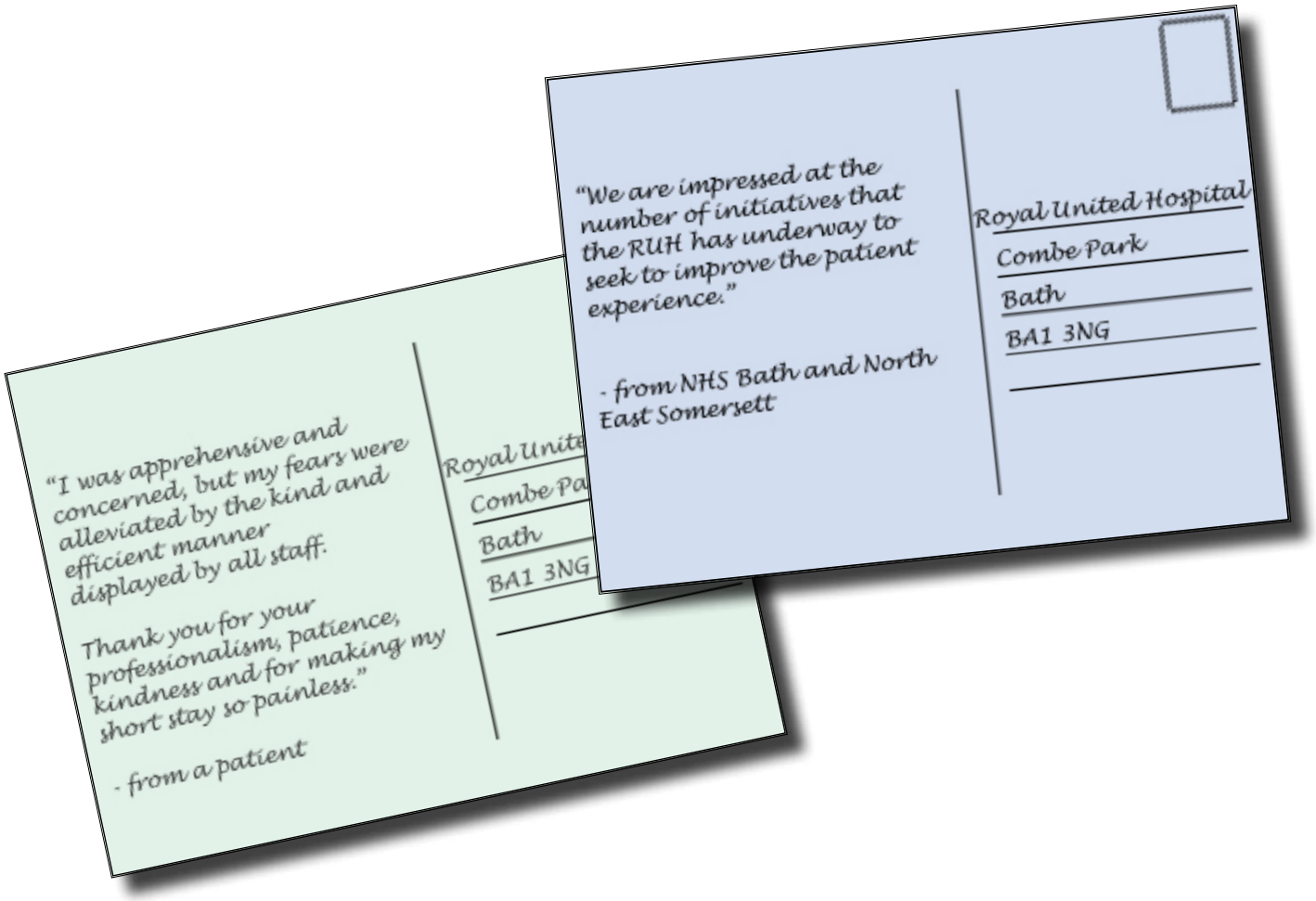
In 2011/12 we will:

- strive to be a centre of excellence for hip fracture



care but recognise that our current performance for this group of patients is below average
• ensure that we get 95% of patients to theatre within 36 hours of admission with a fractured neck of femur.

We will achieve this by:
• increasing the availability of theatres for these patients
• increasing the amount of Consultant Geriatric support to this group of patients
• developing a hip fracture unit jointly run by the orthopaedic and geriatric teams
• reviewing care pathways for these patients to achieve the best outcome, treating the whole patient and not just the hip fracture
• working with community providers to ensure effective discharge planning for this patient group, particularly those that require ongoing rehabilitation.



Priority Five: to improve care for patients who have suffered a stroke

The improvement to stroke services has been identified by the Department of Health as a priority. The National Institute for Health and Clinical Excellence (NICE) has produced 11 quality statements for Trusts to measure themselves against, such as being admitted directly to a dedicated stroke unit and receiving prompt assessment and regular therapy by specialist staff.

Our aim for 2011/12

Although we have made substantial progress towards meeting national targets and ensuring the best possible outcomes for our patients, there is still further work to be done. In particular we are aware that while we have met the national targets in some months, we need to be much more consistent. As a result, we have chosen the delivery of acute stroke standards as a Trust priority for 2011/12.

Our current status

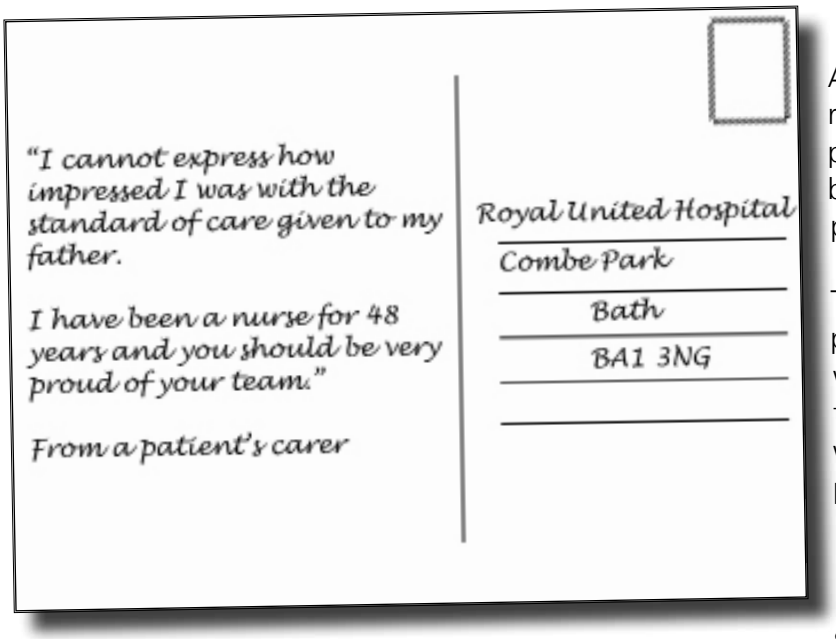
National targets state that 80% of stroke patients are treated for 90% of their time in hospital on an acute stroke ward. From April 2010 to March 2011, we achieved 67.8% overall and achieved the 80% target in November and February. We have followed a planned trajectory of improvement across the year and have developed an action plan to achieve the target more consistently in 2011/12.

What are we doing to improve care for patients who have suffered a stroke?

Last year saw major improvements in stroke services at the Trust. A new 26-bed Acute Stroke Unit (ASU) opened, incorporating a four-bed hyper-acute area with continuous physiological monitoring, and a full stroke-specialist multidisciplinary team of doctors, nurses and therapists. The majority of patients who have suffered a stroke are now admitted directly to the ASU from the Emergency Department, ensuring they get the specialist care they need in the crucial first couple of days after a stroke. The excellence of our service was demonstrated in the 2010 National Sentinel Audit of Stroke – every Trust in the country participates in this audit, and the RUH scored in the top 20% nationally. With patients in the right place, our average length of stay has reduced from ten days to just over five days.

Staff examining the scan of a stroke patient

Working together with the Bath and North East Somerset Community Stroke Service Early Supportive Discharge team, we have made improvements to the



care and processes for patients who have had a stroke. Patients are now routinely followed up either at the RUH or in their own home at six weeks and again at six months. Patients who have suffered a stroke and require complex care in the community are seen by our specialist Nurse Consultant for stroke care.

The ASU has its own research team and is part of the South West Stroke Research Network, recruiting patients to national and international trials which subsequently inform and change clinical practice. Last year we recruited 44 new patients to research trials focusing on acute care following a stroke and preventative studies.

A number of patients took part in the national research study CLOTS 1, which showed that patients who have had a stroke do not appear to benefit from wearing compression stockings to prevent leg clots.

Thanks to a number of willing patients who took part in this trial and the nursing staff on ASU, we were able to contribute valuable data for this trial which then helped to change the way that we care for these patients. As a result, clinical practice was changed and the stockings are no longer used for such patients.

In 2011/12 we will

- work to meet the accelerated stroke improvement target
- sustain delivery of 80% of patients spending 90% on ASU - this will be delivered through continued development of close working relationships with the Emergency Department teams to ensure the early identification of stroke patients. Continued support for community education programme with GPs, ambulance trusts and community staff to ensure patients are FAST-tested before arrival at hospital
- meet the radiology target of 50% of patients receiving a scan within one hour
- sustain 80% of patients being assessed for high risk transient ischaemic attack, or mini-stroke, within 24 hours of presenting with symptoms
- landscape our courtyard area to make a more pleasant environment for our patients and carers.

Chapter Three

Review of quality performance in 2010/11

In this chapter, we take a look back at our performance against the four quality priorities we set ourselves in last year's Quality Accounts.

2010/11 Priority One: to further reduce our healthcare associated infection rate

What we said we would do last year

We said we would reduce our healthcare associated infection rates to no more than five cases of MRSA bacteraemia, and no more than 63 cases of Clostridium difficile during 2010/11.

What we have done

Our involvement with the South West Quality and Patient Safety Improvement Programme continued, and we have consistently reduced the number of MRSA bacteraemias and Clostridium difficile infections.

During 2010/11 the Trust introduced a number of initiatives which have contributed to the continued reduction in the rate of MRSA bacteraemia and the number of cases of Clostridium difficile infection:

	07/08	08/09	09/10	10/11	11/12 target
MRSA bacteraemia	35*	26*	17*	2	Less than 3
Clostridium .difficile	301°	248°	113	51	Less than 51

*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.

°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 are attributed to the Trust.

MRSA screening

From December 2010 all emergency patients have been screened on admission. This enables us to treat patients with MRSA either prior to or on admission; reducing the risk of them developing deep seated infections and also to reduce the risk of cross-infection.

Learning from healthcare associated infection incidents

Root cause analysis investigation is carried out for all MRSA and MSSA bacteraemias and all cases of Clostridium difficile infection. Senior clinicians undertake these investigations to identify practices that can be improved and also to highlight examples of good practice.

Collaborative improvement programmes

Collaborative events have been held to assist with the reduction of Clostridium difficile infection. Staff were presented with data which demonstrated the size of the problem and improvement methodology was used to empower ward teams to identify and make changes to reduce the risk of Clostridium difficile in their departments. Staff involved included therapists, nursing, medical and housekeeping staff. Results have been excellent - the Acute Stroke Unit, which decluttered the ward to make cleaning the area much

simpler, has had no cases of Clostridium difficile for more than one year and all other wards involved have improved significantly.

Maintaining standards

The infection prevention and control audit programme has continued to identify areas of good practice and also highlight where improvement is required. One of these areas is maintaining good standards of hand hygiene for visitors, patients, and staff.

Cleanliness and the environment

Matrons are responsible for ensuring that environment audits are carried out monthly in all clinical areas. Actions are dealt with at the time of the audit and results are reported to the Saving Lives Implementation Committee. The matrons also oversee weekly audits of commode cleanliness. Ward areas have been cleared of clutter to make cleaning easier, and spot checks are carried out to check standards of cleanliness. Keeping a focus on the cleanliness of the environment and equipment is key in reducing infections such as Clostridium difficile.

Leadership

The Infection Prevention and Control Team (IPCT) work closely with senior nurses to provide support with the reduction of healthcare associated infections. The IPCT visit all admission areas daily to identify isolation requirements.

2010/11 Priority Two: to deliver same sex accommodation

What we said we would do last year

We said that all patients who are admitted to our hospital share the room where they sleep only with members of the same sex, and same sex toilets and bathrooms will be close to their bed area.

We said sharing with members of the opposite sex should happen only by exception, based on clinical need, for example where patients need specialist equipment such as in critical care.

What we have done

Additional toilet and showering facilities were placed on the Medical Assessment Unit to ensure same sex toilet facilities are available close to the sleeping accommodation. Further work has been undertaken in this unit to ensure there is better segregation of male and female patients. The national Inpatient Survey 2010 results show significant improvement in the numbers of patients reporting using a bath or shower area which was shared with the opposite sex.

An operational group meets fortnightly to monitor compliance to ensure we are fully compliant with same sex accommodation standards on the Medical Assessment Unit and Surgical Admissions Unit.

Sharing with a member of the opposite sex will happen only when clinically necessary. The nurses assessing these patients will be using their skills and judgement to ensure patients are placed in a clinically safe area, and in their best interests (for example those patients requiring specialist one to one care or equipment).

Any complaint or failure within the standard is analysed to review the causes and ensure actions are taken to resolve it. Progress reports are regularly reviewed by our Trust Board.

We are working to involve a wider range of staff in our privacy, dignity and respect work to ensure awareness of these issues is embedded within our culture.

Regular information is collected from patients about their experience so we can continue to measure how we can improve the patient experience.

2010/11 Priority Three: to reduce the risk of deep vein thrombosis and venous thromboembolism (VTE)

What we said we would do last year

We said that at least 70% of patients would be risk assessed for prevention of VTE on admission to hospital. We said 100% of patients should be given written information on hospital acquired VTE at the pre-operative assessment clinic or during their inpatient stay, and that 100% of patients considered at risk of developing VTE would be offered prophylaxis (preventative drug treatment or therapy).

What we have done

Although many people are familiar with the risks of developing a blood clot or deep vein thrombosis from frequent long haul flights, the risks associated with a stay in hospital are less well known.

To counter this, staff have been raising awareness by routinely providing an information leaflet to every patient, which clearly explains more about deep vein thrombosis, who is most at risk, and how it can be prevented. The leaflet also provides practical tips on what patients can do for themselves to reduce the risk once they go home. Patients were involved in the development of the leaflet to ensure it is accessible and easy to read.

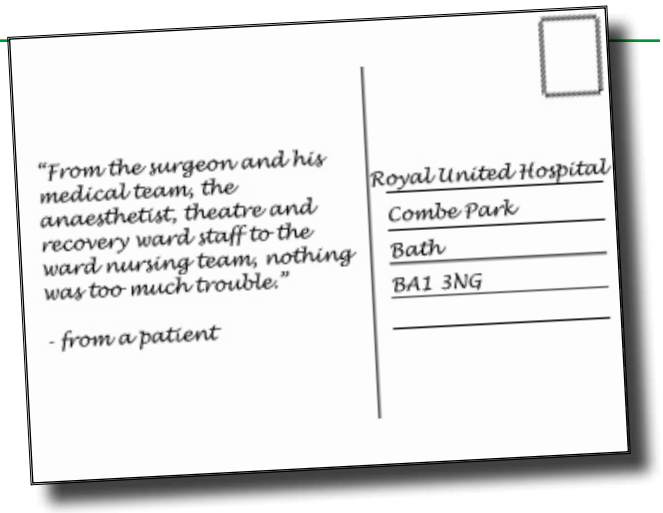
In addition, the hospital's Thrombosis Committee and the Patient Safety Team have introduced a range of measures to embed VTE risk reduction practices across the hospital. All of our doctors and nurses receive training on how to identify and prevent blood clots forming in patients while they are in hospital.

Our aim for 2010/11 was for at least 70% of patients to be risk assessed for the prevention of VTE on admission to hospital. In March 2011, 98.9% of patients had been risk assessed for VTE on admission to hospital. We offered prophylaxis to 94% of those patients considered at risk.

Prevention of hospital-acquired VTE is one of the key themes captured in the Trust's Quality and Patient Safety Improvement Programme, which collects data on the percentage of patients being risk assessed and the percentage of those deemed to be high risk, who receive appropriate thromboprophylaxis. This data is reported to our Trust Board on a monthly basis.

Although it is not one of our identified priorities for 2011/12, reducing the risk of deep vein thombosis and VTE continues to be a focus for us.

2010/11 Priority Four: to reduce the number of hospital acquired pressure ulcers



What we said we would do last year

Pressure ulcers, or bed sores, are given categories from 1 (least serious) to 4 (most serious). We set ourselves the aim of reducing the number of hospital acquired pressure ulcers or bed sores in categories 3 and 4 by 50%, and reducing those in category 2 by 20%.

What we have done

Our performance in 2010/11 showed a 67% reduction in categories 3 and 4 against the target of 50%, but a slight increase in category 2 ulcers. Information from health analysts Dr Foster shows the RUH in the 'low' banding category, which means that the relative risk of acquiring a pressure ulcer at the RUH is less than expected. Continuing to reduce the number of hospital acquired pressure ulcers remains a priority in this year's Quality Accounts.

In 2010/11 we:

- recruited a second Tissue Viability Nurse to help support the reduction of hospital-acquired pressure ulcers
- introduced a new pressure-ulcer prevention tool called 'PRIMED' which is a simple tool to help staff deliver more effective pressure-relieving care
- revised our pressure ulcer reporting form and database to promote more accurate reporting
- held a pressure ulcer awareness week
- produced a patient information leaflet which can be provided for any patient at risk of developing a pressure ulcer or for those who already have a pressure ulcer.

We also took steps to improve the way we communicate with patients, which included:

- introducing 'Tell us about your care cards' for patients to provide feedback about their hospital experience
- establishing a Health Information Group, with a core membership of patients, carers and staff, to review new patient information leaflets and other material
- continuing to use Patient Experience Trackers to provide real-time information about our patients' views
- increasing involvement of patients in strategic groups.

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 tables over the page show our performance against our own quality domains and indicators, and also our performance against nationally-determined targets, along with targets for 2011/12.

Statement

During 2010/11 the Royal United Hospital Bath NHS Trust provided and sub-contracted seven types of NHS services via three clinical divisions, Medical, Surgical and Specialty. During 2010/11 the Trust has reviewed data available to them on the quality of care, using hospital wide performance information such as the Hospital Standardised Mortality Rate (HSMR) and has undertaken further 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, including such things as delay in recovery time)

- 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 category 3 and 4 hospital acquired pressure ulcers

- Participation in national audits in cardiac care, stroke care, joint replacement, and fractured hip surgery

- Monitoring of the completion of Venous Thromboembolism (VTE) risk assessments

- Commitment to eliminating mixed sex accommodation unless clinically indicated.

The income generated by the RUH, in relation to these services, represents 100% of the total income generated from the provision of NHS services by the Trust for 2010/11.

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.

RUH-determined quality domains and indicators

Quality domains and indicators	2010/11 actual performance	2011/12 targets
Patient safety		
VTE: Risk assessments on all eligible patients Patients who require prophylaxis receive it Incident reporting and RCA	 98.9% (March 2011 date) 94% n/a	 95% (CQUIN) 100% tbc
Incident reporting: Timeliness of investigations into Serious Untoward Incidents (NPSA National Reporting Framework)	44.4 days	45 days for level one incidents, 60 days for level two incidents
Clinical effectiveness		
Length of stay: Reduce the average length of stay for both elective (planned) and non-elective (unplanned) patients	Elective: 3.1 days Non-elective: 5.4 Total: 5.1	Elective: 2.7 Non- elective: 5.0 Total: 4.52 (CQUIN)
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	 16 313	 to be determined to be determined
End of Life Care: Patient dying in the place of their choice	Targets not set	under development
To improve outcomes for patients with dementia: Staff training	Targets not set	tbc
Improve care for patients with a stroke: Meeting standards 4 & 5 of the NICE Quality standards for stroke	Targets not set	98% on ASU
Weekend Discharges: Working towards a seven day working week	Targets not set	Targets to be set
Fractured neck of femur - % of patients to theatre within 36 hours	50.3%	95%
Patient Experience		
Cleanliness Patient Experience Tracker (PET) question: 'Is the ward clean?'	PET: 90.3%	PET: Greater than 90%
Treated with Dignity & Respect PET tracker 'Are you being treated with dignity and respect?	PET: 96.3%	PET: Greater than 90%
Information given to patients PET tracker 'Are you being kept well informed?'	PET: 91.4%	PET: Greater than 90%

Nationally-determined targets

2010/11 National target	2010/11 target	2010/11 actual performance	2011/12 target
Number of MRSA Bacteraemias (Post 48 hours)	7	2	Less than 3
Number of Clostridium difficile infections (Post 72 hours)	116	51	Less than 51
% patients treated in A&E within 4 hours	95%	98.3%	n/a
% patients treated in A&E and MAU within 4 hours	95%	99.2%	n/a
A&E re-attendance rate	n/a	n/a	5%
A&E - 95th percentile time to assessment	n/a	n/a	4 hours
A&E Left Without Being Seen rate	n/a	n/a	5%
A&E Time to assess - 95th percentile	n/a	n/a	15 minutes
A&E median time to treat	n/a	n/a	1 hour
Cancer urgent referral to first outpatient appointment - 2 weeks	93%	94.7%	93%
Cancer urgent referral to first outpatient appointment - 2 weeks (breast symptoms)	93%	99.2%	93%
Cancer diagnosis to treatment - 31 days	96%	98.5%	96%
Cancer diagnosis to treatment - 31 days (subsequent surgery)	94%	95.0%	94%
Cancer diagnosis to treatment - 31 days (subsequent drug treatment)	98%	98.8%	98%
Cancer diagnosis to treatment - 31 days (subsequent radiotherapy)	94%	94.3%	94%
Cancer urgent referral to treatment - 62 days (GP referral)	85%	90.4%	85%
Cancer urgent referral to treatment - 62 days (Screening)	90%	94.1%	90%
Cancer urgent referral to treatment - 62 days (hospital specialist)	85%	100.0%	85%
Patients offered date within 48 hours of contacting GUM	98%	100.0%	98%
Patients waiting more than 3 months for revascularisation	0.1%	0.0%	0.1%
Patients seen within 2 weeks for rapid access chest pain	98%	99.8%	98%

2010/11 National target	2010/11 target	2010/11 actual performance	2011/12 target
% elective operations cancelled on day of operation	0.8%	1.1%	0.8%
% cancellations not re-booked within 28 days	5%	5.8%	5%
% Inpatients with delayed transfer of care	3.5%	3.0%	3.5%
Primary angioplasties - % under 150 mins	70%	88.2%	70%
% people spending 90% time on stroke unit	80%	67.8%	80%
Higher risk TIA treated within 24 hours	60%	62.5%	60%
18 weeks from GP referral to hospital treatment - admitted patients	n/a	n/a	90%
18 weeks from GP referral to hospital treatment - non-admitted patients	n/a	n/a	95%
95th percentile - admitted pathways	27.7	27.6	23
95th percentile - non-admitted pathways	18.3	17.1	18.3
95th percentile - incomplete pathways	36.0	29.4	28

Statement

The RUH income in 2010-2011 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework, because a block arrangement for CQUIN was agreed for the financial year in order to manage financial risks across the health community within which the Trust works. The Trust was still expected to improve quality in accordance with national and regional CQUIN areas and has made excellent progress against all the CQUIN areas agreed with our commissioners.

Statement - Participation in clinical audits

During 2010/11 42 national clinical audits and six national confidential enquiries covered NHS services that the RUH provides.

During that period the RUH participated in 83% of the national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the RUH was eligible to participate in during 2010/11 are as follows:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Participation	Cases submitted
Parenteral Nutrition study	Yes	100%
Cosmetic surgery	Yes	100%
Elective and emergency surgery in the elderly	Yes	100%
Peri-operative care study	Yes	100%
Surgery in children	Yes	None eligible
Cardiac arrest procedures	Yes	75%
Audit	**Participation**	**Cases submitted**
Neonatal intensive and special care (NNAP)	Yes	100%
Children	**Participation**	**Cases submitted**
Paediatric pneumonia (British Thoracic Society)	No	
Paediatric asthma (British Thoracic Society)	No	

Acute care	Participation	Cases submitted
Emergency use of oxygen (British Thoracic Society)	No	
Adult community acquired pneumonia (British Thoracic Society)	No	
Non invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	Data collection started February 2011
Pleural procedures (British Thoracic Society)	Yes	100%
Cardiac arrest (National Cardiac Arrest Audit)	Yes	100%
Vital signs in majors (College of Emergency Medicine)	Yes	100%
Adult critical care (Case Mix Programme, ICNARC)	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	99%
Long term conditions	**Participation**	**Cases submitted**
Diabetes (National Adult Diabetes Audit)	Yes	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	100% (data collection ongoing)
Chronic pain (National Pain Audit)	No	Data collection started March 2011
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	100% (organisational) Clinical section – September 2011 deadline
Parkinson's Disease (National Parkinson's Audit)	Yes	41
COPD (British Thoracic Society/European Audit)	Yes	100%
Adult asthma (British Thoracic Society)	No	
Bronchiectasis (British Thoracic Society)	Yes	100%

Elective procedures	Participation	Cases submitted
Hip, knee and ankle replacements (National Joint Registry)	Yes	Hips - 542 Knees - 402 Ankles – 1
(National PROMs Programme): four operations	Yes	Hernia - 18.2% Hip – 35.8% Knee – 53.2% Varicose vein – 40.5% Percentages based on Part 1 patient questionnaires returned (Source: HES Online: April 09-Nov 10)
Coronary angioplasty (NICOR Adult cardiac interventions audit)	No	
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	100%
Carotid interventions (Carotid Intervention Audit)	Yes	100%
Cardiovascular disease	**Participation**	**Cases submitted**
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	Yes	Awaiting data from Royal College of Physicians
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%
Heart failure (Heart Failure Audit)	No	The Trust devised its own heart failure data collection tool to focus on more local issues.
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes (RUH operates as a satellite unit)	100%
Acute stroke (SINAP)	Yes	100%
Stroke care (National Sentinel Stroke Audit)	Yes	100%
Renal disease	**Participation**	**Cases submitted**
Renal colic (College of Emergency Medicine)	Yes	100%
Cancer	**Participation**	**Cases submitted**
Lung cancer (National Lung Cancer Audit)	Yes	100%

Bowel cancer (National Bowel Cancer Audit Programme)	Yes	100%
Head & neck cancer (DAHNO)	Yes	100%
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	Funding received in February to participate.
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes	62%
Blood transfusion	Participation	Cases submitted
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes	100%
Platelet use (National Comparative Audit of Blood Transfusion)	Yes	100%

The reports of national clinical audits were reviewed by the provider in 2010/11 and the RUH intends to take the following actions to improve the quality of healthcare provided:

National Continence Audit

Since the national audit was completed the RUH has established a multi-disciplinary continence group with a key focus on urinary incontinence and catheters. A urinary continence risk assessment and care plan has been developed which forms a referral to BaNES and Wiltshire continence services where clinically required. A catheter task force meeting has also been established by the Primary Care Trusts, which includes representatives across the healthcare community, including the RUH. It has a focus on improved patient safety around catheterisation including reducing the number of long term catheters, reviewing training on catheter insertion and review of the catheter care pathway.

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.

Stroke Improvement National Audit Programme (SINAP)

Following the RUH's enrolment in the SINAP national audit in September 2010, a preliminary report was produced using SINAP data in order to establish any shortfalls in performance. As a result, the Acute Stroke Unit has initiated a drive ensuring that all patients receive a continence plan, whereas this had only previously been the case for 43% of eligible patients.

Heart failure audit

Although the Trust did not participate in the national heart failure audit, it has devised its own data collection tool to focus on more local issues. This data will be used to establish whether the local heart failure service is providing the appropriate care during and after a patient's stay in hospital.

The reports of local clinical audits were reviewed by the provider in 2010/11 and the RUH intends to take the following actions to improve the quality of healthcare provided:

Decreasing radiation doses for children

Children up to the age of 16 years are three times more sensitive to radiation than adults. Decreasing radiation doses is important because of the link between increased radiation and the incidence of cancer. Our focus will be to concentrate on the chest, pelvic, abdomen and spinal exposures as these irradiate sensitive organs. During this audit, clinical staff from our Radiology department have been working alongside staff in Medical Physics to reduce radiation doses for neonates and children by up to 30%. Images are scored by our paediatricians, Emergency Department consultants and a radiologist and there has been no reported reduction in diagnostic image quality.

Patient Satisfaction Survey with the telephone service for patients with Myeloproliferative disorders

The Trust has introduced a nurse / pharmacist led telephone service for patients with Myeloproliferative disorders (MPD). An audit was carried out to find out what patients thought of the service and most were very pleased. However, some patients stated that they would like more information about the service and, in response to this, a patient information card was developed which included contact details for the pharmacist and nurse and a brief explanation about the service. This is now given to all patients with Myeloproliferative disorders.

Re-audit on the cleanliness of commodes

This audit showed an overall improvement in compliance with the standards for the cleanliness of commodes and availability of equipment since the last audit was carried out. The correct equipment was generally available in the sluices and the cleanliness of commodes has improved, and sustained improvements are required. Wards that performed well in the audit were issued with a 'commode cleanliness certificate'. Audits on the cleanliness of commodes are now carried out on a weekly basis by wards with the results monitored.

General surgery audit – 'How do we weigh up?'

This audit was carried out to ensure patients are routinely weighed to aid prescribing of medicines. On the first audit cycle we found that only 25% of patients' notes examined had evidence of a patient's weight having been recorded, and only 23% of those who were actually prescribed antibiotics were weighed. After raising awareness, a re-audit was carried out and it was found that the number of patients weighed had risen to 45%, and 52% of patients prescribed antibiotics had a weight recorded on their drug chart. These results show a significant increase in the level of correct weight recording and clear response to the audit interventions. We recognise this is an area in which we need to improve and further work is planned.

Statement

The RUH is required to register with the Care Quality Commission (CQC) and its current registration status is 'registration without conditions'. The CQC has not taken enforcement action against the RUH during 2010/11. The RUH has not participated in any special reviews or investigations by the CQC during the reporting period

Chapter Four

Participation in clinical research and development

We continue to have a very active research and development department and were recently commended for our performance by the Western Comprehensive Local Funding Network, our main research funders.

All of our research has the ultimate goal of improving the quality of care we give. Most of the research we carry out is funded by the National Institute of Health Research (NIHR), who provided us with more than £700,000 of funds last year.

The hospital hosts the Cochrane Library for Gynaeological Cancer on its campus and this library was recently awarded a research grant of £224,000 from the NIHR to support them in the work they do.

The Library organises systematic reviews of clinical trials in order to determine the most clinically effective treatments and drugs for particular cancers. The information gained is then used by outside bodies who recommend the most effective treatments and drugs to the NHS as a whole.

The hospital is involved in a wide range of research activities, and currently undertakes more than 250 projects. Three current examples include:

Paediatrics

Cystic fibrosis (CF) is the most common life-limiting inherited disorder in Caucasian populations initially occurring in young children and adolescents. Respiratory infections are the main debilitating conditions of this disease. Bacterial infections along with fungal infections have a life-threatening effect on the morbidity for CF subjects.

We are carrying out a research study which compares the two main treatment regimes for this infection. One is 14 days of continuous treatment in hospital with drugs being administered directly into the vein, whilst the other regime involves three months taking tablets.

Both methods of treatment are effective but this study aims to find out which provides the most effective form of treatment.

Diarrhoea diagnostic device from bench to bedside

Clostridium difficile is the most common bacterial cause of hospital acquired diarrhoea. Rapid diagnosis would assist therapy; facilitate recovery, save lives and save money. With financial support from the Wellcome Trust, and working with colleagues in Bristol, we have shown that Clostridium difficile infection can be diagnosed by the analysis of gases from faeces.

The main goal of this research project is to develop our technology so that a member of the clinical team can simply place a faeces sample in the diarrhoea diagnostic device and, within less than 15 minutes, obtain readout of the presence or absence of Clostridium difficile in the faeces.

Working with our colleagues in Bristol, a large study has been established to analyse stools from patients with Clostridium difficile and with other causes of diarrhoea.

Our ultimate goal is to deliver a point of care device which can then be rapidly brought to the market place to improve patient care. An obvious benefit to the Trust would be early detection of a Clostridium difficile outbreak in a ward setting with appropriate actions being taken earlier rather than later and with financial savings to the Trust.

Opthalmology

This 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.

Clinical trials

Last year we were recognised as one of the best performers in the region for the recruitment of research patients, especially in oncology and stroke.

The clinical trials team coordinates and supports national and local oncology and haematology clinical research studies. In 2010/11 the RUH increased recruitment into clinical trials by over 50%. This large increase was made possible by the creation of dedicated genetics and clinical trials officer posts, along with a consultant oncologist taking over as clinical lead for research.

Statement

The number of patients receiving NHS services provided or sub-contracted by the RUH in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 698.

Chapter Five

What others say about us

We have compiled these Quality Accounts and believe they are an honest and transparent review of our quality of care over the past year and of our commitment to continue to make improvements for the benefit of our patients.

This year we invited representatives of a number of external organisations to visit some of our wards and clinical areas and discuss our progress and priorities with senior staff and the Director of Nursing. These organisations included the Wiltshire Overview and Scrutiny Committee, Bath and North East Somerset Overview and Scrutiny Committee, the Bath and North East Somerset Local Involvement Network, and the Wiltshire and Swindon Users Network.

We also have a Patient Experience Group, which is chaired by a non-executive director and includes Trust staff from a variety of departments, and from Community Health and Social Care Services along with a number of patient representatives. The Patient Experience Group made comments on a draft copy of the Quality Accounts last year and was invited to do so again this year. The feedback they have provided has been used to help shape our ongoing priorities in this year's Quality Accounts.

Engaging with the public and our patients is an area we are keen to improve upon. This remains a focus as we continue with our application to become an NHS Foundation Trust.

A draft copy of the Quality Accounts was sent to our local Primary Care Trusts, local council committees and local patient involvement groups, who were invited to comment.

Working with our colleagues in primary care

Summary of comments from Wiltshire Council - Health and Adult Social Care Select Committee Task and Finish Group.

"Councillors felt it was reassuring to see one of the key issues – pressure ulcers – discussed during their visit to the Trust being addressed within the Quality Accounts.

Members recognised the significant achievement and continuing improvements in key areas such as reductions in healthcare associated infections, access to scans and stroke care.

It would be helpful to have more detail on the outcomes of the peer review of services for people with Learning Difficulties, to see how this will be acted upon.

The Task Group welcomes future plans to include carers of patients with learning disabilities and dementia in training scenarios."

Summary of comments from Bath & North East Somerset Council Healthier Communities and Older People Panel

"We support the overall aims of the Trust's Quality Account programme and feel that the following are of particular public importance:
• a continued commitment to decrease hospital associated infection which is a major public concern.
• the aim to collect and assess data on Tissue Viability to reduce the number of category 3 and 4 pressure ulcers.

We believe that the Trust's Quality Accounts are an open and honest reflection of the Trust's performance and that there have been no significant omissions of issues.

The Trust has demonstrated public involvement in developing their Quality Accounts including using feedback from patients to improve acute stroke care and identifying a need to improve services for patients with dementia, learning disabilities and Parkinson's disease.

Additionally, the Trust should be commended for its proactive approach to engaging with local Health Overview and Scrutiny Committee Chairs and Local Involvement Networks. The RUH has had regular meetings with both the Chairs and attended public meetings of the full Panel. The Panel Chair visited the Trust as part of the Trust's engagement process. This included a tour of the Acute Stroke Unit and Marlborough Ward, which was used as the isolation ward during the swine flu outbreak. The Panel Chair was impressed by the dedication of staff on both units to minimise hospital infections.

The Panel is pleased that the average length of stay on the acute stroke ward has been significantly reduced and through their visit learnt that the Trust is working with the Bath Community Stroke Service team to ensure a smooth discharge process.

In March 2011, the Panel received a briefing from the Trust on their plans to achieve Foundation Trust status. The Panel supports the Trust's move towards this and wish it well with its application for Foundation Trust status."

Summary of comments from Bath and North East Somerset LINk

"We commend the achievement of 98% of Emergency Department patients being seen within four hours of arrival, and feel the five priorities identified are laudable.

We hope that the fantastic progress made with reducing pressure ulcers will continue. We are pleased to see improving outcomes for patients with fractured neck of femur identified as a priority since this is very much needed. We notice how much improvement has been made with reducing the number of healthcare associated infections."

Full response from Bath & North East Somerset

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

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Date: 27th May 2011
Ref: VJ/VB

Dear Francesca and Sharon

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 2010/11. 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 provide further support for ensuring robust quality measures are in place. The RUH has demonstrated areas of improvements to patient experience and they have agreed to a further stretch target on the National Inpatient Survey for 11-12 as part of the CQUIN Scheme. NHS B&NES carried out quality assurance visits to a numbers of wards and departments at the RUH and as part of this process we interviewed patients. We have received very 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 10-11 related to pressure ulcers, length of stay, dementia and management of venous thrombus embolus (VTE). Improvements were made in all areas but final confirmation of results was not available in time for this statement.

There are robust arrangements in place with RUH to agree, monitor and review the quality of services, covering the key quality domains of safety, effectiveness and experience of care. This is managed through the Clinical 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 we monitor action plans 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. In 2010-11, RUH extended a standing invitation for the PCT to attend their Clinical Governance Committee. This is a good example of their increasing willingness to be open and engage with the PCT.

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

Statement

The RUH submitted records during 2010/11 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 2010 to December 2010:
- which included the patient's valid NHS number was:
99.2% for admitted patient care; 99.6% for out patient care; and 94.6% for accident and emergency care.

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

The Trust is committed to improving data quality and ensuring that data entry information is accurate at source. During 2010/11 the Director of Operations at Board level was responsible for data quality.

A Data Quality working group supported by the Business Intelligence Unit, Information Technology, Finance department and operational staff was set up to facilitate the training and management of issues; develop tools to monitor data quality including a dashboard; and a clinical outcomes group has been established, chaired by the Medical Director, to monitor Hospital Standardised Mortality Rate performance. This will be supported by the implementation of Millennium (the new RUH patient administration system) this summer.

Statement

The RUH score for 2010/11 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 81%.

Statement

The RUH was subject to the Payment by Results clinical coding audit for outpatients by the Audit Commission. The Trust's outpatient data quality was re-audited in December 2010. The audit showed an improvement in data quality from 10.7% to 5.3%, with no deterioration in data quality arrangements.

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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Telephone: 01225 824033
E-mail: qualityaccounts@ruh.nhs.uk

Website: www.ruh.nhs.uk

We value your opinion

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

Write to:
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