HSC Business Services Organisation

Directorate of Legal Services
Practitioners in Law to the Health & Social Care Sector

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Your Ref:	Our Ref:	Date:
HW-0038-12	HYPB04/02	30th July 2012

Ms H Win
Solicitor to the Inquiry
The Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur St
Belfast
BT1 4GB

Dear Madam,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS – Claire Roberts

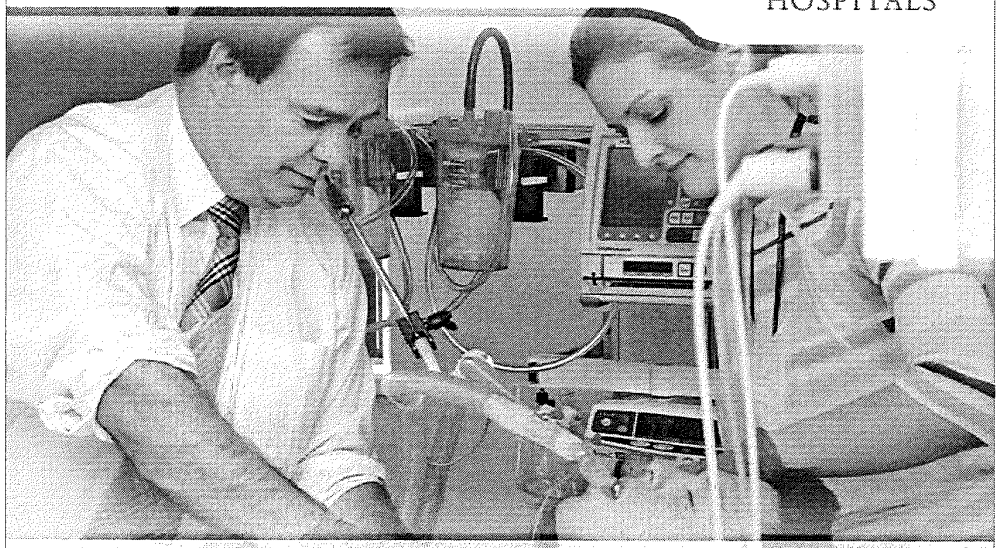
I refer to the above matter and now enclose a copy of the Annual Report for 2004-2005. We await a copy of the report for 2006-2007 and we will forward this directly upon receipt. I trust this is in order.

Yours faithfully,

AMCrawford

Angela Crawford
Solicitor
Email: [redacted]
Tel: [redacted]

The ROYAL HOSPITALS



On course for new critical care building

Plans for the development of a new £95m critical care building on The Royal Hospitals site are at an advanced stage. The building will be located next to the existing accident and emergency department, the outpatients centre and the eyes, ears, nose and throat building. Services within these buildings will be maintained during the five years of the building work.

The critical care building will house a wide range of services. There will be a new accident and emergency department capable of dealing with up to 80,000 attendances a year. Within accident and emergency there will be a resuscitation area, and departments for major and minor injuries and conditions. It is proposed a helipad will be located on top allowing the speedy transfer of major trauma cases to The Royal Hospitals. Dedicated lifts will ensure quick transfer of patients from the helipad to accident and emergency.

Level 3 of the new building will have four additional new theatres. This will facilitate the move of cardiac theatres and the cardiac surgery intensive care unit to the area which forms the nucleus of adult acute services.

Levels 5, 6, and 7 will be dedicated to intensive care. There is capacity for sixteen beds per floor, with two eight-bedded wards on each floor. Each of the intensive care unit's beds will be in single room accommodation and two of the eight beds will be designed as specialist isolation rooms.

A new education centre will be located on level 8 of the building. This will replace the existing education centre located adjacent to the millennium gardens. A range of varying sized lecture theatres and seminar rooms will be provided.

Level 9 will house the new regional burns unit, replacing the existing unit located in ward 2E. There is capacity for 12 beds, as well as supporting accommodation such as a burns theatre and accommodation for physio and occupational therapy services.

The new critical care building (known as phase 2B of our redevelopment plan) is the third project in the redevelopment of the Royal Victoria Hospital, following the new hospital (which was phase 1) and the imaging centre (phase 2A). It is anticipated that building work will take approximately 5 years and the total value of the scheme is £95 million.

We are continuing to strive to improve the environment in which we care for our patients, their relatives and carers. Final details of the business case for the new critical care building are being discussed with the Department of Health and the soon green light for the development is expected in the near future.

■ Dr Gavin Lavery, director of critical care services and Dr Claire Lyttle with patient represented by staff member David Hampton

This annual report is available in large print, on 3.5 computer disc, on audio tape and on The Royal Hospitals website. It can be made available in other languages by request.

A informação contida nesta publicação pode ser obtida em outros idiomas, para aqueles que não falam inglês como primeira ou segunda língua. Quando solicitado, este documento também pode ser obtido em outros formatos.

英语若不是您的母语或第二语言，您可索取有关这册子的其他语言版本。您亦可要求其他形式的版本。

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INVESTOR IN PEOPLE

mark of excellence

Chairman's Report
Anne Balmer

Checking under the bed

If I were chairman of a big hotel chain I'd be delighted with the high bed occupancy rates we have seen at the Royal over the past year. Unfortunately, in a hospital it means something entirely different.

From the neonatal unit to adult intensive care, bed occupancy rates have remained extremely high – putting particular pressure on infection control teams battling with one of the biggest worries for any patient coming into a hospital today.

Our new critical care centre is one of the big capital developments that will give us space to grow and manage the new healthcare challenges facing us such as MRSA. In the meantime, patients coming to our hospitals need to be reassured that we are doing our utmost to make sure they don't become infected.

Hospitals of course can never be sterile places. Normal healthy people – staff, visitors and the patients coming into our buildings – are all covered in bacteria. The aim is to prevent these germs getting to the vulnerable patients in the beds.

So what is being done? In addition to commonsense action such as more hand washing – a practice now firmly embedded in junior doctor training – and priority cleaning of clinical areas, we inspect and chart the control of infection.

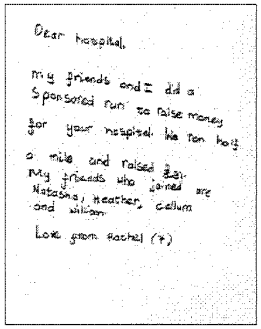
We give data to wards where risk is greatest and help the staff put action plans in place. We also issue guidance to all staff involved in prescribing to prevent overuse of antibiotics. And the Department of Health's new Infection Control strategy will keep this issue to the fore, especially this coming year.

Superbugs aren't caused by hospitals. Hospitals are simply the places where they do the most damage – and everyone needs to play a part in keeping them at bay. So never be afraid to ask your visitor if they have washed their hands.

Keeping patients safe is our number one priority – and the vast majority of the thousands of patients treated at the Royal every year enjoy better outcomes and return home to a better quality of life. National Audit returns, for example, show a survival rate among our intensive care patients which is 15% better than the UK average.

In the small number of cases where the outcome is not good we know the heartache and loss involved for every single family. Trust Board is assured that good systems are in place to make sure that lessons are learned. The Root Cause Analysis approach is painful for staff who come to work in hospitals to save lives and cannot bear to think that this did not happen. Learning to save other lives is the best thing we can do for those left grieving.

Many people, in memory of friends and relatives, make generous donations to all four of our hospitals and I meet as many of them as I can but this is my opportunity to say a public thank you to all who raise money for the Royal. We appreciate every penny and use them all wisely, whether they come from charitable groups or giving individuals, such as the children who recently sent us the letter above.



Dear hospital,

my friends and I did a Sponsored run to raise money for your hospital. We ran half a mile and raised £20. My friends who joined are Natasha, Heather, Callum and William.

Love from Rachel (7)

A firm hand on finances

Balancing the books while delivering high quality patient care is the challenge we set ourselves on an ongoing basis and we're pleased to report that we have managed to achieve this again in 2004/05. The Royal achieved a breakeven position during this very difficult year in which we saw increasing service pressures in a financially constrained environment. It was only through our own rigorous control of avoidable costs and the support of the Department of Health and the four health boards, with whom we have developed extremely positive working relationships that we were able to maintain and even develop our service to patients.

The governance agenda across all disciplines is increasingly important within the health service. It is vital that we have stringent internal controls in place to ensure that the funding provided to deliver services to patients is spent wisely. Over the last year we have carried out an extensive and focussed exercise to ensure that our system of internal control is robust and that the decision-making processes which commit our organisation to spending are appropriate.

Over the next few years there are significant challenges for us as an organisation and for the health service within Northern Ireland as a whole. We are working intensively to deliver the most fundamental pay reform agenda in the NHS since its inception, while ensuring that the service delivered to patients is maintained or improved and the benefits expected from the reforms are realised. There will be very challenging productivity and efficiency targets required from us and these will place significant pressures on the services we provide. The availability of capital money, and more importantly, the associated running costs required to continue the much needed transformation of our site will place particular pressures on the limited new monies within the system.

The financial outlook for the next few years is uncertain and it is vital that the whole system works together to maintain current services, protect vulnerable and regional specialties and ensure that service priorities are delivered equitably across the region. We are committed to playing our part in delivering the immense agenda ahead and are confident that the partnerships that exist between ourselves and our key stakeholders will allow the health service as a whole to address the challenges ahead. *Finance Summary pp18–19.*

improving year by year

Chief Executive's Report
William McKee

Challenging perceptions

The man on the phone to Stephen Nolan's radio show was very angry. He'd just seen an ad in his local paper for a hospital arts co-ordinator – yet his grandson had been told he'd have to travel to Birmingham for a heart operation. "What kind of health service do you call that?" he asked. No prizes for guessing what the other callers said.

The challenge for me, as I look back on what has been a year of truly exceptional achievement by Royal Hospitals staff, is to demonstrate the difference between perception and reality.

To answer the man on the radio – I understand what it must look like. But the fact is that there are certain highly specialised procedures we don't do here – and as Health Minister Shaun Woodward has pointed out – you are entitled to have your operation carried out elsewhere if you are fit to travel. The main thing is that you get the treatment you need as quickly as possible.

We also only have one paediatric cardiac surgeon – a situation we'd be happy to see change if the Department of Health's review of the service results in a recommendation that we carry out operations for patients from health authorities outside Northern Ireland.

It may seem a bit of a leap to move from talking about heart surgery to discussing hospital art, but art in the hospital environment has been shown to help healing and reduce anxiety. The best way to reduce anxiety of course is to reduce the time people have to wait for operations. In Northern Ireland we are dragging around a waiting list that we inherited because of a specific regional approach in the past. When England, for example, was powering ahead, we were just getting changed into our running shoes – and then were told to change back.

Waiting times

Now that we're back in the running we're catching up fast and the table below shows the progress. Here in the Royal we focussed on the length of time people were waiting rather than the number on the list and set ourselves even tougher targets than the Department set for the region.

2002/03	Regional Target	Performance	Trust Target	Performance
	No growth in long waiters (18 months +) from 1/4/02 baseline	Achieved	20% reduction in long waiters from 1/4/02 baseline.	Achieved
2003/04	50% reduction in long waiters from 30/6/02 baseline	Achieved	50% reduction in long waiters from 30/6/02 baseline	Achieved
2004/05	To have no long waiters by 31/3/05	252 patients short of target. It was acknowledged at the start of the year that NI does not have the capacity to treat some complex cases, e.g. cardio ablation and neurosurgery	To have no long waiters by 31/3/05	

We also now measure success by clinical outcomes. For example, among fracture patients we monitor levels of mobility as well as completion of treatment.

Delivering a better service

No-one, therefore, should doubt our commitment to delivering a better service to patients year-on-year – hopefully, in the near future, as part of a new health service structure organised around disease and illness management rather than a large number of institutions. We also look forward to retaining our position as one of the UK's top forty hospitals – one of only fourteen Trusts to have consistently achieved this in the past five years.

A common perception of the health service is that it is awash with managers and money – and that forthright action on both would solve everything. Here in the Royal our clinicians – our doctors and nurses – are a major force in management – and pure management or administration costs remain consistently low.

Savings

In the finance department, despite an acknowledged rise in funding, the gap between income and what we need to spend to keep services running is expected to rise over the next two years.

We are committed to robust management action to save £6m through the kind of efficiencies that can be made in any large organisation during tight financial times. We will also work closely with the health boards who commission our services – and with the Department of Health – on options for finding the remainder without cutting services to patients.

I believe there is enough money in the system but it is parcelled out in ways that may not be making best use of it – and a regional approach to the funding problem should help all of us through the next few financially difficult years.

Success

Important though it is to look ahead and plan realistically for the future, it is also important in this report to look on the year past, to pause and say well done to everyone who works for the Royal. It was particularly heartening to see the results of patient surveys which showed that 98% those who use our services would recommend us – a welcome perception that gives added impetus to our ongoing work to improve the patient experience.

Here are some of the other headlines from the past year:

- Our nursing turnover halved – thanks to a training and career structure second to none.
- We continued with our redevelopment plans to initiate a £500m capital development programme to provide first-class new buildings and facilities for patients.
- Under Agenda for Change we have made significant progress in partnership with staff side colleagues in the implementation of pay modernisation. We are also in the process of implementing a new contract for consultants within our hospitals.

The Royal's *Vision of Success* – the document that sets out what we want to be doing for patients and the wider community in five years time – underlines the importance of driving forward, leading change, and raising standards.

Put simply – we know that we won't achieve success simply by doing what everyone else does so we will always be working to do better. Our patients deserve nothing less.

It is our fundamental purpose in The Royal Hospitals to improve public health and well-being by providing the highest quality healthcare as acute general hospitals and tertiary referral centres in an environment of learning, innovation and research

Board of Directors

Mrs Anne Balmer
Chairman

Mr William McKee
Chief Executive

Non-executive Directors
Mr Frank Caddy
Councillor Tom Hartley
Mr James O'Kane
Mrs Monica Culbert
Mrs Mary Clark-Glass

Executive Directors
Mr Hugh McCaughey
Deputy Chief Executive

Dr Michael McBride
Medical Director

Mrs Wendy Galbraith
Finance Director

Mrs Deirdre O'Brien
Director of Nursing, Patient and Environmental Services

About us

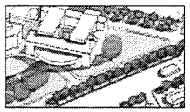
The Royal Group of Hospitals and Dental Hospital Health and Social Services Trust is made up of four internationally known hospitals situated on one 80-acre site. Almost all of the specialist hospital services are found here and we also have a major teaching and clinical research role. One in three families in Northern Ireland will have someone treated at the Royal in any one year.

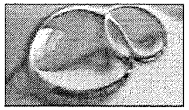
The hospitals are: the 742 bed Royal Victoria Hospital, including the regional trauma centre and 25 critical care beds; the 125 bed Royal Maternity Hospital, housing the Royal-Jubilee Maternity Service and incorporating a neonatal intensive care unit. Last year a total of 5206 babies were born at the hospital; the 106 bed Royal Belfast Hospital for Sick Children with 7 paediatric intensive care beds; and the 6 bed Dental Hospital which carries out complex oral work, largely on a day procedure basis. Because of our role as the trauma centre, we have a very busy A&E department with 300 highly complex major trauma patients included in about 900 major injury cases seen every year.

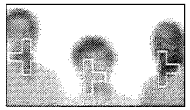
Register of interests

A register of directors' interests is held in the King Edward Building, and may be viewed by request during normal office hours.

At a glance







improving year by year

Improving our service for hepatology patients

In 2004 The Royal Hospitals extended its hepatology services with the appointment of a second consultant hepatologist in the regional liver unit and a hepatology liaison nurse. The role of the specialist nurse, the first in Northern Ireland, has coincided with funding for the most up-to-date treatments in the management of hepatitis C. The expansion of the unit has resulted in a significant improvement in the hepatology service provided by the Royal, including the liver transplantation service run jointly by Kings College Hospital, London, and the regional service for hepatitis B and C.

Waiting lists cut

Expanding the service has positively impacted on the treatment of chronic hepatitis C (CHC) in Northern Ireland. End stage liver disease due to CHC has become one of the most common reasons for liver transplantation. Combination therapy can stop patients from developing end stage liver disease. Prior to this medication being made available in Northern Ireland in 2004, a significant waiting list had developed with some patients waiting 4 years. By the end of October 2005, over 70 patients will have been started on combination therapy and the waiting time for new cases will have been reduced to 6 months. Joint management of haemophilia patients has also been initiated with haematologists at Belfast City Hospital.

Since January 2004 waiting times for general hepatology outpatient referrals have reduced from 9 months to 3 months and the waiting time for routine liver biopsies have reduced from 4 months to 6 weeks.

Nurse-led clinic offers all-round service

Once a patient has been assessed by a consultant and a liaison nurse, and has had treatment prescribed for their condition, the patient is referred to a nurse-led clinic which is managed by the hepatology liaison nurse. This particular service promotes the safe and efficient administration of treatments for patients with hepatitis C. Individual patient monitoring and assessment by the hepatology liaison nurse enables patients to obtain the best possible outcomes from hepatitis C treatment and to minimise any complications. By providing support and education to the patients and their carers, the liaison nurse helps establish a continuity and a compliance with the patient for the duration of their treatment.

The hepatology liaison nurse also has an educational role to play among fellow healthcare professionals. In developing these partnerships the nurse promotes the continuity of patient care between hospital and community and therefore enhances the care delivered to the patient between hospital and home.

A framework for learning

In line with good governance and our commitment to openness and transparency, The Royal Hospitals acknowledges to patients and the public when things go wrong and systematically ascertains what happened, how it happened and why so that we can do all that is possible to ensure lessons are learned to prevent a re-occurrence.

Governance is a system by which an organisation directs and controls its functions and relates to those it serves or comes in contact with.

In 2003 the Board of The Royal Hospitals established an Excellence and Governance Sub-Committee which receives regular reports on patient safety, quality of care, external and independent reviews.

All clinical divisions now have active excellence and governance committees and we have an integrated excellence and governance strategy which outlines the responsibilities of directors, managers and all our staff.

The implementation of this is assured through our internal accountability and performance management arrangements.

With clinical teams we have now also developed a range of performance measures to assess the safety and quality of the care we provide.

We have introduced Root Cause Analysis which ensures that the learning from adverse events is included in the process and systems of patient care to ensure that we do our reasonable best to prevent further adverse incidents or harm to those in our care.

This procedure is the current model recommended by the National Patient Safety Agency (NPSA) in England and is currently being deployed by the Department of Health, Social Services and Public Safety in Northern Ireland through the work of the Clinical Governance Support Team.

Delivering improvements in treatment of coronary heart disease

Coronary heart disease is a major health concern. If you suffer from any form of illness relating to your heart, you want to be treated swiftly and experience the best possible healthcare. Here at the Royal we know that our standard of care is first-class, but we recognise that there have been times when patients have had to wait for treatment longer than we would like. Cardiac care is one area where excellent progress has been made in cutting waiting times for cardiac patients and we aim to bring these figures down even further.

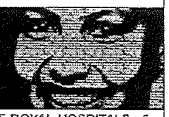
Well over 95% of people experiencing chest pain for the first time are seen by a specialist within two weeks. In 2003 it was not uncommon for patients to wait over two years for heart surgery. From the end of March 2006 no-one should have to wait over six months. The table below is our statement of where we are now and it illustrates how far we have come.

Dr Brian Armstrong, divisional manager of cardiac, vascular and thoracic services says, 'We recognise that there is a good deal more to be done. Improving care for people with heart failure is a priority both in terms of the quality of life of people who have the condition, and in terms of reducing unnecessary and costly emergency admissions to hospital. We need to also work to ensure more consistent provision of cardiac rehabilitation for patients. There is good reason to be optimistic on both these issues, with a combination of substantial investment and real changes to the way that the service operates, we have definitely turned the corner'.

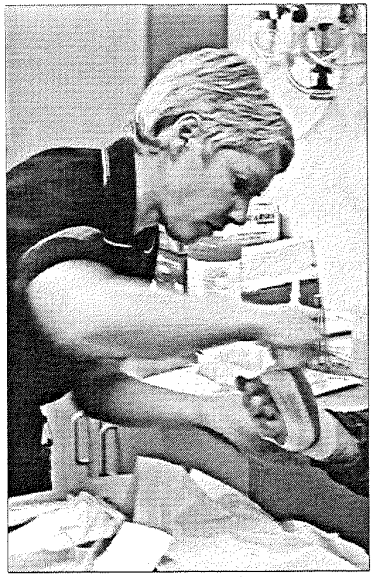
	Then (2002/03)	Now
Number of new cardiology outpatients seen per year	3,477	4,668
Number of patients waiting over 12 months for heart surgery	114 (June 02)	Zero (Dec 04)
Number of patients waiting over 6 months for heart surgery	300 (June 02)	Expected to be zero by end March 06
Number of new patients seen at rapid access chest pain clinic	1255	1556
Number of diagnostic caths with follow-on PCI per year	434	601
Waiting time for ICD follow up within 3/6 months*	50%	90%
Number of revascularisation procedures per year	1,791	1,994
Telephone cardiac rehab support for acute cardiac admissions within 2 weeks of discharge	Less than 200	698

***See page 9 for more on the advances in cardiac care, including how waiting times are being further improved for patients requiring implantable cardioverter defibrillators (ICD), and the rapid chest pain clinic's extended opening hours.**

We will provide the highest quality healthcare in the best possible environment for all our patients



Service improvement for accident and emergency



■ One of our emergency nurse practitioners in action

Modernisation and service improvement activities have been part of another busy and challenging year in the emergency unit of the Royal Victoria Hospital.

Service improvement projects, lead by multi-professional emergency department teams, have been addressing issues such as reducing waiting times for treatment and improving access to investigations, reducing the number of unnecessary emergency admissions which can impact on planned admissions having to be cancelled, and contributing to reducing the waiting time on trolley beds before emergency admission to the wards.

Examples of some initiatives include training for nursing staff to request x-rays. Previously the sole remit of the doctors, nurses can now request x-rays and so speed up the patient's access to treatment. Social work referrals are initiated at the earliest point in the patient's journey which allows for more timely communication between the hospital and community in arranging support for patients. The development of patient group directives means that for some groups of patients attending A&E the nursing staff can supply medication, thus ensuring timely treatment of particular complaints. Developments in near patient testing for heart failure have also enhanced patient care by ensuring appropriate interventions early and in preventing unnecessary admission to hospital.

How nurses are shortening the wait

The concept and implementation of the emergency nurse practitioner has been in the UK for approximately twenty years. Since the publication of the Department of Health's document *Reforming Emergency Care*, there has been a new dawning of this role which the accident and emergency department at the Royal has embraced. Previously, all patients were waiting together and those who were not seriously unwell were waiting to be seen for sometimes as long as six hours. This no longer happens and most patients who are seen by the emergency nurse practitioners are treated and discharged within 1.5 – 2 hours after their arrival in A&E.

The role of the nurse practitioner is a truly holistic one and having acquired a Post Graduate Certificate in Independent and Supplementary Prescribing, the emergency nurse practitioners are totally autonomous. On average, two emergency nurse practitioners see approximately 538 patients, which is 12.6% of all attendances. It is expected that as the emergency nurses skills are further developed, as more conditions are treated, and once a third emergency nurse practitioner is employed, this number will increase.

As part of our evaluation of this new role it was vital for the emergency nurse practitioners to see if the patients were happy with the service they were offering. A patient satisfaction survey was carried out and out of a sample of 100 patients, 31% had heard of the emergency nurse practitioner. Of these patients, 99% of them were satisfied with their treatment and 100% would choose to be treated by an emergency nurse practitioner again and would recommend the service.

Keeping on our toes – planning for a major emergency

This year saw continued development on emergency planning including the introduction of our newly revised major incident plan. This is a plan that comes into effect once an emergency situation has been declared 'major incident', meaning that an event has occurred on such a large scale that the emergency, health and social services cannot deal with it as part of their daily work. For example the recent bombings in London would have activated a major incident plan.

Like all hospitals, we regularly test our major incident plan. This year we arranged a fully-blown practice in partnership with the PSNI, fire and ambulance services and many staff from across the hospital site, including security, A&E, and any department which would have a role to play in a disaster, from intensive care, to social services, to switchboard, to the chaplaincy office. This was a multi-agency exercise. It focussed on a mock accident resulting in a chemical incident which involved the pretend decontamination of patients and some crew, and the treatment of multiple casualties across three of our four hospitals. These practices are extremely valuable and are treated very seriously. Much planning goes into them to make them as realistic as possible, without inconveniencing in any way the daily work of the hospitals. From the practices we can see the efficiency of our plan in action, and iron out any small issues that we feel need looked at. Our plan is then constantly updated, ensuring that we are prepared and confident that our systems will cope with a major incident should that unhappy day ever come.

Major developments in emergency communications

In a major development in information communication technology (ICT) aimed at improving our responsiveness and the efficiency of our hospitals' emergency services, the accident and emergency teams in the Royal Victoria Hospital and the Royal Belfast Hospital for Sick Children have introduced a new computer system. The new system allows clinical and administrative staff to input real time data while patients are in the department. This information allows emergency staff to monitor each patient's journey through the A&E departments. Staff can now respond promptly to patients' and relatives' queries, including patient location in the department. In the development of our services in the emergency departments this information supports staff through audit, research and service improvement activities and enhances the delivery of emergency services to our patients.

improving year by year

Supporting patients through a new stoma care group

A patient support group which aims to provide patients and their families with education, support and advice about all aspects of living with a stoma was launched in early 2005.

Established by the stoma care nurses, Outlet is a patient-centered group which encourages contact and mutual support between patients, medical professionals and carers. All the members of the multi-disciplinary team – surgeons, social workers, dieticians, psychologists, Macmillan nurses and the stoma care nursing team – are represented on the group. Each member is invited to lead the group and patients are encouraged to participate in question and answer sessions.

The Royal Hospitals stoma care team has good working relationships with voluntary organizations such as the Ileostomy Association and the British Colostomy Association. We want to further enhance these relationships by providing patients with the opportunity to meet representatives at open days. Equally, as our patients become more involved in Outlet we hope that they might like to further provide vital support to new patients and aid them in their recovery and rehabilitation.

Outlet is a very good way of keeping patients up-to-date with innovations that could enhance their lifestyle. Equally, the contact patients make with each other offers them strength and encouragement as well as offering solutions to different practical problems that patients sometimes experience. Other potential benefits of having a support group include reducing the amount of outpatient visits for patients as the support group can often answer a query without the need for an appointment. The quarterly meetings allow a variety of subjects to be covered and as a result, enable patients to live normal lives.

Better oral surgery services in dentistry

Sometimes it is the smallest things that can make the biggest difference – that certainly rings true for patients visiting our oral diagnostics outpatients service.

With almost one in five people not turning up for appointments, staff knew something had to be done to reduce the number of people waiting for the service and also reduce waiting times.

The answer lay in working with patients to improve the existing appointment system and ensuring that the new system would work for them as well as the clinicians.

Over the course of a few weeks, patients were asked how they felt the system was working at the moment and how they felt it could be improved. Some were even invited to come along to meetings to give their impressions of how it should work.

After these discussions, a partial booking system was introduced which enabled patients to be involved in booking their appointments but also ensured the whole system could be coordinated centrally.

The results were extremely impressive. There was a 48% reduction in the number of patients waiting for a first appointment and waiting times for urgent cases reduced from one month to two weeks. Patients waiting for more routine procedures saw their wait come down from two years to just over eight months.

Overall, the revised booking system resulted in better use of clinical time and increased satisfaction among patients. And as a by-product, patients suggested how appointment letters and general information about the service could be improved. This was certainly an all round win-win situation for staff and for patients!

Can people with diabetes have their cake and eat it?

If a patient has type 1 diabetes and has completed a DAFNE course, then the answer is yes.

DAFNE (Dose Adjustment For Normal Eating) is a way of managing type 1 diabetes by working out how much insulin is needed for the amount of carbohydrate that is eaten. Although the DAFNE approach has been used in Europe for over twenty years and was introduced to the UK in 2000, it was not available in Northern Ireland until earlier this year. The team in the Royal's Endocrinology and Diabetes Centre felt that patients here were missing out on an excellent opportunity and so sent a nurse, dietician and doctor to England for a week to be trained to run the DAFNE course.

The dose adjustment course is based on a daily injection of long-acting insulin and an injection of quick-acting insulin after every meal. Testing blood glucose levels at least four times a day is also essential. For some patients with diabetes this would be just too much, but for others the benefit of being able to eat what they like is worth all the effort.

So what does training in DAFNE involve? It involves the patient attending a week-long training course (9am-5pm). The structured teaching programme covers topics including carbohydrate estimation, insulin adjustment, hypos, illness and exercise. DAFNE is also about learning from the experiences of other patients in group settings. To date, the Royal has organised two groups, with two more planned for this year. The feedback has been very positive so far and patients are delighted by the choices they now have in their diet. They realise that, like everyone else, healthy options in their diet are preferable but, at least like everyone else, they now have that choice.

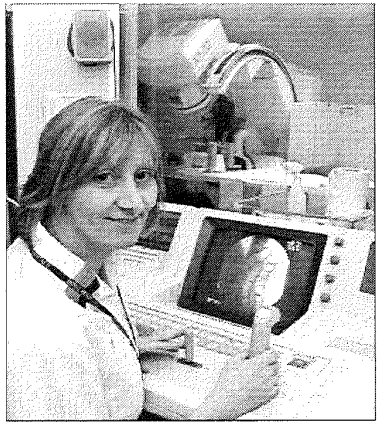
Why DIY injuries are no laughing matter

Staff in A&E see many patients with very serious injuries. They also see patients whose injuries could have been prevented by simple precautions.

Results from the regional trauma database at the Royal shows that in the last two years 133 patients sustained life-threatening injuries from falls. Half of these patients were injured at home mostly through window cleaning, with the remainder of people injured at work or in a public place. Many patients were injured falling down stairs with alcohol a contributing factor. Other patients were injured falling off balconies, ladders, haystacks, horses, roofs, walls and even bar stools! The average stay in hospital was thirty days, five of them in intensive care.

The database shows that falls are a leading cause of serious injury and that safety checks at home can reduce the risk of tripping and falling. Do-it-yourself enthusiasts should use safety harnesses and secure ladders where possible. Alcohol increases the risk of falls and, most importantly, gravity is not a good mixer!

We will redesign and modernise the systems and processes which underpin the way we deliver care



■ Clinical specialist Janet Fletcher who performs barium enema examinations

Revolutionising waiting times for barium enemas

Recently patients at the Royal have seen the waiting list for barium enema examinations plummet from fifteen weeks to just three to four weeks. Barium enema is a diagnostic test for colo-rectal carcinoma, the third most common cause of cancer death. This drop in waiting times is excellent news for all patients suffering stress and anxiety as they wait for the test.

This massive reduction in waiting times comes as a result of the foresight and innovative thinking of staff in the Royal Victoria Hospital's x-ray department, who discovered that equipment for the test was being underutilised to the tune of 50% per week and decided to take action.

Traditionally, barium enemas could only be performed by a consultant or senior registrar and reported by consultant radiologists. With the upcoming retirement of one of the hospital's consultants and a national shortage of both consultants and registrars, the x-ray department anticipated longer waiting lists and decided to train a member of radiology staff to become a clinical specialist in the procedure.

The result of this decision is that patients can undergo the test with a clinical specialist instead of enduring long waiting lists for an appointment with a consultant or senior registrar. Although difficult to substantiate, a more timely diagnosis should also help improve patient outcomes, and the use of radiographic equipment is maximised.

We are aware that some patients have to wait too long for certain diagnostic procedures and we are taking active steps to combat this problem, often with innovative measures. Staff in the x-ray department have continued to lead the way forward by training additional colleagues as clinical specialists in ultrasounds and plain film reporting, as well as a second clinical specialist in barium enemas.

Advances in respiratory care for Belfast and beyond

It has been a significant year for the Royal's respiratory team. Following consultation with the North & West Local Health Economy, we extended our respiratory service with the appointment of a consultant to lead the lung cancer services within the hospital. In addition, two chronic obstructive pulmonary disease (COPD) respiratory nurses and a COPD specialist physiotherapist were also appointed to the team. In parallel, the Mater Hospital appointed a respiratory nurse consultant and North & West Belfast Health and Social Services Trust developed a community respiratory team.

The strategic development of a respiratory team across three Trusts has allowed us to develop a partnership which offers patients a seamless care pathway from admission, right through until discharge into the community respiratory team. Collectively we consider ourselves the one respiratory team serving the local community, with an emphasis on delivering a high standard of care where and when the patient needs it.

Community respiratory health

In line with the Northern Ireland Respiratory Strategy we have developed a Respiratory Early Discharge Scheme (REDS), which offers patients the opportunity to return home at an earlier phase of their journey. Patients and their carers receive a comprehensive package of treatment including rehabilitation, education, and support for the family by a specialist multi-disciplinary team. Once a patient is known to the community respiratory team, he or she is allowed to self-refer themselves for follow-up visits for treatment and advice at home.

To support a seamless care pathway the community respiratory team and the Royal have set up a joint multi-disciplinary respiratory clinic to fast track our patients for further treatment and investigations where appropriate. Patients receive care that is timely, appropriate and closer to home. It is anticipated that the scheme will also reduce length of stay, admission rates and patients waiting on trolley beds in A&E.

Making an impact on respiratory care

The continuing development of ward-based acute ventilation for patients with acute respiratory failure, has allowed a higher dependency of patients to be cared for by a specialist multi-disciplinary respiratory team. A recent audit has shown a reduction in admissions to intensive care and our mortality rates were comparable to the national standard.

Members of Breatheasy Royal, a support group affiliated with the British Lung Foundation, were delighted to be asked to participate in developing the recent Northern Ireland Regional Respiratory Strategy.

Acknowledgement of the exciting developments in the respiratory service over the past year was highlighted when Louise Williamson was selected as one of the prize winners at this year's Royal College of Nursing Northern Ireland Nurse of the Year Awards. At a gala ceremony at the Culloden Hotel Louise was recognised for her efforts to improve access to our respiratory nurse service and for helping to widen the scope of this service. The award recognises the lead role that Louise and the team have played in the modernisation of respiratory services and ultimately for making a difference to patients lives.

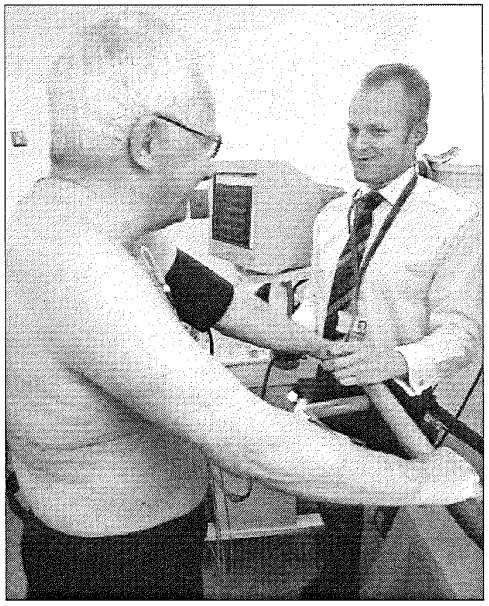
New chart to improve monitoring

The consistent monitoring of patients is crucial to the high level of care we deliver. Our current recording mechanisms are strictly observed, but early recognition of finite changes in a patient's airway, of changes in breathing and circulation, is vital in the prevention of apparent life-threatening deterioration of patients. A strategy has been developed which focuses on the recognition of patients at risk through the use of early warning scores.

A new observation chart with an integrated early warning score to promote early recognition of patients' physiological deterioration has been introduced by the Royal. The RAW (Royal Advanced Warning) chart was piloted over the summer of 2004 and an audit revealed that recording of vital sign observations was improved with a significant rise in the recording of respiratory rates and the addition of a level of consciousness measurement previously not available on the current charts. This improvement in the quality of monitoring should result in improved patient safety through risk identification, reporting and feedback.

improving year by year

Evening opening for our rapid access chest pain clinic



■ Dr John Dougan with a patient at the rapid access chest pain clinic

A soaring success for the Royal, the chest pain clinic (CPC) is a unique rapid access, one-stop clinic and was the first of its kind in Northern Ireland. So successful has it been that since October 2004 its opening hours have been extended into the evening.

Initiated in February 1999, the chest pain clinic was up and running a full year ahead of the publication of the government's *National Framework Document for Coronary Heart Disease* which recommended the set-up of such clinics for the early diagnosis of ischaemic heart disease.

The CPC enables early identification of high risk patients and reduces the number of unnecessary hospital admissions in patients who are at a low risk. Attendance at a CPC reduces numbers at A&E and cardiology outpatient clinics and so reduces waiting times in general.

Since its inception, the chest pain clinic has seen over 4,500 new patients. On average 74% of patients are seen within two working days of referral and 94% within five working days. So successful has it become that the clinic hours have been expanded to ensure that the service does not become a victim of its own success, potentially resulting in an increase in waiting times and a loss of the service which made it unique.

By extending the clinic's hours, staff can see up to 25–30 additional patients each week, representing a 50% increase. This includes having appointments available in the evening which makes the service even more convenient for patients. What started as an initiative has become a major cardiology service for the Royal and one which we intend to keep available for as long as it is needed.

Slashing waiting times in cardiac care

An implantable cardioverter defibrillator (ICD) is a device that is implanted in the chest to monitor and, if necessary, correct, episodes of unstable abnormal heart rhythms (known as arrhythmia). A minor surgical procedure is required to implant the ICD into the patient. The device has a battery life of between four and six years, depending on its usage, though be assured it does not run out unexpectedly. All patients are required to attend ICD review clinics on three or six monthly bases.

What was going wrong?

The purpose of the clinic is to ensure that the battery in the ICD is not depleted, and that it is optimally programmed so that patient's arrhythmia is well controlled by the device or medical management. In April 2004 an internal audit highlighted that patients with a six-month review date were waiting up to thirteen months for an appointment, and patients expecting a three-month review were waiting for up to seven months for an appointment.

How did we fix this?

The clinics were held weekly with a consultant who was assisted by a specialist team of cardiac clinical physiologists (CCPs). To reduce waiting times the hospital decided to start CCP led ICD clinics with consultant support if it was required. A dedicated pacing-ICD room was set up in the cardiac investigations unit and a training programme was developed for cardiac clinical physiologists to run these clinics.

The daily clinics began in November 2004 and by July 2005 95% of the ICD patients were receiving review appointments within the recommended time. In addition, patients who receive therapy between review appointments can contact staff daily during office hours by phone and their devices can be interrogated that same day.

The future

This dedicated group of CCPs has adopted a very personal, caring, and holistic approach which has been warmly received by the patients. It is hoped that this model can be used to set up similar clinics to better manage the pacemaker clinic for the benefit of the patients and their carers. In addition, ICD patients are now leading and developing a successful support group called Livewires (www.livewires.com) with the help of Royal Hospitals staff. The group organise regular regional meetings throughout the province.

Smoke-free by 2007

Buildings at The Royal Hospitals have been smoke-free since 1993 but last year, as part of our new tobacco control policy, we took the step of restricting smoking outside the entrances of our buildings.

The *Butts Out* campaign introduces a package of measures to control smoking on our site and offers support to staff, patients and visitors who want to give up. The new policy means that visitors are asked not to smoke in the immediate areas outside our buildings and that staff are asked to smoke in designated smoking shelters away from the entrances.

Butts Out is an intermediate step that aims to strike the balance between the needs of people addicted to nicotine and the growing community support to ban smoking. However, we are committed to making the entire site smoke-free by 2007.

We will make best use of all our resources

Catering for all our needs

Good food and nourishment are as much integral parts of patient recovery as medical care, which is one of the reasons why earlier this year our catering services department became part of the directorate of nursing, patient and environmental services. Echoing the words of Lord Hunt, in a speech at the Annual Hospital Caterers Conference this year, 'Good food is good for patients, good for NHS Trusts and symbolic of a good National Health Service.' Now that catering and nursing staff are part of a collective team which has patient focus at their core, the good work done over previous years in the catering department is continually growing and developing. In order to ensure the highest quality of service, the catering services department works closely with trade union colleagues in reviewing and developing the needs of our catering staff.

Patient care catering

The results of the quarterly surveys this year indicated that over 90% of patients are either satisfied or very satisfied with the quality and service of food. This is a reflection of the ongoing review of menu choices and delivery of the meal service to patients. This year it included a review of the a la carte menu choice for patients and the introduction of additional healthy options.

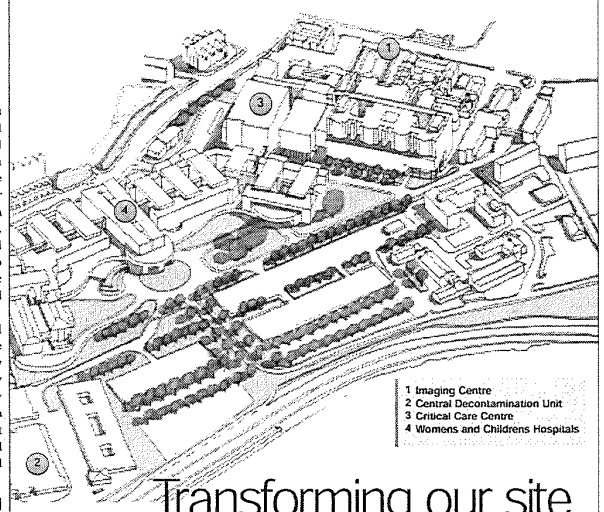
In conjunction with nursing staff a protected meal times policy has been developed. The aim of this initiative is to ensure ward areas are made more comfortable and peaceful during the lunch and evening meal services. Surveys have indicated that patients value a quiet, calm environment, free from unnecessary interruptions at these key meal times.

The Department of Health also participated in a National Day of Choice on 12 May 2005 which was supported by the Hospital Caterers Association, Royal College of Nursing, British Dietetics Association and the Patients Association. On a number of wards patients were offered a choice of additional menu items, healthy options and an extended beverage service. Feedback was so positive that a number of these options have now been introduced onto the daily menus.

A new 'hostess' style meal service was introduced onto the wards in the Royal Maternity Hospital where meals are now served directly to patients by catering services staff from a mobile servery, ensuring that patients receive their preferred choice of meal and that is hot and well-presented.

Staff training and development

In line with our training and development programme for all staff, this year saw a new management development programme specifically designed for unit kitchen managers accredited by the Institute of Leadership and Management. It was also commended at the Belfast Business Awards in the Best People Development/Training Practice category which was a great accolade for the catering services unit. Maire Bermingham, assistant director of patient and environmental services, was delighted with the recognition and commented, 'The Royal Hospitals catering service is ever changing and is committed to making a difference for our patients, visitors and staff. We will continue to look at new and better ways of improving our services to ensure that we meet customer expectations and in doing this we rely on the entire catering services team to help us deliver our vision.'



Transforming our site

Over the next ten years our site is set to be transformed, with the completion of a number of new building projects.

Three years ago phase 1 of the new Royal Victoria Hospital redevelopment was completed. Within the next 6-9 months, an imaging centre (phase 2A) and a central decontamination unit will also be complete. These buildings serve very different functions but both are critical to the day-to-day running of the hospitals.

We are awaiting approval of the business case for a new critical care centre (phase 2B), the third building project in the phased redevelopment of the Royal Victoria Hospital. This building will be linked to the new RVH and the newly-built imaging centre. The fourth project in this phased redevelopment is the replacement of the outpatients centre and our eyes, ears, nose and throat buildings. This building work is referred to as the phase 2C project. A business case has been prepared for submission to the Department of Health and Social Services and Public Safety. The proposed location of phase 2C is the area adjacent to the new imaging centre, between the new Royal Victoria hospital and the old Victorian corridor that runs parallel with Grosvenor Road.

Plans are also underway to develop new women's and children's hospitals, replacing the existing Maternity and Children's hospitals. The proposed location of these hospitals is in the area between the existing Maternity and Children's hospitals – a big challenge given the range of buildings and services currently occupying that site.

Engaging with those parties interested in the development of both Women's and Children's hospitals is one of our primary objectives over the coming years. Work has begun to ensure that we approach this very important area of work in a structured and effective manner. There will be many issues raised over the time of the development of the new Women's and Children's hospitals, from building design to service planning and many more. We will engage with the interested parties and we will be undertaking a range of tasks from information giving to consultation and involvement.

The site plan outlines how we believe The Royal Hospitals will look in ten years time. We occupy 80 acres of land and, without a doubt, our plans are ambitious, however much has already been achieved over the last five years and we look forward to reflecting a new century and an even better health service in the construction work we've planned.

improving year by year

Fighting superbugs on all fronts

Continuing to tackle infection control. The Royal Victoria Hospital was the first hospital in Northern Ireland to use a new decontamination procedure to combat a multi-resistant strain of the Acinetobacter baumanii bacteria.

The process is one of the latest techniques used to prevent the spread of infection and was brought to the Royal to decontaminate a room that housed a patient with this resistant bacterial strain.

The rather inconspicuous equipment releases hydrogen peroxide that eradicates micro-organisms from the environment, thereby ensuring that no other patients are exposed to the organism.

As the vapour does not interfere with electronics or machinery, it is the ideal solution for hi-tech intensive care areas, where often very vulnerable patients are cared for with the most advanced technology.

The Royal is one of 38 hospitals throughout the UK to use the procedure and it is likely that other hospitals will be employing the technique to control infection and protect patients from cross-infection in the future.

Your part in infection control

Infection control is everybody's business – and that includes all of us as visitors. Here are some simple common sense rules to making sure we all do our bit to combat the spread of infection:

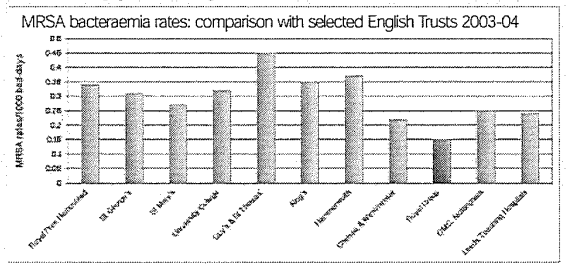
1 If you, or someone you live with has a cold, flu, vomiting or diarrhoea, or if you feel unwell in any way, try to avoid visiting patients in hospital until you're feeling better
2 Wash and dry your hands before visiting a hospital ward, particularly after going to the toilet. Where appropriate use the alcohol hand gel provided at the ward door or at the bedside – it only takes 15 seconds and is one of the most important measures in preventing cross-infection
3 Ask ward staff for advice before you bring in food or drink for someone you are visiting in hospital. Bringing in perishable food is not a good idea as we do not have the facilites to refrigerate food items and thus these can be a source of infection in themselves
4 Never touch dressings, drips, or other equipment around the bed
5 When visiting someone in hospital, don't sit on their bed, and keep the number of visitors to a minimum at any one time. Young children can be vulnerable to infection and should only visit patients in special circumstances. If you bring them with you, keep them close to you at all times
6 And finally…hand wash: hand wash: hand wash!

Working harder to fight hospital infections

Every year the Royal sees more patients, delivers more services and increases the number of staff on its 80-acre site. And we are trying to deliver all these services faster and safer than ever before.

People are living longer and medical practice is continuing to advance, allowing patients to have more complex and challenging treatments and a greater number of invasive interventions. This culminates in hospitals seeing people that are often more susceptible to infection and seeing infections that are tougher to manage because of the increase in micro-organisms that are resistant to antibiotics. This means that we have to work even harder to combat infection in our hospitals.

With the increase in multiple resistant micro-organisms and new and emerging viruses such as SARS and avian flu, we are continually seeking new ways to combat the spread of these infections.



What are we doing about it?

One of our big successes over the years is the ongoing development of an infection control link group in the hospital. Although all staff are responsible for ensuring good infection prevention and control practices, these infection control link members are the first point of contact for colleagues at ward level and are the backbone for infection control throughout the site.

The 100-plus link members meet on a monthly basis to share best practice and receive updates on infection prevention and control. The group deals with the day-to-day practicalities of preventing the spread of infection and one of their more successful projects has been rolling out the use of alcohol gel at all ward levels and carrying out hand hygiene audits. These gels are extremely fast-acting and are proving successful in killing germs in as little as 15 seconds.

The group members provide an important link between the wards and the highly specialist infection control team. They reinforce the practice of wearing disposable gloves and aprons while in contact with patients and with blood or other body fluids and ensure the highest standards of infection prevention and control practice are maintained at ward level.

The table shows that compared to some of the largest hospitals in England we have much lower rates of infection. However, we are aware that there is still some way to go and continue to work with other Trusts in developing and implementing infection prevention and control measures.

Healthcare associated infection: the myths!

A common myth is that all infections are preventable. They are not!

MRSA is commonly perceived as the only problem – it is not!

MRSA is a killer bug – it can be, but so can thousands of others given the right opportunity to cause infection. On the spectrum of killer bugs, it is a fairly medium player.

Healthcare associated infections are said to have escalated beyond control – they haven't.

The UK is said to be worse than everywhere else – it isn't, it's similar to many other countries in Europe.

A common misunderstanding is that most infections occurring in hospitals arise from organisms acquired while in hospital. Patients' own organisms (naturally carried on and within their bodies) are responsible for most of the infections.

Many patients believe that there should be no risk of infection in hospitals or that all patients carry the same risk. All patients carry a risk of infection on entering hospital; however, some procedures carry much more risk than others. Properly designed surveillance programmes (the Royal has been at the forefront of developing these since 1994) will help to define the risks and enable measures to be taken to minimize them.

Nevertheless, healthcare associated infections are still a problem. The Royal, as always, will continue to put the prevention and control of these infections to the top of its list.

We will ensure the care we provide is based on objectively assured standards, delivered within a culture fostering continuous improvement

Some of the work we have carried out this year

5000 babies delivered; 4000 diagnostic scopes of the stomach and intestine; 3500 cataract operations; 3000 cardiac catheterisation procedures with over one thousand of these including widening of coronary arteries to prevent heart attacks; 2500 acute respiratory admissions with 900 of these in paediatrics; 2000 in-patients with cancer; of which almost half had a procedure; 1000 operations to repair fractured hip joints; 1000 head injuries (minor and serious) treated as in-patients with almost 300 of these in children; 600 coronary artery bypass operations; 300 gallbladders removed; 170 appendixes removed; 100 facial fractures fixed in oral surgery

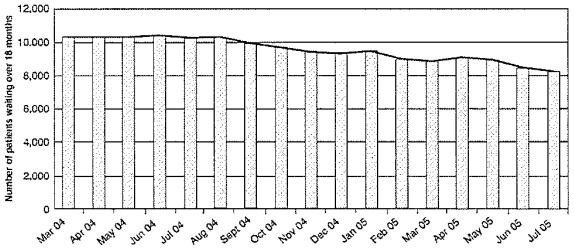
These facts show some of our larger volume procedures. However, it is worth noting that many smaller numbers of complex cases are also treated and require enormous expertise from physicians, surgeons, nursing and support staff and require significant resources.

Working to reduce

No one should have to wait long for treatment yet we know that this can happen. Over the past number of years we have been working hard to reduce the time patients wait for in-patient and day case treatment. Our success can be demonstrated by the graph below which shows how we have managed to reduce the number of patients waiting for treatment.

We also fully understand that the length of time people wait for treatment is only half the story: before they get on a list they have to wait to be seen by a consultant at outpatients. This year we have begun our journey to bring those waits down as well.

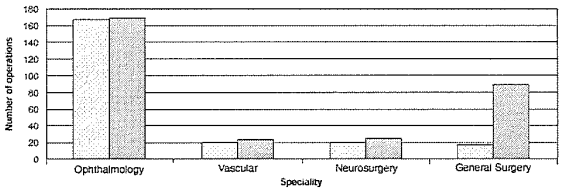
Waiting list by time band



We have been able to make progress in reducing the waiting times for in-patient and day case treatment by taking a number of actions: in some specialties we have introduced extra – often out of hours – theatre sessions.

We have developed an extensive outreach service in the special surgery unit in Lagan Valley Hospital.

Activity undertaken in protected elective facility Lagan Valley Hospital



We have worked with the health boards to make available for patients the option of being treated in other hospitals.

We have improved our systems for ensuring that patients are selected for treatment based on how long they have been waiting (insofar as this is possible within the constraints of clinical priority, medical training requirements, and the ability of patients to come in at short notice to fill a cancellation).

We have become more rigorous in our approach to dealing with patients who turn down reasonable offers of treatment. These days, any patient who refuses two reasonable offers of treatment will be removed from the waiting list and referred back to their GP. Of course, we try to apply this policy with caution and sensitivity, particularly when dealing with children, the elderly or other vulnerable groups, or where the surgeon is concerned about the condition for which the patient is waiting treatment.

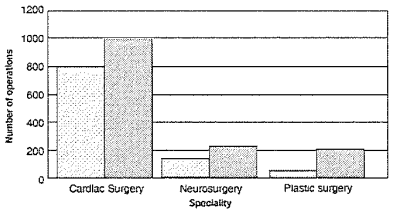
improving year by year

your wait for treatment

Capacity problems

Focusing on waiting times as we have been, we have realised that there is much we can achieve simply by looking at the problem from different angles. We have also noted that in some specialties – neurosurgery being a prime example – the demand simply exceeds our ability to deal with it in a timely way.

Capacity and demand



Staff in our neurosurgery unit have always recognised this and have been working with health boards to develop plans to correct this problem. It is hoped that the priority given to waiting times will help bring specialties like neurosurgery closer to the top of funding priorities.

A delicate balance

The Royal Hospitals is the place to which many of Northern Ireland's most complicated and difficult cases are referred and we have a high emergency workload. We are also the region's principal trauma centre. Most serious road traffic accidents come here and we are of course very proud of the role we have played in dealing with the victims of violence over the past three decades. This role needs to balanced with the priority to keep patients waiting as short a time as possible for more routine, but nonetheless important, operations.

At times, for example during the winter when we have greater numbers of emergency admissions, our ability to perform these routine operations is reduced. This balance is one which we focus intently upon to ensure that we bring waiting times down as fast as we can, and at the same time, maintain our world-class emergency services.

Looking ahead

We are far from satisfied with the current waiting times for inpatient and day case treatment; especially when this is compared with waiting times being delivered in England. This year the whole health community – the Department of Health, Commissioners, ourselves and other hospitals – has been redoubling its efforts to manage downwards waiting times. By March 2006 we aim to have no one waiting longer than 12 months for their treatment, with our ultimate aim of having no one waiting more than 6 months by March 2007.

Reducing the length of your stay

No one likes to remain in hospital for longer than is necessary. We agree and therefore it is our view that a patient's journey through our hospitals' systems should be as speedy as possible for a number of reasons:

Despite our rigorous focus on hygiene hospitals, by their very nature, are sources of infections. The shorter a patient's journey, the less likely he is to develop one of these infections

We know that being in hospital or waiting in A&E is very disruptive to people's lives and we want to minimise this disruption

The quicker we can get patients treated and discharged the more people we can treat within our existing resources and the shorter waiting time for treatment will be.

How we are trying to speed things up

In attempting to speed up our patients' journeys we have been focusing on three areas where delays occur – A&E, internal delays in relation to, for example, accessing blood tests or x-rays, and delays at discharge.

We also recognise that the reasons for delays are often about the whole healthcare system and not just about issues that as a hospital we can control. Our first step has been to establish a team to oversee improvement. This team comprises of Royal staff as well as GP representatives, people from our health board and members of our local community Trusts. Last year this group oversaw a variety of improvement initiatives including:

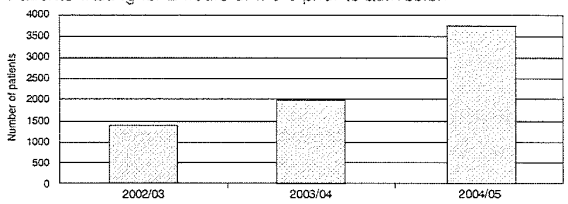
A detailed research project aimed at identifying precisely where the pressure points are in our systems

Making sure that all patients are given an estimated discharge date to ensure that there is greater focus on getting everything in place for that particular date.

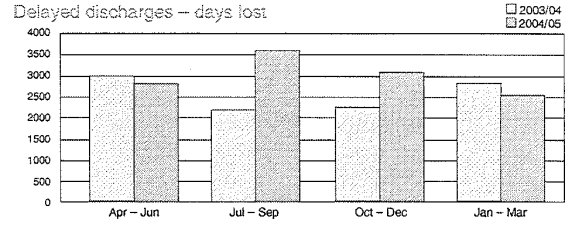
How well are we doing?

We are confident that this is the right approach and in conjunction with other measures, we expect to see improvements in our three highlighted areas. To date, the project team has not been in place long enough to give quantifiable results but we are assessing its progress as we go along and hope to be in a position to report back in the near future.

Patients waiting for 2 hours or more prior to admission



Delayed discharges – days lost



We will improve access to planned services, in particular, reducing the length of time patients wait

Reaching out to victims of domestic abuse

The impact of domestic abuse will vary from person to person, but what is clear is that it has a major impact on health which extends well beyond physical injury alone. There is growing evidence to confirm that domestic abuse has serious and long lasting consequences for the well-being of women and children.

Thirty percent of domestic abuse starts during pregnancy and existing abuse often escalates during this period of a woman's life. This includes physical, psychological, sexual and economic abuse. In April 2005 the Royal Jubilee Maternity Service initiated routine enquiry at The Royal Maternity Hospital when women attend their first antenatal clinic, and then again during their postnatal period. Royal Jubilee is responding to recent reports and recommendations from the Government which is concerned that domestic abuse is a major public health issue for women and their families.

Aims of the initiative

The aims of the initiative are very straightforward: to provide a seamless multi-agency support system for women and their families who are experiencing domestic abuse; to ensure that all women using the service are routinely asked about their experience, if any, of domestic abuse; to provide information about domestic abuse to all women; to give a clear message that domestic abuse is unacceptable.

Putting it into practice

A key element of this initiative is multi-agency working between midwives, medical staff, social workers, Women's Aid, the police service, and clinical psychologists. The agencies involved have a similar approach to any support they give which was considered key to ensuring the quality of help provided to any woman and her family in need.

It was crucial to involve women prior to establishing this initiative. Focus groups were used to discover women's thoughts and feelings about the introduction of routine enquiry during pregnancy. There was positive feedback, with women welcoming the idea. The agencies were equally involved at all stages of planning and implementation. This included the development of policy, guidelines and documentation, establishing a pilot, monitoring evaluation of the pilot and fully implementing the initiative.

Training

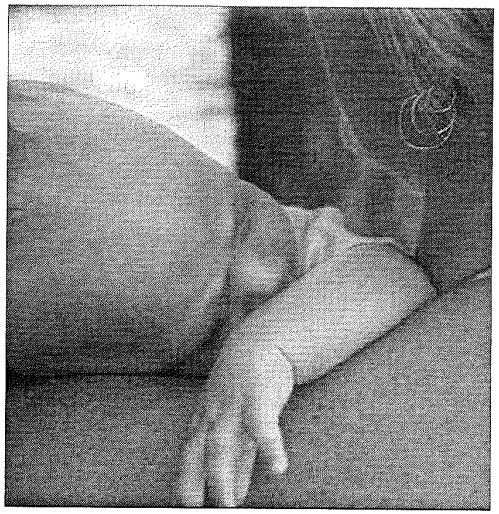
Asking women questions about such a sensitive issue is not easy. It was important to support midwives with some training and so build their confidence and dispel any anxieties about addressing the idea of domestic abuse. Awareness sessions were provided for all staff, with midwives receiving more in-depth training from colleagues, the Women's Aid organisation, the police service and social services.

What happens today?

The initiative was implemented in April 2005. All women are asked routinely at their booking visit and again in the postnatal period. Accurate and confidential documentation systems are in place ensuring safety for the women and the information can be accessed if any woman later wishes to pursue a legal case against the perpetrator. Interpreting services are available, as are robust referral systems for social services, Women's Aid and a clinical psychologist.

Is it working?

Initial evaluation does reveal some disclosures. However, the educational value to women and the impact of raising awareness and reducing the stigma of domestic abuse gives a clear message that abuse is unacceptable. Equally, a healthy alliance has been created between several agencies which can only influence the promotion of health and well-being of the women and families in our care.



Going that extra mile brings an unexpected reward!

Baby Lifeline is a UK charitable organisation which gives parents the opportunity to nominate for an award a maternity hospital of their choice which, in their opinion, has gone beyond the call of duty in helping and supporting them through a difficult period in their lives.

The award is called the MUM award (Maternity Unit Miracles) and this year the Royal-Jubilee Maternity Service was kindly nominated by Mrs Bernice Jordan. To the delight of our staff the nomination won the overall category for Northern Ireland!

Bernice's pregnancy didn't go smoothly: she suffered from pre eclampsia and required hospitalisation before going on to deliver little Alicia eight weeks prematurely. Alicia, as well as having respiratory problems, was diagnosed with Downs Syndrome. This was a difficult period for the whole family, but in Bernice's words she felt 'the staff were brilliant', 'that she became part of a family' and that 'Alicia was in good hands.' This was high praise indeed, and a great boost for staff morale.

A salubrious awards ceremony was held in Coventry. Hosted by television presenters Nick Owen and Emma Forbes, Alicia, Bernice and John Jordan attended as well as representatives from the medical, nursing and midwifery staff of The Royal Maternity Hospital. Our award is proudly displayed in the hospital's meeting room and the television and video which was also presented, enhances the delivery suite rest room. All the staff are delighted at this unexpected recognition of their efforts and caring approach and are happy to see Alicia doing so well.

improving year by year

Working towards real health for all

The Royal Hospitals has a regional role as the centre for many of the specialisms available today in Northern Ireland. We also have a local community to serve and work with and as such we are committed to the promotion of equality and good relations among the people on our doorstep.

Staff training and patient services

During 2004/2005, over 700 of our staff received training on equal opportunities, equality and diversity. The training included information on how to use interpreters, on cultural diversity, disability awareness, and a range of service and employment issues. So key is the training on how we work together as colleagues and how we treat every patient without distinction, that the sessions have been mainstreamed into our in-house training manual to which all staff have access.

Interpreting services

Northern Ireland is attracting more and more overseas visitors who wish to make this part of the world their home. This is reflected in the different patients attending our four hospitals. During the year our staff communicated with patients in over twenty different languages using interpreting services. Over 700 interpreting sessions took place, using both face-to-face and telephone interpreters – the most commonly requested languages being Mandarin and Cantonese. Our staff also communicated with patients and carers using sign language interpreters.

Good relations

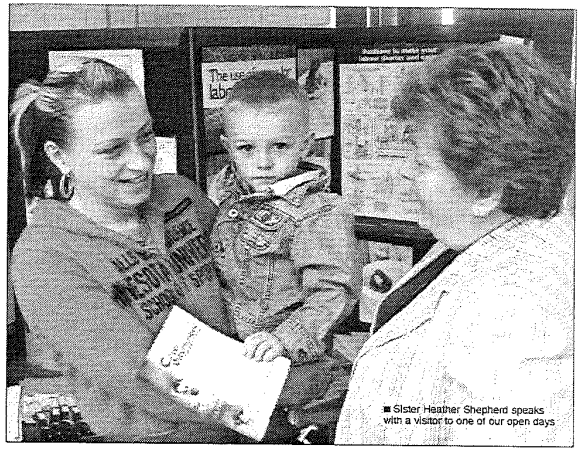
During the year, Royal Hospitals staff have contributed to initiatives promoting good relations in partnership with trade unions and community groups. This has included giving talks at events in the Department of Health, the Eastern Health & Social Services Board, and Belfast City Council. More locally, staff have given talks in schools, community centres and women's groups. Local communities have taken an active role in tackling racism in the west Belfast area and have held a conference to highlight this problem. Members of our staff ran a workshop to dispel myths about overseas staff entitled *Overseas staff at the Royal – Facts and Fiction*. This workshop was very well received and has lead to further partnership work on racism with local communities.

The Royal Hospitals has benefited from being part of the City Bridges Trade Union Good Relations project. This has facilitated partnerships between the Royal and Letterkenny General Hospital with exchange visits to discuss good relations issues. The Royal has also had partnerships with Beaumont Hospital, Dublin, Mayo General Hospital and Bradford Royal Infirmary, with equality and good relations as themes. We are a member of the Eastern Area Best Practice Sub-Group on Good Relations and meets with partners to discuss this particular issue including Community Relations Council, Counteract and Trademark.

Community outreach programmes

A cross-community play project involving staff, children and parents from two childcare centres and two schools was completed during the year. Staff from the two centres came together on the Royal site for an eight-week training course on how to develop skills in therapeutic play. Visits to the Royal were included in the project for community staff and parents. Over two-thirds of participants stated in evaluation that doing the course with staff from another community centre was beneficial. The project was Highly Commended for excellence in Corporate Social Responsibility at the *Belfast Telegraph* Business Awards and was Commended in the Business in the Community Healthly Communities Award.

During May 2005, the Royal Hospitals organised two information days in the Sandy Row and Donegall Road areas. Called 'A Royal Reception' the days were held in partnership with Belfast City Council Community Development Workers and South Belfast Highway to Health. The aim of the events was to introduce services and employment opportunities at the Royal to people who may not have been aware of them. Staff from the Royal-Jubilee Maternity Service, our play department, health promotion office and our equal opportunities department held information workshops. Around fifty people attended the days and in evaluation forms, 86% of respondents said that their outlook on the Royal was more positive because of the day and two thirds said they would consider applying for employment with us.



■ Sister Heather Shepherd speaks with a visitor to one of our open days

Traveller health outreach

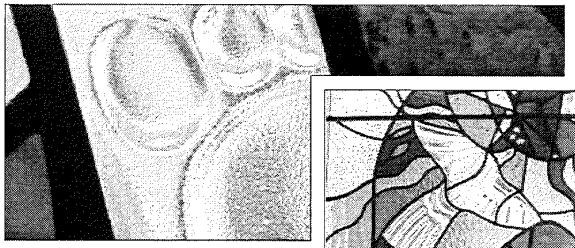
A three year project funded by the Department of Social Development is underway with the aim of improving the health of the Irish Traveller community. This project breaks new ground with a partnership between the Royal and An Munia Tober, the support group for Irish Travellers in Greater Belfast.

Aiming to improve Traveller access to mainstream health services and to raise the awareness of staff in how best to meet Traavellers' health needs, the project includes an accredited course for eight Traveller women and includes visits to the Royal to allow a two-way exchange of information between Travellers and hospital staff. Likewise, staff have undertaken training on Traveller culture. A Traveller Health Perception study was carried out to assess the health needs and views of the Traveller community and a staff survey was conducted to identify training and information needs. Feedback on this strand has been very positive from both staff and Traveller participants and aims to improve relations between Travellers and the Royal.

We have had extensive contact with Travellers over the years particularly in A&E and the Children's Hospital. Travellers have often presented with serious conditions that could have been treated earlier. This project aims to look at both health staff and Travellers needs to ensure more effective and appropriate use of services. By end of June 2005, twelve health workshops had been delivered. Topics included: men's health; depression; physical activity; cancer; bereavement; domestic violence; breastfeeding; nutrition; diabetes; stress; dental health; continence and home safety. By sharing information on a two-way basis it is hoped that Travellers health will, in the long term, improve and resources will be saved by earlier interventions.

We will play our part in developing a better society by promoting equality of opportunity, protecting human rights, targeting social need and fostering good community relations

Consent: respecting the rights of patients and relatives



From 1 April 2004 the Royal implemented new forms for patient consent. This allowed staff an opportunity to undertake additional training to meet professional responsibilities in the consent process and so ensure that patients' rights of autonomy in decision making are respected. Staff became aware that getting a signature on a form does not in itself prove that consent is valid, but that the process of consent involves the sharing of information, free from pressure, is essential for patents making decisions about their treatment and care. Ongoing training for consent and communication skills will be provided for staff involved in getting patient consent.

Human Tissue Act 2004

On 15 November 2004 Parliament passed the Human Tissue Act which comes into effect from April 2006. In a series of schedules the Act sets out the purposes needing informed consent for surgical and post mortem tissue and places strict controls on the removal, storage and use of tissue with criminal sanctions for breaches of the Act. The new standards will be regulated through the Human Tissue Authority with the codes of practice issued for consultation in July 2005. Those wishing to comment should do so at: www.hta.gov.uk

Royal Hospitals staff have been working alongside the Department of Health in preparing for the implementation of the Human Tissue Act through the development of a code of good practice for the service, in improving arrangements for consent, and in standardising information for relatives. These were widely consulted upon before being issued to the service.

Consent for post mortem examination

From 1 September 2005 new consent forms and information for relatives will be used by The Royal Hospitals, in line with the Department of Health's A Code of Good Practice which identifies the arrangements for bereavement care, consent for post mortem examination, and standards for the management of post mortem examinations.

Asking for consent for a post mortem examination is never easy and doctors will usually only do so when there are unanswered questions about the patient's condition or treatment that can help the better understanding of the family and the clinical team. With the new forms different choices can be made by those giving consent. A patient may give consent in advance or nominate an individual to give consent on their behalf; otherwise the next of kin will be responsible for giving consent.

The new forms are set out in such a way as to ensure that relatives know clearly what is involved – that they have the choice of a full or limited post mortem examination, with an understanding of the effect of the limitations. There is an opportunity to consent for the use of tissue for research and education which may be invaluable for understanding diseases and their management. Relatives also have a choice about the return of residual tissue, tissue blocks and slides which are usually retained as part of the patient's clinical record.

Improvements

These improvements in consent for examination, treatment and care and now in post mortem examination are essential for patients and relatives to have confidence that their rights are respected within our hospitals and in providing staff with training in understanding their role in protecting such rights.

Human Tissue – a statement of account for 2004/05

The Royal Hospitals, through Belfast Link Laboratories, provides the regional paediatric and neuropathology post mortem services, and adult post mortem service for Belfast City Hospital, Mater Hospital, and Ulster Hospital as well as for Royal Hospitals patients. The largest part of the work of the department is for surgical and cytopathology services. These are inspected annually and a report produced which is quality assured by an External Reference Group before being signed off by The Royal Hospitals Trust Board.

In the year 2004/05 over 31,000 surgical biopsies were undertaken in pathology, with 27 hospital post mortem examinations of adults (out of 690 adult patients who died) and 4 hospital post mortems of children (of 109 children aged under 18 years of age who died) and 202 post mortem examinations of stillbirths, pre-term and early pregnancy losses. An audit showed that during 2004/05 all these hospital post mortem examinations were undertaken with the informed, written consent of relatives.

During 2004/05 the Royal received 112 new enquiries from relatives about past post mortems, with human tissue returned to 22 families. Two complaints were received in the year both of which are resolved.

A wide range of training is available for staff on bereavement care, consent, post mortem examination and communication skills which is recognised as essential to ensuring the best care of patients and their relatives during this difficult time.

Following last year's *Annual Report on the Management of Human Tissue* a number of recommendations were identified for action. Most of these are either now complete or in the process of being completed. From the 2004/05 inspection additional recommendations were made for implementation by The Royal Hospitals and Belfast Link Laboratories. These will be taken forward by during 2005/06.

The External Reference Group, in their review of the *Annual Report* commended The Royal Hospitals', 'continued commitment to an open and transparent approach to the management of this issue as well as acknowledging and supporting the list of recommendations, and associated actions identified in the report. The Royal Hospitals Human Organs External Reference Group commends the 2004/05 annual statement of account on the management of human tissue without qualification to the Trust Board of Directors.'

■ The memorial window in Belfast City Hall, dedicated to the families of relatives whose tissue was retained without consent by hospitals in Northern Ireland

improving year by year

Protecting patients, visitors and staff from violence

A partnership of care

Hospitals are dangerous places – patients arrive with infections and injuries and are prescribed treatments and drugs that can be harmful if used incorrectly. Everything we do in hospital is an attempt to heal those hurts and to minimize risks to patients, visitors and staff. The responsibilities for care and decision making are shared between clinical staff, patients and, where appropriate, other family members. It is a precious relationship based on trust, mutual respect and understanding.

Twenty-first century risks

Like hospitals across Northern Ireland, one of the rising risks today is the risk of violence from visitors to our site and occasionally from patients. Being the victim or a witness to verbal or physical violence is a frightening experience for patients and staff. The effects can be felt long after the event and have a serious impact on a patient's recovery from illness or injury. For staff, who can often be the target of violent behaviour, this can create a loss of confidence, increased anxiety, and in a number of cases a wish to leave the service. These are disappointing effects of a preventable risk.

Patients who behave violently

It is recognised that for some patients their violent behaviour is caused by their clinical condition or as a side effect of their treatment. There is no doubt that in such cases staff in the hospital have a continuing duty of care for the patient. In practice, this means that we have to exercise our duty to 'do no harm' while also 'doing good' by protecting the other patients and staff for whom we also have a duty of care. Careful arrangements have had to be put in place to ensure the safety of patients and staff, with training and policies developed to respond to this behaviour in a proportional and safe way.

Patient responsibilities

For those patients who behave violently, where it is reasonable to expect that they should not do so, the same duty of care of doing no harm still exists but the patient also has responsibilities for how they behave. In exercising their right to autonomy and self-determination a patient has responsibilities to make choices and take the consequences of those choices. In practice, this means that in behaving violently they have failed their side of the partnership of care and the hospital no longer has an obligation to continue to treat them. In such cases patients can be refused treatment, be discharged from the wards and, in the most extreme cases, be prosecuted for their behaviour. These actions are necessary for the protection of other patients and staff who may be at risk and to enable future patients to feel a sense of confidence about their treatment within the Royal and for us to be an attractive employer of staff.

Visitors who behave violently

Verbal and physical violence from visitors is never acceptable but sadly has occurred on numerous occasions during the past year. We would wish to work with others in highlighting the issue and finding ways of reducing this unacceptable behaviour. We do not believe such behaviour should be tolerated and we are determined to deal with this in a rigorous manner to keep all our visitors, patients and staff safe from physical and psychological harm.

Ultrasound key in trauma diagnosis

The acquisition of a portable ultrasound scanner for the A&E department in the Royal Victoria Hospital has been an important addition to our service. It is a useful aid in diagnosing or ruling out, in a patient suffering major trauma, the presence of free fluid within the abdominal cavity.

In patients who, as a result of injury, are shocked and hypotensive, it is very important to find out if they are bleeding internally. The best way to do this is with a CT scan but this is a dangerous thing to do on a very unstable patient, as it involves time and taking the patient to another department. The other technique previously used is an invasive and inconsistent procedure. Using ultrasound, we can use a technique called FAST – Focussed Abdominal Sonography in Trauma – which allows us to say pretty accurately whether or not there has been any significant bleeding inside the abdomen. We do not try to go any further than this, in terms of a definitive diagnosis, but we have found it to be effective and accurate.

This is a big help in deciding on the priorities in managing patients with multiple, severe injuries, where it is important to make rapid, accurate decisions about their immediate care.

Child protection is everyone's business

Unfortunately, not all children live safely in an environment that promotes their welfare and protects them from harm. In line with the four health boards the Royal has a multi-disciplinary child protection committee whose main concern is to ensure the welfare of the child is protected at all times within our hospitals. We also have two designated professionals – Brenda Creaney, directorate manager and principal nurse for the Children's Hospital and paediatrician Dr Andrew Thompson, both of whom advise on all areas of child protection matters accross the Royal, they ensure our staff are appropriately trained and that our internal policies are closely monitored so that our practise mirrors government legislation.

The Royal has always had the welfare of children at the forefront of its development. Our Children's Hospital is the only designated hospital for children in Northern Ireland and has available the very latest in technology. Our newly-named professionals in child protection are a further testament to our commitment to the welfare of children in Northern Ireland.

Welcoming face eases hospital admittance

A stay in hospital – whether it is for the most minor or major procedure – can be daunting for many people. At the Royal, we understand this and are piloting a new programme that looks to put people at ease when they come into our care.

The new liaison post – called the ward housekeeper – was introduced last year to deliver a welcoming and healing environment for our patients. The scheme was launched by staff in our cardiac care wards to ensure that patients' time in hospital is as comfortable as it possibly can be.

After just six months, the scheme quickly gained success. And it is clear that having a familiar face for patients to talk to as well as someone working behind the scenes to coordinate staff involved in their care is making a big difference.

Patients tell us that they feel extremely satisfied with their overall care and particularly like being personally met on arrival as well as having assistance with ordering meals.

Staff also applaud the scheme and feel that improved coordination benefits the ward environment and the patient experience. Work is ongoing to determine whether the scheme should be introduced in other areas in the hospital.

We will be open and trustworthy in our dealings with patients, the community and each other

CR - INQ

Did you know in the financial year 2004/05...

We used enough concrete in our building programme to cover a depth of 6 inches over 3 full size football pitches

We used an amount of steel equivilent to building 600 family saloon cars

If we joined together all the data and wiring cables used in our building programme last year they would stretch from Belfast to Paris and back

We spent £1million on security over the year

Our drugs and dressings bill was more than £18million compared to £5million five years ago

Treatment at our adult A&E department costs on average £79 per attendance

We spent approximately £385,000 on medical gloves

The average cost of a laboratory test is £7.70, but this ranges from a few pence to hundreds of pounds

Summary Financial Statements

These Summary Financial Statements have been extracted from the full Financial Statements which have been reported on by the Auditors and which have been submitted to the Department of Health, Social Services and Public Safety. The Auditors' Report on the full Financial Statements is unqualified. These Summary Financial Statements do not contain sufficient information for a full understanding of the activities, performance, results, and state of affairs of the Trust. For further information the full Accounts and Annual Report and Auditors Report for the year ended 31 March 2005 should be consulted. Copies of the full Accounts are available, from TSO Ireland, 16 Arthur Street, Belfast, BT1 4GD, Northern Ireland.

The Royal Group of Hospitals and Dental Hospital HSS Trust

Statement of the Comptroller and Auditor General to the House of Commons and the Northern Ireland Assembly

I have examined the summary financial statement of The Royal Group of Hospitals and Dental Hospital HSS Trust.

Respective responsibilities of Board Members and Chief Executive and the Auditor

The summary financial statement is the responsibility of the Board Members and Chief Executive.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the full financial statements, and its compliance with the relevant requirements of The Health and Personal Social Services (Northern Ireland) Order 1972 and Department of Health, Social Services and Public Safety directions made thereunder. I also read the other information contained in the Annual Report, and consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the summary financial statement.

Basis of Opinion

I conducted my work in accordance with Bulletin 1999/6 'The auditors' statement on the summary financial statement' issued by the Auditing Practices Board for use in the United Kingdom.

Opinion

In my opinion the summary financial statement is consistent with the full financial statements of The Royal Group of Hospitals and Dental Hospital HSS Trust for the year ended 31 March 2005 and complies with the applicable requirements of the Health and Personal Social Services (Northern Ireland) Order 1972 and Department of Health, Social Services and Public Safety directions made thereunder.

Northern Ireland Audit Office
106 University Street
Belfast BT 7 1EU

J M Dowdall CB
Comptroller and Auditor General
7 September 2005

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL HSS TRUST
INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2005

	2005 £000	2004 £000
Income from Activities	230,066	209,190
Other Operating Income	56,008	54,309
	286,074	263,499
Operating Expenses	(278,782)	(259,923)
OPERATING SURPLUS	7,292	3,576
Profit / (Loss) on disposal of Fixed Assets	(200)	0
SURPLUS BEFORE INTEREST	7,092	3,576
Interest Receivable	507	350
Interest Payable	(2,020)	(2,180)
SURPLUS FOR THE FINANCIAL YEAR	5,579	1,746
Public Dividend Capital		
Dividends Payable	(5,462)	(1,716)
OPERATING SURPLUS BEFORE PROVISIONS	117	30
Provisions for Future Obligations	277	586
RETAINED SURPLUS FOR THE FINANCIAL YEAR	394	616
OPERATING SURPLUS FOR THE FINANCIAL YEAR BEFORE PROVISIONS	117	30

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL HSS TRUST
BALANCE SHEET AS AT 31 MARCH 2005

	2005 £000	£000	2004 £000	£000
FIXED ASSETS				
Tangible assets		250,634		221,947
CURRENT ASSETS				
Stocks and work in progress	4,198		3,647	
Debtors: Amounts falling due				
Within one year	22,941		19,587	
After one year	5,207		5,467	
Short-term investments	2,613		641	
Cash at bank and in hand	247	35,206	234	29,576
CREDITORS:				
Amounts falling due within one year		(46,956)		(37,442)
NET CURRENT LIABILITIES		(11,750)		(7,866)
TOTAL ASSETS LESS CURRENT LIABILITIES		238,884		214,081
CREDITORS: Amounts falling due After one year		(21,327)		(23,033)
Provisions for Liabilities and Charges		(14,144)		(13,508)
TOTAL ASSETS EMPLOYED		203,413		177,540
FINANCED BY: CAPITAL AND RESERVES				
Public dividend capital		113,684		109,818
Revaluation reserve		84,440		63,577
Donation reserve		7,315		7,215
Income and expenditure reserve		(2,026)		(3,070)
		203,413		177,540

improving year by year

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL HSS TRUST
CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2005

	2005 £000	£000	2004 £000	£000
Net Cash Inflow from Operating Activities		27,452		20,483
Returns on Investments and Servicing of Finance				
Interest received	493		354	
Interest paid	(2,038)		(2,181)	
Net Cash Outflow from Returns on Investments and Servicing of Finance		(1,545)		(1,827)
Capital Expenditure				
Payments to acquire fixed assets	(21,427)		(18,176)	
Net Cash Outflow from Capital Expenditure		(21,427)		(18,176)
Dividends Paid		(1,716)		(9,320)
Management of Liquid Resources				
Purchase of current asset investments	(1,972)		0	
Sale of current asset investments	0		2,334	
Net Cash Outflow from Management of Liquid Resources		(1,972)		2,334
Net Cash Outflow before Financing		792		(6,506)
Financing				
New public dividend capital	4,627		8,778	
Repayment of loans - Government	(1,706)		(1,706)	
Repayment of loans - Others	0		(54)	
Repayment of Public Dividend Capital	(3,700)		(1,034)	
Net Cash Inflow (outflow) from Financing		(779)		5,984
Increase / (Decrease) in Cash		13		(522)

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL HSS TRUST
STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 MARCH 2005

	2005 £000	£000	2004 £000	£000
Surplus for the financial year	5,579		1,746	
Provisions for Future Obligations	277		586	
		5,856		2,332
Fixed Asset impairment losses		(0)		(3,700)
Non-Donated Fixed Assets				
Indexation of fixed assets	14,072		15,775	
Unrealised Surplus on revaluation of Fixed Assets	7,242		4,382	
		21,314		20,157
Donated Assets				
Additions to donated assets	366		343	
Changes to Donation Reserve (except transfers to realised donation reserve)	0		(355)	
		366		(112)
Total Gains recognised in the financial year		27,536		18,677
Total recognised gains / losses) for the year (as above)		27,536		18,677
Prior year adjustments (note 1j) (Note 28)		0		615
Total gains and losses recognised since last annual report		27,536		19,292

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL HSS TRUST
ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2005

Senior Employees' Remuneration

Name	Salary, Including Performance Pay £000's	Benefits in Kind (rounded to nearest £100) £000's	Real Increase in Pension and related lump sum at age 60 £000's	Total accrued pension at age 60 and related lump sum £000's	* CETV at 31/3/04 £000's	CETV at 31/3/05 £000's	Real Increase in CETV £000's
W McKee	105-110	2.5 - 5.0	10.5-12.5	145-150	570-575	635-640	25-30
H McCaughey	70-75	0-2.5	5.0-7.5	65-70	180-185	205-210	5-10
W Galbraith	65-70	0.0	5.0-7.5	25-30	60-65	75-80	5-10
M McBride	105-110	0.0	5.0-7.5	95-100	270-275	295-300	0-5
D O'Brien	60-65	0.0	5.0-7.5	55-60	240-245	265-270	15-20
M Mallon	60-65	2.5-5.0	5.0-7.5	90-95	300-305	330-335	10-15
C Burns	60-65	0-2.5	2.5-5.0	45-50	170-175	195-200	10-15
E Bates	50-55	0-2.5	2.5-5.0	45-50	165-170	180-185	5-10
D Stockman	45-50	0.0	0-2.5	20-25	55-60	65-70	0-5

"As Non Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members. A Cash Equivalent Transfer Value (CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-2005 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HPSS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within guidelines and framework prescribed by the Institute and Faculty of Actuaries

"Real Increase in CETV - This reflects the increase in CETV funded by the employee and the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period."

Trust Management Costs

	2005 £000	2004 £000
Trust Management Costs	10,407	9,721
Total Income	286,074	263,499
% of total income	3.64%	3.69%

The above information is based on the Audit Commission's definition of "M2" Trust management costs, as detailed in HSS (THR) 2/99 .

Related Party Transactions

During the year, none of the board members, members of the key management staff or other related parties has undertaken any material transactions with the Royal Group of Hospitals and Dental Hospital HSS Trust.

Public Sector Payment Policy - Measure of Compliance

The Department requires that Trusts pay their non HPSS trade creditors in accordance with the CBI Prompt Payment Code and Government Accounting Rules. The Trust's payment policy is consistent with the CBI prompt payment codes and Government Accounting rules and its measure of compliance is:

	2005 Number	£000	2004 Number	£000
*Total bills paid 2004/2005	114,697	105,512	104,302	92,661
*Total bills paid within 30 day target	99,971	91,377	78,852	72,276
% of bills paid within 30 day target	87.2%	86.6%	75.6%	78.0%

Bills paid within 30 days or under other agreed payment terms with the Trust.

The Late Payment of Commercial Debts Regulations 2002

The amounts included within Interest Payable arising from claims made by small businesses under this legislation are as follows.

	2004 £000
	2
Total	2

*The HPSS pension scheme is a contributory scheme in which employees make a contribution of 6% of their monthly salary.

We will develop appropriate financial and accountability systems which will support the delivery of services

302-096-011

Trade union partnership working

■ Successful NVQ graduates enjoy the success of their achievements

This past year our staff side trade unions have channelled much of their time and energy into helping to roll out Agenda for Change and all that it entails. To this end, the trade unions have a team of representatives who work in partnership with Royal Hospitals management to keep the process on track.

For trade unions on the Royal site there are many other areas where they are continually striving to make a difference to the workplace, as well as delivering improved services for patients and visitors.

These include highlighting training and development needs for staff, consulting on policy changes which affect how services are delivered, and participating in the various committees and sub-groups which help to highlight and implement change. For example, trade unions assist in improving access to services for staff and patients, help update equal opportunities policies which improve the work life balance of staff, and, continue to promote equality of opportunity for all staff. Through processes such as Investors in People they help to ensure that the contribution staff make to the organisation is recognised and valued.

The trade unions and the Royal have formed a partnership with Beaumont Hospital, Dublin. This group meets regularly and has already set up a joint partnership management development course for staff. The primary aim of this course is to identify areas across different professions where best practice could be identified and subsequently developed in either the Beaumont or Royal hospitals.

Our next project aims to look at issues which give rise to high rates of absenteeism with a view to addressing some concerns and in turn, learning from each other's experience.

The Royal Hospitals' management and staff side have always recognised that to have good partnership arrangements there needs to be effective communication and consultation structures in place. These are continually being developed and in the future should provide benefits from our sharing of resources and efforts made to address issues common to both sides.

Recruiting and training the workforce for the 21st century

The Royal Hospitals employs 1% of the total workforce in Northern Ireland and 10% of the health service workforce. As an Investor in People we place great value on our 6800 staff. We are regarded as a high performing organisation, and a key factor to this success is long-term investment and commitment to all our staff and to clinical leadership. We rely heavily on a community of leaders, many from a clinical background. We also have a strong track record of working in partnership with trade unions as well as the Department of Health, other hospitals and local community organisations.

Appraisal is another key element and we have continued to review our mechanisms to ensure all staff receive regular feedback and identify their development needs. This work has complemented our plans to implement the knowledge and skills framework which is a part of the new Agenda for Change pay system, through which we will ensure all staff have a personal development plan. We continue to take account of what our staff have to say to us through our annual staff survey and act on its outcomes. Our annual Big Day Out is an opportunity for staff and their families to relax and enjoy a day out with their colleagues.

Pay modernisation

During the last twelve months the human resources directorate has lead and contributed to the continuing implementation of the national pay reform initiatives including Agenda for Change, the new Consultants' Contract, and the Junior Doctors New Deal. These programmes are seeking to modernise the delivery of services and to provide better ways of working. There will be opportunities for staff to work differently and to work across the traditional professional boundaries to deliver modern services.

This is an exciting time. These programmes are the first major change to the terms and conditions of hospital staff since the inception of the health service in 1948. As such, both implementation, which is taking place simultaneously across the UK, and realising the expected benefits from the various programmes, is likely to take place over a number of years.

Equal opportunities

We are an equal opportunities employer and overall, our workforce reflects broadly the community mix in Northern Ireland. We employ more than 200 nurses from the Philippines who have integrated well and are valued members of staff. We encourage recruitment applications from under-represented groups. In particular staff groupings where the certain sectors of the community are under-represented a detailed programme of affirmative action is underway. Our staff have participated in a number of workshops, school visits, careers forums, job fairs and various other initiatives aimed at improving the employability potential of the organisation.

Also within the organisation a number of training sessions have been held aimed at ensuring our staff are aware of their responsibilities in recognising and valuing the diversity of both their colleagues and the public we care for.

Delivering our services

Last year, excluding Junior Doctor rotational training positions, there were a total of 487 jobs advertised for which a total of 1494 appointments were made from the 6454 applicants. Staff turnover fell during the last year, with a figure of 6.35% being recorded for our nursing workforce. This has enabled services to be maintained in areas where previously workforce shortages created difficulties in delivering services. We look forward to realising the benefits of the various pay modernisation programmes which aim to improve our recruitment and retention potential.

Staff training

We encourage all staff to avail of the courses we facilitate to ensure they meet the objectives of the hospitals and to fulfil their personal potential. Every newly employed member of staff attends a corporate induction session where they learn more about the wider organisation and can better understand the service we provide for our patients and the role each of us has in delivering that care. We recognise success in learning through an annual Recognising Achievement event where staff who have gained qualifications, or those who have gone that extra mile, are rewarded for their successes.

In respect of internal staff training, over 2,700 staff participated in training events. The courses attended ranged from induction courses, computer skills training, to team development sessions, all of which were made available through our *Learning for Excellence* training brochure.

Our learning and development strategy is consistently revised. It identifies key issues for us in the years ahead which will help us to ensure that our staff are trained and developed appropriately in order to deliver our key goals and provide the best possible service.

improving year by year

Nursing – recruiting and retaining the best

In recent years there has been a shortage of registered nurses in Northern Ireland. This situation is not unique and is also apparent in England, the United States and the Republic of Ireland.

Belfast hospitals have been particularly affected by the shortage and at the Royal we have worked hard at finding creative ways to attract and retain our nurses. Our retention rates have fallen steadily over the last three years and we are very pleased that we are able to attract so many of the new graduate nurses from our local universities as well as more experienced staff and return-to-practice nurses. Our overseas recruitment has been extremely successful with over 220 overseas staff currently working in the organisation. Many of the overseas nurses are so happy here they have renewed their contracts and some have applied for permanent residency.

Student nurse experiences

Our nursing executive is committed to providing a positive experience for every student nurse. There are approximately 200 student nurses with us at any one time and welcome and feedback meetings are held during which the students are encouraged to give constructive feedback about their time with us. With the student's permission any action which is required can be taken forward in a particular area with the individual lead nurse to enhance the experience of the next student.

Every student has a mentor within the ward or department where they are working. This is essential to making the student's experience more positive and many trainee nurses are impressed by the patience, knowledge and skills of their mentors. We firmly believe that nursing students are our future and investing in their future is key to the success of nursing in the Royal.

Professional development

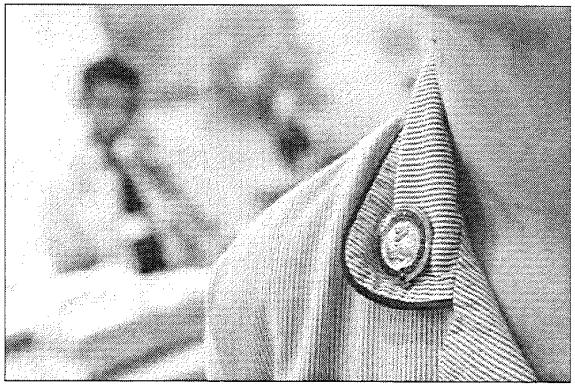
Recruiting staff is only half of the equation. Retaining and valuing the expertise, professionalism and diversity of our workforce is just as important. We are leading the way with regards to encouraging continuous professional development and in finding ways to support nurses who want to learn from their practice. Our approach is built on supporting reflective practice among nurses which helps to create a culture where nurses feel valued, are keen to learn and who will go on to become the nursing leaders of the future. There are over 1000 nurses within the Royal who are currently engaged in developing their practice in this way and whose work will positively impact on their patients. The REACH project, which provides a clinical career framework for nurses, has been one of our major successes and underpins all of this work.

Retaining our nurses

The recruitment and retention committee works hard to ensure that opportunities to recruit and retain staff are maximised. The group drives all the recruitment campaigns and open days, and each event is meticulously planned to achieve maximum results. This year alone over two hundred students have applied for posts at the Royal.

Our recruitment and retention success is due to the participation and enthusiasm of all nursing staff. Everyone has a role to play from mentors to administrators to professional developers. This is the future of nursing and we are buoyed to see the future is bright at the Royal.

Research and innovation are keys to successful healthcare



The presence of a vibrant and successful research environment is central to the mission of The Royal Hospitals. As a major teaching hospital complex, it is important that there is an extensive research culture which underpins clinical activity throughout the site. It is vital to make sure that all staff within the four hospitals are aware of the value of research, and have an opportunity to bring forward research projects. The staff of the Royal Research Office organise research training and guide staff to ensure that research is done in the most effective way.

At present, over 470 research projects are taking place within the hospitals complex. All research projects are approved by the Royal Research Office and an independent external research ethics committee, and no patient or member of staff takes part in research without giving their informed consent. A very wide range of research projects are in progress, from large national studies through to focussed projects designed to examine the process of patient care within the hospitals. Each research project has one thing in common – they are being undertaken for the benefit of patients and each one aims to ensure that the highest standards of care are maintained throughout our hospitals.

One example of an important and large-scale research project based in the Royal is the Diabetes and Pre-eclampsia Intervention Trial (DAPIT), led by Dr David McCance and Professor Ian Young. This is a major UK study devised and developed by Royal staff and is addressing the question of whether giving mothers who have diabetes high doses of vitamin C and vitamin E during their pregnancies can prevent high blood pressure and pre-eclampsia. A number of other UK hospitals are taking part and send information to the Royal for analysis. The study is funded by a major UK charity, The Wellcome Trust, and will last for five years. If the study shows that vitamins are beneficial, then this will change the treatment of pregnant women with diabetes throughout the world.

At the other end of the research spectrum, there are a number of small studies throughout the hospitals which are assessing local aspects of patient care. For instance, one current study developed and led by nursing staff is looking at how patients are transferred from the high dependency unit to the wards. By conducting interviews with nursing staff and asking them to identify problems and suggest solutions, it should be possible to improve the handover process and therefore patient care.

The emphasis on research within the Royal brings a number of important benefits. Patients can receive the most up-to-date and effective treatments, which are often introduced as part of clinical trials; the presence of a strong research culture within the hospitals ensures that the best staff are attracted to work in the Royal; this also ensures that the reputation of the Royal as one of the UK's best hospitals is maintained both nationally and internationally.

We will recruit and retain the highest caliber staff ... and ... promote research, an ethos of thoughtful enquiry and creative action

Managing energy

Just as food is the energy source that drives the human engine, so electricity, gas and oil provide the energy to drive the engine of the Royal. Without it, our four hospitals would not be able to operate yet most of us take this power supply for granted.

Beneath our feet are labyrinths of ducts and a complex network of pipes and cables delivering energy to every corner of this vast site. Water too, rushes into the site at the rate of up to five gallons every second.

By the end of this year, and to ensure we can continue to provide our services in the event of a power failure, there will be 17 emergency electricity generators on site, fuelled by oil, and to provide us with steam and hot water, 15 boilers fuelled by natural gas – the main boilers having oil as a back-up.

Managing an insatiable appetite for energy

A hospital's health comes at a cost, both in terms of cash, commitment and its profound influence on the environment. Having recognised that a co-ordinated effort to conserve energy in the Health Service was needed, Government set targets back in 1990 that have changed our way of thinking ever since. By April 2000, the Royal's energy consumption, inclusive of the Broadway complex, had fallen by 22.35%. This represented a savings value at that time of £450,000 per annum.

Spending to save

To date, we have invested £1.75million solely in energy conservation schemes, ranging from simple draught proofing to sophisticated heating controls. As installation costs reduce, future consideration should be given to renewable solar energy which was previously not cost effective.

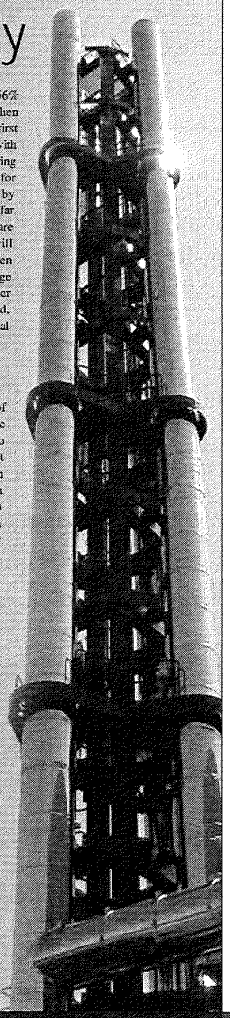
Reflections on water

Water consumption is 56% less than it was when conservation measures were first undertaken in 1991, and with minimal expenditure. Replacing our old pipe work would pay for itself in a short time by eliminating known but so far undetectable leakage. We are anticipating this subject will gain more prominence when proposed charges for sewage outflow, based on water consumption are introduced, potentially doubling our annual water bill to £500,000.

The outlook for energy conservation

With the prominence of global warming and the introduction of the Kyoto Agreement, Government emphasis has changed from setting energy conservation targets to reducing carbon dioxide (CO^2) emissions, with large penalties in place for any organisation not hitting these. Our CO^2 emissions are the lowest they have ever been, which paradoxically may make it challenging for us to meet the new targets! As fuel and electricity prices escalate and with a present energy and water budget approaching £3million per annum, the incentive to do better is even more urgent.

Each of us has a part to play in energy conservation. As an organisation we are committed to playing our part by efficiently managing our energy needs, avoiding unnecessary waste, and by pumping any costs averted back into patient care.



■ One of the many chimneys across the Royal site

Tackling waste

Reduce, reuse, recycle – that is what we, the Northern Ireland public, are being encouraged to do in our homes. The Royal is no different, though our waste generation is on a much larger scale!

In 2004–2005 the Royal produced in excess of 2500 tons of waste – a mixture of clinical, general office, and catering waste, as well as confidential material. Approximately one third of all of the waste produced by us was clinical, requiring specialist and additional treatment prior to its final disposal which costs up to twenty times the price to treat than conventional waste.

Laying the foundations

In order to formulate a sustainable waste management programme and to help us achieve our legislative goals we commissioned, in October 2004, a waste contractor to perform what is known as a waste characterisation study. The results indicated in detail what volume of waste we produce and in how many categories. Using the study we devised an informed plan of action and set up a steering group that would oversee this strategic and operational change.

By weight, cardboard was found to be the single largest household waste type generated within the Royal. It was therefore logical that any sustainable waste management solution would begin with cardboard and move onto the next largest category, which is paper, whilst also looking for opportunities to minimize our other bulk waste materials like plastics, glass and cans. We implemented a cardboard recycling scheme which now recovers over 10 tons of cardboard every month.

Getting it right

With every solution comes a small niggle to be ironed out. The biggest niggle facing us in recycling cardboard is flat-packing. If our departments do not flat-pack their old cardboard boxes and place them into the correct recycling bin, then both space and time are wasted. Clearly, recycling is also about educating ourselves and altering our habits. Once you get the hang of it, there's nothing to it! Our aim is to ensure that all of our staff become more involved in sustainable waste management. Once we get behind it, each of us can be assured that we are not only making a financial difference, but that we are positively impacting the environment.

Setting targets

Our first goal is to achieve between 5–10% recycling of non-clinical waste in 2005–06, thereafter rising annually to anticipate future changes in legislation. This modest target is necessary to ingrain recycling into the culture of this large organisation so that we have a clear strategy to achieve sustainable results in the future. To-date, we are achieving the year one target.

Recycling the future

We hope that future waste management schemes will include the introduction of an office paper recycling scheme, battery banks, and the recovery of waste electronic and electrical equipment. Our over-riding concern is to reduce the volume that we currently send to landfill sites and ultimately, to provide a high quality, cost effective service. While recycling does not attract much income, it reduces the cost of disposal and therefore provides opportunities to save money. It is also the most pro-active way to ensure we look after our site and our environment for future staff and patients.

improving year by year

Spotlight on Regional Fertility Centre

The Regional Fertility Centre, based in the Royal Maternity Hospital, provides a secondary care service to the residents of the Eastern Board and is also a regional specialist, tertiary centre.

The RFC's work is very heavily regulated by the Human Fertilisation and Embryology Authority (HFEA). This is the authority from whom our license to practice is granted. We are the only health service facility in Northern Ireland which is licensed by this Authority.

The legislation governing donating sperm has changed recently and this has had an impact on our patients. For some couples the only chance of conception is with the use of sperm donated by a third party. In the past it was possible for men across the UK to donate sperm anonymously. The law has now changed and from 1 April 2005 it is no longer possible for men to donate anonymously. Their details are registered with the HFEA so that any child born as a result of their sperm having been used in a treatment cycle, has the legal right to contact the donor when he or she reaches eighteen.

The loss of donor anonymity has had a devastating effect on the number of men donating sperm and has resulted in our being able to offer this treatment to a greatly reduced number of patients. The legislation also affects women wishing to donate eggs, and has had a similar effect. We are working with the Department of Health to raise awareness of the need for donated sperm and eggs, which we hope will result in an increase in the number of donors coming forward.

The biggest challenge for the next year is another legislative change, this time in the shape of the European Tissue and Cell Directive. From April 2007 all fertility centres in the European Union must comply with stringent new standards. The Directive will affect everything from the quality of air changes in the embryology laboratory to administrative systems. We are working closely with our colleagues in Belfast Link Labs who are advising us on how to meet the challenges we face in complying with the Directive.

Laser therapy to aid cancer patients

The Royal has acquired new laser facilities that will greatly aid the treatment of lung cancer and oesophageal cancer patients. A recently appointed consultant is a welcome addition to the team and his presence will increase the service we are able to provide.

The latest apparatus is called a Diode machine. It will not only allow us to treat cancer patients but will hopefully allow us to intervene at an earlier stage before the cancer has developed.

As with many cancers, doctors can help alleviate their patients' symptoms without necessarily being able to cure the disease. One example of where the new laser treatment will, we hope, be very effective, is with patients who suffer with cancer of the gullet. Swallowing is difficult with this type of cancer and YAG lasers are used to relieve these symptoms.

There are other proposed developments within the Royal to aid cancer patients including photodynamic therapy. This is proving an increasingly effective therapy for patients with cancer who cannot undergo curative surgery.

Cancer Challenge research fund

A large number of people with cancer are treated at the Royal. Our strategy group continues to meet regularly and a core group also meets with colleagues at Belfast City Hospital. Over the past year there has been an exciting number of developments in the provision of services to cancer patients and successful joint initiatives have been established with some of the local charities.

Macmillan Cancer Relief, who already generously support an active team of cancer nurses in the Royal, has set up a Benefits Advice Project to aid cancer patients with information and advice together with the Citizen's Advice Bureau. Macmillan has also initiated a project to provide an information and support services centre within the hospital and are resourcing a study to precisely delineate the necessary support required.

Action Cancer Northern Ireland has established a partnership with the Royal that will initiate a study into psychological support for cancer patients. Resources for such psychological support are normally difficult to obtain and the hospital is grateful to Action Cancer for their support.

In an increasingly difficult research environment the Royal is to launch The Royal Hospitals Cancer Challenge. This will be a fund that will help health professionals to initiate important cancer research projects. Totally dependent on voluntary donations we would like to acknowledge the considerable donations made by our cancer patients and their relatives in establishing this vital funding source for cancer research in The Royal Hospitals.

We will continue to look for a better environment by reducing waste ... and ... we will continue to develop cancer services

This annual report was produced by the Publications Unit of Corporate Communication, The Royal Hospitals. We welcome any comments you might have. Please send them to: The Publications Manager, Corporate Communication, The Royal Hospitals, Grosvenor Road, Belfast BT12 6BA. Or email: publications.manager@royalhospitals.n-i.nhs.uk