Royal United Hospitals Bath
NHS Foundation Trust

Quality Accounts
2019-2020

Royal United Hospitals Bath NHS Foundation Trust

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Contents

List of abbreviations

A	ACE OPU	Assessment and Comprehensive Evaluation Older Person's Unit
	ACS	Acute Coronary Syndrome
	AKI	Acute Kidney Injury
	AHSN	Academic Health Science Network
	ANNP	Advanced Neonatal Nurse Practitioners
	AMU	Alongside Midwifery Unit
B	BANES	Bath and North East Somerset
	BAPM	British Association of Perinatal Medicine
	BAUS	British Association of Urological Surgeons
	BBC	Bath Birthing Centre
	BIS	Bath Improvement System
	BSW	BaNES, Swindon and Wiltshire
C	CAP	Community Acquired Pneumonia
	CCG	Clinical Commissioning Group
	cDMARD	Conversational Disease Modifying Anti- Rheumatic Drugs
	CGA	Comprehensive Geriatric Assessment
	CHA2DS2-VASc	Congestive heart failure, Hypertension, Age, Diabetes, previous Stroke/ transient ischaemic attack- Vascular disease and Sex category
	CHAT	Consider Have Advise Transfer
	CMP	Case Mix Programme
	COPD	Chronic Obstructive Pulmonary Disease
	CQC	Care Quality Commission
	CQUIN	Commissioning for Quality and Innovation
	CT	Computer Tomography
	CYP	Children and young people
D	DTT	Decision to Treat
	DEXA	Dual Energy x-ray Absorptiometry
E	EAP	Employee Assistance Program
	ECG	Electrocardiogram
	ECIST	National Emergency Care Intensive Support Team
	E. coli	Escherichia coli
	ED	Emergency Department
	E. Obs	Electronic Observations
F	FFFAP	Falls and Fragility Fracture audit program
	FFT	Friends and Family test
	FLS	Fracture Liaison service
	FMU	Free Standing Midwifery Unit
	FSG	Falls Steering Group
G	GI	Gastrointestinal
	HEE	Health Education England

H	HEESWSN	Health Education England South West Simulation Network
	HMSR	Hospital Standardised Mortality Ratios
	HSJ	Health Service Journal
I	IBD	Inflammatory Bowel Disease
	IV	Intravenous
L	LMS	Local Maternity Services
	LocSSIPS	Local Safety Standards for Invasive Procedures
M	MAU	Medical Admissions Unit
	MDT	Multi-Disciplinary Team
	MH	Mental Health
	MRSA	Methicillin Resistant Staphylococcus Aureus
	MOP	Minor Operating Procedures
	MSK	Musculoskeletal
N	NABCOP	National Audit of Breast Cancer in Older People
	NACEL	National Audit of Care at the End of Life
	NAPH	National Audit of Pulmonary Hypertension
	NASH	National Audit of Seizure Management in Hospitals
	NatSSIPS	National Safety Standards for Invasive Procedures
	NBOCA	National Bowel Cancer Audit
	NBSR	National Bariatric Surgery Registry
	NCAA	National Cardiac Arrest Audit
	NCAP	National Cardiac Audit Programme
	NCEPOD	National confidential enquiry into patient outcome and death
	NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
	NEIAA	National Early Inflammatory Arthritis Audit
	NELA	National Emergency Laparotomy Audit
	NEWS	National Early Warning Score
	NHS	National Health Service
	NHSE/I	National Health Service England / Improvement
	NICE	National Institute for Health and Care Excellence
	NJR	National Joint Registry
	NLCA	National Lung Cancer Audit
	NMPA	National Maternity and Perinatal Audit
	NNAP	National Neonatal Audit Programme - Neonatal Intensive and Special Care
	NOD	National Ophthalmology Audit
	NOGCA	National Oesophago-gastric Cancer
	NPDA	National Paediatric Diabetes Audit

P	PALS	Patient Advise and Liaison Service
	PAS	Patient Access system
	PGMC	Post Graduate Medical Centre
	PICANet	Paediatric Intensive Care Audit Network
	POMH	Prescribing Observatory for Mental Health
	PQIP	Perioperative Quality Improvement Programme
	PROMS	Patient reported outcome measure
Q	Q1	Quarter 1 (April, May, June)
	QI	Quality Improvement
	QSIR	Quality, service improvement and redesign
R	RCA	Route Cause Analysis
	RCEM	Royal College of Emergency Medicine
	RNHRD	Royal National Hospital for Rheumatic Disease
	ROP	Retinopathy of Prematurity
	RUH	Royal United Hospitals
	RTT	Referral to treatment
S	SAMBA	Society for Acute Medicine's Benchmarking Audit
	SAU	Surgical Assessment Unit
	SHMI	Summary Hospital level mortality Indicator
	SJR	Structured Judgment Review
	SKIP	Sepsis and Kidney Injury Prevention
	SSNAP	Sentinel Stroke National Audit Programme
	SPCT	Specialist Palliative Care Team
	SPR	Specialist Registrar
	SSNAP	Sentinel Stroke National Audit programme
	STP	Sustainability and transformation plan
	SWAST	South West Ambulance Service
U	UNICEF	United Nations International Children’s Emergency Fund
	UTC	Urgent Treatment Centre
V	VQ	Ventilation perfusion
	VTE	Venous thromboembolism
W	WEAHSN	West of England Academic Health Science Network

Part 1

Letter from our Chief Executive

Quality Accounts 2019-20

Part 1: Chief Executives Statement –statement on quality

The Board of Directors is committed to providing the highest quality services to our patients, their families and carers, and to being responsive to individual needs. As an organisation, we are constantly striving to ensure that the safety of our patients and a commitment to service improvement is at the heart of everything that we do. We aspire to play our part to the full within the wider local health and care system: working innovatively and collaboratively to improve the experience of all who use our services and working closely with partner organisations and third sector colleagues to deliver integrated care across the local area.

The Trust values: **Everyone Matters, Working Together, Making a Difference** are central to everything that we do, and they encapsulate our aspiration for the type of hospital that we are aiming to be.
The Trust identifies a series of quality priorities each year, and we are pleased to report on the progress against our quality priorities for 2019/20 as described below.

The Trust is proud of its staff and the contribution that they make on a daily basis to the welfare of their patients. I am pleased to report that during 2019/20, several teams have been recognised for their outstanding work and nominated for a number of awards during the year. This has included, among others:

- Our Cancer Information and Support Centre team named as Healthcare Team of the Year at the Bristol and Bath Health and Care Awards 2019, and
- The Dementia Co-Ordinator Team who were finalists at the prestigious Dementia Care Awards in 2019.

Many of the Trust's services also gained national and international recognition, including the neonatal service which became only the 6th service of its type nationally to achieve the coveted UNICEF baby friendly status, our 24/7 upper Gastrointestinal (GI) bleed service has been described by the Joint Advisory Group on Gastrointestinal Endoscopy as exemplary, while our Respiratory Department is one of only a few in the UK to have complied with the Best Practice Tariff requirements for asthma care in every quarter of the year. The acute emergency general surgery service is nationally recognised as excellent, and the hip fracture unit is ranked second best in the country.

In common with many other acute trusts across the country, this year, we have continued to face significant pressure in our Emergency Department, with increasing admissions of, in most cases, very unwell patients. Indeed, in December 2019, the number of emergency presentations reached 9,208, making the period between October and December the busiest in our history, with an average of more than 300 patients attending the department each day. This sustained level activity has had a severe impact on our ability to achieve the national target of treating 95% of patients attending the Department within 4 hours, but we remain committed to ensuring that regardless of the level of demand, all our patients are treated in as timely a manner as possible. Going forward, we will be taking concerted action across the hospital and with our partners across the local health and care sector in Bath and North East Somerset and Wiltshire to, for example, secure discharges as early in the day as

possible, thus freeing up beds for new patients, and better coordinating the work of our Emergency Department and the Urgent Treatment Centre.

We recognise that our staff are crucial to the success of our commitment to provide high quality services and care. Like many trusts across England, we have had to cope with significant numbers of unfilled vacancies among our clinical staff, particularly nurses. We have taken a number of measures to address this, including targeted local and international recruitment exercises, and working with NHS Improvement/England on a number of measures to encourage existing staff to stay with us.

During the course of the year, our exciting four year quality improvement programme, Improving Together, has continued to gain momentum, becoming a key driver of how we want the organisation to work – that every member of staff, regardless of their professional background or seniority, takes responsibility for making improvements in their work and in their areas. We have continued to roll out in-depth training and development in this methodology across all of our frontline teams, and increasingly we are seeing colleagues gaining the confidence to effect positive changes for the benefit of their patients.

I confirm that to the best of my knowledge the information in these quality accounts is accurate, and I hope that you find it interesting and informative. I would welcome any feedback you would like to share.

Signed:

Libby Walters
Interim Chief Executive

Date: 29 July 2020

Why are we producing a Quality Account?

All NHS Trusts are required to produce an annual Quality Account to provide information on the quality of services to service users and the public, as part of the drive across the NHS to be open and honest.

The Trust welcomes this opportunity to demonstrate how we are performing, taking into account the views of service users, carers, staff and the public, and comparing our progress against the previous year and where we can, against national performance. We proactively use this information to make decisions about our services and use it as an opportunity to identify areas for improvement.

In this year's Quality Account, we have set out how we have performed against the Trust's patient safety priorities as well as the national priorities, setting out plans for improvement where we have not met any of these priorities.

For 2019-20 we set four quality account priorities under the categories of safe care, effective care and patient experience. This Quality Account will explain why we chose these priorities and will summarise how we have performed against them and any improvements we have made.

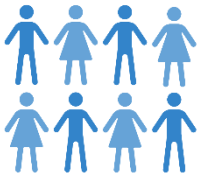
Our Quality Account Priorities 2020-21 have been aligned to our 2018-2021 Strategy which is built around our five True North Goals which reflect out Trust Values:

Part 2
Our Priorities

Part 2: Priorities for Improvement and statements of assurance from the Board of Directors

2.1 About Royal United Hospitals Bath NHS Foundation Trust

At a glance:

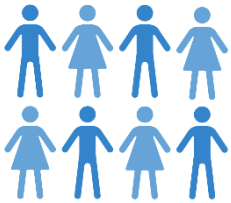
Care Quality Commission rated us GOOD	
759 acute beds, covering a range of services	
	**We provide healthcare services to around 500,000 people across Bath and North East Somerset, Wiltshire, Somerset and South Gloucestershire**
We provide a comprehensive range of acute services, including medicine, surgery, services for women and children, accident and emergency services, specialist rehabilitation services and diagnostic and clinical support services	
We run 1254 outpatient clinics per week	

The RUH is a major acute hospital on the north western side of the city of Bath. We provide care to approximately 500,000 people across Bath, North East Somerset, north and west Wiltshire, Somerset (Mendip) and South Gloucestershire. We run a number of clinics at other centres across the region. Since 2015 we have incorporated the specialist services of the Royal National Hospital for Rheumatic Diseases (RNHRD).

We provide a service for patients needing emergency and unplanned specialist care, 24 hours a day, every day of the year. From that core is built a comprehensive planned surgical, medical and diagnostics service for adults and children. Specialised care is delivered in a number of areas including:

- Cancer care
- Cardiac and stroke
- Care for older people, particularly those with dementia
- Higher levels of critical care
- Maternity services
- Rheumatology, pain and fatigue (RNHRD)
- Specialist orthopaedics (surgery on joints and bones)
- Tertiary and pulmonary hypertension.

Our Staff At a Glance:



We employ approximately 4800 staff

The RUH employs approximately 4800 skilled and caring staff (whole time equivalent), working across all our services in a wide range of clinical and support roles. Over the last five years we have expanded our workforce by more than 25%.

We see staff engagement and wellbeing as a priority, and continue to monitor levels of satisfaction and actively seek new ways to support our employees.

The Trust, in partnership with local universities and colleges, also plays a significant role in education and research. Doctors, nurses and many other healthcare professions have been with us as students and have stayed with us as qualified staff. This focus on learning supports innovation and improvement in the excellent care provided for our patients. The Trust continues to work collaboratively with system partners across the local sustainability and transformation plan (STP) to improve and transform services for our patients.

In common with other health service providers, we have faced shortages of staff in some areas, that impact on our staffing levels. Our staff are central to our strategy to provide quality services and care.

What we have achieved during 2019-2020
National and Local Awards – Won or Shortlisted

In 2019-20 the Trust was externally recognised for the care and or innovations provided by winning or being shortlisted in a number of national or local awards. The teams or staff members and the awards won or highly commended for are detailed in the table below:

Awarding Body	Award Status	Award name or category	Team or Individual
Dementia Care Award	Finalist	Team of the Year 2019	Dementia Coordinators
Bristol and Bath Healthcare Award	Winner	Healthcare Team of the Year 2019	Cancer Information and Support Centre Team
Bristol and Bath Healthcare Award	Winner	Volunteer and Community Sector of the Year 2019	Compassionate Companions
Bristol and Bath Healthcare Award		Lifetime Achievement	Brenda Oliveira Health Care Assistant
Bath Life Awards 2020	Finalist	Civic Award	Art at the heart of the RUH
HEE Health Care and Training	Finalist	Inspiring Educator	The Bath Tea Trolley Training
Association of Optometrists	Shortlisted	Hospital Optometry Team of the Year 2020	Optometry Team
NHS Sustainability Awards	Winner	Staff Engagement	Estates and Facilities Sustainability Team
NHS Sustainability Awards	Winner	Infrastructure	Estates and Facilities Sustainability Team
UNICEF	Achieved	Baby Friendly accreditation	Dyson Centre for Neonatal Care
Quality in Care Diabetes Award	Finalist	Type 1 Specialist Service – children, young people and emerging adults	Paediatric Diabetic Team
Health Service Journal	Finalist	Best Not For Profit Working In Partnership With NHS	Tracie Miles Gynae Oncology Nurse Specialist & Genomics Practitioner Genomics Strategy Group

unicef UNITED KINGDOM
THE BABY FRIENDLY INITIATIVE

10th National Dementia Care AWARDS 2019 WINNER
National Dementia Care Awards

QiC Diabetes
Quality in Care Programme 2020
CELEBRATING 10 YEARS

BathLife AWARDS 2020

BristolLive | BathLive
HEALTH & CARE AWARDS 2019
care

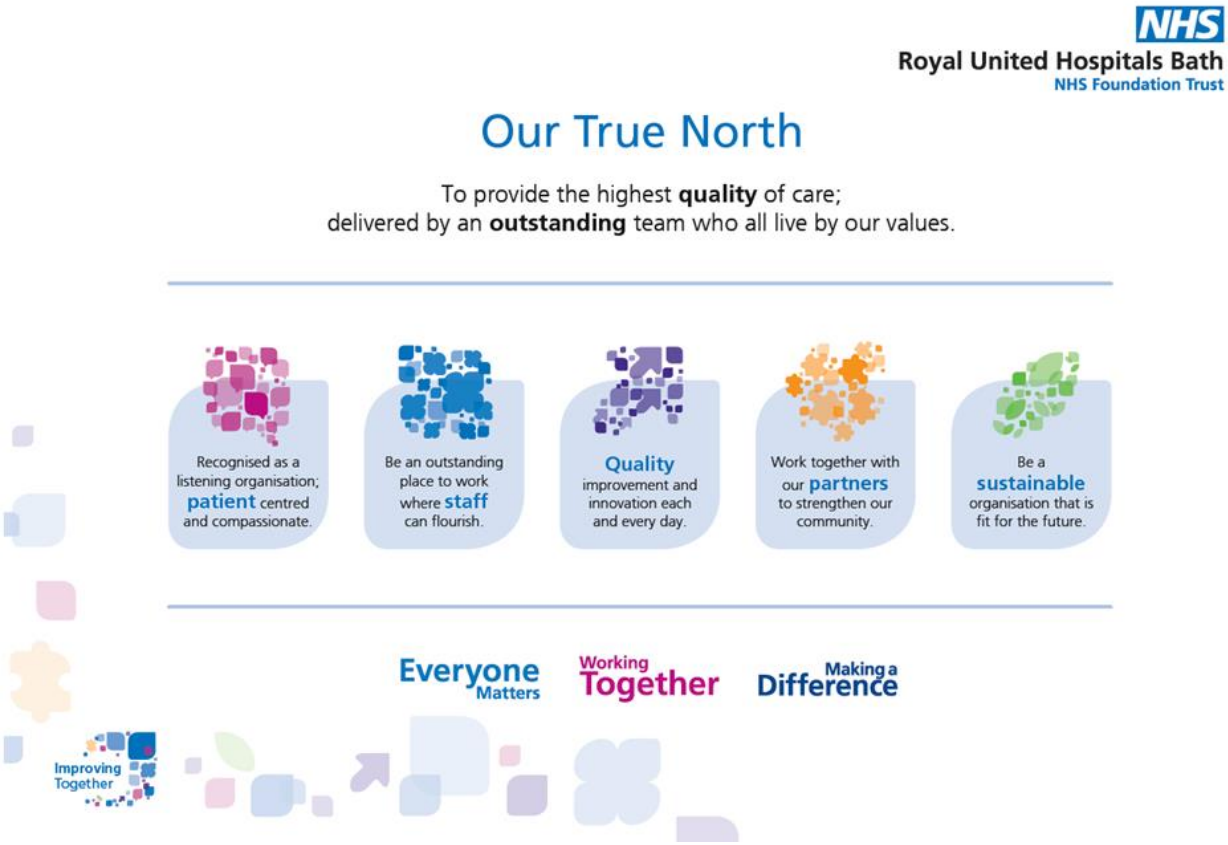
NHS
Health Education England

2.2 Quality improvement, leadership and governance

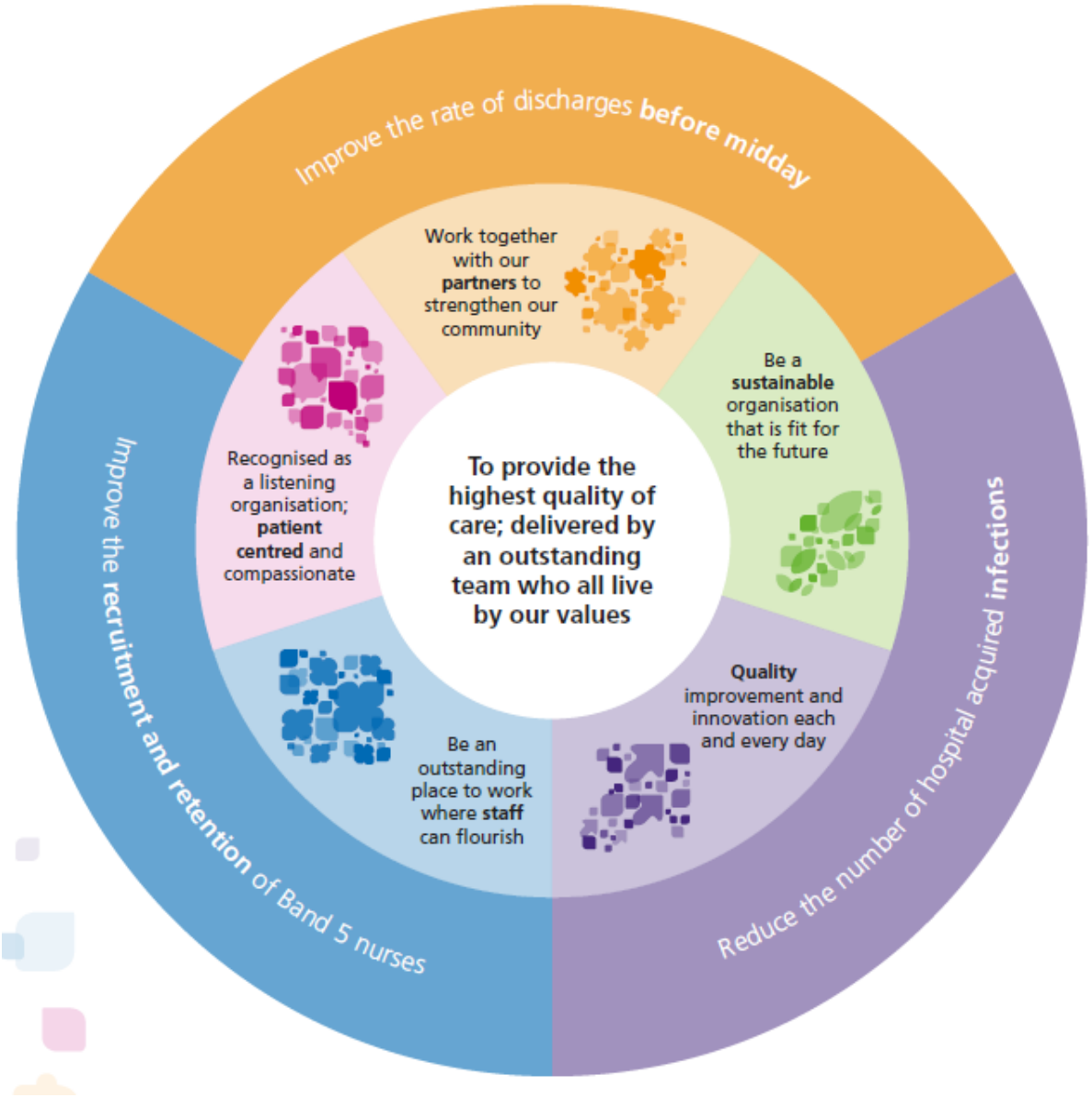
Our approach to quality improvement and governance is led by our Director of Nursing and Midwifery and Medical Director. The Medical Director chairs Quality Board, which reports to Board of Directors, and the Director of Nursing and Midwifery leads the Trust's Quality Improvement Centre, which brings together staff working in patient safety, risk management, quality improvement, clinical audit and patient experience. Each of the chosen quality priorities reports into Quality Board quarterly. Here progress is monitored and challenges highlighted and discussed.

Quality Improvement Approach

Our True North describes our vision "to provide the highest quality of care; delivered by an outstanding team who all live by our values" and the five strategic goals which are our focus areas. True North is the compass that keeps the RUH heading in the right direction – a fixed point we should always refer to when identifying which improvements and projects to prioritise.



The breakthrough objectives for 2020-21 are shown below:

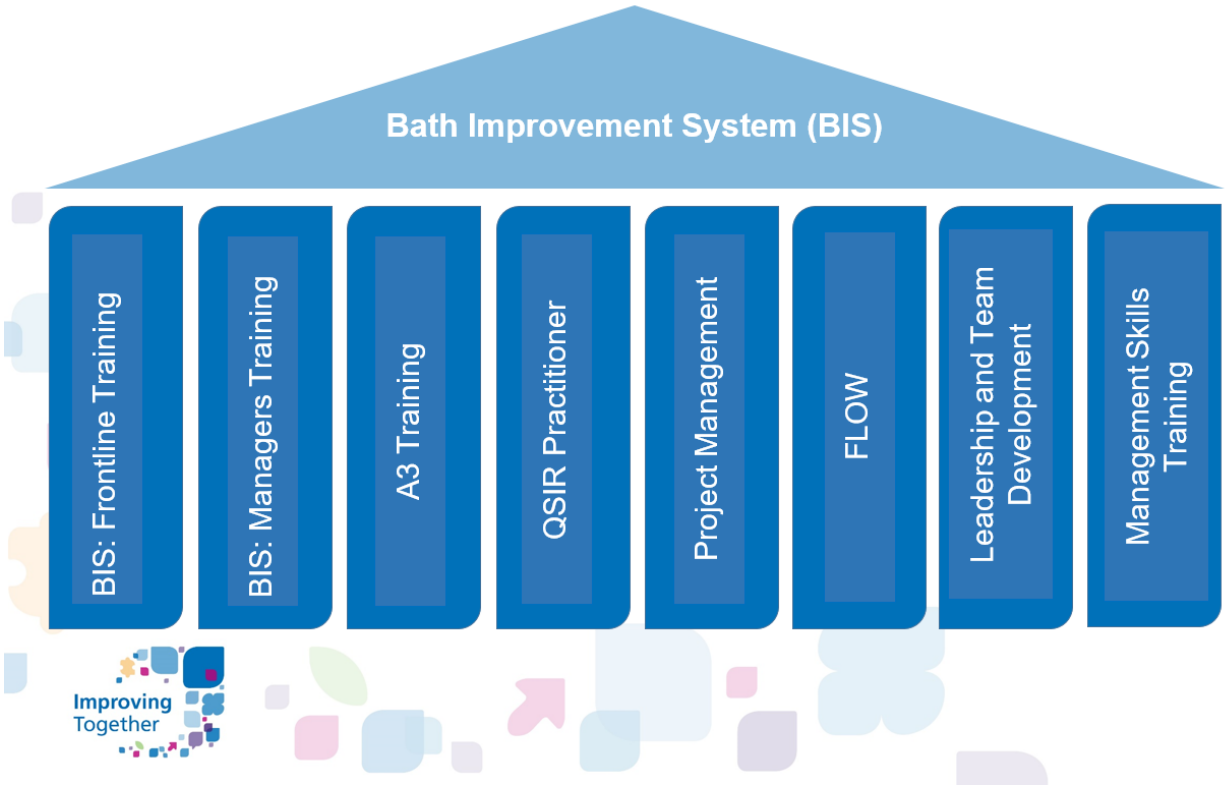


Quality Improvement and Innovation each and every day

To deliver True North we have developed the Improving Together Programme – a bespoke approach to sustaining a culture of continuous improvement. Building capacity and capability for improvement and embedding quality improvement skills is fundamental to the Improving Together programme. We recognise that the strength in our hospital lies in our staff and we are starting to build a culture that empowers teams and individuals to make lasting change.

To support staff in their improvement journey we have made the connections between all the individual training courses at the RUH on Quality Improvement and Leadership Development and created the “Bath Improvement System” (figure 1).

Figure 1: Bath Improvement System (BIS) House



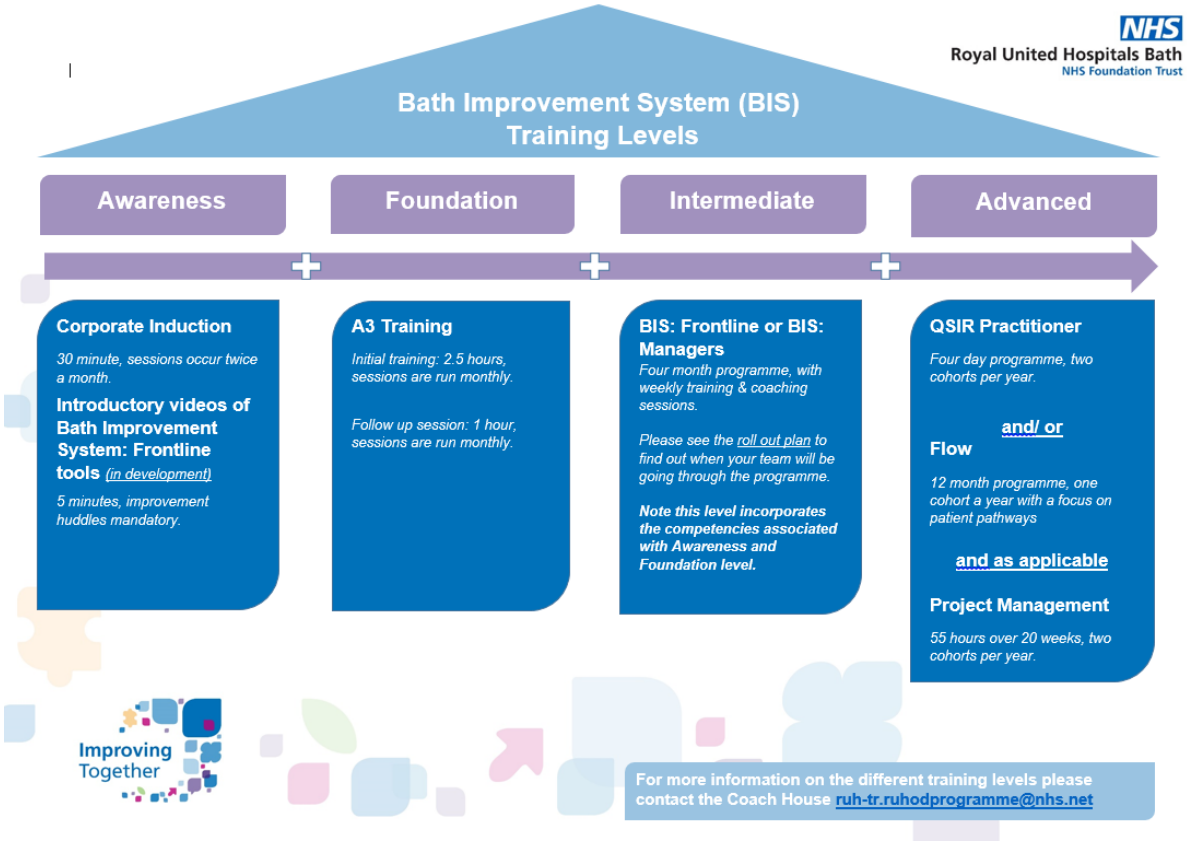
Bath Improvement System (BIS) incorporates training on the tools, routines and behaviours to enable continuous improvement alongside care pathway re-design project management and leadership / team development. It is built on a philosophy of incremental and continuous improvement by front-line staff empowered to initiate and lead positive change as well as providing the skills to support and sustain large-scale improvement projects.

The BIS; Frontline and Management training involves four months of training for each ward or department team through attendance at a series of modules and team days. Staff learn to implement the tools and routines in their areas and adopt new "Lean" management techniques including 'A3 problem solving' (a structured and simple to use problem solving and continuous improvement that typically uses a single sheet of A3 sized paper, hence the name), standard work (the established best practice for performing a task or process), process observation (confirming exactly what is happening during a particular process), and carrying out improvement huddles (short, stand up meetings to help review performance in a clinical setting and flag any concerns).

The Quality Improvement Service and Redesign (QSIR) Practitioner course, a nationally accredited course with NHSI, enables staff to take forward an improvement project to the next level looking at measurement for improvement, generating ideas with teams and testing solutions using a 'Plan Do Study Act' (PDSA) approach.

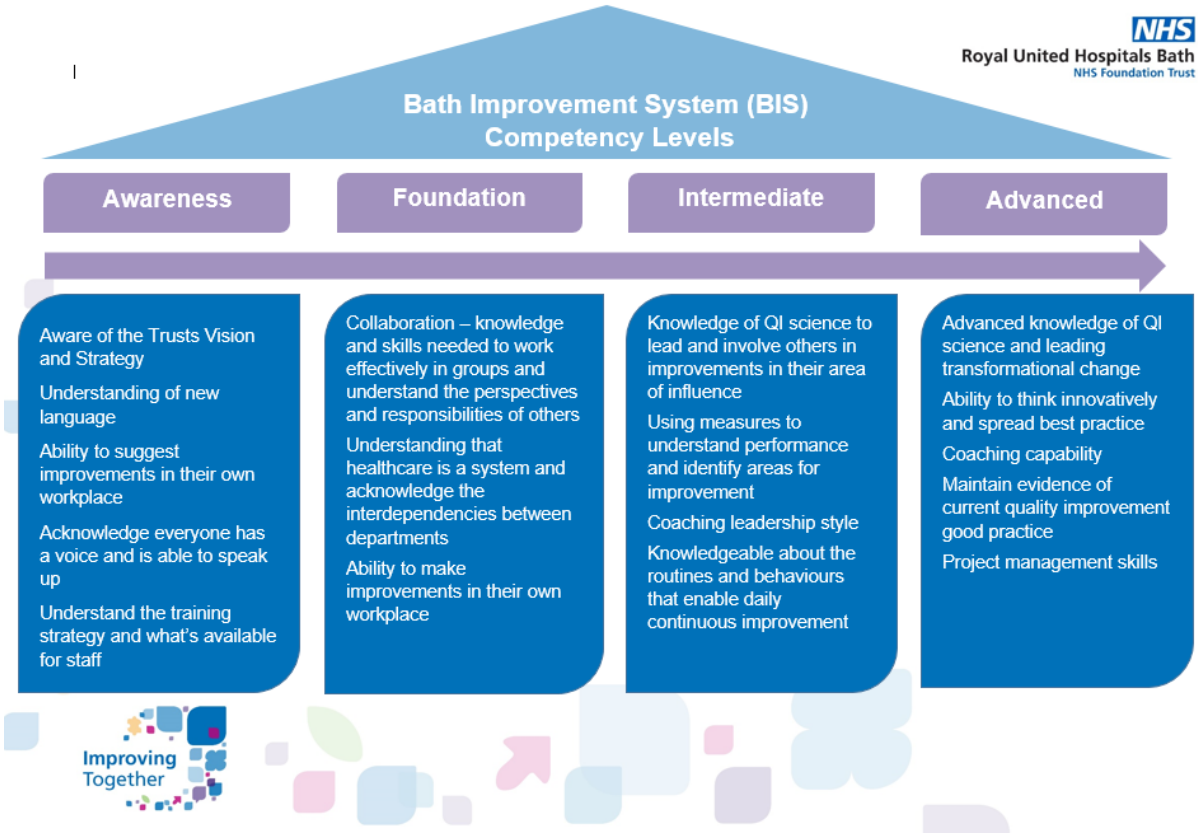
We have developed a learning pathway (figure 2) for staff to develop their quality improvement skills alongside giving an organisational perspective on what change capacity is within the RUH.
There are four training levels starting with an Awareness level moving to Advanced that incorporates QSIR and Project Management.

Figure 2: Training Levels



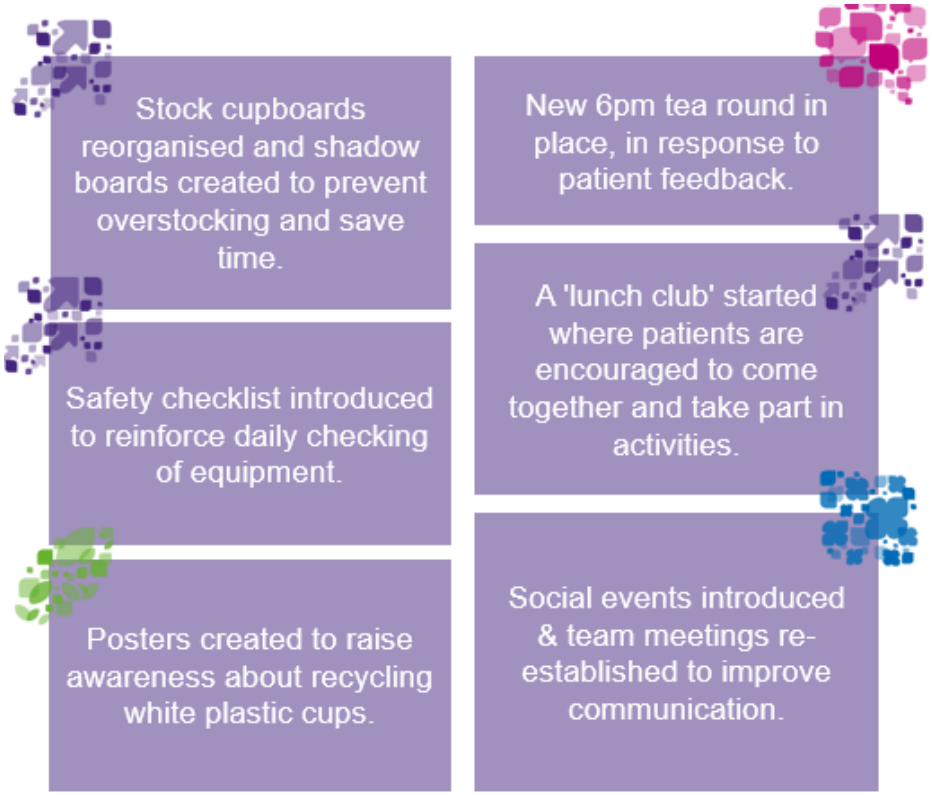
In 2018/19 16 teams and 250 members of staff were trained to Intermediate level and 29 members of staff to Advanced. From January 2020 we were launching the Awareness and Foundation levels and these courses were made available to all staff. However, the declaration of the COVID pandemic in March led to a suspension of the programme. Steps are being taken in 2020/21 to re-launch the programme virtually. The competencies that support each training level are detailed below in figure 3

Figure 3: Training Competencies



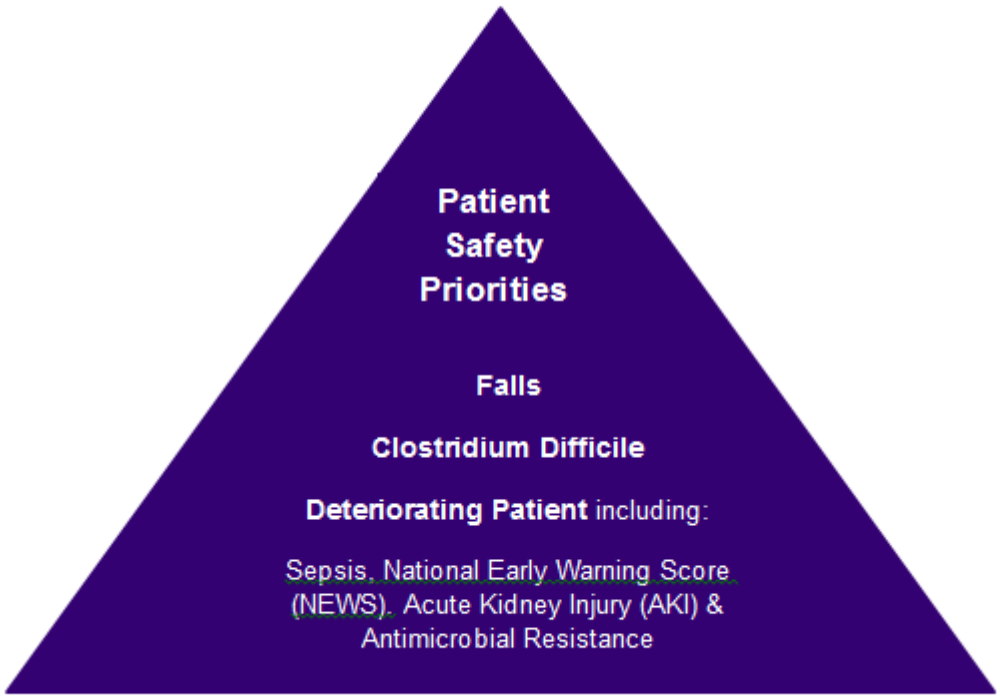
The frontline teams have so far implemented over 700 'improvement tickets' via their improvement huddles, these can be small quick wins that benefit our patients and/or staff but overall have a positive outcome for those involved. Examples below in Figure 4;

Figure 4: - Improvement Huddle ticket examples



2.3 Patient Safety Priorities 2019/20

The Trust is committed to providing safe and compassionate care and we have established a culture of improving patient safety through our patient safety priorities. The Trust patient safety priorities are set out in our patient safety triangle and consist of our three top patient safety priorities and four executive sponsored patient safety priorities.



Each patient safety priority has an established clinical leader, and an executive sponsor, who are jointly responsible for setting the work-plan with agreed process and outcome measures. These are reported to Quality Board and to the Board of Directors.

1. Falls

Preventing our patients from falling while they are in hospital is one of our safety priorities. The Falls Prevention pathway is the framework for the falls improvement work.

The priorities for 2019/20 have focused on:

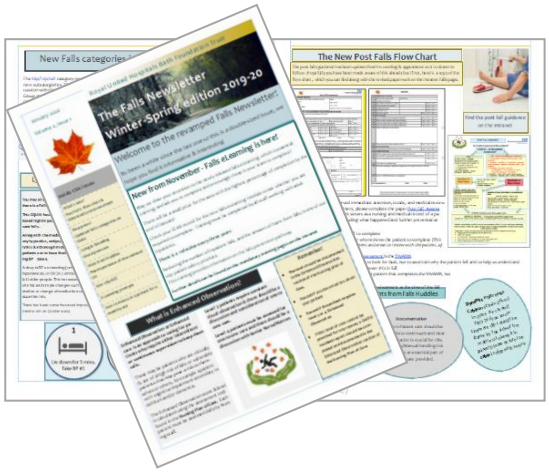
- redrafting the medical and surgical plans of care based on reviews and learning from serious incidents involving falls, and reviews of audit data
- revising and redefining the Enhanced Observation/Enhanced Care process
- developing and launching a revised falls e-learning package for all inpatient clinical staff to increase the understanding of and compliance with falls prevention tools and practices.

The target was to reduce the number of inpatient falls in year across the Trust by 5%.

In July 2019 the Falls Steering group (FSG) held a falls link worker study session event attended by 26 healthcare staff from a range of 17 clinical areas. A series of workshops around aspects of falls prevention was showcased including practical demonstrations of using the falls retrieval kit, enhanced observations, recording of lying and standing blood pressure, assessing high risk medications and meaningful activities for dementia care.

To further support and educate staff, a falls eLearning package was developed by the FSG and launched in November 2019. The eLearning is aimed at all patient facing staff. Compliance of eLearning completed is being triangulated against areas following serious incidents as part of the Serious Falls Investigation process. Agreed targets for eLearning completion by staff in an area is the responsibility of the Senior Sister and has become an integral part of the all falls action plans.

A quarterly falls newsletter was developed and circulated to all areas and link nurses in January 2020.This will be a regular quarterly publication, to support and maintain a focus upon falls within the Trust



Data

All patient falls are reported via the Trust's incident reporting tool DATIX. Data regarding the numbers and harm levels of falls is reported at Trust and divisional level. The Falls Steering Group oversees this data and monitors Trust wide trends and themes. The Falls Steering Group includes the review of Serious Incidents related to falls, this involves reviewing the results of all root cause analysis (RCA's) investigations into moderate harm and above falls that have occurred. This process enables us to learn from incidents, identify themes and trends and look for improvements ensuring they are captured within the falls work plan. Between January 2019 and January 2020 a total of 23 serious incidents were heard at the FSG Serious Incident review meeting.

Since January 2019 a more effective approach to falls of moderate and above harm investigations was developed by the falls steering group to focus on prevention rather than investigation. A falls huddle takes place in the clinical area where a fall of suspected moderate or above harm has occurred within 2 working days, wherever possible, to identify if learning is already included in the falls work plan or if there is new learning around the cause of the fall.

In November 2019 the FSG reviewed the wording in Datix sub-categories to support better reporting and understanding of circumstances of falls. The changes introduced includes a sub-category of assisted to floor, these are not true falls and as such from December are not be included in the monthly reported data. For December and January this equates to a 6% reduction in month.

Enhanced care tool

In January 2020 there was a relaunch of the Enhanced care process (the Enhanced observation tool was initially launched in 2018) incorporating feedback from staff. Enhanced care is an approach to caring for patients who require either intermittent or continuous supervision to keep them safe. These may be patients who are critically ill, are of a high risk of falls or vulnerable patients that may pose a risk to themselves or others, for example a patient with cognitive impairment secondary to delirium and/or dementia. The Enhanced Observation tool calculates a score and level and is an integral part of the Nursing Plan of Care. Each patient must be assessed daily by nursing staff; Level 3 patients require constant visual observation and there should be a discussion and consideration of one-to-one care and Level 4 patients must be assessed for one-to-one care.

There was a relaunch of the Enhanced observation tool through a trolley dash to all adult wards taking training and resource to the clinical staff. Copies of all of these are available on the falls Intranet site

CQUIN

The falls CQUIN 2019/20 focused on the three high impact actions to prevent hospital falls:

- No hypnotics, antipsychotics or anxiolytics (drugs that can cause drowsiness and affect balance) given during hospital stay OR the rationale for giving these drugs documented. The Older Peoples Unit (OPU) wards have achieved 100% compliance in all 3 quarters so far for this criterion.

- Lying & Standing blood pressure recorded at least once during the inpatient stay. The OPU wards achieved:
    - 43% in Q1
    - 42% in Q2
    - 52.8% in Q3
    - 47% in Q4

  A substantial improvement had been observed towards the end of Q2 and across Q3, when one of the wards implemented daily audits to ensure Lying and Standing blood pressure is performed on all eligible patients.

- A mobility assessment documented within 24 hours of admission to an inpatient unit – The OPU wards achieved:
    - 93% in Q1
    - 94% in Q2
    - 90% in Q3
    - 89% in Q4

- Documentation of whether a walking aid required is provided within 24 hours of admission to inpatient unit – The OPU wards achieved:
    - 91% in Q1
    - 66% in Q2
    - 62% in Q3
    - 59% in Q4

The ultimate aim of the CQUIN was for 80% of older inpatients to receive the key falls prevention actions, but at the end of quarter 4, only 43% of patients had been reached. Unfortunately, quarter 4 saw a slight drop in compliance during the COVID affected period as a result of the acuity of the patients admitted, and pressures of meeting the additional demands that this situation has brought.

The Falls Steering Group will continue to work towards achieving the original aim for all patients over the next year, continuing to increase compliance within the OPU wards, working with the organisational falls lead representatives and sharing good practice once consistency in the trial areas has been embedded.

It has been challenging to achieve the 5% reduction in the falls rate set in 2019, although the FSG is continually looking at ways to improve falls prevention interventions. Overall compliance with the CQUIN at the end of quarter 3 was 47%.

2. *Clostridium difficile* infection

The Trust continues to work to reduce the number of *Clostridium difficile* infections using an improvement plan with multidisciplinary input. The improvement plan includes antimicrobial stewardship including the introduction of ARK (antibiotic review kit), a focus on improving environmental and equipment cleanliness, learning from root cause analysis investigations and the introduction of a diarrhoea pathway. Infection prevention and control education continues to be a focus with significant improvement across the divisions working towards the 90% compliance target.
All hospital onset PCR positive *Clostridium difficile* samples are now ribotyped, regardless of whether the toxin test is positive. Ribotyping is a molecular technique undertaken in a laboratory to identify the characteristics of a particular strain of bacteria. This has helped to identify our predominant strains and also to assist with investigation of potential outbreaks, however having two of the same ribotype in an area does not necessarily indicate that there has been cross contamination.

The 2019/20 trajectory for Trust attributed *Clostridium difficile* infections was to receive no more than 59 cases. This included both hospital onset (2 or more days after admission) and community onset healthcare associated (within 28 days of discharge) cases. During the reporting period there were a total of 42 reported via the Public Health England Healthcare Associated Infections Data Capture System. In 5 cases there were no lapses in care identified and it was agreed by the Commissioners that these cases would not count towards the year-end total, resulting in 37 cases. There are another 2 cases that have been submitted to Somerset CCG *Clostridium difficile* panel, the result of these appeals are not yet known. If they are all agreed this will take the year-end total to 35 cases.

3. Deteriorating Patient

Early recognition of the deteriorating patient remained a patient safety priority for the RUH in 2019/20 and is also a national and regional safety priority.
To support continuing improvement in the early recognition, prevention and management of Sepsis and Acute Kidney Injury, the Sepsis and Kidney Injury Prevention team (SKIP) was formed in May 2019, with the permanent appointment

of band 7 and band 6 specialist nurses. The team has been available 6 days a week in 2019, and funding for a further team member is being investigated for 2020 to enable to team to be available for 12 hours, 7 days a week. They have continued to support management of Sepsis for emergency admissions and inpatients, promote the early identification of Sepsis and AKI to enable earlier treatment and potential prevention and improve outcomes for patients. The SKIP team also have an important educational role and provide frontline staff with training.

In 2019, the Critical Care outreach team was also expanded and will be available 24 hours a day from March 2020. With the development of both of these new teams, a new 'deteriorating patient team' will be available to support the staff 7 days a week and new robust processes for escalation are being developed.

The focus on early identification of deterioration by raising awareness of the increase in NEWS score indicating potential deterioration, was the key focus of the 'NEWS up What's UP' campaign early in 2019/20. This was supported by 'Deteriorating Patient champions which have been established on each ward.

The ongoing work has led to continued improvements in 2019/20:

- 90% inpatients received antibiotics within an hour of being diagnosed with sepsis
- 100% of mothers have received antibiotics in an hour from diagnosis of sepsis, with a continued decrease in the requirement for critical care in these mothers
- Sepsis screening for children at risk has remained over 90%
- Mortality rate from infective causes showed a further 7% decrease, resulting in an overall 25% decrease in mortality since 2016
- Mortality from AKI showed a further 8% decrease (12% decrease overall since 2016)
- Incidence of AKI acquired during a patient's admission showed a further 7% decrease (23 decrease overall since 2016).

Our focus in 2019 has been to take steps to further improve outcomes which require, not only an increase in support available in terms of staff as above, but also the implementation of reliable electronic systems to support automatic identification of abnormal signs. In 2019 we have therefore implemented a system for electronic recording of vital signs (EObs), incorporating automatic recording of the National Early warning Score (NEWS). An automated alert is produced if the score has increased by 2 or more points from the previous score, signifying a patient's deterioration. An automatic Sepsis screen is then completed and an electronic sepsis pathway has been developed if sepsis is likely.

Implementation of EObs started in August 2019, and has been spread ward by ward to ensure adequate support and learning for each area. The expectation was for Trust wide implementation by July 2020, but unfortunately, roll out was paused in February 2020 due to the COVID-19 pandemic. It was restarted in June 2020, with all ward areas implemented by July 2020, and trust-wide completion planned by October. The SKIP team has been essential to this rollout, ensuring staff in each area are up to date with training and supporting feedback following implementation.

The electronic system has also resulted in availability of weekly compliance with sepsis screening, which is fed back to the team for ongoing improvements. Prior to the COVID-19 pandemic, compliance with sepsis screening had improved to 90%.

The availability of the vital signs electronically also facilitates proactive review of those patients with high NEWS scores, which is guiding prompt review by the SKIP and Critical Care outreach teams in 2020

A Local Sepsis patient support group has now been established and has been supported by the Trust Sepsis Lead. The SKIP team have been attending this in 2019 and using feedback to improve the service.

2.4 Caring for people with a learning disability and autism

During June 2018 NHS Improvement published four standards that Trusts need to meet. The standards were developed with partners and by demonstrating that the Trust meets the standards will identify that we are delivering high quality services for people with learning disabilities, autism or both. Several inquiries and investigations have found that some Trusts are failing to adequately respect and protect people's rights with devastating consequences for them and their families. Also, skills deficits in the NHS workforce mean's people's needs are sometimes misunderstood or responded to inappropriately. As a result of these failings, people with learning disabilities, autism or both are at risk of preventable, premature death and a grossly impoverished quality of life.

To enable people with learning disabilities, autism or both to have the same human rights as the general population, their specific requirements need to be reflected in all NHS Trust policies and procedures. These standards are rooted in a human rights –based approach to meeting people's needs.
These standards are supplemented by improvement measures or actions that Trusts are expected to take to make sure they meet the standards and deliver the outcomes that people with the learning disabilities, autism or both and their families expect and deserve

Currently the RUH does not have service delivery outcome measures or data in order to understand how effective our services are for people with learning disabilities. For example, we do not currently collect the numbers of patient safety incidents or complaints involving staff or patients with a learning disability or instances when we have had to use restraint, and do not routinely conduct post incident reviews and debriefs following incidents involving a person with a learning disability. However, from April 2020 the Trust will be able to extract data reports from DATIX that will give us the information around incidents and complaints specifically related to patients with learning disabilities an or autism.

The Trust has recently introduced a Learning Disabilities Steering Group. This group will review staff training, focus on raising concerns and reporting incidents involving people with a learning disability. We will ensure adjustments are made to the complaints process for people with a learning disability, and we will seek feedback from our staff and service users that the incident or complaint investigation has

covered their questions and they feel assured the Trust has learnt from their experiences.

NHSE are commissioning eLearning packages to support staff caring for patients with a learning disability and autism that will be available for implementation later this year.

Following a successful consultation with local overview and scrutiny groups and public engagement activities across 2018/19, all services from the Royal National Hospital for Rheumatic Disease (RNHRD) were transferred from their city centre site at the Mineral Water Hospital, to purpose built facilities in the new RNHRD and Therapies centre based on the site of the Combe Park site of the RUH in the summer of 2019

2.5 Improving Maternity Services

In 2016 a Local Maternity System (LMS) was created across the Bath, Swindon and Wiltshire area, this system was designed to support the delivery of the national Better Births recommendations with the aim to improve the maternity experience for mums and their families. In parallel to this, the Royal United Hospital had begun a review of the birth locations on offer within the service. This review was then extended to include the birth options for mothers across the whole of Bath, Swindon and Wiltshire.

This review identified two key elements:

- There was a lack of parity of choice for mothers when choosing where to have their babies; only women living in Swindon and North Wiltshire had access to an Alongside Midwifery Unit (AMU) and only women living in Bath, North East Somerset and West Wiltshire had access to a Free Standing Midwifery Unit (FMU).
- There had been a significant reduction in the number of women choosing to have their babies in a Free Standing Midwifery Unit resulting in an increase in the number of low risk mothers choosing to have their babies in an Obstetric Led Unit.

A number of engagement events took place to understand the reasons for these changes and to seek the views of women and their families; proposals for change were co-created which also included a review of the community post-natal beds, antenatal and postnatal care and home birth services. Expert opinion on the proposals was sought from the Clinical Senate and following approval a public consultation took place between November 2018 and February 2019. Responses were independently academically analysed and a final set of recommendations were presented to an independent expert panel in September 2019 and in January 2020 they were presented to the Clinical Commissioning Group Governing Body where the final recommendations were approved.

There were six different elements but together they form one proposal for change for transforming maternity services across Bath, Swindon and Wiltshire.

1. To create an Alongside Midwifery Unit at the Royal United Hospital in Bath
2. To create an Alongside Midwifery Unit at Salisbury Hospital
3. Continue to support births in two not four Freestanding Midwifery Units. Births will continue in Chippenham and Frome Midwifery Units and will cease in Paulton and Trowbridge, this decision was based on a Travel Impact Assessment, an assessment of the environment in the locations and activity levels.
4. To enhance provision of antenatal and postnatal care
5. To improve and better promote home birth services
6. To replace the five community postnatal beds in Paulton and the four postnatal beds in Chippenham with support closer to or in women's homes.

As a result of these changes our maternity service will be able to deliver services that better meet the needs and choices of women and their families, improve parity of access and support a more efficient model of care.

2.6 Quality Account Priorities 2019/2020 and 2020/2021

Choosing our Quality Account priorities is important to us and our aim is to ensure the chosen priorities are ones which will make a real difference to our patients. We have engaged with our staff, the Governor Quality Working Group, the Trust's Council of Governors, the Patient and Carer Experience Group, the Board of Directors, and our Clinical Commissioning Groups to determine the priorities. We have agreed four priorities and for each priority, we outline below why it is important to us as a Trust and for our patients, and identify specific indicators we aim to achieve and how progress will be measured. Our priorities for 2020/21 focus on improving pathways of care building on two of our priorities from 2019/20. We also value the work that our volunteers undertake and how they support both the staff and patient experience The Governors Quality working group were particularly keen to endorse and support taking forward the 24/7 Critical Care Outreach priority whilst the Patient and Carer group were very supportive of the Working with Volunteers to improve staff and patient experience priority'.

The next two sections will set out our progress against the four Quality Account priorities chosen for 2019/20 and describe the four priorities agreed for 2020/21. The table in section 2.16 below, demonstrates how each of the four chosen priorities relates to Patient Safety, Patient Experience and Clinical Effectiveness, in addition to how each of the priorities complements our True North goals.

The Quality Account priorities and the progress will continue to be monitored through Quality Board, which is chaired by the Medical Director.

2.7 Priorities for improvement - looking back over last year Overview 2019-20

Priority 1	Priority 2	Priority 3	Priority 4
Continuity of carer model to personalise maternity services	**Development of a frailty assessment unit**	**Improving patient and carer experience**	**Improvement in early recognition of deteriorating patients**
			
Achieved	**Achieved**	**Achieved**	**Achieved**

Priority 1: Continuity of carer model to personalise maternity service

Why is it important:

Quality services for pregnant women need to be personalised as each pregnancy and family are different. Child birth is a life-changing event with experiences that can shape the lives of mothers and their babies. Continuity of carer models will enable maternity services to support this. The model will ensure that care is centred around the woman and her baby so she can access support and information to meet their individual needs. Women will build strong trusting relationships with midwives and other professionals which will improve the safety and quality of their care.

What we said we would do	What we did
20% of pregnant women will be booked onto a pathway that provides continuity of carer	Develop two continuity of carer teams based in the community, who are caring for 20% of our women on a continuity pathway.
Create two pilots at two different birthing centres (Frome and Trowbridge)	Two pilot teams have been developed in Frome and Chippenham. They are working in a team midwifery model and following women allocated to the teams through their pregnancy, birth and postnatal care
Create a working group to include members from the birthing centres and the acute unit, to scope how	Working groups have been set up in each of the clinical areas which feed into our quarterly “Better Births group”. The group monitors the progress of the development of continuity teams across the

we can work across more areas to provide continuity	service and reports to Women and Children's divisional governance.

How we will continue to work with this priority

The next stage of our plan is to model our workforce across the service and work with staff to develop teams to ensure we reach the target of 35% of women booked on a continuity of carer pathway by March 2020.
This will be achieved through the development of further teams based in community who follow women through their pregnancy, birth and postnatal care.
This will be done in a staged approach to enable the safe release of staff from existing clinical areas into teams.
Feedback mechanisms are being developed to obtain feedback from women and their families about their specific experience of being in continuity of carer team as well as from the staff who are working in this model.

The development of the continuity of carer model to personalise maternity care remains a Quality Priority for 2020/21. More detail about how we will continue to work with the priority is set out in 2.8.

Priority 2. Development of a frailty assessment unit

Why it is important:

This development will continue to improve the service provision for our frail and elderly population, and builds upon the previous work to develop the front door frailty assessment in the Emergency Department and the introduction on the Frailty Flying Squad. The Frailty Flying Squad is a multi-disciplinary team made up of a consultant geriatrician, a medical nurse practitioner and a therapist, who aim to assess patients with a Rockwood Frailty Score (a measurement of fitness and frailty) of 5 or more by commencing a Comprehensive Geriatric Assessment. The team works across the patient entry points into hospital, such as the Emergency Department, Medical Assessment Unit, and ACE OPU to identify older patients who, with some intensive assessment and treatment, have the opportunity to return to the community with a clear holistic plan and also have a shorter length of stay in the acute hospital (see table on Rockwood Frailty Score below).

The proposal is to develop a Frailty Assessment Unit where frail patients would be assessed and receive comprehensive geriatric assessment (CGA) in a purpose built setting.

A recognised clinical frailty score (Rockwood frailty score) would determine the frailty of the patient and then whether the patient requires admission to the ACE OPU.

What we said we would do	What we did
Define the frailty pathway to ensure that all appropriate patients are admitted directly to ACE OPU	The established bi-weekly project group (Frailty Big Room) is now meeting weekly with a quality improvement focus. The options for both frailty assessment and short stay have been process mapped. The preferred option is for a standalone unit within the current footprint of ACE. The options for the clinical model and the workforce requirements are currently under review. The principle of an acute frailty assessment unit is a proven concept; supporting faster and more senior medical input in the care of frail older patients. In terms of the current limitations, ACE does not have front door status including urgent blood tests, community services and investigations. In October 2019, the Frailty Assessment Area on ACE was launched with the aim of assessing patients in a timely way and discharging the patient to their usual place of residence. Furthermore, a surgical ward was temporarily transferred to OPU for a period of 5 months to support patient flow. The aim was for patients to be directly admitted to ACE OPU, wherever possible, as part of the Winter Plan 2019/20. This change has reduced the number of outliers and supported patient flow across OPU. It has also facilitated an increase in direct admits.
Provide a consistent Frailty Flying Service from 08:00 – 20:00	The Frailty Flying Squad was developed as part of the Frailty Big Room in 2017 and provides consistent front door cover seven days a week.
Increase the number of patients that have a completed Rockwood score and if the score is five and above for the clinical assessment, risk assessment, care planning and ongoing referral to be completed.	The Rockwood frailty score is a risk stratification tool used to identify the health status of people who are living with moderate and severe frailty. Early identification of frailty can help older people stay well and live independently for as long as possible. The current compliance rate varies by ward and as at January 2020, 54% of medical non-elective patients had been frailty scored, as shown in the tables below:

	<table><tr><th>Admission Month (Short)</th><th>Year Of Admission</th><th>Number of Attendances</th><th>Inpatients Who were Rockwood scored</th><th>% of medical non elective inpatients Rockwood scored</th></tr><tr><td>Jan</td><td>2019</td><td>1173</td><td>697</td><td>59.%</td></tr><tr><td>Feb</td><td>2019</td><td>990</td><td>575</td><td>58.%</td></tr><tr><td>Mar</td><td>2019</td><td>1078</td><td>623</td><td>58.%</td></tr><tr><td>Apr</td><td>2019</td><td>1021</td><td>579</td><td>57.%</td></tr><tr><td>May</td><td>2019</td><td>1075</td><td>611</td><td>57.%</td></tr><tr><td>Jun</td><td>2019</td><td>1000</td><td>610</td><td>61.%</td></tr><tr><td>Jul</td><td>2019</td><td>1016</td><td>604</td><td>59.%</td></tr><tr><td>Aug</td><td>2019</td><td>972</td><td>597</td><td>61.%</td></tr><tr><td>Sep</td><td>2019</td><td>963</td><td>586</td><td>61.%</td></tr><tr><td>Oct</td><td>2019</td><td>1004</td><td>613</td><td>61.%</td></tr><tr><td>Nov</td><td>2019</td><td>1080</td><td>605</td><td>56.%</td></tr><tr><td>Dec</td><td>2019</td><td>1104</td><td>608</td><td>55.%</td></tr><tr><td>Jan</td><td>2020</td><td>1184</td><td>638</td><td>54.%</td></tr></table> <table><tr><th>Admission Financial Year</th><th>Admission Financial Quarter</th><th>Number of Attendances</th><th>Inpatients Who were Rockwood scored</th><th>% of medical non elective inpatients Rockwood scored</th></tr><tr><td>2018/2019</td><td>4</td><td>3241</td><td>1895</td><td>58.%</td></tr><tr><td>2019/2020</td><td>1</td><td>3096</td><td>1800</td><td>58.%</td></tr><tr><td>2019/2020</td><td>2</td><td>2951</td><td>1787</td><td>61.%</td></tr><tr><td>2019/2020</td><td>3</td><td>3188</td><td>1826</td><td>57.%</td></tr><tr><td>2019/2020</td><td>4</td><td>1184</td><td>638</td><td>54.%</td></tr></table>
Decrease length of stay for patients with a Rockwood score of five or above	The length of stay for patients on OPU wards is monitored via weekly reporting. The focus was identifying patients with a frailty score of 5 or more as this forms part of the admission criteria for ACE OPU. The average length of stay for a patient with a frailty score of 5 or more was 4.72 days in January 2019 compared to 3.2 days in January 2020.

Rockwood Clinical Frailty Score

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

How we will continue to work with this priority

The development of the Frailty Assessment Unit remains a Quality Priority for 2020/21. How we will continue to work with the priority is set out in 2.8.

Priority 3. Improving patient and carer experience

Why it is important:

The experience that a patient and family have in the hospital has a lasting impact and is what they remember. Feedback from patients and their families tells us that we don't consistently listen and act upon their feedback, learn from them and share the learning with each other. This not only impacts on patient experience, but can affect care quality, especially when learning is not embedded.

What we said we would do	What we did
Improve internal communication of patient experience feedback and the subsequent learning and improvements	The Patient Experience Team worked closely with the Communications Team to improve internal communication to staff about patient and carer experience feedback and subsequent learning and improvements, in particular: • identify the variety of communication channels available to share patient and carer experience across the Trust and externally to the local community • look at appropriate and appealing messages and stories to share the information • plan the articles. The Patient Experience Team posted more than 35 items for staff 'In the Week' and 10 items in other publications, e.g. @RUH, Insight, Bath Chronicle, RUH website, and social media during 2019-20.
Design and implement a training programme that empowers staff to confidently respond to verbal concerns	We identified and developed tips, guidance and tools to support staff at all levels to respond to verbal concerns and act on formal complaints. These were launched on the RUH intranet pages in January 2020 to help staff to listen, assess the situation, and work together to resolve patient and family concerns. In particular, the Patient Experience team has developed guidelines to help staff to: • walk towards a patient or their family who have concerns, actively listen to them and make sure that their body language communicates their empathy and understanding • communicate well with a concerned patient or their family on the telephone • work out what to do next if they are not sure how to resolve their concerns. If their role includes dealing with formal complaints guidelines were developed to support them to: • arrange and conduct meetings with patients and their families who have a complaint

	• Investigate formal complaints and provide written responses to patients and their families' complaints. This information is also available as face-to-face training modules.
Establish a governance structure to identify areas of improvement based on patient / carer experience	The Patient Experience Team has aligned this work with the Quality Improvement teams supporting the reduction of risk and focusing on improving shared learning. The Quarterly Patient Experience Report has been improved with an increased focus on the learning identified from what patients and their families are telling us and how we are improving patient experience.

The Trust organised the first Improving Patient Experience Award Ceremony and Celebration Event for Tuesday 31st March at the RUH. Unfortunately, as a result of the COVID-19 pandemic, this event was cancelled, however we were delighted to receive 23 applications for the award. These were the finalists:

Winner - Inflammatory Bowel Disease (IBD) Team

This was awarded to the IBD team for improving patient attendance at its twice yearly information evenings.

The event was advertised through RUH social media channels and on the IBD Patient Website (Crohn's and Colitis UK). Messages via Facebook were sent to their followers in the local area. Posters were also displayed in the RUH Gastroenterology Outpatients area. Patients often contacted the IBD team for advice via e-mail and at the end of the reply to patients, an invite to the IBD evening was added.

Changes were also made to the quality of the evening, with shorter, patient-focussed lectures with a guest speaker e.g. a speaker was invited from London to give a talk about the 'IBD passport', so patients would have a better understanding of how to prepare for travelling.

Second Place - Riverside Sexual Health Team - Telephone consultations in preparation for intrauterine device technique (IUT) fitting

A short questionnaire was designed by clinicians asking patients whether they were happy with telephone consultations versus face to face counselling and preparation for IUT fitting. The feedback from patients was overwhelmingly positive and as a result of this, clinicians routinely telephone consultations with women prior to their IUT fitting appointment. Prior to this patients had to make several visit to the clinic.

Joint Third Place Therapies Oncology Team - Information and support for patients during their cancer journey

A patient experience questionnaire was developed to give patients the opportunity to input into the development of the services offered by the Therapies Oncology Team.

In partnership with patients, the therapies oncology team are co-creating a pre-habilitation pathway with the head and neck cancer and lung cancer clinical teams. A patient information leaflet has been developed explaining what the service can offer at the pre-treatment talk given by Cancer Support Workers from the Cancer Information and Support Centre.

Joint Third Place - Oncology Menopause Team - Aftercare Pathway for patients with breast and gynaecological cancers receiving hormone treatments

A patient questionnaire based on a validated Menopause questionnaire was adapted to find out what the experience at the hospital was like for this particular group of patients and whether there was a need to develop a specialist service.

Using the feedback from patients, a multidisciplinary clinic was set up to support patients on appropriate therapy, switching to safe alternatives where necessary and stopping therapies where they may no longer be beneficial and risks outweigh benefits, allowing them to make clearly informed decisions about their treatment while improving the quality of their life living with and/or beyond cancer.

How we will continue to work with this priority

This Quality Account links across all aspects of our improving together work and we will continue to improve on the success of this year:

- ‘Recognised as a listening organisation, patient centred and compassionate’ (Strategic Goal)
- Training for frontline staff on listening and responding to patient concerns
- Implement a programme of staff training and information sessions – ‘walking towards concerns’.

Priority 4. Improvement in early recognition of deteriorating patients

Why it is important:

Early recognition of any deterioration in a patient's clinical condition is essential to allow early review and decision making to occur, so that actions can be taken promptly to either prevent further deterioration, escalate care to a higher level, or make decisions that more aggressive intervention is not in the interests of the patient and allow appropriate care and comfort to be maintained.
The Royal United Hospitals has been using the national Early warning score (NEWS) for many years to support identification of deterioration and an updated version NEWS2 was introduced in November 2018 in line with national recommendations. This is, however, still being manually collected by the nursing staff and to ensure reliable information is available for all patients' electronic tools are required

What we said we would do	What we did
For 2019/20 we will continue to improve processes to identify both Sepsis and Acute Kidney Injury (AKI), as early as possible, as well as working on early identification of deterioration from any cause. We have joined the Sepsis, AKI and NEWS working groups to form a Deteriorating Patient Working Group from 2019 and aim to improve early decision making and early implementation of appropriate management for any deteriorating patient. To support that we will be implementing electronic recording of vital signs, such as heart rate and blood pressure. This will enable automatic prompts for deterioration in a patient's condition, facilitating more reliable identification of unwell patients and automatic screening for Sepsis where indicated. By April 2020,	In 2019 we have implemented electronic recording of vital signs (EObs), incorporating automatic recording of the National Early warning Score (NEWS), as well as an electronic alert if the score has increased by 2 or more points from the previous score, signifying a patients deterioration. Sepsis screening must then be completed electronically and an electronic sepsis pathway has been developed if sepsis is likely. The system started to be rolled out across the Trust in August 2019, and has been spread ward by ward to ensure adequate support and learning. By February 2020 three quarters of the Trust had EObs implemented, and weekly reports of compliance with sepsis screening demonstrating an improved compliance of 90%. The initial aim was for Trust wide implementation by July 2020, but as a result of the COVID-19 pandemic, roll out was paused in February. It was restarted in June 2020, with all ward areas being implemented by the end of July and full trust wide implementation expected by October 2020. Each team's compliance is fed back weekly by the Sepsis and Kidney Injury Prevention (SKIP) team for feedback. The availability of this information has enabled proactive review of those patients with high NEWS scores by the SKIP and Outreach teams. What we achieved:

acute teams will also be able to view a patient's vital signs remotely from other areas of the hospital, enabling them to review those patients with high early warning scores proactively	• Implementation of electronic recording observations to three quarters of areas by February 2020 (then paused, and restarted in June), all ward areas by July 2020. • All admission areas to be implemented by October 2020 • Sepsis Screening compliance 90% for all eligible patients including children and maternity by February 2020, including maternity and children • In 2019/20, 95% of in- patients with sepsis received antibiotics within an hour of diagnosis.
In 2019 we will also appoint a permanent prevention team for Sepsis and Acute Kidney Injury, the SKIP team (Sepsis and Kidney Injury Prevention), who will continue to educate and support staff in all areas of the hospital to identify Sepsis and any decrease in kidney function early, aiming to improve outcomes further.	In May 2019, the Sepsis and Kidney Injury Prevention (SKIP) was formed, with the permanent appointment of a band 7 and band 6 SKIP nurse. The team have continued to support management of Sepsis for emergency admissions and inpatient, and promote the early identification of Sepsis and AKI to enable earlier treatment and potential prevention, improving outcomes for patients. The team has been available 5-6 days a week. They also have an important educational role, and have been essential in the roll out of EObs. A second band 6 is required to enable the team to be available for 12 hours, 7 days a week from 2020, and funding for this post is awaiting approval. What we achieved: • SKIP Band 7 and Band 6 nurses appointed to permanent positions in May 2019 • Service available 5-6 days a week.
We will develop 'deteriorating patient champions' on all wards; to continue awareness at ward level and also support awareness campaigns planned throughout the year. These 'NEWS UP, WHATS Up" campaigns, in all ward areas will focus on ensuring staff understand the processes for early identification of any deterioration and continue to focus on sepsis screening and accurate recording of urine output. Tea trolley training (a method of taking training to	The focus for the second half of 2019 has been the roll out of EObs, and the SKIP team have been focusing on wards due to receive EObs, ensuring they are up to date with training. Tea trolley training has also occurred for some of these areas with support from the champions. The trust wide campaign planned for July once EObs has been implemented has been postponed until October 2020 because of the disruptions caused by the COVID-19 pandemic. What we achieved: • Deteriorating champions on all wards in April 2019 • Deteriorating champions event held on April 2019

the clinical area, where staff of all disciplines are encouraged to stop what they are doing for 5- 10 minutes, have a refreshment and undertaking some learning), will be used to support the campaigns and the campaigns will also focus on supporting the new electronic system.	
We will continue to use patient stories in our training and involve patients in our awareness campaigns.	A Local Sepsis support group has been established and has been supported by the Trust Sepsis Lead. The SKIP team have been attending this in 2019 and using feedback to improve the service.
We will develop a process for requesting NEWS score from community colleagues when referring patients including community hospitals, South West Ambulance Service (SWAST) and General Practitioners', to enable rapid assessment of those with high scores on arrival.	A process for requesting a NEWS score for all patient referrals to acute medicine has been tested in 2019 and is still being improved. Aim: 80% of patients referred from primary /community care will have a NEWS score on referral by March 2020. What we have achieved • SWAST routinely monitors NEWS scoring and it is therefore reliably available on admission • Work with the GPs to request NEWS on referral of patients is ongoing. This was paused during the COVID-19 pandemic, but will be an area of focus for 2020/21.

<u>Evidence of Improved outcomes Sepsis and AKI:</u>

Mortality rates from infectious causes are available from the National Suspicion of Sepsis dashboard. At the RUH there has been a further 7% decrease in 2019/20 in mortality from infective causes, with an overall 25% decrease in mortality since 2016.

Mortality rates:
2016/17 – 9.43%
2017/18 – 8.34%
2018/19 – 7.6%
2019/20 – 7.07%.

Mortality rates from AKI have shown a further 8% decrease in 2019/20, with a 12% decrease since 2016.

Mortality rates:
2016/17 – 24.6%
2017-19 – 23.5%
2019/20 – 21.7%

The incidence of AKI acquired during a patient's stay at the RUH has shown a further 7% decrease in 2019, resulting in a 23% decrease in incidence since 2019. Length of stay for patients with ALI has continued to decrease by a further 1.9 days over 2019.

How we will continue to work with this priority

This remains a patient priority for the Trust and is a national and regional safety priority. A deteriorating patient CQUIN commenced in 2020 although this is currently paused. The RUH will be submitting data for this once it re-commences.

The deteriorating patient working group will continue to drive improvements in early identification of the deteriorating patient and will be able to do this more proactively with the new information available from EObs. The critical care outreach team has expanded to be available 24/7, and with the new SKIP team also available 7 days a week, a new 'deteriorating patient team' will be available. Robust processes for escalation will be further developed as well as the expertise of both these teams, aiming for early rescue and prevention of deterioration as well as earlier admission to critical care when required.

A trust-wide 'Deteriorating Patient' campaign is currently planned for October 2020 to ensure all staff are aware of the new processes and teams.

2.8 Priorities for improvement 2020/21
Priorities at a glance:

	Priority 1	Priority 2	Priority 3	Priority 4
	Continuity of carer model to personalise maternity services	**Development of a frailty assessment unit**	**24/7 Critical Care outreach**	**Working with volunteers to improve staff and patient experience**
				
Patient Experience	√	√		√
Clinical Effectiveness	√	√	√	

Patient Safety	√		√	
True North Goals				
Recognised as a listening organisation; patient centred and compassionate	√	√	√	
Be an outstanding place to work where staff can flourish	√			√
Quality improvement and innovation each and every day	√	√	√	
Work together with our partners to strengthen our community	√	√		√
Be a sustainable organisation that is fit for the future	√			√

Priority 1:
Continuity of carer model to personalise maternity services

Why is it important?

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth.

Principles:
There are four main principles that will need to underpin the provision of continuity of carer models across the country:
1. Provide for consistency of the midwife and/or obstetrician who cares for a woman throughout the antenatal, intrapartum and postnatal periods
2. Include a named midwife who takes on responsibility for co-ordinating a woman's care throughout the antenatal, intrapartum and postnatal periods
3. Enable the woman to develop an ongoing relationship of trust with her midwife
4. Where possible be implemented in both the hospital and community settings.

What we will do in 2020-2021

- Work with maternity staff to transition our staffing model to develop teams which provide continuity of carer to 51% of women booked to have care at RUH Bath Maternity.
- Second Frome Birth Centre team development
- Specialist team for women with complex social needs development
- Elective caesarean birth team development
- Three further birth centre teams
- Develop feedback measures to measure both service user and staff satisfaction with the pilot models

How will we know we are making a difference

- Women and their families will give feedback about their experience of receiving care
- Staff will give feedback of their experience of working in the models.
- We will measure outcomes, looking specifically at improvements in safety.

Priority 2:
Development of a frailty assessment unit

Why is it important?

This development will continue to improve the service provision for the frail elderly. It builds upon the previous developments with the Frailty in-reach to the Emergency Department and the introduction of the Frailty Flying Squad.

What we will do in 2020-2021

- Increase the proportion of patients who have a Rockwood Frailty score (all patients); and for patients admitted under Medicine, for a comprehensive geriatric assessment (CGA) to be completed
- Increase the number of frail older patients being directly admitted to ACE OPU
- Increase the number of discharges from ACE OPU within 72 hours to usual place of residence
- Establish the baseline for the number of patients assessed in the Frailty Assessment Unit, with a view to increasing this throughput during 2020/21 – working with the Emergency Department and scoping the appropriateness of direct admits
- Capture patient feedback in the Frailty Assessment Unit to be reviewed in the Frailty Big Room

- Number of patients not requiring inpatient admission.

Priority 3:
24/7 Critical care outreach

Why is it important?

Early recognition of any deterioration in a patient's clinical condition is essential to allow early review and decision making to occur. This is so that actions can be taken promptly to prevent further deterioration, escalate care to a higher level (i.e. intensive care), or to make the decision that more intensive intervention is not in the interests of the patient and allow appropriate care, comfort and dignity to be maintained. The referral processes to escalate care in the RUH are currently not always consistent. There are a number of routes depending on day of the week, and time of day therefore the introduction of 24/7 critical care outreach services will introduce a standardised process of escalating patient care on the wards to enable the right care, at the right time, in the right place. This may see an increase in the number of patients admitted to critical care, but, through this earlier intervention, these patients will not be as sick (defined by 4 organ e.g. heart, lungs, kidney etc. failure or more) when we make the decision to admit.
Our aim:

1. To reduce the number of patients admitted to Critical Care with 4 or more organ failure through earlier intervention
2. To ensure there are no 'missed opportunities' in management and escalation of the deteriorating patient

What we will do in 2020-2021

- We will reduce the number of patients requiring admission to the Intensive care unit with 4 or more organ failure
- We will deliver the ability to act on any patient with a high NEWS2 score. - NEWS2 is the national early warning score that takes a patient's vital observations to determine the degree and illness and prompts critical intervention if required.
- We will achieve a timelier referral, review and intervention of patients who require admission and organ support into the critical care.
- We will deliver more support for ward level staff looking after unwell or deteriorating patients
- We will support ward staff needing to deliver advanced techniques outside of Critical Care (we can assist breathing support to patients through non-invasive ventilation or nasal high flow).

- We will give senior clinical oversight to the electronic observations (EObs) programme in the RUH, both during the day and during the night. Twenty-four-hour clinical oversight of the Trust wide EObs programme will provide a safety-net for patients who trigger the need for a review based on their flagged observations.
- We will reduce Critical Care length of stay (due to more timely admission to Critical Care).
- We will develop an operational delivery protocol and a process of referral to the outreach team.
- Acquisition of additional skills for outreach nurses in line with guidance from the national outreach framework.
- We will work towards the combination of the critical care outreach and the sepsis nursing teams to provide a single point of contact for the deteriorating patient, thereby reducing risk of delayed referrals and care to our patients.
- We will broaden our scope of practice to include the review of patients on the Bath Birthing Centre (BBC) who may require obstetric high dependency

Priority 4:

Working with volunteers to improve staff and patient experience

Why is it important?

Volunteers make a huge contribution to support the NHS; giving their time, skills and expertise freely each year. The time volunteers give every day, in a very wide range of roles, makes a valuable contribution to the quality of care patients' experience and eases the pressure on staff. We want to be able to offer quality volunteering opportunities ensuring that our volunteers feel valued and an integral part of the RUH team.

What we will do in 2020-2021

In partnership with the League of Friends of the RUH, we will introduce robust systems and procedures to ensure good governance around the appointment, supervision and development of our volunteers, in particular:

- We will work with staff to identify meaningful volunteer roles that supports the work that they do
- We will recruit volunteers into these roles.

- We will ensure the volunteers have the appropriate training and support to enable them to effectively undertake the required tasks.
- We will also develop a Trust Volunteer Strategy and ensure this is communicated across the organisation
- We will improve communication between the hospital and volunteers to ensure they feel informed and valued.

In addition to the priorities described above, the Trust and its partners in the local health and care sector will continue to ensure that the management of patients suffering with COVID-19 is in line with recognised best practice, taking account of latest research, techniques and medications. At the same time, the Trust will continue to build on learning derived from the pandemic in managing patient care in the "new normal".

Statement of assurance from the Board of Directors

Mandatory Statement 1

1. During 2019/20, the Royal United Hospitals Bath NHS Foundation Trust provided and/or subcontracted eight relevant health services across three clinical divisions: Medicine, Surgery and Women and Children's.

    1.1 The Royal United Hospitals Bath NHS Foundation Trust has reviewed all the data available to them on the quality of care in all eight relevant health services.

    1.2 The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by the Royal United Hospitals Bath NHS Foundation Trust for 2019/20.

Mandatory Statement 2

During 2019/20, 44 national clinical audits and 3 national confidential enquiries covered relevant health services that the Royal United Hospitals Bath NHS Foundation Trust provides.

During that period the Royal United Hospitals Bath NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal United Hospitals Bath NHS Foundation Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
NCEPOD		
Child Health Clinical Outcome Review Programme	N/A	N/A (Data not collected nationally during 2019/20)
Mental Health Clinical Outcome Review Programme: **National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)**	N/A	N/A (Mental Health Trusts only)
Medical and Surgical Clinical Outcome Review Programme: **Out of Hospital Cardiac Arrest**	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: **Dysphagia**	Yes	100%
Medical and Surgical Clinical Outcome Preview Programme: **Acute Bowel Obstruction**	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: **Long-Term Ventilation**	N/A	N/A (the Trust does not admit patients on Long-Term Ventilation or manage their respiratory care)
National Audits		
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes	TBC (data collection August 2019 to January 2020)
BAUS Urology Audit - Cystectomy	N/A	Not relevant to RUH
BAUS Urology Audit - Female Stress Urinary Incontinence	N/A	Not relevant to RUH
BAUS Urology Audit - Nephrectomy	Yes	100%
BAUS Urology Audit - Percutaneous Nephrolithotomy	Yes	100%
BAUS Urology Audit - Radical Prostatectomy	Yes	100%
Care of Children in Emergency Departments	TBC	100%
Case Mix Programme (CMP)	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
Elective Surgery - National PROMs Programme	Yes	100%
Endocrine and Thyroid National Audit	Yes	100%
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	100%
Major Trauma Audit	Yes	100%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	100%
Mental Health - Care in Emergency Departments	Yes	100%
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health (U&E MH) Care and Intensive	N/A	Not procured for third national CYP U&E MH care survey. Project closed
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation (NACR)	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (Care in general hospitals)	Yes	100%
National Audit of Pulmonary Hypertension (NAPH)	Yes	100%
National Audit of Seizure Management in Hospitals (NASH3)	Yes	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	32 cases submitted (currently no requirement for a specific number of cases to be submitted)

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
National Bariatric Surgery Registry (NBSR)	N/A	Not relevant to RUH
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Cardiac Audit Programme (NCAP)	Yes	100%
National Clinical Audit of Anxiety and Depression	N/A	Not relevant to RUH
National Clinical Audit of Psychosis	N/A	Not relevant to RUH
National Diabetes Audit – Adults	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastro-intestinal Cancer Programme	Yes	National Oesophago-gastric Cancer (NOGCA) National Bowel Cancer Audit (NBOCA) – 100%
National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%
National Ophthalmology Audit (NOD)	Yes	N/A (Central funding was discontinued and devolved to Trust levels. Trust did not agree funding in time for inclusion in audit)
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Smoking Cessation Audit	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
National Vascular Registry	N/A	Not relevant to RUH
Neurosurgical National Audit Programme	N/A	Not relevant to RUH
Paediatric Intensive Care Audit Network (PICANet)	N/A	Not relevant to RUH
Perioperative Quality Improvement Programme (PQIP)	Yes	100%
Prescribing Observatory for Mental Health (POMH-UK)	N/A	Not relevant to RUH
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	100%
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
UK Parkinson's Audit	Yes	100%

The reports of 28 national clinical audits were reviewed by the provider in 2019/20 and Royal United Hospitals Bath NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Audit of Care at the End of Life.

The Trust performed better than other trusts for recognising possibility of imminent death, involvement of patients / carers in decision making, meeting needs of families and others, individual plans of care and governance. There were 3 standards where the Trust performed about the same as other trusts; communication with the dying person, communication with families and others, workforce / specialist palliative care. Within the palliative and End of Life Care work plan for 2019/20 embedding the Consider Have Advise Transfer (CHAT) Bundle and Priorities for Care Bundle and implementing the updated Priorities for Care will support improvements for recording the outcome of discussions around the dying person's care plan. The standard for 7-day working will improve with the next audit, with the implementation of Specialist Palliative Care Team (SPCT) 7 day working.

National Early Inflammatory Arthritis Audit.

The Trust is above average for time to initiation of disease modifying anti-rheumatic (cDMARD) therapy for those patients with a confirmed diagnosis of Rheumatoid Arthritis (RA) pattern early inflammatory arthritis (EIA), treatment target set and

agreed and patients provided with contact details for the department in the event of a problem. The Trust is significantly worse than other Trusts for referral made within three working days of presentation with EIA symptoms, in accordance with NICE Quality Standard 1. Following the audit, the triage criteria for the early arthritis clinic has been revised and the move to electronic triage has improved the potential for delay in triage. Patients are highlighted that may be breaching the 3 week from referral time to appointment.

National Emergency Laparotomy Audit 2018-19.

Figures up until December 2019 show improvement from the period December 2016 to November 2017 in two areas: Consultant Anaesthetist in theatre is now 90% and geriatric input is now 60% of patients following the appointment of a geriatrician with some surgical liaison sessions in May 2019. The other areas have been sustained with risk assessment, critical care admission and surgical consultant all being above 90%. The Trust is performing above national standards in all areas and has sustained a reduction in mortality, which for 2019 was 5%, half the national average. Results for Quarter 3 for 2019/20 indicate improved compliance with the audit standards with no standards rated as 'Red'. The audit results are routinely presented to the Anaesthetic Department. A protocol for Critical Care admission post-op has been developed and disseminated. Unpublished data shows 95% had consultant anaesthetist in 2019.

National Ophthalmology Database Audit.

The audit showed that the Trust is performing better than the national average for Consultant Surgeon Posterior Capsular Rupture rate (0.5% compared to 1.1% nationally). The Trust is performing worse than the national average for overall Consultant Surgeon Visual Acuity loss (1.2% compared to 0.9% nationally). The audit findings were disseminated to the Surgery Division Clinical Governance meeting. The visual acuity issue was investigated by a Consultant and it showed that it was a data entry issue that has now been corrected.

National Neonatal Audit Programme

The 2018 report showed that the Trust was in the expected range for 6 of the 7 audit standards. The Trust is performing worse than expected for documented consultation with parents / carers by a senior member of the neonatal team within 24 hours of admission. Advanced Neonatal Nurse Practitioners (ANNP) undertook a case note review under the supervision of the Neonatal Nurse Consultant (Service Lead) to ascertain the accuracy of the data capture and documentation of a consultation with the parents by a senior member of the team. This demonstrated that the consultation was not being specifically highlighted but may have been evidenced through a ward round note or as part of other clinical activity where the parents were present. The clinical teams now indicate that a consultation has happened with the parents, regardless of the context or other form of note taking, by completing a sticker placed in the medical records. The revised process involves a data clerk inputting missing data and an ANNP having oversight of all data. To support this data for Quarter 3, 2019/20 showed 94.8% performance against the standard of a documented consultation with parents by a senior member of the neonatal team within 24 hours of a baby’s first admission.

National Maternity and Perinatal Audit Clinical Report 2019

The Trust is performing significantly better than the national average for proportion of live born babies who are breastfed for the first feed and at discharge from the maternity unit. The Trust is performing significantly worse than expected for proportion of small for gestational age babies who are not delivered before their due date, proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no clinical indication for early delivery and the proportion of single, term infants with a 5 minute Apgar score of less than 7. The Trust has implemented a maternal neonatal safety collaborative improvement project running jointly between maternity and neonatology. This involves risk assessment in labour to recognise the deteriorating woman and optimising the outcomes for the baby at birth. This is reported monthly to NHS Improvement as part of the safety collaborative. Staff interviews have been undertaken on how risks are assessed at the start of labour and how this is monitored on going throughout labour. Data is collected for the number of women screened for sepsis, how many women have received appropriate antibiotic prophylaxis in labour and the number of women who have had fetal monitoring reviews as per local protocol. The next stage is to involve larger numbers of the team to engage in weekly safety huddles and roll out education and completion of current risk assessments in the maternity notes.

Society for Acute Medicine National Benchmarking (SAMBA) Audit 2019

This audit identified that senior reviews for patients admitted early evening are often delayed. A new on call medical model commenced in January 2020 ensuring more consistent evening cover until 8pm. The prompt review of evening and night patients the following morning will improve compliance with the 14-hour senior review standard.

The reports of 119 local clinical audits were reviewed by the provider in 2019/20 and the Royal United Hospitals Bath NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Main Theatre Swab and Instrument Count

Good compliance was demonstrated with the Operating Theatre Standard 65 indicating that swab and instrument counts are carried out in a safe and timely manner. There were two standards identified where improvement is required related to recording and reporting of discrepancies in counts. The audit was discussed at the Theatres Clinical Governance Meeting. The issue of discrepancies in the count were identified in 2 cases on the audit form. This was investigated and it was identified that the poor compliance was due to incorrect recording of the response for this question on the audit proforma rather than any discrepancies in the count. The audit will be repeated in 6 months.

Audit of the Safeguarding Children Supervision Policy

The audit found that more than half the staff identified as requiring planned supervision had not attended a safeguarding supervision session. The audit findings were highlighted at the Safeguarding Children's Committee. Ongoing work is being

undertaken to encourage staff to attend supervision through individual supervisors and the Supervision group, with the support of ward managers/matrons. The audit forms were reviewed to find out which staff groups or departments did not know how to access supervision.

Outcomes of DEXA imaging (bone scan) in Coeliac patients

The audit identified that more than 80% of patients were below the local intervention threshold with 74% of scans making no treatment recommendations. The audit has resulted in a new Integrated Clinical Environment (ICE) referral pathway and education of the multidisciplinary teams. Guidance to be developed to avoid unnecessary scans.

Children's Social Care Referral Documentation Audit

The audit found that referrer's details, nature of concerns/risk and consent were consistently documented in most areas. There were some inconsistencies in the details that were being documented in the referral documentation in some areas, particularly the Emergency Department. Bespoke training and a Situation, Background, Assessment Recommendation (SBAR) toolkit has been developed following the audit.

Head Injury Management in the Emergency Department (ED)

The audit found that all adults and children had a Computer Tomography (CT) scan within the required timeframes. However, improvement was required for completion of the head injury proforma, adults with head injuries having neuro observations performed and adults and children being given verbal or printed discharge advice following a head injury. A new head injury proforma and guidelines will be developed and these will be made available on the Intranet. A poster will also be developed to provide visual reminders. Verbal reminders of best practice have been given to staff through daily handovers.

Mandatory Statement 3

The NHS has a clear mandate from government that it should be committed to research and the use of research evidence in its clinical activities. Patients benefit from access to clinical trials including cutting edge treatments and the NHS benefits from new medicines, technologies and processes. Consequently, the RUH aims to provide as many patients as possible with the opportunity to participate in research trials and have access to treatments that might not otherwise have been available to them.

The number of patients receiving relevant health services provided or sub-contracted by the Royal United Hospitals Bath NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 1872.

At any given time, the Trust has around 300 individual research studies ongoing across a wide range of clinical specialities and departments. Many of these

research studies are collaborative in nature and support relationships with local and national research funders, Universities, NHS organisations and commercial partners within the life sciences industry.

The RUH continues to expand its portfolio of research which is initiated and run by our own research staff, encompassing consultants, research nurses and allied health professionals, a number of whom hold academic Professor and lectureship positions in a variety of clinical areas. The RUH continues to work collaboratively with surrounding universities including the Universities of Bath, Bristol and The West of England; this ensures that the research conducted at RUH addresses the health needs of our local community.

Research grants awarded 2019-2020 (as of 05/03/2020)

Lead Applicant	Speciality	Title of project	Money awarded	Awarding Organisation
Jenny Lewis	Therapies (OT)	Creating a Visual Hand Illusion to treat chronic pain	£ 9,800	UWE
Mark Beresford	Haematology / oncology	Unravelling the roles of insulin-like growth factor binding proteins (IGFBPs) in breast cancer progression	£ 1,850	CR@B
Mark Beresford	Haematology / oncology	Does exercise enhance the efficacy of immunotherapy	£ 2,000	CR@B
Raj Sengupta	Rheumatology	Project Nightingale	£ 30,000	UCB
Raj Sengupta	Rheumatology	Validation of 3D ultrasonography for the analysis of spinal load in Axial Sponyloarthritis	£ 4,000	BIRD / University of Bath
Raj Sengupta	Rheumatology	Assessing the impact of rehabilitative interventions on the natural history of ankylosing sponylitis	£ 19,723	NASS / University of Bath
Alison Llewellyn	Pain Service	Establishing evidence-based management of Complex Regional Pain Syndrome to improve clinical outcomes throughout the care pathway	£ 162,535	NIHR
Sandi Derham	Rheumatology OT	A feasibility Randomised Controlled Trial (RCT) of a Fibromyalgia Self-Management Programme (FSMP) in a community setting	£ 111,121	UWE / University of Bristol
John Pauling	Rheumatology	Mycophenolate in limited cutaneous Systemic Sclerosis	£ 496,380	Versus Arthritis

John Pauling	Rheumatology	Development of a novel PRO for digital ulcers in Systemic Sclerosis	$ 15,000	SCTC
Esther Crawley	Child Health	Measuring Health in Children with CFS/ME – refinement, application and evaluation of new PROM (PEACH) in routine practice	£ 149,385	NIHR

Mandatory Statement 4

(a) A proportion of Royal United Hospitals NHS Foundation Trust income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between Royal United Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.
Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

Mandatory Statement 5

The Royal United Hospitals Bath NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered'. The Royal United Hospitals Bath NHS Foundation Trust has no conditions attached to its registration.

The Care Quality Commission has not taken any enforcement action against the Royal United Hospitals Bath NHS Foundation Trust during 2019/20.

Mandatory Statement 6 **Removed**

Mandatory Statement 7

The Royal United Hospitals Bath NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Mandatory Statement 8

Royal United Hospitals Bath NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:
which included the patient's valid NHS number was:

- 99.7%for admitted patient care
- 99.9% for outpatient care and
- 98.2% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 99.8% for outpatient care; and
- 100% for accident and emergency care.

Mandatory Statement 9

The Royal United Hospitals Bath NHS Foundation Trust Information Governance Assessment Report overall score for 2019/20 was "Standards Met" where all 116 mandatory assertions were completed.

Mandatory Statement 10

The Royal United Hospitals Bath NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 financial year by the Audit Commission.

Mandatory Statement 11

The Royal United Hospitals Bath NHS Foundation Trust will be taking the following actions to improve data quality.

- Continue to use and further develop the Data Quality Assurance Framework implemented during 2015/16 as a way of assessing the quality of information reported to the Board. This process assigns a confidence rating to key performance standards based on the outcome and frequency of internal and external data quality audits.
- Continue to incorporate Data Quality in the internal audit programme, ensuring that the quality of information remains a high priority for the Trust.
- Continue the work of the Data Quality Steering Group, which meets regularly to oversee data quality within the Trust. The group monitors data quality issues and receives the outcomes of audits and external data quality reports to support resolution of issues and improvement work. The meetings are attended by staff from the Information Department and staff working in operational roles as well as Finance and IM&T to make sure that the Trust maintains high quality and accurate patient information to support patient care.
- Action any data quality issues raised by commissioners and other NHS and non-NHS bodies that receive and use the Trust's data. This includes monthly reporting of the Trust's performance against Secondary User Service (SUS) data quality reports and the NHS Data Quality Maturity index.

Learning from Deaths

Mandatory statement 27

Mandatory statement 27.1

During 2019/20, 1511of the Royal United Hospitals Bath NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 365 in the first quarter;
- 317 in the second quarter;
- 399 in the third quarter;
- 430 in the fourth quarter.

Mandatory statement 27.2

By 2019/20 218case record reviews and 23 investigations have been carried out in relation to 213 of the deaths included in item 27.1.

In 10 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 41in the first quarter;
- 25 in the second quarter;
- 8 in the third quarter;
- 14 in the fourth quarter.

Mandatory statement 27.3

1 representing 0.04% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- 1 representing 0.3% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0%for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review Process.

Mandatory statement 27.4

The Trust has developed a methodology that allows us to review all deaths. We are reporting 1 case during the reporting period judged to be more likely than not to be due to problems in the care provided to the patient, we have been able to identify problems with care that did not directly contribute to the death. This has provided important learning. Examples of areas of learning include:

- Delayed recognition of deterioration of patients on medical wards due to acute surgical problems

- Peri-operative nutrition
- Record keeping
- Medicines reconciliation on admission
- Delay in escalating deterioration in NEWS

We expect to gain greater insights and learning as the work gains momentum.

Mandatory statement 27.5

As part of our Trust Strategy we have identified our Quality True North Goal to achieve “quality improvement and innovation each and every day” as measured by a reduction in avoidable harm and mortality. We are focusing in particular on the recognition of the deteriorating patient, hospital acquired infections, falls, medicines safety and incident reporting. These areas are themes in the reviews.

Mandatory statement 27.6

The Trust has made good progress with rolling out electronic observations to support our teams in appropriately utilising the early warning scores and to facilitate early escalation of the deteriorating patient. There is deteriorating patient group chaired by the Medical Director. This group coordinates developments such as the recent expansion of the critical care outreach team into 24/7 working, it also oversees the coordination of sepsis screening, acute kidney injury detection and escalation of clinical concerns.

Mandatory statement 27.7

74 case record reviews and 2 investigations completed after 31/03/2019 which related to deaths which took place before the start of the reporting period.

Mandatory statement 27.8

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Royal College of Physicians Structured Judgment Review (SJR) tool which is used to investigate the care of patients whose deaths trigger initial review using a screening tool

Mandatory statement 27.9

0 representing 0 % of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Reporting against core indicators

SHMI

	Measure	Latest Reporting Year	RUH Performance		National Average	National Best	National Worst
			Feb 19 - Jan 20	Feb 18 - Jan 19	Feb 19 - Jan 20		
Summary Hospital Level Mortality Indicator (SHMI)	Value	2019/20	1.04	1.02	1.00	0.68	1.20
	Banding	2019/20	2	2	2	3	1
	% of Patient Deaths with Palliative Care Coding	2019/20	27.0%	28.0%	36.0%	58.0%	9.0%

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data is published by NHS Digital using data provided by the Trust. SHMI is reported as a twelve month rolling position, and the reporting periods shown are the latest available from NHS Digital.

The SHMI value is better the lower it is. The banding level helps to show whether mortality is within the “expected” range based on statistical methodology. There are three bandings applied, with a banding of two indicating that the mortality is within the expected range. The Trust has a value of two meaning that mortality levels are not significantly higher or lower than expected.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

The Trust scoring against this measure is within the expected range and the latest published figures show an improvement on the previous period. Because of this no specific improvement actions have been identified, however the Trust is committed to continuing to reduce mortality as measured by both SHMI and HSMR (Hospital Standardised Mortality Ratio) indicators. The Trust performance against HSMR is detailed in section three of the Quality Accounts.

Our Clinical Outcomes Group, chaired by the Medical Director, monitors these indicators on a regular basis, and we use the Dr Foster Intelligence System to monitor mortality and clinical effectiveness.

PROMS

Measure		Latest Reporting Year	RUH Performance		National Average	National Best	National Worst
			Apr 19 - Sep 19	Apr 18 - Mar 19	Apr 18 - Mar 19		
PROMS: Patient reported outcome measure	Groin Hernia - EQ VAS	2017/18	*				
	Groin Hernia - EQ-5D Index	2017/18	*				
	Total Hip Replacement EQ VAS	2017/18	*	12.608	14.103	20.734	6.444
	Total Hip Replacement EQ-5D Index	2017/18	*	0.421	0.457	0.546	0.348
	Total Hip Replacement Oxford Hip Score	2017/18	*	21.426	22.258	25.377	18.694
	Hip Replacement Primary EQ VAS	2017/18	*	11.676	14.422	21.297	6.602
	Hip Replacement Primary EQ-5D Index	2017/18	*	0.412	0.465	0.557	0.348
	Hip Replacement Primary Oxford Hip Score	2017/18	*	21.706	22.680	25.376	18.752
	Hip Replacement Revision EQ VAS	2017/18	*	*	7.704	11.762	3.290
	Hip Replacement Revision EQ-5D Index	2017/18	*	*	0.287	0.396	0.206
	Hip Replacement Revision Oxford Hip Score	2017/18	*	*	13.864	18.961	7.853
	Total Knee Replacement EQ VAS		*	10.314	7.537	11.524	0.938
	Total Knee Replacement EQ-5D Index		*	0.377	0.337	0.406	0.262
	Total Knee Replacement Oxford Knee Score		*	18.554	17.197	19.979	13.546
	Knee Replacement Primary EQ VAS	2017/18	*	10.061	7.621	12.121	0.553
	Knee Replacement Primary EQ-5D Index	2017/18	*	0.372	0.338	0.405	0.266
	Knee Replacement Primary Oxford Knee Score	2017/18	*	18.507	17.330	20.011	13.774
	Knee Replacement Revision EQ VAS	2017/18	*	*	5.240	5.810	2.311
	Knee Replacement Revision EQ-5D Index	2017/18	*	*	0.288	0.297	0.196
	Knee Replacement Revision Oxford Knee Score	2017/18	*	*	13.598	15.784	9.014
	Varicose Vein Aberdeen Varicose Vein Questionnaire	2017/18	*	*			
	Varicose Vein EQ VAS	2017/18	*	*			
	Varicose Vein EQ-5D Index	2017/18	*	*			

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data is published by NHS Digital using data provided by the Trust and patient responses. The Trust give pre-operative questionnaires to all eligible patients and a follow up post-operative questionnaires sent to patients by an external company in line with national guidance.

Information is only available for some measures for the Trust against PROMS measures for the most recent reporting period. This is because a low number of the post-operative questionnaires have been returned to date, due to the time it takes to gather and process responses. Small numbers are not published because it is difficult to make accurate assumptions about improvements in care, and in some cases information has to be excluded to protect patient confidentiality.

The reporting periods shown are the latest available from NHS Digital

The data for April to March 2018/2019 are finalised figures published by NHS Digital. Finalised figures are not available for the 2019/20 year.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

Re-admissions

Measure		Latest Reporting Year	RUH Performance		National Average*	National Best*	National Worst*
			Apr 19 - Nov 19	Apr 18 - Mar 19	2018/19		
Patient readmitted to a hospital within 28 days of being discharged	0-15 years old	2019/20	10.80%	11.00%	9.60%	3.10%	16.10%
	16 years or over	2019/20	10.40%	9.90%	8.70%	5.90%	11.50%

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

Published data from NHS Digital for the most recent time periods was not available at the time of reporting, and so in order to provide more up to date information the performance above has been taken from a different source. The data has been taken from Dr Foster Intelligence, a benchmarking tool used by the Trust to monitor patient outcomes using data submitted by the Trust. National comparison figures have also been taken from Dr Foster for 2019/20 based on non-teaching Acute Hospital Trusts.

Due to the time it takes to publish the data we are only able to include figures from April – November 2019 as the latest period.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

Re-admission rates published by Dr Foster are reviewed at the Trust's monthly Clinical Outcomes Group meeting that is chaired by our Medical Director. When individual diagnostic groups are outside of the expected range for readmissions a review is undertaken to understand what may be contributing to this.

Responsiveness to personal needs of patients

Measure		Latest Reporting Year	RUH Performance		National Average	National Best	National Worst
			2018/19	2017/18	2018/19		
Responsiveness to the Personal needs of Patients	Inpatient Overall score	2018/19	68.8%	70.3%	67.2%	85.0%	58.9%

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data is published by NHS Digital using patient responses to the National Inpatient Survey. The list of patients was provided by the Trust using the methodology and criteria specified for the survey. In order to protect the confidentiality of responses the survey was administered and analysed by a Care Quality Commission (CQC) approved external contractor. The inpatient overall score uses the results of a selection of questions from the survey looking more broadly at hospital care.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

The results for the National Inpatient Survey 2018 were presented to the Board of Directors in June 2019. The CQC compared the Trust responses to the survey questions against all other acute Trusts and whether the RUH was 'better', 'worse' or 'about the same'. In 2018, the Trust scored better than average on one question 'Did you feel you were involved in decisions about your discharge from hospital?' (7.5/10) There were no questions where the Trust was in the 'worse' performing category.

There were four questions where the Trust results for this year were 'significantly lower' than the previous year and some of these relate to patient experience in the Emergency Department (ED). In particular, having enough privacy when being examined and treated and waiting for a bed on a ward. Better curtains were purchased to provide increased privacy in ED, however the Trust recognises that for patients waiting in corridors to be seen that privacy is of utmost importance. One of the Trust priorities next year is to focus on improving the flow of patients through the hospital and to free up bed spaces earlier in the day.

Staff recommending the Trust to family and friends

Measure	Latest Reporting Year	RUH Performance		National Average*	National Best*	National Worst*
		2019	2018	2018		
Staff who would recommend the trust to their family or friends	2019	73.2%	76.7%	70.5%	87.4%	39.7%

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data shown is taken from the NHS Staff Survey. The survey is run and analysed by an external company and so this cannot be calculated internally. This is done in line with national guidance. For the past five all staff members were given the opportunity to complete a staff survey to make sure opinions were captured from as many people as possible.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

The Trust scored above the national average for acute trusts for this measure, although the proportion of staff who would recommend the Trust for treatment to friends and family has deteriorated in comparison to year's results. The Trust is building on its long term quality improvement programme, Improving Together, which will help the organisation to deliver its vision to provide the highest quality of care,

support staff to live the Trust's values, and help them to work together on shared goals.

VTE

Measure	Latest Reporting Year: 2019/20	RUH Performance		National Average	National Best	National Worst
		2019/20	2018/19	2018/19		
Patients admitted to hospital who were risk assessed for venous thromboembolism	Q1	91.50%	93.00%	95.42%	100.00%	75.84%
	Q2	90.20%	92.84%	95.37%	100.00%	68.67%
	Q3	87.40%	92.26%	95.37%	100.00%	54.86%
	Q4	82.70%	93.07%	95.50%	100.00%	74.03%

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data shown is published by NHS Digital using data provided by the Trust. The figures published are consistent with local calculations of the information that has been submitted. Performance is published as quarterly totals.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

Data continues to be available for all patients per area following implementation of the electronic risk assessment in November 2017. Compliance has been above 90% except in quarters 3 and 4 in 2019/20, which may reflect changes in patient admission locations, particularly during the COVID-19 pandemic. This may therefore be a data accuracy issue rather than drop in compliance. Further analysis of the data to ensure accurate location inclusion is being undertaken. Compliance is also fed back to individual areas with plans for improvement being put in place where required.

Clostridium difficile (C. difficile)

Measure		Latest Reporting Year	RUH Performance		National Average	National Best	National Worst
			2019/20	2018/19	2018/19		
Rate of C.difficile infection	Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over	Reported (Hospital Onset, Healthcare Associated)	11.7	10.3	13.57	0.0	90.0
		Actual (Hospital Onset, Healthcare Associated)	10.2				

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The performance shown for the current reporting period (April 2019 to March 2020) has been calculated internally by the Trust using data submitted nationally as published data was not available at the time of reporting. The comparative data for 2018/19 is published by NHS Digital.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

- Strengthening the process for recording the patient's normal bowel habit on admission
- Improving documentation on stool charts; senior sisters are undertaking regular audits of documentation and feeding back to staff
- Keeping a focus on antimicrobial stewardship; the Antibiotic Review Kit training will become mandatory for junior medical staff, a 5 year plan for progressing antimicrobial stewardship will be launched, and the number of antimicrobial stewardship ward rounds carried out is increasing
- Ensuring that all patients with *Clostridium difficile* infection are reviewed by the Microbiology Team at least once a week so that treatment can be adjusted if required and other medications rationalised to reduce the risk of further episodes of diarrhoea
- Improving cleanliness standards of the environment and equipment; including increased cleaning resources in wards and departments to cover 7 days a week, increased cleaning frequency of patient equipment, and regular audits to monitor standards and rectify issues if identified.

Patient Safety Incidents

Measure		Latest Reporting Year	RUH Performance	RUH Performance	RUH Performance	National Median*	National Best*	National Worst*
			Oct 18 - Mar 19	Apr 18 - Sep 18	Oct 17 - Mar 18	Oct 18 - Mar 19		
Patient Safety incidents and the percentage that resulted in severe harm or death	Number of Patient Safety Incidents	2018/19	3940	3623	3308	3964	8289	1580
	Rate of Patient Safety Incidents (per 1000 bed days)		35.5	32.4	31.1	44.7	95.9	16.9
	Number Resulting in severe harm or death		24	42	34	15	1	42
	% resulting in severe harm or death		0.22%	0.38%	0.32%	0.15%	0.01%	0.49%

The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The performance shown is for the latest and most recent reporting periods published by NHS Digital.

Incident reporting remains consistent for the patient population using Trust services. The increase in the number of patient safety incidents is a reflection of a drive to improve staff awareness of the impact incident reporting has on care and service delivery. The data also reflects pressures on services as an increasing population and longer life expectancy impact on admissions to hospital. Winter pressures are known to result in an increasing number of patients attending the emergency

department and patients awaiting packages of care for discharge into the community.

Staffing, admission issues and Patient Falls feature as the top three highest reported incidents. Concerns reflect a continuing national picture of infrastructure where recruitment to full establishment is a challenge and resources for social care impact on the options to discharge patients with appropriate packages of care in place. Patient falls reporting is monitored by the falls steering group. The introduction of an overarching action plan to steer serious falls investigations has enabled the Trust to identify areas of new learning requiring further analysis and focus work on prevention of harm from falls.

The level of significant harm has decreased compared to the same time period of the previous year. The Trust has been pro-active in sharing learning across the Trust through Governance processes and ensuring staff are informed of the positive impact of incident reporting and learning. The Trust identified that there were delays in the initial review of incidents to determine whether a Serious Incident investigation was required. This delay was impacting on meeting the 60 working day target for completion of investigations for serious incidents. A Serious Incident Task and Finish Group has been established with representation from the central Risk Team and Divisional Risk leads with the objective of improving the quality and timeliness of Serious Incident Investigations. A new 72-hour report process has been introduced which has resulted in a more timely decision of the level of investigation required for incidents.

Investigations are conducted by a panel which includes experts to advise on gaps in systems and processes. The panels are supported by the central risk team and Divisional patient safety leads, which is a role recently established within all Clinical Divisions. The National data shows a continued improvement in pro-active culture with a reduction in severe harm events.

The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

- Maintaining training in reporting and management of patient safety incidents by the clinical risk team working with staff in ward areas.
- Rolling out an approach to pressure ulcer investigations and hospital acquired Venous thrombosis events using a similar process to falls investigations with an overarching work plan in place to enable a focus on prevention and reducing harm from common events.
- Focus on new learning from incidents by conducting deeper dives into themes and trends from frequently occurring incidents such as falls
- A review of decision making around significant harm incidents. It was agreed that an initial review of incidents, to determine whether a serious incident investigation is required, would be undertaken at a divisional level with the senior leadership teams, with support from the Risk Team. These discussions take place within 72

hours of the incident being reported, and is a shift away from Rapid Incident Review meetings at which a more extensive review of the incident was undertaken at the start of the process before a decision on the level of the investigation was made. This often led to delays in starting the investigation due to challenges in getting all relevant staff together at short notice to review the incident.

- Once the initial decision has been made on whether a serious incident investigation is required, a more extensive review of the incident is undertaken using a 'Round Table' panel approach. This involves a review of the incident and relevant documentation with clinical experts, the central Risk Team and divisional patient safety leads to ensure the production of good quality reports in a timely manner with robust action plans in place.
- Documentation has been reviewed to ensure the information gathered is consistent and in line with National guidance for investigating.
- Action plans will be monitored 6 months after investigations are closed to identify if work is effective or requires improvement.
- The central risk team are working with the Clinical Commissioning Group to ensure assurances of serious incidents are considered and addressed in a timely manner.

Part 3 Other Information

3.1 Local Quality Indicators – clinical effectiveness; patient safety; and patient experience

This section of our Quality Accounts provides an overview of the quality of care we provided in 2019/20. The information shows our performance against mandated indicators as set out in the guidance from NHS Improvement and also against a number of indicators selected by the Board of Directors in consultation with our Commissioners.

Three indicators have been selected from each of the domains of patient safety, clinical effectiveness and patient experience. Where possible, we have included our previous year's performance and how we benchmark against the national average.

These indicators have been selected from the Trust's Integrated Balanced Scorecard and fit with the domains of caring, effective, safe, responsive and well led. They also link with areas that we have identified in our Quality Account priorities, CQUIN targets and patient safety priorities. We believe that our performance against these indicators demonstrates that we are providing high quality patient centred care which will continue to be monitored over the coming year.

Patient Safety

The patient safety indicators are:

1. Falls
2. Infections
3. Pressure Ulcers

Falls

For information about falls please see section 2.3

	Trust local target	2019/20 Performance	Did we achieve in 2019/20 against our target?	2018/19 Performance	Did we achieve in 2018/19 against our target?	2017/18 Performance	Did we achieve in 2017/18 against our target?
Number of admitted patient falls resulting in harm (average per month)	2	2	✗	2	✗	3	✗
Falls resulting in harm per 1000 bed days	N/A	0.12	N/A	0.11	N/A	0.16	N/A

Infections

The Trust continues to work towards reducing the numbers of -Meticillin sensitive *Staphylococcusaureus* (MSSA), *Clostridium difficile* (C diff) and Escherichia coli (E coli) infections. NHS Improvement made a supportive visit to the Trust in July 2019 to review progress against the infection control improvement plan, following which they made a number of recommendations.

Immediately after the NHS I visit the Director of Nursing and Midwifery along with the infection prevention and control (IPCC) team held a number of IPCC summits during which the recommendations were shared with senior clinicians. These included a review of the infection prevention and control Trust-wide meeting structure which has resulted in a more robust systematic approach to undertaking local projects, upward reporting and holding to account. The meeting structure now includes a fortnightly Trust-wide senior sister meeting chaired by one of the divisional matrons with infection control team representation. The senior sisters are encouraged to undertake local level infection control improvement projects using quality improvement methodologies and sharing good practice. The themes from infection related RCA's are reviewed at this meeting as well as gaining understanding of how the Trust benchmarks locally and nationally. An amended Infection Prevention and Control Committee meeting structure has been put into place to look initially at the operational issues related to infection prevention and control and also a strategic group which meets to provide the overview and scrutiny of Trust-wide performance.

Meticillin sensitive *Staphylococcus aureus* bloodstream infections

We set ourselves with a 10% reduction trajectory to improve the numbers of patients who develop hospital onset MSSAbloodstream infections. A number of initiatives have been undertaken such as changing the gauze dressing that is used when intravenous peripheral cannulas (PVC) are removed from "clean" to sterile, and also

reviewing and updating the documentation related to insertion and removal of PVC's. Consequently we have seen a reduction in the numbers of MSSA infections and have achieved a 32% reduction in hospital onset infections.

E coli bloodstream infections

In 2017 a Government ambition was set to bring about a year on year reduction of 10% in healthcare associated E coli bloodstream infections. This target is shared with our community partners. The most common source of E coli sepsis are urinary tract infections. The Trust has undertaken work to reduce these infections which has included reducing the number urinary catheters inserted and improving patient hydration. During 2019/20 there was a 14% reduction in hospital onset E coli bloodstream infections.

Pressure Ulcers

		2019/20				2018/19	2017/18	2016/17
		2019/20 Trust local target	2019/20 Total	Did we achieve in 2019-20 against our local target?	Have we improved on 2018/19?	Total	Total	Total
Category two	Category two	16	19	✗	✗	8	15	34
	Medical device related	4	2	✓	✓	5	6	15
Category three		0	11	✗	✗	2	1	3
Category four		0	1	✗	✗	0	0	1

The ambition for 2019/20 is a **10%** reduction of all category 2 pressure ulcers, **50%** reduction of all Medical Device Related pressure ulcers and the elimination of all category 3 and 4 pressure ulcers.

From the work produced as part of the NHS Improvement programme "Stop the Pressure" on the 1st April 2019 the reporting of all pressure ulcers is now mandatory – whether avoidable (lapses in care) or unavoidable (no lapses in care), therefore the target was raised to 16 category 2 pressure ulcers to take this in to account. There has been an anticipated rise in pressure ulcers due to the new reporting system.

There were 19 category 2 pressure ulcers in 2019-20 which is an increase on 2018-19. 13 were found to have had lapses in care following investigation. Six pressure ulcers had no lapses in care. There were 2 medical device related pressure ulcers with lapses in care in 2019-20 which is a 50% decrease from 2018-19.

There were 11 category 3 pressure ulcers in 2019-20 which is an increase from 2018-19. 6 were found to have had lapses in care following investigation, contrary to the ambition to have none.

There has been 1 category 4 pressure ulcers in 2019-20, which is a 50% increase

from 2018-19.

The Royal United Hospitals NHS Foundation Trust has a clear pathway for pressure ulcer prevention. Where the Trust saw an increase in the number of category 3 pressure ulcers from June 2019 onwards, further improvement plans were put in place and monitored by the Senior Nursing team and the Tissue Viability Steering group.

- The Deputy Director of Nursing and Midwifery has met with Senior Sisters and Matrons to identify areas for improved practice which has led to further work using the Bath Improvement System. This is an umbrella term for the approach that is being taken across the RUH to train and support staff to continuously improve the quality of care and outcomes for everyone.
- Medical and Surgical Division have reviewed its incident data and the top contributors will be completing an A3 for improvement. This is a structured and simple to use problem solving and continuous improvement approach that is being used across the Trust. The approach typically uses a single sheet of A3 sized paper, hence the name.
- Medical division is looking at red flags attached to patient flow for identifying those patients who have had long lies at home and in the Emergency Department.
- Risk management and tissue viability proposal to increase learning from incidents and reduce the time spent on formal root cause analysis; learning from incidents in real time, monitored by the Tissue Viability Steering group.
- Pressure ulcer incident reporting continues and trend analysis following RCA's demonstrates that the occurrence of pressure ulcers remains more prevalent within the demographic of our most vulnerable age group, the elderly. Targeted training has been implemented across our older persons' wards to ensure transference of the knowledge and skills required to care for this cohort of patients.
- TVNs held an awareness event for the international STOP the pressure day – held in the PGMC on 21.11.19 which was well attended.
- The Trust signed up to the NHS England and NHSI Pressure Ulcer Improvement Collaborative, commenced in September 2019. The focus was around access points to the hospital and the team comprised of staff from ED and MAU. This provided an opportunity to acquire new skills, share learning and network with colleagues across the country. The aim was to improve the patients' provision of pressure ulcer prevention strategies including early skin assessment and equipment. Following the process of PDSA (Plan, Do Study, Act – a 4-step management approach for the control and continuous improvement of processes), a new approach was taken regarding patients in ED who are high risk or with existing pressure damage. No pressure damage has occurred in the ED or MAU since the programme began.
- Tissue Viability Link Nurse Conference 3rd July 2019 to keep link nurses up to date with current and new practices enabling them to disseminate to their areas. The system has now changed and the TVNs are meeting with ward link nurses and sisters on an individual basis to identify specific issues, educational needs and solutions to improve care.
- Legs Matter week June 2019 to raise awareness to the public for leg and foot care – including pressure ulcers.

- Launch of HCA Pressure Ulcer Prevention and management e-learning package
- The TVNs working on projects to improve the quality of referrals to the service which will release more time to spend on the wards.

Local benchmarking indicates a similar picture across local acute hospitals. All hospital acquired pressure ulcers are investigated to identify any themes and potential learning. These are then used to drive improvement work at local and Trust level.

The Trust remains confident that its pressure ulcer data is accurate. Pressure ulcers are recorded on the electronic patient record and the incident reporting system. These are then checked and confirmed by the Tissue Viability team.

Clinical Effectiveness

The clinical effectiveness indicators are:
1. Cancer Access
2. SHMI
3. HSMR

Cancer Access

		Royal United Hospitals Bath NHS Foundation Trust							National
	Measure	Target	2019/20 RUH Total	Did we achieve in 19/20?	2018/19 RUH Total	Did we achieve in 18/19?	2017/18 RUH Total	Did we achieve in 17/18?	2019/20 National Total
Two week wait	From GP referral to 1st outpatient appointment	93.0%	89.5%	✗	93.0%	✓	94.2%	✓	90.9%
	From GP referral to 1st outpatient appointment - breast symptoms	93.0%	93.4%	✓	94.2%	✓	90.1%	✗	83.7%
31 day wait	From diagnosis to first treatment for all cancers	96.0%	97.5%	✓	98.5%	✓	99.0%	✓	96.0%
	From diagnosis to subsequent treatment - surgery	94.0%	98.2%	✓	97.6%	✓	100.0%	✓	91.3%
	From diagnosis to subsequent treatment - drug treatments	98.0%	98.8%	✓	100.0%	✓	100.0%	✓	99.1%
	From diagnosis to subsequent treatment - radiotherapy treatments	94.0%	99.7%	✓	100.0%	✓	100.0%	✓	96.4%
62 day wait	From urgent referral to treatment of all cancers	85.0%	81.7%	✗	83.3%	✗	88.6%	✓	77.2%
	From referral to treatment from a screening service	90.0%	91.3%	✓	94.8%	✓	92.7%	✓	84.6%

In 2019/20 Trust performance against the 62 Day GP Referral to Treatment standard has been challenged, with a decline in performance in the second half of the year. Despite this the RUH consistently delivered performance above the national average, achieving 81.7% against the national average of 77.1% The RUH ass also one of the higher performing Trusts in the South West.

Performance has been impacted by an increase of 8% in 62 Day activity in the past year. Furthermore, the growing complexity of clinical pathways with the increasing number of specialist diagnostics required impacted performance. This is most

evident in the more complex clinical pathways of Colorectal, Prostate, Upper GI, Head & Neck and Lung. Consultant staffing vacancies in other key specialties of Breast and Skin also presented challenges in consistently delivering the standard.

Working with the Cancer Alliance and STP and utilising the nationally available Cancer Transformation Funds, the RUH has made great improvements through implementation of early diagnostic pathways in key tumour sites. This is helping patients achieve a swifter diagnosis and more timely access for treatment for those patients with cancer. Establishment of the *Straight to Test* diagnostic pathway within in Colorectal has been a particular success in year, as has the implementation of a more efficient diagnostic pathway for Prostate cancer patients, both of which are supporting improvements in performance in those individual areas. In addition we have established the administrative infrastructure required to manage patients against the new 28 Day Faster Diagnosis target and report activity and performance and are close to delivering the required standard through the early diagnosis pathway work.

The RUH has also taken steps to improve access to treatment for those patients requiring oncological care which has contributed to the RUH performance. Creation of a future state model for the Oncology service will support the long term planning for the department and achieve more timely access for chemotherapy and radiotherapy treatments.

Standard Hospital-level Mortality Indicator (SHMI)

For information on the Trust's SHMI value, please see page 59.

Hospital Standardised Mortality Ratio (HSMR)

			2019/20		2018/19		2017/18	
			April to December		April to March		April - March	
		National Average	HSMR value	Were we within expected range?	HSMR value	Were we within expected range?	HSMR value	Were we within expected range?
HSMR	Overall	100	113.0	✗	101.0	✓	105.5	✓
	Weekday	100	109.4	✗	98.7	✓	101.9	✓
	Weekend	100	125.5	✗	109.0	✓	118.0	✗

The Trust uses the Dr Foster Intelligence benchmarking tool to monitor its HSMR performance. This looks at observed and expected outcomes to measure mortality. The calculation uses statistical methods to identify whether mortality is significantly better, worse or within the expected range of the national average.

The HSMR is monitored through the monthly Clinical Outcomes Group meeting that is chaired by the Trust Medical Director and is attended by clinical and non-clinical staff within the Trust. As part of this any areas of concern are investigated.

The data shows a deterioration from last year. The Clinical Outcomes Group has commissioned an in depth review of which factors may be contributing to this. The emphasis is on identifying clinical pathways or diagnostic groups where improvements need to be made. In addition, a careful review of all the factors that contribute to this data will include the recording of clinical information that helps accurate coding for all episodes of care. Significantly lower recording of palliative care and comorbidity data is known to adversely affect the HSMR and effect its accuracy. It is important to note the discrepancy between the HSMR data and SHMI, with SHMI data providing a more reassuring picture. The low palliative care coding may be a contributor to this.

Patient Experience

The patient experience indicators are:

1. Emergency Department Four hour waiting times
2. Referral to Treatment Times
3. Friends and Family

Emergency Department Four Hour Waiting Times

	Royal United Hospitals Bath NHS Foundation Trust									National
Measure	Target	2019/20 RUH Total	Did we achieve in 19/20?	2018/19 RUH Total	Did we achieve in 18/19?	2017/18 RUH Total	Did we achieve in 17/18?	2016/17 RUH Total	Did we achieve in 16/17?	2019/20 National total
Patients attending the Emergency department waiting a maximum of four hours before a decision is made to treat, admit or discharge - All Types - Including the Urgent Care Centre	95.0%	72.0%	✘	80.5%	✘	82.7%	✘	83.3%	✘	84.2%
Patients attending the Emergency department waiting a maximum of four hours before a decision is made to treat, admit or discharge - Type 1 - Emergency Department only	95.0%	67.9%	✘	77.3%	✘	80.6%	✘	80.8%	✘	75.3%

In common with many other acute hospitals in the country, the RUH has found the delivery of Emergency Department 4 hour waiting time target extremely challenging. During 2019/20, the Trust focused on a number of key actions to support the flow of patients out of the Emergency Department and to increase the number of patients that go directly to an assessment unit. The Trust continues to work collaboratively with all partners within the local Health and Social Care system to ensure that all patients are seen, treated and cared for in the most appropriate setting for their needs.

Performance improved significantly in March 2020 as a result of the COVID-19 pandemic due mainly to a dramatic reduction in the number of attendances to the Emergency Department. Patient feedback about the quality of the care that they receive in our Emergency Department and other access areas continues to be positive.

Moving into 2020/21, achieving the 4-hour performance standard, as well as other key clinical indicators, remains a high priority for the RUH albeit now with the added complexity of the COVID-19 outbreak.

Referral to Treatment Times

	Royal United Hospitals Bath NHS Foundation Trust							National
Measure	**Target**	**2019/20 RUH Total**	**Did we achieve in 18/19**	**2018/19 RUH Total**	**Did we achieve in 18/19**	**2017/18 RUH Total**	**Did we achieve in 17/18**	**National 2019/20**
Incomplete pathways - patients waiting no longer than 18 weeks for treatment	92.0%	86.0%	✗	87.1%	✗	87.8%	✗	84.5%
Incomplete pathway total reduction	Less than March 2019	13.8%	✗	-2.4%	✓			

The Trust has worked hard to balance elective, non-elective and an increase in Cancer referrals throughout 2019/20. This has resulted in us being unable to meet the Open Pathway performance access standard of 92%. The Trust has met the locally agreed trajectory and is performing better than the national performance.

The new Referral To Treatment (RTT) measure was introduced in 2019 which was to reduce the number of patients on an incomplete pathway from the March 2019 to March 2020 position. The Trust has not met this measure with an increase of 11% predicted at year end, noting that 4.6% of this was related to technical/guidance changes.

The contributory factors are related to 2 main causes:

- Non- elective demand - as part or winter planning the Trust handed over a surgical 30 bedded general surgical ward to support non-elective demand and patient flow, resulting in a 3-month period of reduced surgical bed base. This allowed the Trust to continue elective operating for major joint procedures over winter, supporting the waiting list growth seen over the previous year winter months.
- Cancer referrals – increase in referrals for suspected cancer that are prioritised over routine referrals resulting in long waits in outpatients.
- The Trust has made good progress with surgical specialties including the expansion of the Chair Port (a section of the Day Surgery Unit with 5 reclining chairs where patients can be recovered) now providing day case recovery for more than 60% of all day cases. This has meant that there have been far fewer cancellations and this has improved waiting times for treatment.
- The declaration of COVID-19 as a global pandemic in March 2020 had three distinct impacts on elective work – firstly, the hospital's focus shifted almost

entirely to treating patients who were acutely ill with coronavirus symptoms; secondly, for some weeks, elective patients were prevented from attending the Trust, and thirdly, social distancing requirements have had a significant impact on the Trust's capacity, with 107 beds having to be taken out of circulation. This last impact continues to affect the Trust's ability to address the backlog of cases that developed during the peak of the outbreak.

The Trust has been working with Commissioners and Independent providers to manage elective care over the year. As part of winter planning the Trust contracted with other providers, to provide treatment for the longest waiting patients.

In outpatients two large volume specialties of Gastroenterology and Dermatology have seen an unprecedented increase in referrals for suspected cancer which has resulted in longer waits and impacted significantly on the ability to meet the 92% standard, resulting in high numbers of Gastroenterology 52 week breaches.

Priority areas for improvement include:

- The Trust will continue to work with local system to improve elective services. Aligned to the BaNES, Swindon, and Wiltshire (BSW) prioritisation of outpatient transformation in 2020/21. The Trust will be undertaking an internal Outpatient Improvement Programme, using *Improving Together* methodology to embed change in the organisation. The Trust is working to support the 30% less face to face appointments as outlined in the Long term plan
- Through the Acute Hospitals Alliance work will continue in 2020/21 on Get It Right First Time and clinical service reviews in Cardiology and Gastroenterology.
- Internally, further priority areas of work in 2020/21 include theatre transformation and Chairport (day case elective activity).

Our workforce plan identifies risks and planned mitigations relating to delivery of the elective activity plan.

The Trust will work to meet the standard to ensure that the total waiting list size at March 2021 remains at the same level as 31st January 2020, as identified in planning guidance. The Trust is taking part in a pilot from April 2020 across BSW to offer patients waiting over 6 months' alternative providers, including where the RUH may be offered to patients from other providers.

We are confident that the recording of RTT pathways is robust and includes a number of daily reports to monitor patient pathways. The Trust has accepted NHSI validation resource commencing in March 2020 to further support our waiting list.

During 2020/2021 the Millennium Patient Administration System (PAS) will be upgraded to include a simplified outpatient interface supporting a reduction in 52 week breaches related to administrative process errors. The waiting time performance is derived from nationally submitted Consultant-led RTT waiting times data that are published by NHS England.

Friends and Family

Measure		Royal United Hospital			National	
		2018/19 RUH Total	Have we improved on 2017/18?	2017/18 RUH Total	How do we compare to National?	2018/19 National Total [1]
Inpatients	Percentage of patients that would recommend the RUH to friends and family	97.0%	About the same	96.9%	✓	95.6%
A&E	Percentage of patients that would recommend the RUH to friends and family	97.0%	About the same	97.2%	✓	86.9%

We are confident that our patients have been given the opportunity to provide feedback via the Friends and Family Test (FFT), and that the information displayed represents the responses that we have received. Patients are given the opportunity to complete feedback cards, which are then entered onto our patient experience system. Eligible patient numbers are taken from our Patient Administration System. Responses are eligible populations reported in line with national definitions.

Performance is good and the Friends and Family Test continues to be reported through the Trust Performance and Quality Groups and is on the Trust Scorecard. In addition, the additional comments submitted by patients on the questionnaire are logged and analysed to pick up on any issues. There has been a small reduction this year in the percentage of patients that would recommend the Emergency Department to friends and family. The response rate for the Emergency Department is low and the department are working to improve this through other means of patient feedback. The Trust also monitors patient feedback from the National Emergency Department survey and through patient contact with the Patient Experience team through the Patient Advice and Liaison services (PALS) and this information is available on the Trust website.

This year has been another particularly challenging year for our patients and staff in the Emergency Department particularly in terms of patients waiting for a bed. Improving the flow of patients through the hospital is a Trust priority for 2020/21.

Care Quality Commission (CQC)

The Trust has not received any inspections from the Care Quality Commission (CQC) during 2019/20. The Trust last received an inspection from the CQC in June 2018 where the CQC inspected five core services (urgent and emergency services, medical care, critical care, children and young people's services) and reviewed the management and leadership of the Trust to answer the key question about whether the Trust is well led. The CQC rated the Trust overall as 'Good' but identified four actions where the Trust must improve, all related to urgent and emergency services. An improvement plan was developed and returned to the CQC detailing the actions to address the four compliance recommendations from the inspection report. Implementation of this improvement plan has continued to be monitored on a quarterly basis through Quality Board and the Board of Directors throughout 2019/20. The Trust's internal auditors, Grant Thornton carried out a review of the actions the Trust had taken following the CQC inspection to check that the issues raised by the CQC had been addressed. The review concluded that the processes that had been put in place provided significant assurance with three low level recommendations made.

The CQC issued the Trust with the Provider Information Request in January 2020 which signals the start of the inspection process with an inspection due within the next six months. However, as a result of the COVID-19 pandemic, the Trust's inspection was put on hold by the CQC.

3.2 Commissioning for Quality and Innovation (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) is a payment framework which enables Commissioners to reward excellence by linking a proportion of acute healthcare provider's income conditional on demonstrating improvements in quality in specified areas of care. For 2019/20 all schemes have been nationally mandated and applied to all acute Trusts. Schemes are aligned to the 4 key areas in support of the Long term plan; Prevention of ill health, Mental Health, Patient Safety and Best practice pathways.

Where relevant the scheme is led by a clinician, who supports the achievement of the quality indicator milestones and is accountable for the financial performance of the scheme. The following outlines the progress with the 2019/20 CQUIN schemes.

Normally, provider Trusts would be required to account for the extent to which they have achieved the agreed improvements. Fir 2019/20, however, as a result of the COVID-19 pandemic, NHSE/I recommended that commissioners and trusts take a pragmatic approach to agreement of the final payment amounts for the CQUIN scheme, and that this should be done on the basis of available data. NHSE/ I stated that they would not be seeking the submission of 2019/20 quarter 4 data from providers via the national CQUIN data collection. Set out below are the schemes that were agreed for 2019/20.

National CQUIN schemes for 2019/20

Lower Urinary Tract Infections in Older People

This scheme supports the major Long Term Plan priority of antimicrobial resistance and stewardship. The scheme required four steps; to reduce inappropriate antibiotic prescribing, improved diagnosis (reducing the use of urine dip stick tests) and improve the treatment and management of older patients diagnosed with a lower urinary tract infection.

Antibiotic Prophylaxis in Colorectal Surgery

As with the above this scheme supports the antimicrobial agenda by requiring a minimum 60% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery to be a single dose and prescribed in accordance with local guidelines. This is expected to bring safer patient care, increased effective antibiotic use with the resulting improvement in both patient mortality and length of stay.

Staff Flu Vaccinations

Staff flu vaccinations are a crucial lever for reducing the spread of flu during winter months, where it can have a significant impact on the health of patients, staff, their families and the overall safe running of NHS services. The scheme required the Trust to achieve an uptake of flu vaccinations of 80% of frontline clinical staff.

Alcohol & Tobacco

Smoking rates have fallen significantly, but smoking still accounts for more years of life lost than any other modifiable risk factor. Around 6.1 million people in England still smoke (Office of National Statistics 2018). Smoking is linked to nearly half a million hospital admissions each year.

Alcohol contributes to conditions including cardiovascular disease, cancer and liver disease, harm from accidents, violence and self-harm and puts substantial pressure on the NHS.

Screening inpatients for their alcohol and tobacco status as they are admitted and delivering brief advice regarding support available is a key component of patients' path to cessation. The Trust's Healthy Choices team is a 7 day per week service for inpatients available on inpatient wards, who are able to link in with clinical staff to ensure provision of nicotine replacement therapy and onward referral to community cessation services or alcohol liaison teams.

Three high impact actions to prevent Hospital Falls

Falls in hospitals are the most commonly reported patient safety incident reported in acute hospitals, community hospitals and mental health trusts in England annually. Each year falls in hospitals in England result in hip fracture or brain injury, typically subdural haematoma.

Costs for patients are high in terms distress, pain, injury, loss of confidence, loss of independence and mortality, and costly in terms of increased length of stay to assess, investigate or treat even modest injury.
A fall in hospital often affects plans for a patient to return to their own home or usual place of care as it impacts on the older person's confidence and the confidence of their family and carers. This scheme supports the consistent implementation of three high impact actions to help prevent hospital falls by ensuring a patient's lying and standing blood pressure is recorded, that no hypnotic or antipsychotic medication is prescribed, or if it is what the rationale is and finally that a mobility assessment is undertaken to identify if the patient requires a walking aid and if so that one has been provided within 24 hours of admission to an inpatient unit.

Same Day Emergency Care

This CQUIN applies only to patients identified as being clinically appropriate to receive same day emergency care. This is care delivered within a 24-hour period, generally in an Emergency department, clinical decision unit, MAU or equivalent.

Pulmonary Embolus

Patients diagnosed with pulmonary embolus and treated within a 24-hour period to receive Computerised Tomography (CT) / Ventilation Perfusion (VQ) scan and anticoagulation treatment.

Tachyarrhythmia with atrial fibrillation

Patients diagnosed with atrial fibrillation and treated with a 24-hour period to receive electrocardiogram (ECG), a CHA2DS2-VASc calculated (Congestive heart failure, Hypertension, Age, Diabetes, previous stroke/ transient ischaemic attack- Vascular disease and Sex category) – a way to predict the risk of developing a stroke in patients with atrial fibrillation), and if CHA2DS2-VASc >1 anticoagulation commenced / considered and commencement on rate or rhythm controlling drug (with exceptions).

Community acquired pneumonia (CAP)

Patients diagnosed with community acquired pneumonia and treated with a 24-hour period to receive a chest x-ray and a CRB65 score calculated - this score helps to inform clinical judgment about whether a patient's care can be best managed in the community or whether hospital assessment is required.

Improving efficiency in the Intravenous (IV) Chemotherapy pathway pharmacy to patient

This scheme seeks to address IV chemotherapy wastage by requiring the Trust to embed a waste calculator in our systems. The tool highlights which drugs have the highest amounts of waste, and in turn allows us to explore solutions to address this both internally and by NHS England who will work with suppliers to optimise vial sizes or other presentations.

Supporting national treatment criteria through accurate completion of prior approval – Blueteq

Blueteq is an online clinical decision support tool which the Trust is required to utilise for the prescribing of high cost drugs excluded from tariffs. This ensures that treatment decisions are made in line with agreed commissioning or NICE policies. The scheme required the Trust to audit particular drugs prescribed to demonstrate that prior approval forms are being completed for high cost drugs.

Faster adoption of best value med and treatments

This scheme aims to support the procedural and cultural changes required to optimise the use of medicines commissioned by specialised services. The following priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office, namely:

- Faster adoption of best value medicines with a particular focus on the uptake of best value generics, biologics and Commercial Medicines Unit frameworks as they become available
- Significantly improved drugs data quality
- The consistent application of lowest cost dispensing channels
- Compliance with policy/ consensus guidelines to reduce variation and waste.

The pharmacy team have worked with clinical teams across the hospital to amend prescribing practice when new medicines are approved and put in place additional processes to ensure all appropriate data is captured and reviewed.

Antifungal stewardship

NHS England Specialised commissioning has commissioning responsibility for antifungal drugs that are excluded from national tariff. The emergence of a wider selection of immunosuppressive agents, especially those used in haemato-oncology patients, significantly increases the risk of developing a serious fungal infection. The scheme required the Trust to review our Antifungal guidelines, undertake a diagnostic gap analysis and identify an Antifungal Stewardship team who will then undertake audits of patients prescribed with antifungals.

3.3 Duty of Candour

Duty of Candour, the process of spontaneously saying sorry when things go wrong, is monitored through the incident reporting system. Duty of Candour is a legal requirement and is triggered where a notifiable patient safety incident occurs: this is where harm to the patient is identified as moderate, serious, or death or prolonged psychological harm. In complying with the Duty of Candour, of primary concern is to ensure that patients/their families are told about notifiable patient safety incidents that affect them, receive appropriate apologies, are kept informed of any investigations and are supported to deal with the consequences.

Duty of Candour leads are identified at the point an incident is confirmed to have caused significant harm. The Duty of Candour lead is advised to update the relevant section on the incident system to enable central monitoring.
A KPMG audit in 2019 resulted in a Trust work plan to address recommendations highlighted by the audit. Completed actions include:

- Root Cause Analysis (RCA) training
- Revision of RCA template
- Duty of Candour training delivered at Clinical Governance meetings
- Appointment of clinical divisional patient safety leads
- 72 hour reporting process to include identifying the Duty of Candour lead
- Action plans for Serious Incidents are monitored weekly by Heads of Nursing to prevent breaches of timescales
- Task and Finish Group established to oversee the serious incident process.

In addition, the Duty of Candour policy is currently being reviewed and updated to incorporate these changes.

Following recommendations from the KPMG Duty of Candour review, the Head of Risk and Assurance presented the Duty of Candour process at Clinical Governance meetings across the Trust. These meetings were attended by senior nursing and medical staff.

Duty of Candour requirements are outlined within the Trust Corporate Induction Programme for all new staff.

The Head of Risk and Assurance runs monthly root cause analysis training for staff with responsibility for undertaking Serious Incident investigations. This training includes the Duty of Candour process and how this should be applied throughout the investigation process.

The Risk Management pages on the RUH Intranet have been updated to provide staff with a clear and easily accessible overview of the Duty of Candour process. These pages include the most up to date Duty of Candour letter and investigation templates for staff. The Duty of Candour checklist has been incorporated into the RCA report template and into the incident reporting system so that the process can be easily and regularly monitored and audited in line with the key performance indicators. Compliance with the Duty of Candour process will be closely monitored and performance shared with Specialties/Divisions through regular reporting such as the quarterly incident reports, presented at the Trust's Operational Clinical Governance Committee and Management Board.

3.4 Additional considerations:

Seven Day Working

Seven Day Services is a mandated set of acute emergency care standards that were conceived by Sir Bruce Keogh. There are ten standards which we must deliver by 2020. This delivery is being performance managed by NHSI who demand twice yearly returns to demonstrate delivery/improvement. These standards align perfectly to acute emergency care delivery and we would be implementing these changes even if we were not required to do so as they are the main building blocks to patient flow in our health system. The delivery of these standards is resource intensive given the 24/7 provision of service required.

We have made significant progress over the last five years. We are compliant in all standards except:

- Standard 2 - Is both the most important and most difficult to deliver. It requires that all acutely admitted patients are seen by a consultant with 14 hours of their admission. The key to improving this standard is the ability to collect live data on our performance to give us continuous feedback on which to iterate our improvement. We have built a method to collect this data in our electronic patient management system and are now trialling this on the medical assessment unit before rolling it out further. The consultants who undertake General Internal Medicine have agreed to a new working model which was implemented on 1 January 2020 in which they are on site delivering acute emergency medicine from 8am to 8pm 7 days a week. This will improve our performance in standard 2 and initial observations look promising regarding a positive impact on patient flow through the system.

- Standard 6 – 24hr access to consultant delivered interventions. We are compliant in all of these except vascular interventional radiology. We are working with North Bristol NHS Trust to come to a working agreement where they provide vascular interventional services that we are unable to provide.

Freedom to Speak Up

In many circumstances an individual will raise a concern with their line manager, clinician or tutor. The Freedom to Speak Up Service is provided by the Trust to empower staff to raise a concern outside of an individual's management process should they require it. The service consists of a Guardian and a team of Advocates who support individuals raising concerns in The Trust. The remit of the service is to change the culture to one of openness and transparency regarding raising concerns so that raising concerns becomes business as usual for all staff.

Staff are able to use the service as an impartial source of support and guidance in raising their concern. Should a concern need investigating, the Guardian has access to anyone in the organisation. This includes the Chief Executive, Non Chief Executive Chair and external sources of support such as National Guardians Office and NHSI/E. Therefore, should a concern require escalation, the correct resources

are there to ensure patient safety and resolution to any concerning factors of the concern.

The Freedom to Speak Up Service is a confidential service, ensuring timely support to staff in listening to the concern. Staff are able to access the service in a number of ways, by e mail, text, phone or drop in sessions. Any emerging themes of concerns and perceived detriment is reported to Board to ensure learning takes place. Feedback is also gathered from Staff regarding the service to ensure a safe and supportive service continues.

ANNEX 1: STATEMENTS FROM NHS ENGLAND OR RELEVANT CCG, LOCAL HEALTHWATCH ORGANISATIONS, & OVERVIEW & SCRUTINY COMMITTEES

Statement from BaNES, Swindon and Wiltshire Clinical Commissioning Group on Royal United Hospital NHS Foundation Trust 2019/20 Quality Account

NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (BSW CCG) welcome the opportunity to review and comment on the Royal United Hospital NHS Foundation Trust's (RUH) Quality Account for 2019/2020. In so far as the CCG has been able to check the factual details, the view is that the Quality Account is materially accurate in line with the information presented to the CCG via contractual monitoring and quality visits and is presented in the format required by NHS Improvement's 2019/2020 presentation guidance. The CCG supports the Trust's identified quality priorities for 2020/21.

It is the view of the CCG that the Quality Account reflects the Trust's on-going commitment to quality improvement, including identifying and addressing key issues pro-actively using the Improving Together programme being delivered by the Trust. The Trust priorities for 2019/20 have outlined achievement in:

- Developing two continuity of carer teams based in the community as part of maternity services and implementing pilots in Frome and Chippenham.
- Process mapping completed for frailty assessment and short stay.
- Launch of the Frailty Assessment Area on ACE to improve timely assessment of patients and discharging to their usual place of residence.
- Front door cover provided by the Frailty Flying Service 7 days a week.
- Reducing the length of stay for patients on the OPU ward with a frailty score of 5 or more by more than one and a half days, between January 2019 and January 2020.
- Improvements made in internal communications of patient experience feedback and subsequent improvements using a variety of channels.
- Development of guidelines by the Patient Experience Team to help staff feel confident in approaching and listening to patients in an empathetic and understanding way; to improve communication with patients over the telephone; and enabling staff to work out how to resolve patient concerns.
- Organising the first Improving Patient Experience Awards.
- Implementation of electronic observations to 75% of teams in the Trust, incorporating automatic recording of NEWS and an electronic alert system.
- 95% of inpatients identified as having sepsis received antibiotics within an hour of diagnosis.
- 32% reduction in MSSA infections.
- Formation of the Sepsis and Kidney Injury Prevention Team (SKIP), supporting management of sepsis and promoting early identification, the expansion of the Critical Care outreach team and the establishment of deteriorating patient champions.

- Continuing reduction in mortality from infective causes and Acute Kidney Injury.

The CCG welcomes continued work on the above areas and the new priorities identified for 2020/21 including:

- Increasing the coverage of continuity of carer in maternity services and development of community teams, with an aim for 51% of women booked to receive care at the RUH, to have this provided.
- Development of methods to receive feedback measures from staff and patients on their satisfaction of the pilot models in place.
- Falls prevention and the promoting three high impact actions to prevent falls to reduce the number of patients who fall resulting in high harm
- Increasing the direct admissions of frail older patients being admitted to ACE OPU and discharge within 72hrs to usual place of residence.
- Reducing the number of patients requiring intensive care with four or more organ failure by implementing timely referrals, reviews and interventions and providing more support at ward level for unwell and deteriorating patients.
- 24hr senior clinical oversight of electronic observations and implementation of a single point of contact for the deteriorating patient to provide more timely advice, care and escalation.
- Developing a Trust Volunteer Strategy to include identifying meaningful volunteer roles, training and improved communication.

In addition, the CCG would like to highlight the work of the Trust to support and enable staff at all levels to be involved in quality improvement methodology, specifically the individual training and development programme which has been developed – Bath Improvement System (BIS). The CCG looks forward to seeing how the relaunch of BIS will continue to build upon the existing quality improvement work and the further changes implemented through staff feedback generated via improvement huddle tickets. It is also positive to note how the Trust and staff have been recognised externally for their care and/or innovations.

The CCG notes the Trust's continued focus towards the reduction of Clostridium difficile infections including the introduction of an antibiotic review kit (ARK), improving cleanliness of the environment and equipment, investigating and learning from incidents and introducing a new pathway related to diarrhoea. The total number of infections attributed to the Trust in 2019/20 is significantly below the assigned tolerance of 59 incidences.

The increase in the number of Trust acquired pressure ulcers is acknowledged with the associated actions and improvement plan. The Trust performance in the Falls CQUIN is also noted and the CCG would like the RUH to consider linking the work of

the Falls Steering group with the Frailty improvement plan. The CCG looks forward to working with the Trust towards a system-wide improvement strategies on falls and pressure ulcers in 2020/21.

The CCG acknowledges the Trust's candour regarding the changes required to improve the service delivery outcome measures for those patients who have learning disabilities and autism, including the way their care is reported. The CCG has identified the care of patients with learning disabilities and autism as a quality improvement priority for the system, and we look forward to working with the RUH to progress this further to meet the learning disability improvement standards.

Furthermore the CCG notes the analysis of the HSMR data compared to the SHMI data and the planned commissioned review by the Clinical Outcomes Group. The CCG looks forward to noting the outcome of the report and the actions to be taken forward.

NHS Bath and North East Somerset, Swindon and Wiltshire CCG, together with associated co-commissioners, are committed to sustaining strong working relationships with the RUH and together with wider stakeholders, aims to continue collaborative working that can support achievement of the identified priorities for 2020/21 across the whole health and social care system.

Healthwatch Bath and North East Somerset and Healthwatch Wiltshire combined response to the Royal United Hospitals Bath NHS Foundation Trust Quality Account 2019/20

Healthwatch thanks the Trust for sharing its Quality Account 2019/20 in paper and audio formats, and welcomes the opportunity to comment. Healthwatch is an independent organisation that champions the voice of patients and the wider public with respect to health and social care.

Healthwatch welcomes the list of abbreviations at the front of the document, as a public document this is always a welcome addition.

Priorities 2019/20

Healthwatch is pleased to see that in the most part, priorities from 2019/20 were met:

Priority one

As part of the continuity of carer model to personalise maternity services, Healthwatch are interested to know if 35% of women booked on a continuity of care pathway by March 2020 was achieved and note this continues to be a priority for 2020/21

Priority two

Healthwatch were pleased to read about the development of the frailty assessment unit and to that the Rockwood frailty score is being used for early identification of frailty, Healthwatch are glad that this continues to be a priority for 2020/21

Priority three

The organisation of the first Improving Patient Experience Award Ceremony and Celebration Event was positive, it was unfortunate that it was cancelled due to the COVID-19 pandemic. Healthwatch were interested to read about the finalists for this award.

Priority four

Healthwatch welcome the introduction of the National Early Warning Score (NEWS) as part of the improvements in early recognition of deteriorating patients and notes this remains a priority for 2020.21

Healthwatch appreciate the work that has been done to improve patient and carer experience. Healthwatch recognise the work that has been done to develop guidance for staff at all levels, and that the guidance supports them to respond to verbal concerns and act on formal complaints. Healthwatch are interested to learn how patients' concerns have been managed.

Healthwatch have been very interested to read about the outcomes that continue to improve on both Sepsis and Acute Kidney Injury (AKI), in terms of a reduction in mortality levels year on year, for the last four years. This is to be commended.

Healthwatch are pleased that from April 2020 the trust will be able to extract data reports to give information around incidents and complaints specifically related to patients with learning disabilities and autism and welcome the learning disability groups set up to ensure that the trust learns lessons from the experiences of people with learning disabilities and autism.

Healthwatch will watch with interest the changes to maternity services following the proposal for transforming maternity services across Bath, Swindon and Wiltshire (BSW).

Healthwatch are pleased to see the number of incidents resulting in severe harm or death has been reduced from last year's figures. Healthwatch were encouraged to read that the Trust has been pro-active in sharing learning and ensuring staff are informed of the positive impact of reporting and learning.

Healthwatch usually comment on the number of compliments and complaints received from patients and note that this information is not available in this draft quality account. Healthwatch would like to see this included in future years.

Healthwatch Bath and North East Somerset and Healthwatch Wiltshire welcome the priorities set for 2020/21.

Priority one - Continuity of carer model to personalise maternity services

Feedback received by Healthwatch often highlights the importance of continuity of care staff for patients and so we are pleased to see this as a priority area.

Priority two - Developing a frailty assessment

Healthwatch will be interested to see if the number of discharges from ACE OPU within 72 hours will be increased during the coming year.

Priority three - Critical Care Outreach

Healthwatch will follow with interest the combination of critical care outreach and the sepsis nursing team in providing a single point of contact for the deteriorating patient.

Priority four – Working with volunteers to improve the staff and patient experience

Healthwatch welcome the work with volunteers and would like to discuss how our Healthwatch volunteers may be able to support this work.

Mandatory Statements

Healthwatch is pleased to read that the trust has developed a methodology to review all deaths and be able to identify new areas of learning.

Healthwatch understand that the Trust has not met its targets for referral to treatment times, but recognise the reasons for this, including the Covid-19 pandemic.

Healthwatch were disappointed to read about the increase in pressure ulcers this year in all categories and note that further plans have been put in place and are being monitored by the senior nursing team.

Healthwatch read with interest that the trust C Dif figures are below the national average this year and hope that the figure will continue to fall in the coming year.

Healthwatch were pleased to read that staff recommending the trust to friends and family in 2019 was higher than the national average.

Healthwatch recognises the pressures that the emergency department faces, and understand that the trust has not been able to achieve the national target of treating 95% of patients attending the department within four hours. Healthwatch are encouraged that the Trust remains committed to achieving this, and that the trust continues partnership working to support this.

Healthwatch note that the trust is taking part in a pilot on 'referral to treatment times' from April 2020 across BSW to offer patients waiting over six months' alternative providers, including where the RUH may be offered to patients from other providers.

Healthwatch were happy to read about the new seventy two hour report progress for serious incident investigations and a serious incident task and finish group has been established.

Healthwatch see the last CQC inspection was 2018 when the trust was rated overall 'Good', with four actions related to urgent and emergency services. And note any future inspection has been put on hold due to Covid-19.

Healthwatch would welcome a meeting with the trust to discuss the achievements with the 2020/21 priorities in six months.

healthwatch Wiltshire

healthwatch Bath and North East Somerset

Quality Account Response Form For 2019-20:

Royal United Hospital Bath NHS Foundation Trust

Children, Adult, Health & Wellbeing Panel

We believe that the Royal United Healthcare (RUH) priorities should and do match those of the needs of the local community. The report demonstrates how the organisation is constantly striving to ensure the safety of patients and its commitment to service improvement. It also provides evidence of how the organisation has been working innovatively and collaboratively to improve the experience of services users and working closely with partner organisations and third sector colleagues to deliver integrated care across the local area.

The Panel members recognise the significant pressure placed upon the Emergency Department and the impact that this has had on the RUH's ability to achieve the national targets set. Members also note the shortage of staff in some areas that have impacted the staffing levels for the Trust.

We welcome the development in the Improving Together Programme and its bespoke approach to sustaining a culture of continuous improvement and are pleased to read about the recognition of the strength of staff to build a culture that empowers teams and individuals to make lasting changes. Members also note the work undertaken to support staff in their improvement journey and are encouraged to hear that even in light of COVID you will now be re-delivering some of the planned learning pathway training for staff.

The Panel welcome the work that the Trust is doing to ensure that the Trust meets the NHS improvement of the 4 standards for caring for people with learning disabilities and autism. Members note that currently the RUH does not have a service delivery outcome measure or data in order to understand how effective the RUH services are for people with disabilities. The Panel will look forward to reviewing the data reports that will hopefully provide information around incidents and complaints specifically related to people with learning disabilities and autism within next year's report.

The Panel is encouraged to learn of the plans for 2020-21 and recognise all the work that has been done in meeting the priorities from last year. Members are also interested in the Trust's reflection on the learning derived from the pandemic in managing patients care in the "new normal" and would welcome comparable data in next year's report.

Members acknowledge the 4 questions from Audit where the Trust's results were significantly lower than previous years, some of which relate to patients experience in the emergency department and will look forward to reviewing these actions in next year's quality account report.

Overall, the members feel that the report undertaken was positive, whilst acknowledging where there are areas of pressure and improvement. The Panel will continue to support the RUH in its actions and priorities for the year ahead.

Children, Adult, Health & Wellbeing Panel

Councillor Vic Pritchard (Chair)

Donna Vercoe Senior Scrutiny Officer (scrutiny@bathnes.gov.uk)

ANNEX 2: STATEMENT OF DIRECTORS RESPONSIBILITIES FOR THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20*;

- the content of the quality report is not inconsistent with internal and external sources of information including:

    - board minutes and papers for the period 01 April 2019 to 31 March 2020;

    - papers relating to quality reported to the board over the period 01 April 2019 to 31 March 2020;

    - feedback from commissioners dated 07/09/2020;

    - feedback from governors dated 13/10/2020;

    - feedback from local Healthwatch organisations dated 10/09/2020;

    - feedback from overview and scrutiny committee dated 10/09/2020;

    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29 July 2020;

    - 2019 and 2020 national patient surveys;

    - 2019 and 2020 national staff surveys;

    - the Head of Internal Audit's annual opinion of the trust's control environment dated 27/05/2020;

    - CQC inspection report dated 26 September 2018;

- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information reported in the quality report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;

- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board.

.....28/10/20.....Date..... .....Chairman

.....28/10/20.....Date..... .....Chief Executive