Royal United Hospitals Bath
NHS Foundation Trust

Quality Accounts
2021-2022

Royal United Hospitals Bath NHS Foundation Trust

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Contents

List of abbreviations

A	A3 thiking	Process for step by step, team-based problem identification and solving used as part of the Improving Together methodology
	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
H	HEE	Health Education England
	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

Part 1

Quality Accounts 2021-22

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 we keep our patients safe, and we are looking to continuously improve the services that we provide. We aspire to play our part to the full within the wider local health and care system by working innovatively and collaboratively to improve the experience of all who use our services and working closely with partner organisations to deliver integrated care across the local area.

The Trust values: **Everyone Matters, Working Together, Making a Difference** form the basis of 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 2021/22 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 2021/22, several teams have been recognised for their outstanding work and nominated for a number of awards during the year. This has included, among others:

- Bex Walsh, our Lead Bereavement Midwife, who was awarded the Chief Midwifery Officer's Silver Award by the Chief Midwife for England, Professor Jacqueline Dunkley-Bent, and
- Professor Tim Cook, Consultant in Anaesthesia and Intensive Care Medicine, who was awarded an OBE in the Queen's Birthday Honours List for services to anaesthesia during the COVID-19 pandemic.

A number of the Trust's services also gained national and international recognition, including for contributing, alongside the West of England Academic Health Science Network and other local trusts, to the PreciSSIon Collaborative. This is playing an important role in reducing surgical site infections, and won the Infection Prevention and Control Award at the 2021 HSJ Patient Safety Awards.

Throughout 2021/22, like other NHS organisations up and down the country, the Trust faced and dealt with the dual challenges of the direct impacts of the COVID-19 pandemic, including a rise in demand for our intensive care service, and significant numbers of staff absences. There is also the need to make significant reductions in the number of our patients waiting for elective care, a backlog that had been building up since 2020. In addition, we have seen the numbers of patients attending our Emergency Department gradually return to pre-pandemic levels, but staff shortages and pressures on our beds, caused both by the need to keep our patients safe from infection and the inaccessibility of support services in the community, has led to

delays in being able to see and treat these patients. This has contributed to significant delays in offloading the ambulances that convey patients to the department. We continue to work closely with our local authority and community partners to try to solve these problems, and we anticipate that as COVID-19 infection levels continue to fall, more of our staff return to work and nursing and care homes start to take new patients, these pressures will ease.

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 and continue to cope with significant numbers of unfilled vacancies among our clinical teams. We have taken a number of measures to address this challenge, including targeted local and international recruitment exercises, and working with NHS England on a number of measures to encourage existing staff to stay with us.

Our experience of managing through the pandemic and having to adapt to different ways of working across the organisation has further highlighted the importance of quality improvement, and the need to embed this in everything we do. To enable all our teams to focus on the response to the COVID-19 emergency, we paused the roll out of our innovative quality improvement programme, Improving Together. However, we are now in the process of relaunching this with even more ambition and enthusiasm, as a key component of our recovery as an organisation and for all of our teams. The focus of Improving Together going forward will be on empowering everyone, regardless of their position, seniority or profession, to be a problem-solver, and for local managers to facilitate this process. We are very excited about the energy and innovation that this approach can unleash across our organisation, and we are keen to ensure that we have the right systems in place so that we are able to capture and share the ideas and learning as they emerge.

Finally, we are keenly aware of the heavy toll that the last two years have had on all our staff, clinical and non-clinical. We also recognise that many colleagues have had little or no opportunity to refresh and replenish themselves, as the pressures of managing the pent up demand for our services remains intense. As a Trust we are doing the best that we can to help teams and individuals to manage their health and wellbeing, and we constantly ask ourselves if there is more that we can do. I would like to take the opportunity to once again say a big thank you to all our colleagues for their hard work, resilience and dedication in the face of another challenging 12 months.

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:

Cara Charles Barks
Chief Executive

Date: 22 September 2022

Why are we producing a Quality Account?

All NHS organisations 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 2021-22 we set three 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 2022-23 are in the process of being agreed, and they will be built around our five True North Goals which reflect out Trust Values:

Everyone Matters

Working Together

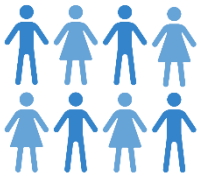
Making a Difference

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	

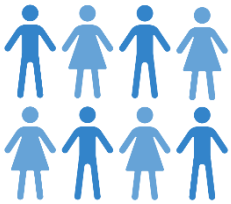
The RUH is a major acute hospital on the north western side of the city of Bath. We provide care to approximately 500,000 people across Bath, North East Somerset, north and west Wiltshire, Somerset (Mendip) and South Gloucestershire. We run a number of clinics at other centres across the region. Since 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.

In June 2021, the RUH purchased 100% of the share capital of the then Circle Bath Hospital, a private hospital situated in Peasdown St John on the outskirts of Bath. The hospital was subsequently renamed Sulis Hospital Bath. It remains an independent establishment that is run by its own board, and retains separate registration with the Care Quality Commission (CQC), but it is a wholly owned subsidiary of the RUH.

Our Staff At a Glance:



We employ approximately 5700 staff

The RUH employs approximately 5700 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%.

The COVID pandemic and its impact on all our teams has emphasised the importance of staff health and wellbeing. The physical, mental and emotional toll of the multiple waves and variants of the disease on our continues to be felt. While some teams have had the opportunity to decompress and replenish themselves as the worst of the pandemic appears to have passed, others have not, and are now managing the backlogs of patients whose care, in many cases, needed to be put on hold at various times in the last two years. We know that many of our colleagues our exhausted and the Trust is doing all it can to relieve the pressures that are on them.

The Trust, in partnership with local universities and colleges, plays a significant role in education and research. Doctors, nurses and many other healthcare professions continue to have significant portions of their training here, many of whom then go on

to join the organisation upon qualification. This focus on learning supports innovation and improvement in the care provided for our patients. With the BaNES, Swindon and Wiltshire Integrated Case System becoming a legal entity on 1 July 2022 following the passing into law of the Health and Care Act 2022, the Trust's collaborative work with its system partners will further help to improve and transform the services that we are able to provide for our patients.

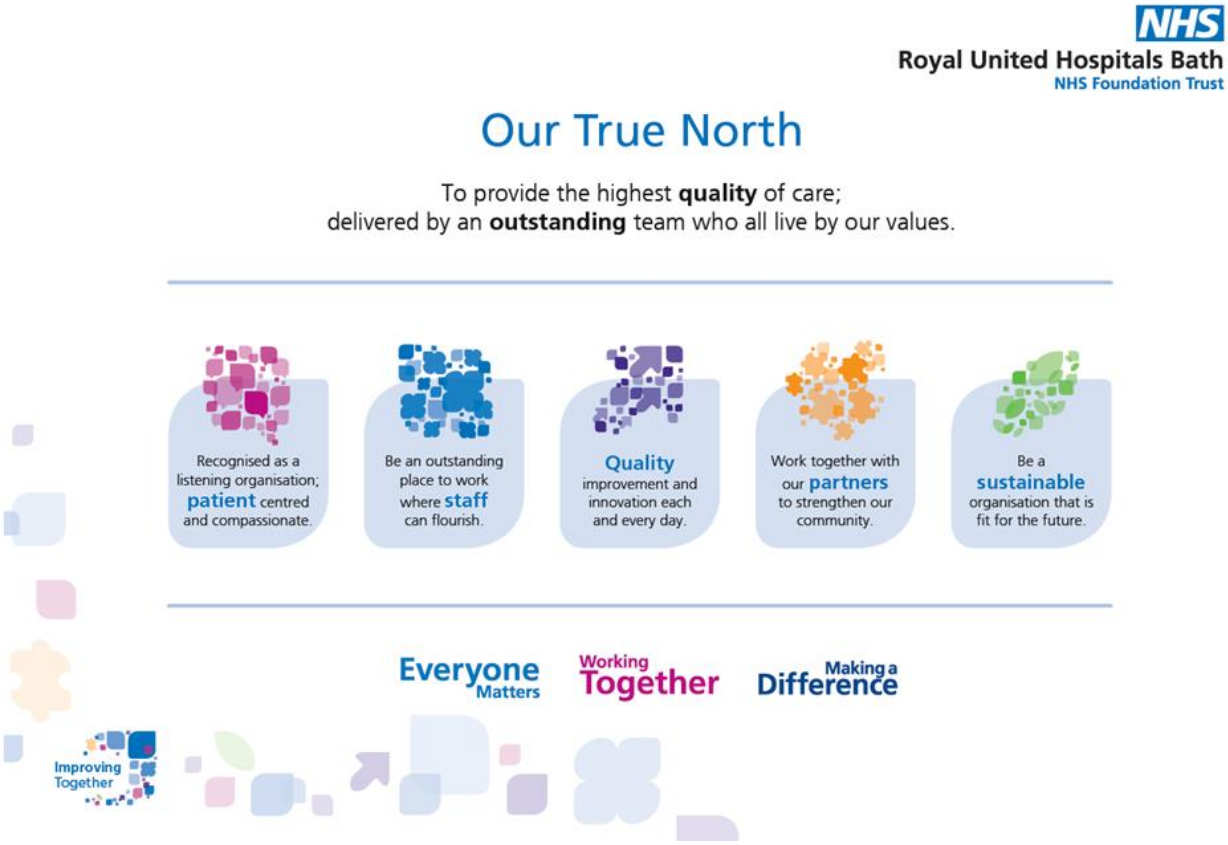
In common with other health service providers, we continue to face shortages of staff in some areas. This has had an impact on our overall staffing levels, as a result of which we are taking decisive action to address these, including increasing our support for the adoption of novel ways of gaining entry into the professions including via apprenticeships. We are also stepping up our recruitment of nurses in particular from overseas.

2.2 Quality improvement, leadership and governance

Our approach to quality improvement and governance is led by our Chief Nurse and Medical Director. They jointly chair the Quality Board, which reports to Board of Directors via Management Board, and the Chief Nurse 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, where 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 2022-23 are shown below:

Ambulance handover delays is to be retained as an objective, taking account of the significant patient safety risk that such delays can cause. The 2021/22 measure of reducing delays over 60 minutes to 0 has been replaced with the aim that the Trust achieves top quartile performance in this area.

Nurse recruitment to establishment replaces health and wellbeing. The Trust is carrying a large number of vacancies, particularly within its nursing workforce, and recruitment activity to fill these, as well as a taking steps to retain as many of the staff currently in post, will remain a key area of focus.

Infection Prevention and Control is a continuation from the 2021/22 Breakthrough Objective, as reducing the number and impact of Hospital Acquired Infections continues to be a major objective for the Trust.

Quality Improvement and Innovation each and every day

To deliver our True North we have developed the Improving Together Programme – a bespoke approach to developing and 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 ambitious 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”

Over 30 teams have been trained in Improving Together since it was launched back in September 2018, but not unexpectedly, the COVID-19 pandemic slowed its roll out, with the restrictions on personal contact and the pressures on staffing making it difficult to connect and learn together.

As we emerge from the worst of the pandemic, the Trust remains firmly committed to ensuring that we put our people first, and therefore, the Improving Together programme is as relevant as it has ever been. A full re-launch was held in March 2022, with the focus of the training moving towards a team-based and away from a centralised approach – it is expected that managers will focus on helping to create a culture within their teams where every member is engaged frequently in often small but occasionally large scale change.

Why do we need Improving Together?

At its heart, Improving Together is about Quality Improvement, giving the people closest to the issues the time, permission, skills and resources they need to problem solve. It involves a systematic and coordinated approach to solving problems using specific methods and tools with the aim of bringing about a measurable improvement.

As well as improving the quality of care, outcomes and experience for our patients, their families and our community, quality improvement improves the working lives of our staff. After all our people are at the heart of everything we do

We recognise that behaviours are of equal importance and have the most significant impact on influencing culture. This is why behaviours feature alongside our tools and routines and are now a large part of our training on Improving Together.

Figure 1 below describes the components of Improving Together; the behaviours, the tools and routines.

New approach to rolling out Improving Together

As described earlier, the COVID-19 pandemic was at least partially responsible for a rethink in the approach to rolling out Improving together. Members of staff with line management responsibility are being invited to participate in training aimed at developing and strengthening their leadership skills, with a strong focus on leadership behaviours. The tools and routines are also being implemented in parallel on a step by step basis across the organisation, meaning that every ward and department will be part of this transformation over the next 12 months. The roll out plan leading into winter 2022/23 is set out below.

2.3 Patient Safety Priorities 2021/22

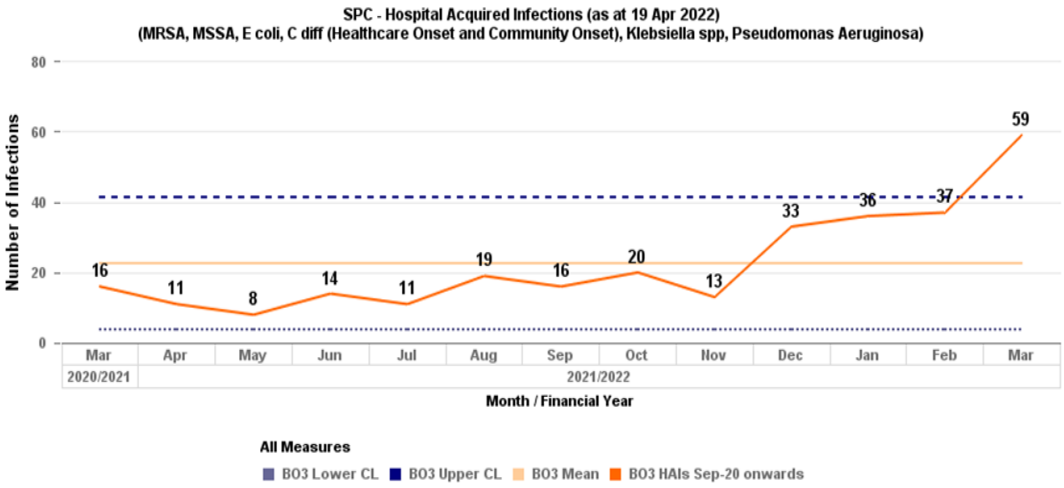
The Trust is committed to providing safe and compassionate care and we have established a culture of improving patient safety through our patient safety priorities. The Trust patient safety priorities are set out in our Avoidable Harm Prevention A3 document.

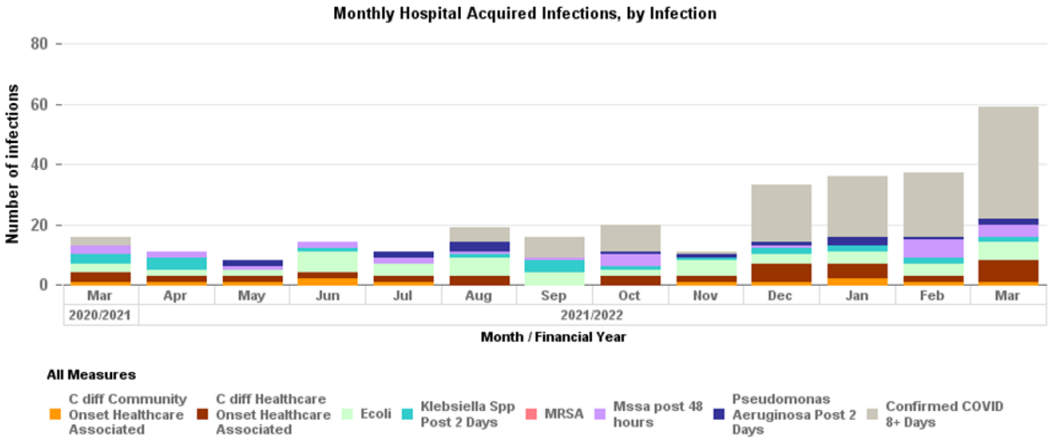
Each patient safety priority has an established clinical leader, and an executive sponsor, who are jointly responsible for setting the work-plan with agreed process and outcome measures. These are reported to Quality Board and to the Board of Directors.

1. Infection Prevention and Control

During 2021/22, the Trust recognised the need to improve its approaches to infection prevention and control across the hospital. The tables below show the number of healthcare associated infections (HCAI) that were recorded throughout the year, and a breakdown of the types of infection. The Trust exceeded its agreed thresholds at different times of the year in respect of Clostridium Difficile (C Diff), MSSA and E Coli infections.

Early in the year, the Divisional Directors of Nursing led peer audits across wards and departments focusing on a number of key areas including hand hygiene compliance, stool chart completion and patient isolation and antibiotic review. A number of actions were agreed and implemented as a result of these audits, including the establishment of weekly IPC huddles involving the Matrons and Divisional Directors of Nursing, focusing in particular on C diff, and an increase in the number of antimicrobial stewardship ward rounds.





There was a recognition of the need to improve standards of cleanliness within clinical areas across the hospital. In June 2021, the Bed Planning Steering Group, made up of representatives from the clinical and operational teams and colleagues from Estates and Facilities, identified and prioritised work to improve the clinical environment and facilitate effective cleaning. The IPC team also stepped up their regular walkabouts with Estates to assist with this process.

By far, the most challenging aspect of managing IPC during 2021/22 related to the COVID-19 pandemic. The table above reflects the extent to which COVID became the most pre-eminent hospital acquired infection from August 2021 onwards. Between December 2021 and April 2022, the Trust registered a total of 91 nosocomial (hospital acquired) infections. Actions that were taken to reduce this level of infection within the hospital included a strict adherence to regular patient and staff testing, closing a number of beds where social distancing was challenging, reluctantly stopping visiting on 31 December 2021, and ensuring full compliance with national guidance around the use of FFP3 masks from December 2021 onwards.

In spite of these measures, the position remained challenging, largely as a result of the high prevalence of infection within the community and the limitations of the Trust estate – including the lack of segregation areas for suspected COVID cases within the emergency department and the shortage (compared to other similar sized hospitals) of bathroom facilities outside patient rooms and bay areas, which made full isolation of infected patients difficult.

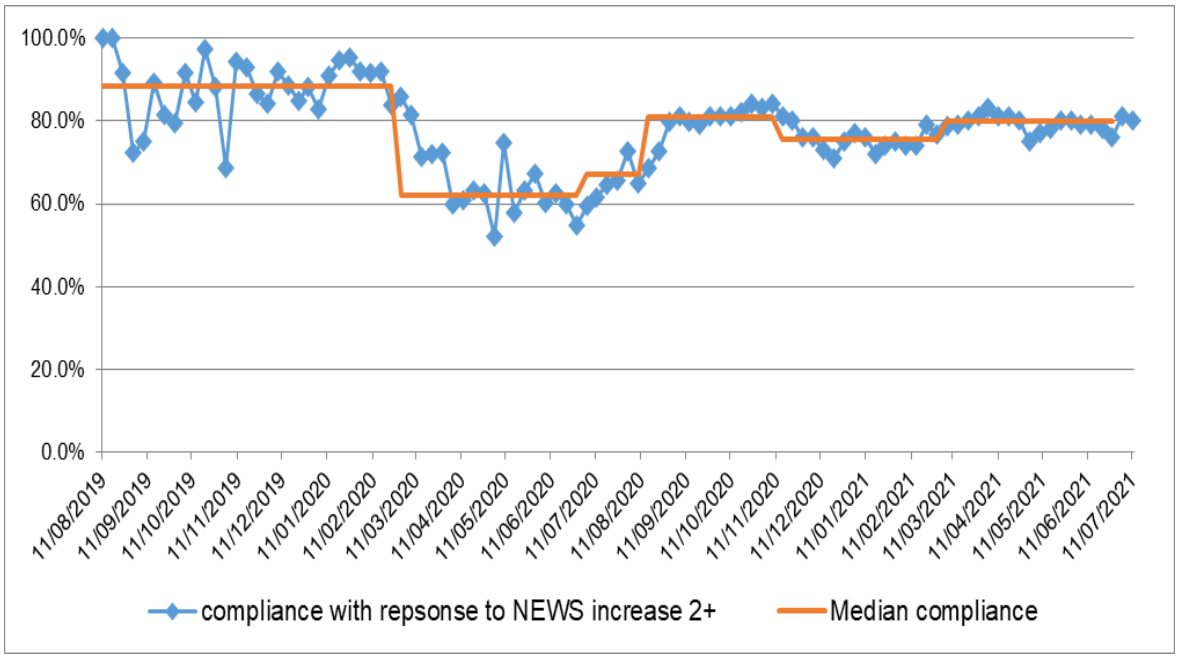
Overall, we conclude that this priority was partially achieved.

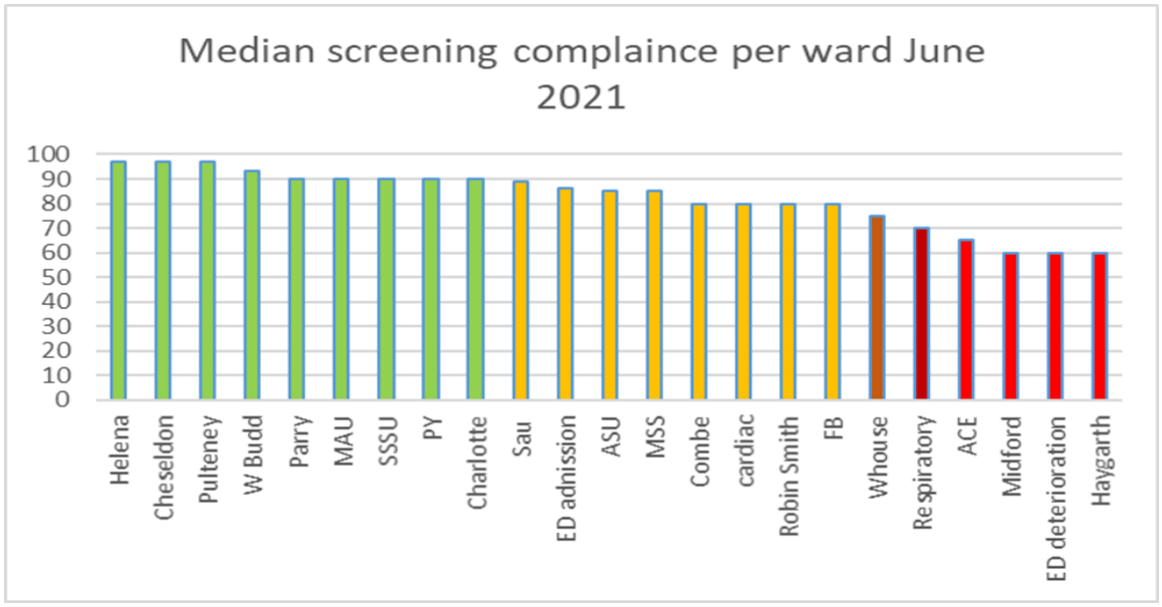
2. Deteriorating Patient

Early recognition of the deteriorating patient remained a patient safety priority for the RUH in 2021/22 and is also a national and regional safety priority. The implementation of an electronic system for the recording of vital signs (EObs) , which commenced in August 2019, has now been rolled out to all adult wards and clinical areas.

The focus on early identification of deterioration by raising awareness of the increase in NEWS score indicating potential deterioration remained the key area of focus in

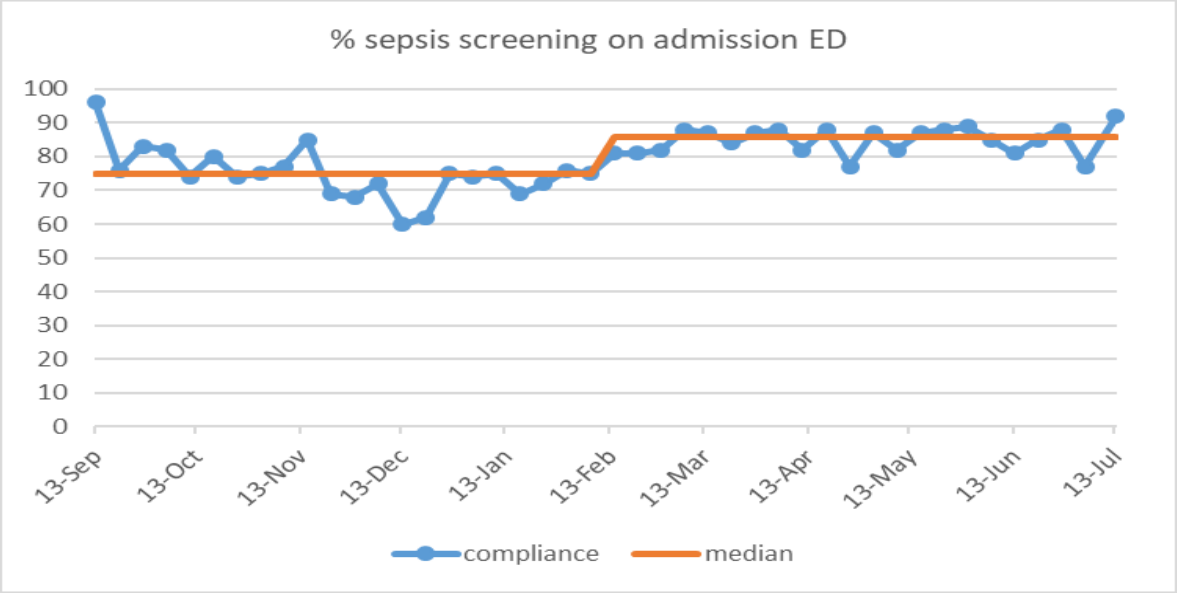
2021/22 with ‘Deteriorating Patient champions on each ward continuing to provide support. Response rates to EObs alerts when NEWS increased by 2 or more actually decreased during the first wave of COVID when EObs only remained operational in a few areas. However, the system has spread trust-wide since July 2021, and the response improved as a result of focused work. There was a slight drop during the second wave, but compliance was maintained at 80% throughout the year. The Trust is aiming to achieve 90%, and although 9 wards were observed to be achieving this in June 2021, some others were at 60%, as can be seen in the table below.





The need to increase education around worsening abdominal pain as a sign of deterioration was identified, and additional resource from Health Education England to roll this out, as part of a deteriorating patient campaign relaunch has been identified.

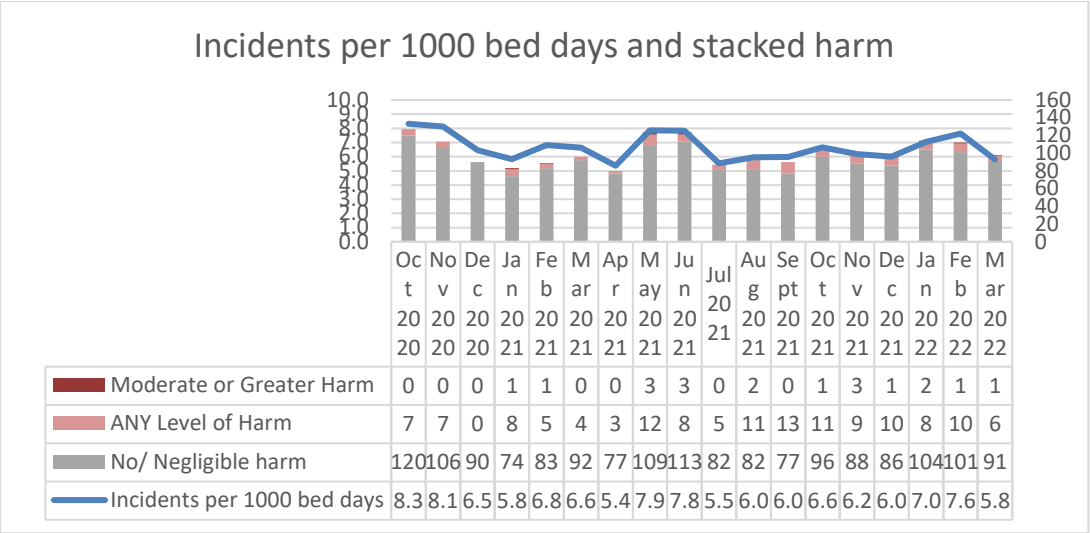
The percentage of at risk patients screened for sepsis on admission remained at around 86% for most of the year, reflecting continuing improvement in the early recognition, prevention and management of Sepsis and Acute Kidney Injury. The Sepsis and Kidney Injury Prevention team has been in place since May 2019, and it has been available to support clinical areas 12 hours a day, 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.



It is recognised that some patients who have a Learning Disability may refuse, or may be unable to tolerate the sort of physical vital sign observations that have been described above. There is a danger, therefore, that there would be no record of the deterioration in their condition and no way of establishing their baseline observations. The Trust had in 2021/22 been piloting the use of a Soft Signs (Non-contact physical health observations) Tool that is already in use at some other local acute and mental health NHS provider organisations. Unfortunately, the pilot was very limited, and did not in fact include any patients with a Learning Disability. A number of other tools have been considered to date, but none have been found to be appropriate for this cohort of patients within a hospital setting. It is anticipated that work will be revisited during 2022/23 by the new Specialist Practitioner for Learning Disabilities and Autism.

Overall, we conclude that this priority was achieved.

3. Medicines Safety



	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Moderate or Greater Harm	0	0	0	1	1	0	0	3	3	0	2	0	1	3	1	2	1	1
ANY Level of Harm	7	7	0	8	5	4	3	12	8	5	11	13	11	9	10	8	10	6
No/ Negligible harm	120	106	90	74	83	92	77	109	113	82	82	77	96	88	86	104	101	91
Incidents per 1000 bed days	8.3	8.1	6.5	5.8	6.8	6.6	5.4	7.9	7.8	5.5	6.0	6.0	6.6	6.2	6.0	7.0	7.6	5.8

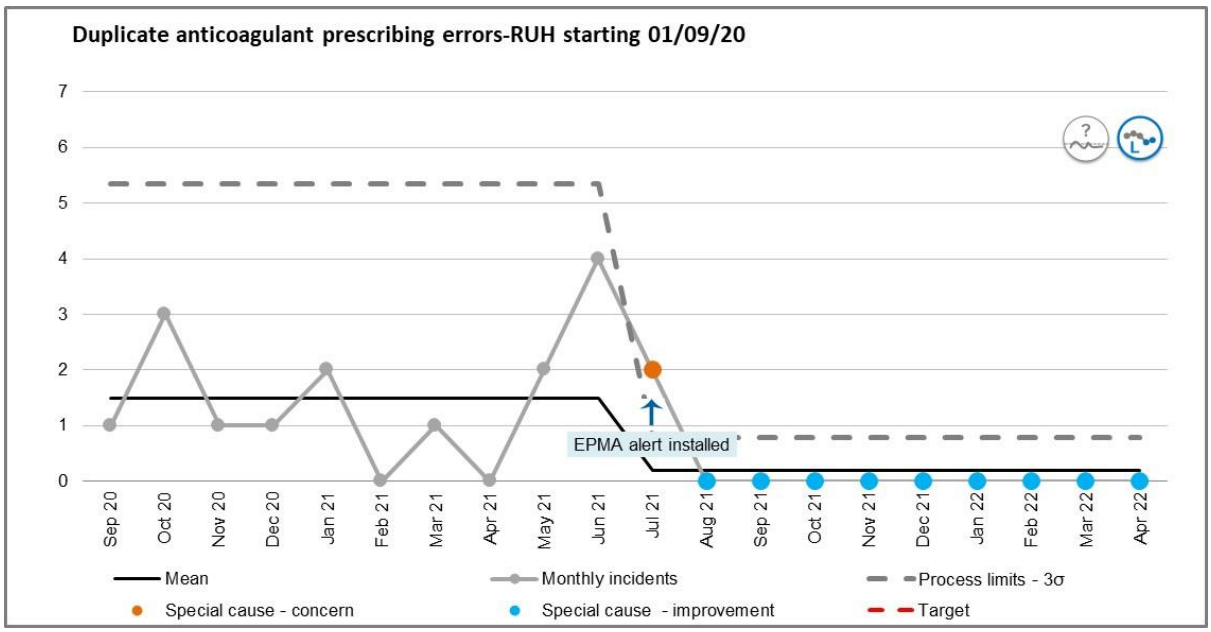
The RUH encourages an open reporting, no blame culture with regards to medication incidents, with the focus on eliminating errors that cause harm to patients. Between April 2021 and March 2022 the Trust had on average 6.4 errors per 1,000 bed days and 1.2% of incidents causing moderate-severe harm.

The identification of themes from medication incidents remained a patient safety priority for the RUH in 2021-22, and is a key requirement for compliance with CQC regulation 12 (Safe Care and Treatment). The RUH appointed a dedicated Medication Safety Officer in November 2020 to ensure capacity to do this identification and to work with all staff groups to improve quality of care with medicines, and in line with CQC requirements.

The Trust implemented an electronic prescribing and medicines administration (EPMA) system in 2017 across most inpatient wards. This initial rollout excluded particularly high risk areas in Phase 1: Intensive Care Unit, Theatres and Children's/Neonatal wards. The further rollout to the Children's wards was planned for 2020, delayed by the COVID pandemic but successfully completed in August 2021.

EPMA remains a key enabler for improving timely access to medicines, facilitating safe discharge and freeing up nursing time to care. In addition, through the Trust Medicines Advisory Group it provides the means by which prescribing errors can be reduced, through co-design with clinicians and nurses, once themes are identified.

A key example of both the benefits of EPMA and the interface between the clinical governance structure and improved medicines safety was the implementation of a new alert in July 2021 following repeated incidents of anticoagulant duplicate prescribing:



Similar interventions have improved care in Antimicrobial prescribing and avoided paracetamol overdose.

Our focus in 2022-23 is to strengthen our ability to embed best practice in use of medicines by:

1. Making Medicines Safety one of three key priorities in the relaunch of the Patient Safety Strategy with a focus on opioids and anticoagulants;
2. Expanding the Medicines Safety team by recruiting a Specialist Nurse in Medicines Management;
3. Investing in equipment and training and improving patient and medicine barcode scanning, which potentially prevents over 100 additional errors per month;
4. Increasing the level of medicines-related teaching available to staff;
5. Establishing a dedicated Medicines Safety Group as part of a governance structural review; and
6. Implementing a Digital Medicines Tracker to reduce the risk of patients missing critical medicines following ward transfers or discharge.

Overall, we conclude that this priority was achieved.

2.4 Quality Account Priorities 2021/2022

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 the BaNES, Swindon and Wiltshire Clinical Commissioning Group to determine the priorities. We have agreed three 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 2021/22 focus on improving pathways of care building on one of our priorities from 2019/20.

This section will set out our progress against the three Quality Account priorities chosen for 2021/22 and describe the process for agreeing our priorities for 2022/23. 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 2021-22

Priority 1	Priority 2	Priority 3
Implementation of Enhanced Recovery	**The PERIPrem Care Bundle (Perinatal Excellence to Reduce Injury in Preterm Birth)**	**Continuation of the Frailty Assessment Unit**
Achieved	**Achieved**	**Achieved**

1: Implementation of Enhanced Recovery

Why is it important?

Enhanced recovery is an evidence-based approach that helps people recover more quickly after having major surgery. Many hospitals – although not all – have enhanced recovery programmes in place, and it is now seen as standard practice following surgery for many procedures.

Enhanced recovery is sometimes referred to as rapid or accelerated recovery. It aims to ensure that patients:

- are as healthy as possible before receiving treatment
- receive the best possible care during their operation
- receive the best possible care while recovering

Having an operation can be both physically and emotionally stressful. Enhanced recovery programmes try to get patients back to full health as quickly as possible. Research has shown that the earlier a person gets out of bed and starts walking, eating and drinking after having an operation, the shorter their recovery time will be.

What we said we would do	What we did
Define the enhanced recovery pathway (ERP)for patients undergoing colorectal, urological and major joint replacement surgery	We have introduced ERP for patients undergoing elective colorectal surgery. Work is underway as to how this can be extended for urological surgery. ERP is in place for Knee and Hip replacement surgery but this has been placed on hold with the reduction in major joint replacement work as a result of the COVID-19 response and the use of the orthopaedic ring faced environment for non-elective escalation.
Review process and pathways to enhance recovery	Introduction of a patient information leaflet to educate patients pre-operatively. Introduction of videos and virtual pre and post-operative education for major joint replacement in orthopaedics. A patient daily goals logbook has been introduced to ensure that patients are aware of the goals that are to be achieved each day - empowering patients and their families to achieve goals and become partners in their own recovery. Introduction of marked patient walking routes to encourage mobility. Ward therapy roles focused on ERP. Introduction of a coffee machine for patient's post op to reduce post op ileus by stimulating gut function. Introduction of chewing gum and mouthwash as standard. Introduction of the colorectal enhanced recovery MDT five day booklet comprising seven sections to ensure that patients' recovery follows the ERP protocol. Introduction of the ICOUGH device (supported by the Innovation Panel) to support respiratory function and reduce the incidence of post-operative respiratory conditions.

	We have collected patient feedback which has been positive and patients have reported being 'motivated' and 'feeling supported'
Decrease length of stay for patients on the enhanced recovery pathway	We have seen a reduction in length of stay from 7.93 days during 2019/20, 6.4 days in 2020/21 and down to 6 days in 2021/22. To support the reduction in length of stay and enhanced recovery we have seen an increase in removal of catheters by day 2 post-operatively from 43% to 63% of patients, and by day 3 75% of patients have their catheter removed. Reduction in surgical site infections as part of the Precission surgical site infection bundle. From 24% to 7%. The number of atients commencing oral fluids on day zero increased from 50% to 100%. Oral diet on day zero has increased from 9% to 12%, and by day 1 we have seen an increase of more than 85% of patients starting on an oral diet.
Introduce an enhanced recovery lead role within the existing ward senior nurse team	Our elective ward has identified key nursing and therapy staff to promote ERP and nursing staff leads within the unit to support staff, increase skill set and knowledge.

Vision for the future and what's next?

The enhanced recovery pathway (ERP) will continue, as this is now embedded for colorectal patients within our elective ward, but additional work is needed to support pre-operative education and advice so that this is consistent for all patients.

We are reviewing the clinical nurse specialist role and how this becomes part of the ERP. Work is underway to re-establish ERP in orthopaedics in our ring fenced orthopaedic elective ward.

The team are keen to develop a permanent follow up phone call system to support early discharges and gather routine patient feedback that is live.

There is an ambition to implement a dedicated ERP lead (AHP/RN) to oversee the expansion of ERP.

Priority 2. The PERIPrem Care Bundle (Perinatal Excellence to Reduce Injury in Preterm Birth)

Why it is important:

- PERIPREM consists of 11 evidence-based interventions throughout pregnancy and the neonatal period
- The bundle supports the optimal timing of care and multidisciplinary working between maternity and neonatal professionals and with parents
- PERIPREM supports the NHS Long Term Plan (2019) reducing neonatal morbidity and serious brain injury by 50% by 2025.

What we said we would do	What we did
More than 85% of babies would be born in the right place (with appropriate neonatal facilities) More than 90% of birthing women will have received antenatal steroids prior to the birth of their preterm baby More than 90% of birthing women will have received IV Magnesium Sulphate prior to the birth of their preterm baby More than 85% of preterm babies would have optimal delayed cord clamping at birth More than 90% of preterm babies would be supported to maintain thermoregulation following birth More than 85% of preterm babies would be given early breastmilk. Mothers will be supported with hand expression.	• Revised preterm birth guideline (M44) • Introduced Fetal Fibronectin point of care testing • PERIPREM Launch and staff education (series of infographics) • Theme of the month to promote each element of the bundle • 15 minute training slot on Maternity PROMPT day to teach PERIPREM to all maternity staff • PERIPREM Champions • Collaborative working • Hydrocortisone neonatal guideline developed • Monthly meetings to review data • Monthly feedback to staff outcome infographics

More than 85% of preterm babies would receive appropriate caffeine therapy on the neonatal unit More than 85% of preterm babies would receive appropriate probiotics on the neonatal unit More than 85% of preterm babies would receive prophylactic Hydrocotisone on the neonatal unit	• Co-production with parents • Raised profile of recognising risk around pre-term birth utilising QI support from regional organisers

How we will continue to work with this priority

- In January 2022, compliance with the care bundle was achieved
- Continue data collection
- Monthly meeting will explore case by case using debrief tool
- Although the regional PeriPrem QI project is now completed, the work will continue, embedded within the Maternity Neonatal Safety Improvement Programme.
- Develop some local patient stories to present
- Strive to maintain the compliance achieved in January 2022 for all babies.

Priority 3. Continuation of Frailty Assessment Unit

Why it is important:
This Quality Account priority was commissioned in 2019 with an aim to continue to improve the service for the frail elderly patients. This project sought to build upon the previous work, developing the front door Frailty Assessment and the introduction of the Frailty Flying Squad.

Progress in years 1 and 2 have been reported previously, although year 2 was significantly affected by the COVID-19 pandemic. The Frailty Assessment Unit changed both its nursing workforce and location in the last 6 months of the 2020/21 financial year. The Older Persons Assessment Unit (OPAU) was re-launched on 12 April 2021 in D1 footprint.

Five KPIs have been identified to demonstrate the benefits and challenges of the Continuation of the Frailty Assessment Unit Quality Improvement Project:

- 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
- To increase the number of frail older patients being directly admitted to OPAU
- To increase the number of discharges from OPAU with 72 hours
- To establish the baseline for the number of patients assessed in the Frailty Assessment Unit, with a view to increasing this throughput during 2021-2022 – working with the Emergency Department and scoping the appropriateness of direct admits
- To capture patients' feedback, reviewed in the Frailty Big Room.

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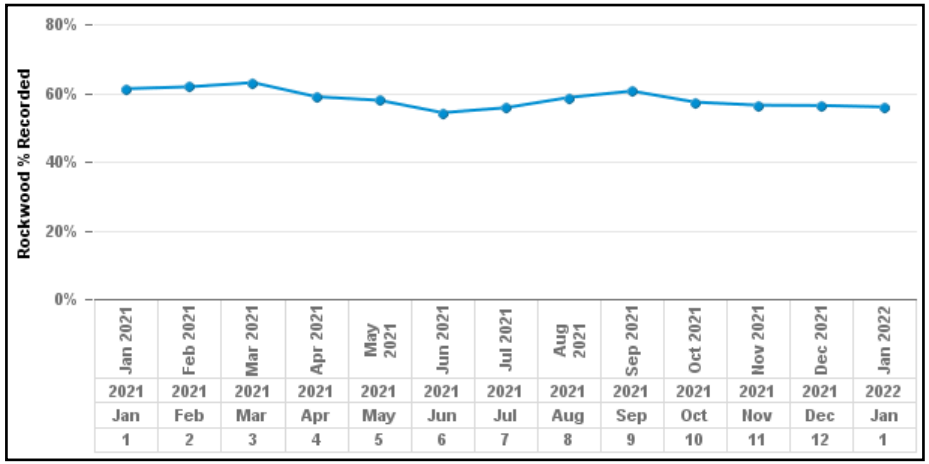
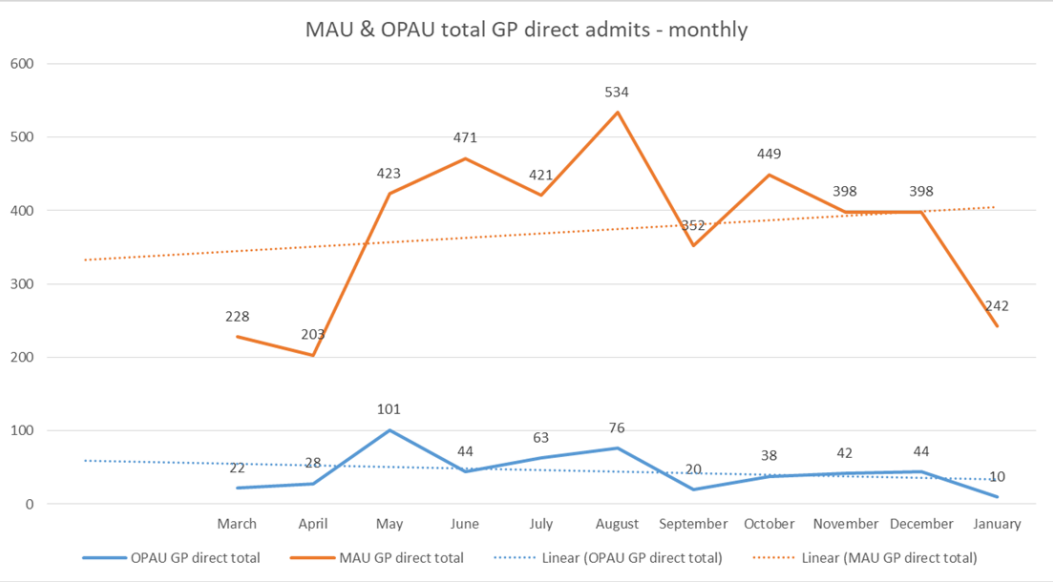
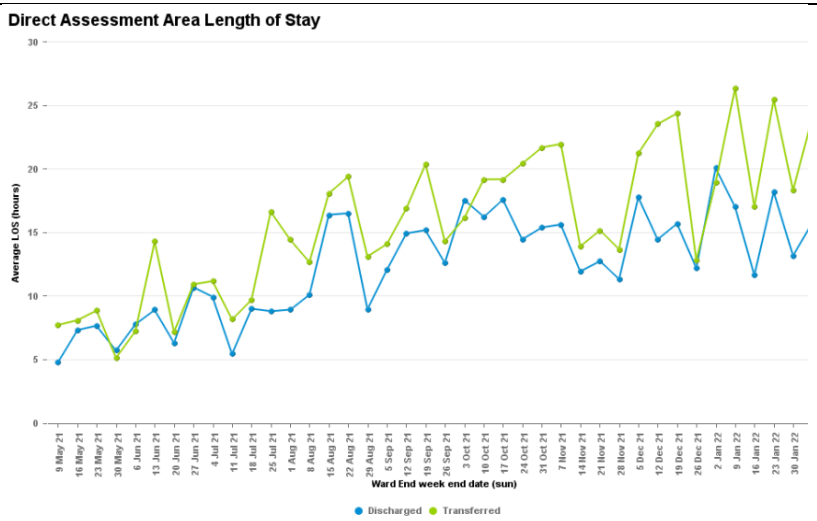
What we said we would do	What we did
Increase the proportion of patients who have a Rockwood Frailty Score (all patients	Overall, the number of patients with a recorded Rockwood score remains stable January 2022 (56% of all admissions ≥ 75 years of age). In January 2022, 425 patients were not scored on admission, which could compromise the selection of ward and team appropriate for their care needs, however mitigated by the close working between MAU/DAA and OPAU/Frailty Flying Squad.  Ongoing work with the front door areas, particularly the Emergency Department. Frailty Flying Squad (FFS) and the Medical Nurse Practitioners (MNPs) educating staff and raising awareness to improve the compliance in ED.

Comprehensive geriatric assessment (CGA) to be completed for medical admissions	Frail older people admitted for acute inpatient hospital care are at high risk of adverse events, long stays, readmission and long term care. Comprehensive Geriatric Assessment (CGA) improves outcomes for this group, particularly on specialised wards. Actions: 1. Rockwood scoring is not consistent across the trust with 56% of eligible patients scored in January 2022. Frailty scoring forms part of the CGA and therefore raising awareness and completion of the Rockwood scoring is a key fts step for all eligible admissions. 2. Data capture to record that a CGA has been completed on each admission, move to electronic capture and monitoring of completion and completeness. OPU team currently liaising with BIU to report weekly for review in the Frailty Big Room.
Increase the number of frail older patients being admitted directly to OPAU	**OPAU:** Through January 2022 OPU wards having been significantly impacted a number of ward closures due to COVID outbreaks. This has led to limited flow out of OPU leading to a lack of direct admissions capacity. OPAU has been functioning as a COVID ward in late December and early January not allowing for any direct admissions. A side room on OPAU been closed and is being for COVID testing of direct admission patients prior to admission to reduce the risk of infection. **MAU:** Flow through DAA & MAU in January 2022 has been more challenging due to a couple of reason: There have been significant staffing challenges on MAU, as well as across the Trust, especially the first two weeks of January. This resulted in delays in every step in patients' pathway and therefore flow, see graph on next page for increases in LOS on DAA in January, particularly for patients needing to be admitted from DAA. There have been a significant number of medical beds closed throughout January due to infection, resulting in an increased length of stay in DAA. DAA has been used as an ED admission area throughout January to avoid 12 hour breaches. This reduced flow has resulted in DAA being full on several occasion and unable to admit directly to MAU/DAA.



The graph below shows the LOS in DAA on a week by week basis, in green for those who are transferred out of DAA – these are patients that have been assessed and need to be admitted in to the hospital, their average LOS should be under 10 hours, in January it was an average of over 20 hours from arrival to being transferred out of DAA in to the main hospital.

LOS for patients being discharged from DAA also increased in January, although only slightly compared to the increase in LOS for those transferred (admitted from DAA). This is due to staffing shortages across all clinical staff groups on MAU, as well as in other departments (such as portering). Reduction in DAA flow compromises front door flow and patients are required to go via the Emergency Department,

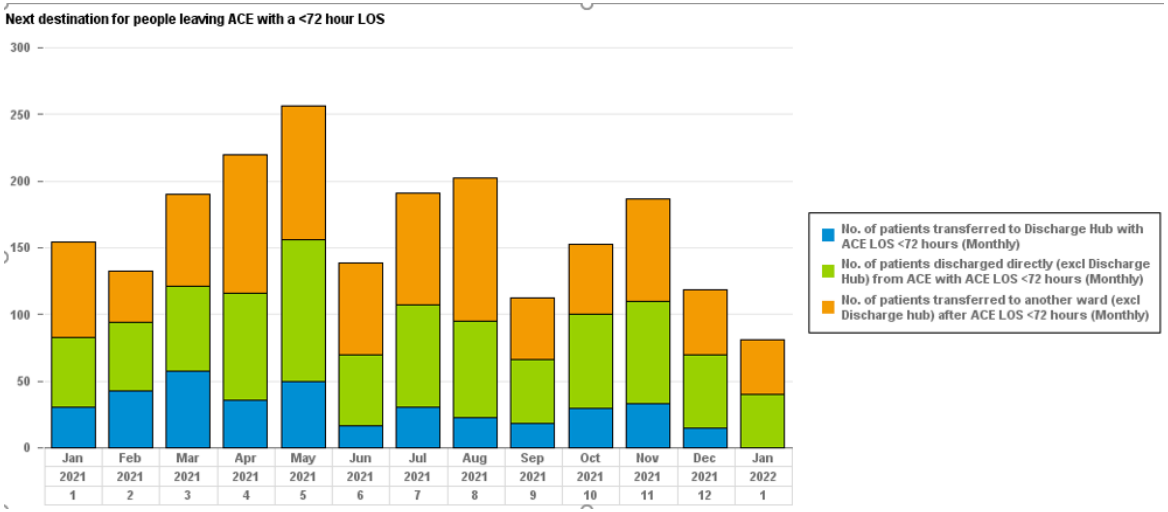


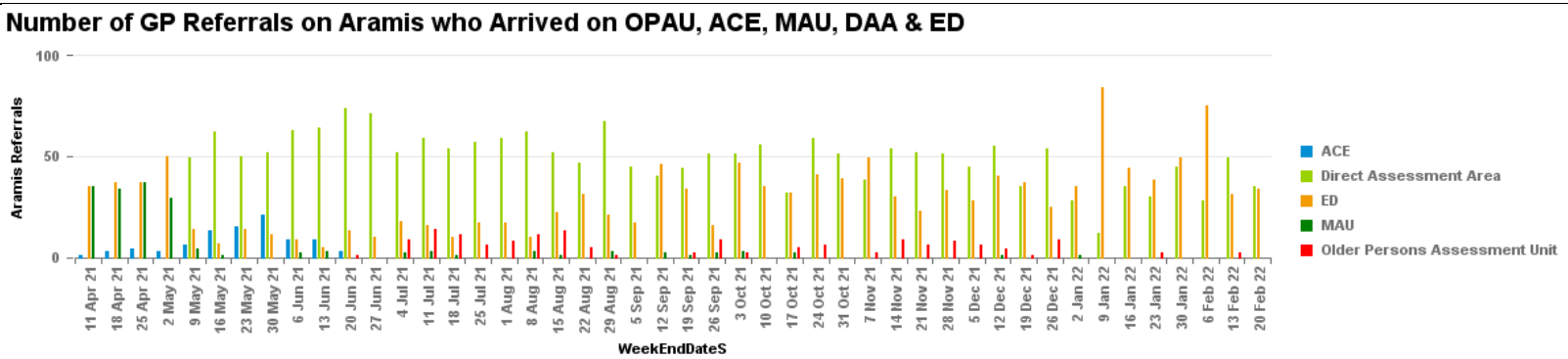
Next steps; March 2022 launch of a medical direct admission Big Room. The key stakeholders are MAU and OPAU, the aim to maximise opportunities to support a direct admission pathway for frailty and acute medicine without compromising either service, plus an opportunity to share learning and best practice.

Increase the number of discharges from OPAU within 72 hours

For the period June to the end of January 2022, the average length of stay for OPUA has increased to 4.3 days, not achieving the target of 72-hour length of stay, due to increase in trust wide non-criteria to reside and restrictions due to IPC restrictions. To note OPAU has been used in the last covid-19 phase as a receiving ward.

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Older Persons Assessment Unit	Discharges	68	285	286	180	244	279	220	158
	Average LOS	4.67445	2.67324	2.59175	4.04818	3.2118	2.82123	3.7988	4.29734

	The number of discharges throughout this period are relatively stable, reducing in December due to covid-19 admissions directly to OPAU and not functioning as a direct admission area. The number of patients however discharged within 72 hours of admission are reduced, due to change in function of OPAU to support covid-19 admissions.  The consistency of transfer to OPU wards is now centrally coordinated by the OPAU team and is reflected in the destination of patients transferring out of OPAU – right patient, right bed after assessment.
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	Overall since May 2021 the majority of expected patients do not go through an ED pathway unless for clinical need, i.e. resus or recognised pathway. In January 2022, there have been several days when DAA & OPAU have been at capacity, resulting in flow diverted through ED (seen by the increase in arrivals to ED in the chart below).

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	There is a patient story presented at the Frailty Big Room
Number of patients not requiring inpatient admission.	Work underway in conjunction with the discharge team; patient stories to be highlighted to COO and shared at the frailty weekly Big Room.

How we will continue to work with this priority

- Hot clinic or GP referrals requiring ambulatory assessment may be possible following discussion with the on call consultant via Consultant Connect. This service is planned as stage 2 of the AF-SDEC development.
- Paramedic direct referrals will form stage 3 of the AF-SDEC development – a pilot is underway
- Hospital@Home patients will be reviewed in the AF-SDEC area during their virtual admission.
- Improved community links will be created through integrated work with GP's, Care Homes and Community care providers
- March 2022 will see the launch of the medical direct admission Big Room (MAU and OPAU).

Statement of assurance from the Board of Directors

Mandatory Statement 1

1. During 2021/22, 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 2021/22 represents 100% of the total income generated from the provision of relevant health services by the Royal United Hospitals Bath NHS Foundation Trust for 2021/22.

Mandatory Statement 2

During 2021/22, 35 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 2021/22, 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 (National Confidential Enquiry into Patient Outcome and Death)	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death)	Yes	100%
Case Mix Programme (Intensive Care National Audit & Research Centre)	Yes	100%
National Audits		
Chronic Kidney Disease registry (The Renal Association/The UK Renal Register)	N/A	Not relevant to RUH
Cleft Registry and Audit NEtwork Database (Royal College of Surgeons - Clinical Effectiveness Unit	N/A	Not relevant to RUH
Elective Surgery (National PROMs Programme)	Yes	100%
Emergency Medicine QIPs - RCEM: Pain in Children (Care in Emergency Departments)	Yes	100%
Emergency Medicine QIPs RCEM: Severe sepsis and septic shock (care in Emergency Departments)	N/A	RCEM committee decision taken to not run this QIP during 2021/22
Falls and Fragility Fracture Audit Programme (FFFAP) : Fracture Liaison Service	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Inpatient Falls	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP) : National Hip Fracture Database	Yes	100%
Inflammatory Bowel Disease (IBD) Audit	Yes	100%
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRACE-UK)	Yes	100%
Mental Health Clinical Outcome Review Programme	N/A	Not relevant to RUH
National Diabetes Audit – National Adults Core Diabetes Audit	Yes	100%
National Diabetes Audit - National Pregnancy in Diabetes Audit	Yes	100%
National Diabetes Audit - National Diabetes Foot Care Audit	Yes	100%
National Inpatient Diabetes Audit – including National Diabetes Inpatient Audit Harms(NaDIA)	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) : Paediatric Asthma Secondary Care	Yes	85%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) : Adult Asthma Secondary Care	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) : COPD Secondary Care	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) : Pulmonary Rehabilitation	N/A	The RUH does not have a Pulmonary Rehabilitation Centre
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Cardiovascular Disease – Prevention (NHS Benchmarking Network)	N/A	Not relevant to RUH
National Audit of Care at the End of Life (NACEL)	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
National Audit of Dementia (NAD)	N/A.	Provider did not run audit – carried over into 2022/23
National Audit of Pulmonary Hypertension	N/A	The RUH does not have a Pulmonary Rehabilitation Centre
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	100%
National Cardiac Audit Programme (NCAP) National Audit of Cardiac Rhythm Management (CRM)	Yes	Awaiting response from NICOR
National Cardiac Audit Programme (NCAP) Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Adult Cardiac Surgery Audit	N/A	Not relevant to RUH
National Cardiac Audit Programme (NCAP) – National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	100%
National Cardiac Audit Programme (NCAP)-National Heart Failure Audit	Yes	Awaiting response from NICOR
National Congenital Heart Disease	N/A	Not relevant to RUH
National Child Mortality Database - University of Bristol	N/A	Not relevant to RUH
National Clinical Audit of Psychosis (NCAP)	N/A	Not relevant to RUH
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Comparative Audit of Blood Transfusion programme - 2021 Audit of Patient Blood Management & NICE Guidelines	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
National Comparative Audit of Blood Transfusion programme - 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	N/A	Not relevant to RUH
National Early Inflammatory Arthritis Audit (NEIA	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastro-intestinal Cancer Programme – National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	100%
National Gastro-Intestinal Cancer Programme – National Bowel Cancer Audit (NBOCA)	Yes	100%
National Joint Registry	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review Tool 1 University of Oxford / MBRRACE-UK collaborative	Yes	100%
National Prostate Cancer Audit (NPCA)	N/A	Data collection to now commence in March 2022
National Vascular Registry	N/A	Not relevant to RUH
Neurosurgical National Audit Programme	N/A	Not relevant to RUH
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	N/A	Not relevant to RUH

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
Paediatric Intensive Care Audit (PICANet)	N/A	Not relevant to RUH
Prescribing Observatory for Mental Health UK (POMH-UK). Prescribing for depression in adult mental health services	N/A	Not relevant to RUH
Prescribing Observatory for Mental Health UK (POMH-UK). Prescribing for substance misuse: alcohol detoxification	N/A	Not relevant to RUH
BTS Respiratory Audit: National Outpatient Management of Pulmonary Embolism	Yes	100%
BTS Respiratory Audit: National Smoking Cessation 2021 Audit	N/A	RUH does not have a smoking cessation service
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion Scheme (SHOT)	Yes	100%
Society for Acute Medicine Benchmarking Audit	Yes	100%
Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment BURST Collaborative / British Urology Researchers in Surgical Training	N/A	Not relevant to RUH
The Trauma Audit & Research Network (TARN)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
BAUS Urology Audit: Cytoreductive Radical Nephrectomy Audit	N/A	Workstream closed 31/12/20
BAUS Urology Audit: Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	N/A	N/A

The reports of 35 national clinical audits were reviewed by the provider in 2021/2022 and Royal United Hospitals Bath NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Audit of Inpatient Falls Facilities Audit

The 2020 report showed that the Trust performed better than other trusts for making written information about falls prevention available to patients and relatives. The Trust also met the National Institute for Health and Care Excellence (NICE) recommendation that screening tools should not be used to identify people at high risk of falls but rather a multi-factorial falls risk assessment (MFRA). The Trust scored well for having access to flat lifting equipment throughout the hospital; a multi-disciplinary falls working group meeting at least four times a year; all incidence of falls are routinely presented/discussed at falls working groups; falls incidence are presented as falls per 1000 occupied bed days and mandatory falls training is in place for all clinical staff. However the audit showed that the Trust needed to improve on the access to walking aids for newly admitted patients 7 days a week and a system was needed to assess the extent of the gap between actual and reported falls. Following the audit actions included the addition of a Non-Executive Director to the Falls Steering Group, working with Therapies to provide the provision of 7 day access to walking aids for newly admitted patients and working towards a system that would assess the gap between actual and reported falls.

Trauma Audit and Research Network (TARN) 2020/2021

The Trust was above the national average for: the submission of good quality patient data; the delivery of Specialty Register (StR) 3 or above led trauma teams for patients on arrival and for pre-alert and/or trauma team patients; rapid access to Specialist Major Trauma Centre (MTC) care with patients transferred within 12 days; the proportion of patients with Glasgow Coma Scale less than 9 (GCS <9) having definitive airway management within 30 minutes of arrival in the Emergency Department (ED). However, the Trust needed to improve performance in the following areas: the number of TARN eligible patients submitted; the proportion of patients meeting National Institute for Health and Care Excellence (NICE) head injury guidelines receiving a computerised tomography (CT) scan within 60 minutes of arrival; patients being administered tranexamic acid within 3 hours of the incident when receiving blood products within 6 hours of the incident; delivery of consultant led trauma teams within 30 minutes with pre-alert and/ or trauma teams and Injury Severity Score greater than 15 (ISS>15) patients; delivery of consultant led trauma teams within 30 minutes for patients with ISS>15. Actions taken to improve performance included undertaking a Hospital Episodes Statistics (HES) exercise issued by NHS Digital, Radiology and ED working together to develop a Category A trauma plan and ongoing work to clarify imaging request pathways. The trust also

undertook an A3 time to CT improvement project which resulted in the appointment of a Radiology dedicated CT Emergency Department Assistant (EDA) for portering patients to CT according to clinical priority, the relaunch of the major trauma team activation and the introduction of ED major trauma education sessions.

Fracture Liaison Service Database Annual Report January 2022

The Trust was significantly higher than other trusts for good compliance with 4 Key Performance Indicators (KPIs) and these were the identification of all fractures, identification of spine fractures, time to Fracture Liaison Service (FLS) assessment within 90 days and Falls Assessment completed or referred and Bone Therapy recommended as appropriate. However the RUH scored below the national average for KPI 11 Patient confirmed adherence to bone therapy at 12 months. At the time of the audit there was insufficient capacity to focus on all KPI's and the decision was to focus on the 4 month follow up appointments at the expense of the 12 month review. Although there is currently a lack of capacity to meet the full requirements for all KPIs, a second osteoporosis specialist nurse has been appointed to maintain the current good position on a number of the KPIs and to improve adherence to the other KPIs including KPI 11.

National Clinical Audit of Seizures and Epilepsies for Children & Young People (round 3 cohort 2) 2020 including standards incorporated from National Institute for Health and Care Excellence (NICE) guidelines CG137:

Overall data completeness for the Trust was 100% which was higher than the national average. The trust compliance for epilepsy surgery referrals for children and young people was significantly better than the national average. Areas where the Trust performed well below the national average included the number of patients with comprehensive care planning content, those with school individual healthcare plan, those who had an electroencephalogram (EEG) within 4 weeks of first request and those with input from a paediatric neurologist. Since data for cohort 2 was collected the configuration of the epilepsy service has been entirely redesigned. All referrals now come directly via the epilepsy team and as a result every patient has involvement of the team from the onset including contact with the epilepsy nurse. Every patient that needs to be seen will be reviewed by an epilepsy specialist in a dedicated clinic alongside the epilepsy nurse. This will mean fewer patients are sent for unnecessary investigations including EEGs.

National Comparative Audit of Blood Transfusion and National Institute for Health and Care Excellence (NICE) QS138

The Trust performed significantly well with all patients with known iron deficiency anaemia prior to being admitted being treated with iron before surgery. The RUH also scored better than the national average for patients receiving elective red blood cell transfusions having had both haemoglobin (Hb) checked and a clinical re-assessment after a unit of transfused red cells. However the Trust scored lower than

the national average for receiving tranexamic acid when moderate blood loss was expected and for evidence of patients receiving written and/or verbal information about the risks, benefits and alternatives to transfusion. Following the audit, plans to address the shortfalls included examining the procedures for implementing the NICE Quality Statements for Blood Transfusion, exploring the barriers to their implementation and work to overcome them in order to improve the provision of patient information.

Sentinel Stroke National Audit Programme (SSNAP) March 2022

The Trust scored either A or B for Domains 1) Scanning, 4) Specialist assessment, 9) Standards by Discharge and 10) Discharge process. In the majority of cases the Trust was either just above or in line with the national average. All patients discharged were given a named person to contact after discharge. Most patients were scanned within 12 hours of clock start and scored well for the median time between clock start and scan. Most eligible patients were given thrombolysis and most were seen by the stroke consultant within 24 hours. Most patients had a swallow screen and were assessed by a speech and language therapist within 72 hours and were screened for nutrition and seen by a dietitian by time of discharge. Most patients also had a continence plan drawn up within 3 weeks. Improvement is required for Domain 2) Stroke Unit patients meeting 4 hour target for admission to the Acute Stroke Unit (ASU), Domain 3) Thrombolysis of patients admitted directly to the ASU and 8) Multi-Disciplinary Team (MDT) Working, particularly with the therapy teams resource issues which have been ongoing for some time with no improvement despite a recruitment drive. Following the results there are now weekly breach meetings and regular thrombolysis review meetings with the stroke consultants / medical nurse practitioners (MNPs) / specialty manager. To address the ongoing resource difficulties with therapists an extra bay (E bay), has been open on ASU for some time now for extra patients needing review. During the Trust escalation plan the therapy gym was used as an extra patient bay, with a reduction in rehabilitation space for the therapists to use for stroke patients. This has now been changed so the therapy gym can be used as usual.

National Emergency Laparotomy Audit (NELA) 2021 Q3

The Trust scored above average for the majority of standards including: computerised tomography (CT) scan performed and reported by a consultant radiologist before surgery; risk of death documented before surgery; arrival in theatre within a timescale appropriate for urgency; Consultant anaesthetist and surgeon present in theatre when risk of death is ≥ 5%. In all cases where risk of death ≥ 5% a Consultant surgeon was present in theatre and in nearly all cases the consultant anaesthetist was also present. The majority of patients were admitted to Critical Care following surgery when the risk of death was ≥ 5% or > 10%, very few patients had an unplanned return to theatre after emergency laparotomy and no patient had an unplanned admission to Critical Care. However, the Trust was below the national average for Care of Elderly Review and this was due to the Care of

Elderly physician being pulled back into Older Patient Care due to COVID. However with the easing of COVID the Care of Elderly review should improve. The Best Practice Tariff (BPT) was met with 84% eligible high risk cases receiving critical care and consultant surgeon and anaesthetist care.

The reports of 64 local clinical audits were reviewed by the provider in 2021/22 and the Royal United Hospitals Bath NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Sjogren's Syndrome Pathway Audit 2021

The audit showed there was evidence of excellent practice around the prescribing of early symptomatic relief in the form of eye drops and considering treatment with hydroxychloroquine in the majority of cases, as well as providing patients with a standard written information leaflet about the condition itself. However diagnostic criteria had only been met in a third of cases. Improvement was also needed in offering advice on Meibomian gland stimulation / home interventions for stimulating tear and saliva production, advising patients on regular visits to a general dental practitioner , chewing sugar free gum, using fluoride toothpaste and patients having a baseline ultrasound scan. Following the audit actions to improve practice included revising the Patient Information leaflets and distributing the Versus Arthritis information leaflet which had recently been produced. A written local pathway for Primary Sjogren's Syndrome (pSS), based on (British Society for Rheumatology (BSR) and European Alliance of Associations for Rheumatology (EULAR) guidance, has been drafted. The pathway includes agreed follow up intervals and treatment, as well as an up to date list of available prescription and over the counter eye drops and saliva substitutes. This document was being implemented following consultant review.

Audit assessing compliance with NICE of the Initiation of Biologic Therapy for Psoriasis January 2022

Compliance was green for the majority of standards and 100% patients receiving biologic therapy were treated appropriately. This means that they had previously been treated by a systematic medication and had their first biologic recorded in their electronic records. Most of the patients' disease was classed as severe at baseline, as defined by the total PASI (psoriasis area and severity score) of 10 or more. (PASI 20 or more for Infliximab) and the DLQI (Dermatology Life Quality Index) of more than 10 (DLQI more than 18 for Infliximab**)**. All patients had the selected biologic agent listed. However less than half the patients had completed a 12 or 16 week follow up review. The main reason for this was due to COVID-19 and reduced staffing levels to meet the demand. Since the audit was carried out clinics have now resumed on a regular basis and staffing levels have increased to help meet the demand for patient review. Clinic capacity is also being increased to achieve a reduced time to first follow-up after starting a biologic therapy for psoriasis in line

with the recommended time-frame set by NICE. The first follow-up will also be face-to-face.

Audit on assessing compliance with NICE guidance within hip fracture operations – supervision during operative management of hip fractures and intramedullary fixation of extracapsular hip fractures

The audit showed that the Dynamic Hip Screw (DHP) operation undertaken for extracapsular hip fracture (Type A1/A2) guidance was followed in the majority of cases. Two thirds of operations were supervised by either a consultant or associate specialist. However the data submitted to the National Hip Fracture Database (NHFDB) contained some inaccuracies in the classification of the fracture and one incorrect operation was listed but this did not apply to the patient record. Actions following the audit included education / raising awareness / presenting guidance regularly at Trauma meetings to ensure that operating clinicians document accurately on the operation note and theatre records and trauma co-ordinators check documentation before uploading. Where possible, senior supervision should also continue.

Intermittent Auscultation during Labour Q3

The audit showed that the Trust was compliant for most of the standards including carrying out an initial assessment to ensure the appropriate method of fetal monitoring was used. Intermittent Auscultation was well documented during the first stage of labour. However, the Trust did not perform so well for documenting the fetal heart during the second stage of labour or the documentation of the maternal heart rate as a comparison to the fetal heart rate. Actions taken following the audit included publishing the results in the newsletter and including and using the audit results as part of the learning in the fetal monitoring study day. Update the Care in Labour guideline to ensure that the guidance is clear.

Introduction of Mainstreaming Cancer Genetics (MCG) to the Royal United Hospitals Foundation Trust (RUH)

The Trust performed well in this audit with good compliance for all 4 standards. The majority of patients presenting to the breast unit with a new diagnosis of breast cancer had an assessment of eligibility for MCG and where applicable were approached for consenting. In most cases this discussion was documented and where consent was given, the signed consent form was uploaded to the medical records. All appropriate patients who consented for testing, regardless of results were referred to genetics, Whilst the audit results were good, the team were reminded of the need to maintain and improve practice, particularly around inputting history sheets / questionnaires, to follow the pathway and input data out of appo

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 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 3,071 with a further 2,700 registered into an ethically approved retrospective data collection study. Many of these patients were included in research studies into treatments and vaccines for COVID-19.

At any given time, the Trust has around 250 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 since April 2020 – June 2022

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
Dr Jonathan Rodrigues/Dr Ali Khavandi	Radiology/ Cardiology	Super Rehab- Can we reverse coronary heart disease in metabolic patients?	£297,477	NIHR - RfPB
Dr Ali Khavandi/Dr Jonathan Rodrigues	Radiology/ Cardiology	Reversing the burden of atrial fibrillation with a novel lifestyle and risk factor modification intervention (Super Rehab)	£244,804	RUH X/Forever Friends
Dr Jonathan Rodrigues	Radiology/ Respiratory	Developing Artificial Intelligence Tools to Improve Diagnosis and Risk Stratification in Acute Pulmonary Embolism and Chronic Thrombo-Embolic Pulmonary Hypertension.	£833,816	NHS X

Dr Daniel Augustine	Cardiology	IMPULSE – Improving pulmonary hypertension Screening by Echocardiography	£592,997	Jansenn Pharmaceuticals
Melody Rich	Maternity	Pre-doctoral fellowship	£54,852	NIHR
Prof Esther Crawley	Paediatrics	GEM - How common is late onset Pompe disease in young people and adults treated for Chronic Fatigue Syndrome or Myalgic Encephalomyelitis (CFS/ME): cross-sectional study.	£577,255	Sanofi With University of Bristol
Dr Raj Sengupta, Dr Inma Mauri-Sole, Dr Tom Welsh	Rheumatology Dermatology Aging	Qualitative evaluation of virtual appointments at RUH	£3769	UKRI via University of Bath
Jennifer Haworth	Orthodontics	The use of digital water technology in orthognathic surgery	£14,950	British Orthodontic Society
Anna Pease (UWE) Karen Patrick (RUH)	Maternity	Preventing Sudden Unexpected Deaths in Infancy: an assessment and planning tool for families at increased risk	£4647	NIHR RfPB with UWE
		Total	**£2,670,511**	

Mandatory Statement 4

The Royal United Hospitals NHS Foundation Trust income in 2021/22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework due to no requirement for contracts between Providers and Commissioners, national guidance and block payments applied.

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 2021/22.

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 2021/22 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
- 98.5% for outpatient care and
- 99.4% for accident and emergency care.

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

- 97.5% for admitted patient care;
- 98.0% for outpatient care; and
- 90.3% for accident and emergency care.

HES data as presented in Dr Fosters has been used to generate this data and for GP Practice codes both blank and defaulted V81* codes have been counted as invalid.

Mandatory Statement 9

The Royal United Hospitals Bath NHS Foundation Trust Information Governance Assessment Report overall score for 2021-22 was Approaching Standards Met with an internal audit for this submission graded as Significant Assurance with minor improvement opportunities Amber / Green.

Mandatory Statement 10

The Royal United Hospitals Bath NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 financial year by the Audit Commission or its successors.

Mandatory Statement 11

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

- Continue the work of the Data Quality Action 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 Business Intelligence 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.
- In-line with The Government Data Quality Framework the Data Quality Action Group are implementing Data Quality Action Plans to ensure that efforts to improve data quality are focused, monitored and action driven.

Mandatory statement 27:

Learning from Deaths

Mandatory statement 27.1

During 2022/22, 1386 of 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:

- 282 (↑1) in the first quarter;
- 336 (↑58) in the second quarter;
- 417 (↑37) in the third quarter;
- 357 (↓38) in the fourth quarter.

There were a higher number of deaths in Q1 – Q3 compared to the previous financial year.

Mandatory statement 27.2

By the end of 2021/22 (patients who died during 2021/22 and had their cause death reviewed before the expiry of that period) 112 case record reviews and 12 investigations have been carried out in relation to the deaths included in item 27.1.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 41 SJRS and 0 investigations in the first quarter;
- 30 SJRs and 5 investigations in the second quarter;
- 34 SJRs and six investigations in the third quarter;
- 7 SJRs and 3 investigations in the fourth quarter.

Mandatory statement 27.3

We have adopted the Royal College of Physicians' National Mortality Case Record Review Programme methodology known as the 'Structured Judgement Review' (SJR).

The Royal College of Physicians has stated that "SJR methodology does not allow the calculation of whether a death has a greater than 50% probability of being avoidable" and, further, that "The NMCRR programme, supported by the RCP, does not endorse the comparison of data from the SJR between trusts."

As such, we can only present the data available which is summarised below. These numbers have been estimated using the Structured Judgement Review Process.

1 = Very Poor Care
2 = Poor Care
3 = Adequate Care
4 = Good Care
5 = Very Good Care

The table below details all SJRs completed for patients who died during 2021/22, even if the SJR was completed after the expiry of that period.

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.06	155	0	5	24	83	43
Ongoing Care	3.94	139	0	9	28	65	37
Care During	4.02	46	0	0	7	31	8
Return To Theatre	4.25	4	0	0	1	1	2
Perioperative Care	3.88	33	0	1	4	26	2
End Of Life	4.09	131	0	4	15	77	35
Overall	3.91	154	0	7	33	81	33
Patient Record	3.72	151	0	6	64	48	33

Whilst the Trust is unable to calculate the avoidability of a death, the Structured Judgement Reviewer is asked to consider whether any care problems identified are likely to have contributed to the death occurring. The number of care problems likely to have contributed to death can be calculated per quarter as follows:

Q1: 0

Q2: 3

Q3: 3

Q4: 1

The care problems identified above included an inpatient fall, nosocomial COVID infection, and delays in scanning and senior review. All have been subjected to a second, more detailed review, to establish if the threshold for a serious incident had been met.

Mandatory statement 27.4

The Trust methodology for reviewing all deaths includes a process to escalate cases for further investigation if care or service delivery issues may be a concern. In the

time period we identified 4 cases which were escalated for serious incident investigation following a Structured Judgement Review (SJR).

The learning identified from the four incidents included:

- Management of diabetic patients on medical wards
- Environmental impact on outbreaks of infection (COVID)
- Communication between medical teams
- Recognition and escalation of deteriorating patients

Mandatory statement 27.5

The Trust has undertaken a thematic review of all incidents and information from complaints, inquests and structured judgement reviews in order to identify priorities for the development of the RUH Patient Safety Programme for 2022-2025. Improving Together has evolved as part of that programme to facilitate involvement of all staff in learning and implementing new practices and processes arising from the developing A3 work streams. The Quality A3 describes the harm that could be caused to patients if consistently high quality and safe care is not delivered. Five patient safety priorities reflect themes identified within incidents and complaints. These are:

- Early identification of the deteriorating patient
- Prevention of infection
- Prevention of medication errors
- Prevention of falls
- Improved processes for hospital discharge

Learning and progress of actions from serious incident investigations is reported through the A3 work plans.

Mandatory statement 27.6

An investigation into COVID outbreaks resulted in the Trust prioritising environmental concerns in future developments - to include ventilation, social distancing, standards of hygiene, training, the need to isolate patients and the use of single rooms.

Monthly integrated performance reports are overseen by the Board of Directors. These provide progress on performance measures in place to monitor for zero avoidable harm.

Mandatory statement 27.7

82 case record reviews and 4 investigations completed after 31/03/2021 related to deaths which took place before the start of the reporting period.

Mandatory statement 27.8

8 deaths, representing 0.6% of the patient deaths recorded before the end of the reporting period, are judged to have been contributed to by 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

18 deaths, representing 1.3 % of the patient deaths during 2020/21, are judged to have been contributed to by problems in the care provided to the patient.

Reporting against core indicators

SHMI

	Measure	Latest Reporting Year	RUH Performance Feb21-Jan22	Feb20-Jan21	Feb19-Jan20	National Average	National Best	National Worst
Summary Hospital Level Mortality Indicator (SHMI)	Value	Feb21-Jan22	1.041	1.031	1.040	1.000	0.712	1.196
	Banding	Feb21-Jan22	2	2	2	2	3	1
	% of Patient Deaths with Palliative Care Coding	Feb21-Jan22	31%		27%	39%		

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. 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.

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
PROMS: Patient Reported Outcome Measure	Total Hip Replacement - EQ-5D	2020/2021	0.437	0.467	0.579	0.378
	Hip Primary - EQ-5D		0.468	0.475	0.555	0.395
	Hip Revision - EQ-5D		0.541	0.329	-	-
	Total Knee Replacement - EQ-5D		0.346	0.317	0.434	0.215
	Knee Primary - EQ-5D		0.352	0.319	0.436	0.22
	Knee Revision - EQ-5D		0.204	0.285	0.212	0.195
	Total Hip Replacement - EQ-VAS		11.852	14.683	20.688	6.819
	Hip Primary - EQ-VAS		14	15.056	21.539	9.894
	Hip Revision - EQ-VAS		-44	7.935	-	-
	Total Knee Replacement - EQ-VAS		5.68	7.483	12.137	0.868
	Knee Primary - EQ-VAS		6.125	7.687	12.571	1.181
	Knee Revision - EQ-VAS		-5	4.029	-	-3.254
	Total Hip Replacement - Oxford		23.926	22.579	25.948	17.564
	Hip Primary - Oxford		24.68	23.007	25.387	17.826
	Hip Revision - Oxford		14.5	15.079	16.526	13.366
	Total Knee Replacement - Oxford		15.778	16.884	21.622	13.567
	Knee - Primary - Oxford		15.462	13.277	21.607	13.526
	Knee Revision - Oxford		24	13.277	11.961	8.606

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 2020/2021 are finalised figures published by NHS Digital. Finalised figures are not available for the 2021/22 year.

Re-admissions

Measure		Latest Reporting Year	RUH Performance			National Average	National Best	National Worst
			2020/2021	2019/2020	2018/2019			
Emergency Readmissions within 30 days of discharge from hospital	0-15 Years Old	2020-2021	12.9	13.2	14.0	11.9	2.8	64.4
	16 Years or Over		14.3	14.3	14.1	15.9	10	21.7

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 through submissions to Secondary Users Services. The indicators presented measure the percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital over the 2020/21 period, the latest available dataset.

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	National Best	National Worst
Overall, how was your experience while you were in the hospital	2020	8.4	9.5	7.5
Ranking Compared to Other Trusts	2020	About the Same	Much Better	Much Worse

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

The data displayed is taken from the CQC staff survey as published by NHS England. All eligible NHS trusts in England participate in the NHS Patient Survey Programme, asking patients their views on their recent health care experiences. The findings from these surveys provide organisations with detailed patient feedback on standards of service and care, and can be used to help set priorities for delivering a better service for patients. The survey results are also used by the Care Quality Commission to measure and monitor performance at both local and national levels.

Staff recommending the Trust to family and friends

Measure		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	RUH Performance	1.7%	5.7%	19.0%	54.7%	18.9%
	Comparator	3.1%	7.4%	21.7%	49.3%	18.5%

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

The data presented is collected during the national NHS Staff Survey which describes how NHS people experience their working lives. Each autumn everyone who works in the NHS in England is invited to take part in the NHS Staff Survey. The aggregated survey results are official statistics, providing a rich source of data that is used by a wide range of NHS organisations to inform understanding of staff experience locally, regionally and nationally.

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 displayed is for the last reported period via NHS Digital.

The national VTE collection was suspended as a part of the pandemic response and detailed in the NHSE letter 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic', Publications approval reference: 001559.

Clostridium difficile (C. difficile)

Measure		RUH Performance		National Average	National Best	National Worst
		2020/21	2019/20			
Hospital Onset, Healthcare Associated C.Difficile Infection	Rate per 100,000 bed days for specimens taken from patients aged 2 years and over	17.0	10.5	17.7	5.5	80.6

* Note Best excludes Specialist Hospitals

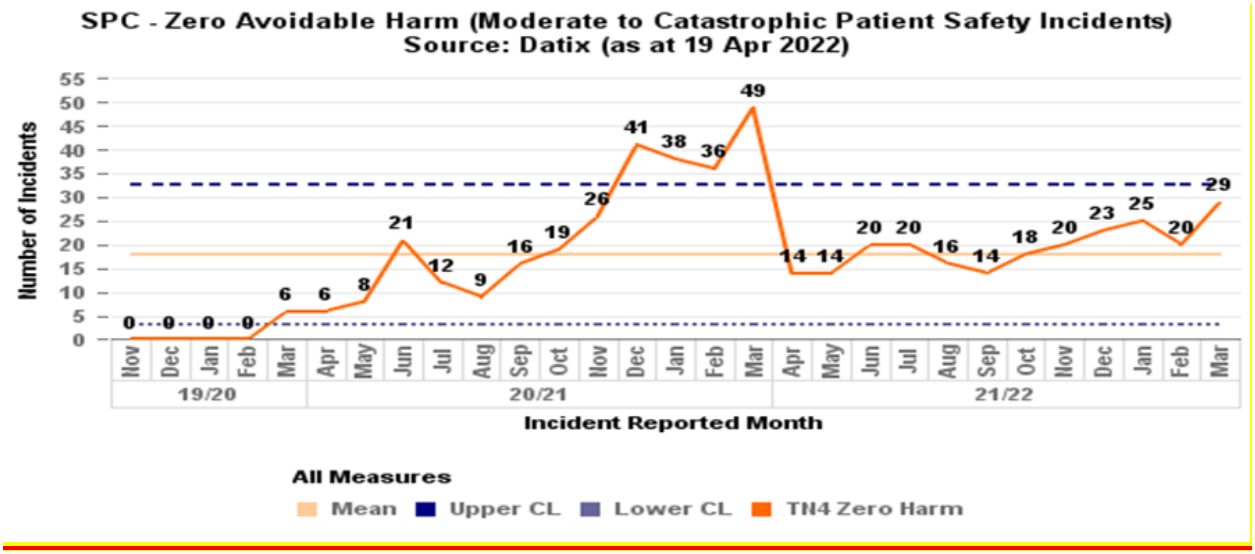
The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The performance shown is taken from the most recently published Public Health England annual counts and rates of *C.difficile* infections, by acute trusts in patients aged 2 years and over

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
- 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



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 that is available to the Trust internally. The table below shows a breakdown of the category of incidents for the year. Actions being taken on the basis of this information includes:

- An in-depth review of incidents relating to delayed procedure, treatment and diagnosis which was reported to the Patient Safety Steering Group in April 2022.
- A thematic review of low and no harm incidents, with a view to identifying near misses and other themes to help inform patient safety priorities for 2022/23
- eLearning in Patient Safety for all staff on the new National Patient Safety Syllabus to be launched in 2022.
- Patient Safety Incident Response Framework planning being undertaken on the basis of fewer but higher quality investigations focusing on learning and improvement.

Category of incident	Apr – Mar 2022	Mar 2022
Treatment or procedure	49	12
Patient falls	37	2
Infection Control	31	1
Clinical Assessment or Review	27	3
Tissue Viability	26	3
Obstetrics	18	2
Discharge, Transfer or Transport	8	1
Medication	6	2
Admission	8	0

Part 3 Other Information

3.1 Local Quality Indicators – patient experience

This section of our Quality Accounts provides an overview of an aspect of the quality of care that we provided in 2021/22.

Improving Patient and Carer Experience

Improving patient and family experience is one of the objectives of the Trust's vision to deliver the highest quality care, delivered by an outstanding team who all live by our values. For our patients and carers this means that it is our ambition to be a 'listening organisation, patient centred and compassionate'.

Our vision for improving patient experience is that we will listen, hear and act, putting the patient and family voice at the heart of our services.

Our goal is to continuously improve our patient experience and strengthen our patient voice in every service across the Trust.

We have used a problem-solving tool called an A3 to identify areas, where we know from patient feedback that we do less well, as a result the Trust is able to focus on projects to improve patient experience, such as:

- Developing a **Family Liaison Facilitator Team** to support communication between inpatients and their families and wards (further information is in the Responding to Patient Experience Feedback section below).
- Developing a **patient and carer engagement and experience strategy**. The Patient Experience Team are working with staff, patients and their families and carers, and the local community to co-produce a strategy. This will set out plans to assist staff to work together with patients and their families and

carers to design services, improve service provision and improve patient and carer experience.

- Based on the findings of patient feedback we have identified areas of priority to **enhance communication**, such as:
    - a 'listening service' to work alongside the PALS and Complaints teams, as a further opportunity for patients' voices to be heard and used to learn and improve,
    - 'the waiting room experience' where staff and patients will work together to consider their first impressions of the waiting areas, from the perspective of a service user, recording the impact of how it appears; looks; sounds; smells as well as the information and communication provided in the area. The outcomes will inform improvement actions.

Collecting patient feedback to improve our services

Patients and their carers and families share their experiences of using the services we provide. This information is collected through a variety of ways, for example:

- Friends and Family Test (FFT)
- Patient Advice and Liaison Service (PALS) Concerns and Complaints
- Patient Stories
- Hospital questionnaires, telephone interviews, focus groups
- Social media – NHS website/Twitter/Facebook
- Annual and bi-annual National Patient Experience Surveys – Inpatient/Maternity/Emergency Department/Cancer

Friends and Family Test (FFT)

The response to the national FFT question helps us to understand patient experience across the hospital. The Covid-19 pandemic and the impact on patient experience is reflected in the feedback, for example difficulties due to visiting restrictions, communicating with family when an inpatient, waiting for appointments and attending outpatient appointments alone. This corresponds with feedback received via Complaints and PALS. The Trust's responses to patient experience feedback is detailed in the Responding to Patient Experience section below.

Patient Stories

Bi-monthly, a patient/ carer story is heard at the Board of Directors. This is the first item on the Board agenda and staff involved in the care of the patient attend the virtual Board meeting to share what has changed as a result of the patient/carer story. Their story is either filmed, voice-recorded or the patient/family member shares their experience in person by attending the virtual Board meeting.

As a result of listening to patient/ family stories we improve the care we provide and we also share good practice on the Trust's Intranet for staff to use in training and education, for example:

- A story from the wife of a patient who was admitted as an inpatient after contracting COVID-19 emphasised the kindness of all the staff involved in her husband's care, noting the support from the Royal Marines. She spoke about the daily telephone calls she received that provided much needed reassurance about her husband's condition and praised the staff for giving her enough time to ask questions and understand his situation. The patient spent a number of weeks in the Intensive Care Unit and during that time highlighted the small things that made a difference – being able to see her husband on FaceTime, going outside for fresh air and photos with family messages around his bed space.

- A male patient shared his experience of Oncology services (brain) at the hospital. He suggested that there are four pillars that support a positive patient experience:
    - Clinical Excellence – RUH to aspire to be a Centre of Excellence
    - Communication – appointment letters, using IT to improve communication
    - Information – more information in the letters, open evenings
    - Environment – impact of this on patient experience

  The Oncology team are reviewing clinic letters to include more information about the appointment and its purpose. The feedback was also shared at the Outpatient Steering group and will be used to inform the business case for a Patient Portal/improved outpatient communication. The team are also planning to implement an electronic pre-habilitation programme for all tumour sites.
  The design of the new Cancer building has included feedback from patients and their families.

<u>See It My Way</u>

In 2020/21, due to the pandemic, the Trust suspended its very successful 'See It My Way' programme, in which patients and carers came to the hospital to share their experiences of a condition and/or care with staff.

In 2021/22 we reintroduced a virtual programme. A short film is produced following each event and is available on the Intranet for staff to use in education and training.

The Patient Experience team released a film **'See it my Way' film 'experience of COVID'**. Three patients who were cared for in Intensive Care shared their experience of having the illness, the impact on their family/friends and the care they received at the hospital. The video also featured staff reflecting on working in intensive care throughout the pandemic, describing how small acts of kindness can make such a difference for patients and their families. The film received excellent feedback from staff and patients.

'I have just watched the video which was incredibly moving and I just wanted to say how amazing it is and how fabulous everybody was.'

'well done they are so well produced, and really good to hear from the patients how the little things make such a difference to them… brought a tear to my eye, especially as I lost two family members to COVID, great to hear from those who survived.'

Complaints handling

Our Patient Advice and Liaison Service (PALS) aims to resolve patient and carer concerns and answer questions regarding treatment and care within 48 hours. The Trust sees complaints as a valuable source of feedback as it shows us where our services have not provided high quality care and gives early signs of service failures. The process of learning from complaints continued to be prioritised in 2021/22 and a focus on ownership of the learning at divisional level. The Trust is keen to hear from patients and their families when their care and treatment goes well but also when concerns have been raised so that we can use this information to learn and improve.

The trust is also committed to ensuring that the opportunity to provide feedback is responsive and humane, to achieve this we have been exploring the best option for providing feedback or resolving concerns or complaints. We have introduced an initial contact/triage call, undertaken by the Head of Complaints which allows exploration of the best option with the patient or family. Early engagement by Matron's or other senior staff to engage, listen and resolve complaints at the earliest opportunity has also supported the Trust commitment to Actively listen – make time to listen, hear people and respond.

In 2021/22, the Trust received 422 complaints compared to 249 in the previous year. There was a significant increase in the number of complaints received and has presented a challenge for the complaints team and clinical colleagues in terms of workload and timely responses. The majority of complaints related to communication issues and clinical care and concerns.

On receipt of a complaint, staff are encouraged to seek to resolve concerns at the time either through informal meetings or conversations on the telephone. We have developed and published guidance on our internal website to help staff effectively manage concerns informally where possible. Staff are also trained in how to manage the formal complaint process, including complaint meetings. This training has been given to junior doctors as well as junior and senior Sisters.

Complaints are logged and tracked on Datix, the Trust's reporting system which is also used for incident reporting. There is a 35-day local target for responding to formal complaints and performance against this target is included in the quarterly Patient Experience reports to the Quality Board and the Board of Directors and in the Trust's annual complaints report. Less complex complaints may be responded to in a quicker timeframe, but more complex complaints which may be better resolved through face-to-face meetings may take longer. The Trust encourages the use of such meetings as a means of resolution.

Clinical leads and managers are responsible for investigating and responding to complaints made in their respective areas. The Divisional Directors of Nursing and Midwifery have oversight of all complaints, the investigations and the Trust's response. All formal complaints are reviewed by the Director of Nursing and

Midwifery or Medical Director and responses signed by the Chief Executive. Complaints are discussed at nursing and governance meetings and the learning from complaints is included in the quarterly Patient Experience report to Quality Board and the Board of Directors.

Patient Engagement to Improve Services

During 2021/22 the Patient Experience Team supported 38 RUH teams to collect patient and carer feedback (via questionnaires, telephone interviews and virtual focus group meetings) and use the information to improve their service. The **Improving Patient Experience Awards** provided an opportunity to celebrate the good practice:

The **Dementia Team** won the award for improving patient and family experience, particularly for vulnerable patients with Dementia. There work was judged as '*a fantastic project and that the team had been responsive to the needs of Dementia patients as a result of the pandemic. The project also included great feedback from families and carers*.'

The **Cancer Support Team** was awarded second place for improving patient and family experience for cancer patients. The judges were '*particularly impressed with the examples given such as attending appointments with needle phobic patients. An amazing project that benefits patients at their most difficult time*.'

The **MSK & Pelvic Health Physio teams** were awarded third place for improving patient experience for those patients having virtual physiotherapy appointments. This was judged as a '*great project with good evidence of patient engagement and changes being made as a result of patient feedback*.'

Detailed information on patient experience is included in the quarterly patient experience reports to the Quality Board and is available on the Patient Experience Matters section of the Trust's website.

Responding to Patient Experience Feedback

The impact of the pandemic on patient experience has continued to be evident with the restrictions on visiting and volunteers on the wards. The Arts Programme Manager has continued to provide wards with a range of **art and craft activities**, for example, 'Boredom Buster' newspapers, crossword puzzles, etc.

The Patient Advice and Liaison Service team have continued with the **Keeping in Touch service.** Families use a generic e-mail address to send messages to their loved ones during their hospital stay. These messages are sent to the wards with a card from the PALS team. Families were also able to bring in items of **food and clothing** to main reception for these to be taken to wards.

Following an increase in PALS concerns relating to poor communication at ward level and restrictions on visiting due to wards closed as a result of COVID or hospital visiting restrictions it was recognised that there was a need to improve communication with relatives and carers and facilitate virtual visits via Facetime or Whats App. To support communication between families and patients, each ward was given an iPad and iPhone in 2020/21 to enable **virtual visiting** to take place.

However, the recognised need for good communication between families and the wards and families and their loved ones in hospital enabled the Trust to take this further and fund a new service across all medical wards and admitting areas (ED and Medical Assessment Wards). The **Family Liaison Facilitator Team** (FLF) support is very often for the most vulnerable patients, those with Dementia, frail elderly and those with additional communications needs (deaf or patients with a learning difficulty/disability). Since the introduction of the service in December 2021 and 31 March 2022 the team have facilitated 2,986 telephone calls and video calls between patients and their families and families and staff on wards.

During the pandemic, patients attending outpatient appointments at the hospital were asked to attend alone to reduce footfall and minimise the risk of infection. Some patients told us that they missed having their loved one at their appointment as they sometimes found it difficult to remember everything that was said. As a result patients are encouraged to '**phone a friend/family member'** during the appointment and use loudspeaker function so that the family member can be included in the consultation.

We have had a number of patients contacting the PALS service enquiring about when their outpatient appointment would be as **waiting times** have increased over the last year. A review of the Trust's external web pages highlighted that the information wasn't easy to understand or kept up to date. This was reviewed and is now updated every month. In addition there is an increased focus on improving communication channels between patients and outpatient departments, for example setting up dedicated email addresses for patient correspondence for each outpatient department and improving the telephone system.

Care Quality Commission (CQC)

The Trust last received a full inspection from the CQC in June 2018 during which 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.

A short notice inspection of the Emergency Department was carried out in January 2021. This had no impact on either the Trust's overall ratings or those of the ED itself. The CQC team returned in March 2022 to assess the extent to which their recommendations had been implemented, and were overwhelmingly satisfied with the progress that had been made on the majority of issues.

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.

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 Quality Board and Management Board.

Statement from Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board on Royal United Hospitals Bath NHS Foundation Trust 2021-22 Quality Account

NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) welcome the opportunity to review and comment on the Royal United Hospitals Bath NHS Foundation Trust (RUH) Quality Account for 2021/2022. In so far as the ICB has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the ICB via contractual monitoring and quality visits and is presented in the format required by NHSE/I presentation guidance.

The ICB recognises that 2021/2022 has continued to be a difficult year due to the COVID-19 Pandemic and that this has impacted on services provided by RUH. The ICB would like to thank the RUH for their continued contribution to supporting the wider health and social care system during the COVID-19 recovery phase.

It is the view of the ICB that the Quality Account reflects the RUH on-going commitment to quality improvement and addressing key issues in a focused and innovative way. Although achievement of some priorities during 2020/21 have continued to be affected by COVID-19, RUH has still been able to make achievements against all of their priorities for 2021/22 including:

Patient Safety Priorities:

1. Infection Prevention and Control. The Trust recognised the need to improve its approaches to infection prevention and control across the hospital. Part of this was a recognition of the need to improve standards of cleanliness within clinical areas across the hospital. Wider engagement was carried out to prioritised work to improve the clinical environment and facilitate effective cleaning. This was challenging due to managing IPC during the COVID-19 pandemic. Even with the additional measures in place the position remained challenging as a result of the high prevalence of infection within the community and the limitations of the Trust estate which made full isolation of infected patients difficult.

2. Deteriorating Patient. Early recognition of the deteriorating patient remained a patient safety priority for the RUH in 2021/22 and is also a national and regional safety priority. The implementation of an electronic system for the recording of vital signs (EObs), which commenced in August 2019, has now been successfully rolled out to all adult wards and clinical areas.

   Continuing improvement in the early recognition, prevention and management of Sepsis and Acute Kidney Injury maintained the percentage of at risk patients screened for sepsis on admission at around 86% for most of the year. The Sepsis and Kidney Injury Prevention team 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 2021/22 the Trust piloted the use of a Soft Signs (Non-contact physical health observations) Tool. Some patients who have a Learning Disability may

refuse or may be unable to tolerate the sort of physical vital sign observations. There is a danger, therefore, that there would be no record of the deterioration in their condition and no way of establishing their baseline observations.

3. Medicines Safety. The identification of themes from medication incidents remained a patient safety priority for the RUH in 2021-22. The RUH encourages an open reporting, no blame culture with regards to medication incidents, with the focus on eliminating errors that cause harm to patients. The RUH appointed a dedicated Medication Safety Officer in November 2020 to ensure capacity to do this identification and to work with all staff groups to improve quality of care with medicines, and in line with CQC requirements.

   The Trust implemented an electronic prescribing and medicines administration (EPMA) system in 2017 across most inpatient wards but this excluded particularly high risk areas such as Intensive Care Unit, Theatres and Children's/Neonatal wards. The further rollout to the Children's wards was planned for 2020 but delayed by the COVID pandemic but successfully completed in August 2021.

Quality Account Priorities:

1. Implementation of Enhanced Recovery. An enhanced recovery pathway (ERP) was introduced for patients undergoing colorectal surgery. This will help people recover more quickly after having major surgery. This has also resulted in a reduced length of stay for patient.

2. The PERIPrem Care Bundle (Perinatal Excellence to Reduce Injury in Preterm Birth). This consists of 11 evidence-based interventions throughout pregnancy and the neonatal period and supports the optimal timing of care and multidisciplinary working between maternity and neonatal professionals and with parents. This work included revised preterm birth guideline, introduced Fetal Fibronectin point of care testing and introducing PERIPREM Champions.

3. Continuation of Frailty Assessment Unit. This Quality Account priority was commissioned in 2019 with an aim to continue to improve the service for the frail elderly patients. This project sought to build upon the previous work, developing the front door Frailty Assessment and the introduction of the Frailty Flying Squad. The Frailty Assessment Unit changed both its nursing workforce and location in the last 6 months of the 2020/21. The Older Persons Assessment Unit (OPAU) was re-launched on 12 April 2021.

The ICB supports the RUH's identified Quality Priorities for 2022/2023. It is recognised that several of the priorities described in this Quality Account align to the NHS priorities set out in the NHS Long Term Plan and Operational Planning Guidance with a crucial focus on reducing inequalities. The ICB welcomes continued engagement in the agreed service improvement plan and focus on:

1.Medicines Safety

The focus in 2022-23 is to strengthen the RUHs ability to embed best practice in use of medicines by:

- Making Medicines Safety one of three key priorities in the relaunch of the Patient Safety Strategy with a focus on opioids and anticoagulants;
- Expanding the Medicines Safety team by recruiting a Specialist Nurse in Medicines Management;
- Investing in equipment and training and improving patient and medicine barcode scanning, which potentially prevents over 100 additional errors per month;
- Increasing the level of medicines-related teaching available to staff;
- Establishing a dedicated Medicines Safety Group as part of a governance structural review; and
- Implementing a Digital Medicines Tracker to reduce the risk of patients missing critical medicines following ward transfers or discharge.

2. Discharges

3.Infection Prevention

4. Deteriorating patient

5. Falls

The ICB would also like to highlight the RUH's response to the COVID pandemic and the continued commitment and adaptability of the organisation and employees to deliver services and support the wider healthcare system locally. This was especially noted during the extreme system pressures during the early part of 2022.

NHS Bath and North East Somerset, Swindon and Wiltshire ICB are committed to sustaining strong working relationships with the RUH and together with wider stakeholders, will continue to work collaboratively to achieve our shared priorities as the Integrated Care Alliance develops further in 2022/23.

Yours sincerely

Gill May
Chief Nurse Officer
BSW ICB

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 account is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period 01 April 2021 to 31 March 2022;
    - papers relating to quality reported to the board over the period 01 April 2021 to 31 March 2022;
    - feedback from commissioners dated 6 December 2022;
    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24 October 2022;
    - 2020 and 2021 national patient surveys;
    - 2020 and 2021 national staff surveys;
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 6 June 2022;
    - CQC inspection report dated 26 September 2018;
- the quality account presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the quality account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- the quality account has been prepared in accordance with National Health Service (Quality Accounts) Regulations 2010.

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.

.....Date.....Chairman

.....Date.....Chief Executive