Royal United Hospitals Bath
NHS Foundation Trust

Quality Accounts

2023 - 2024

Royal United Hospitals Bath NHS Foundation Trust

The RUH, where you matter

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List of abbreviations

A	**A3 Thinking**	A step-by-step approach to breaking down a problem, identifying root cause and testing ideas to address the problem
	AAA	Abdominal aortic aneurysm
	AHP	Allied Health Professional
	AI	Artificial Intelligence
	AIS	Accessible Information Standards
	ASU	Adult Surgical Unit
B	**BAD**	British Association of Dematologists
	BADs	British Association of Day Surgery
	BAF	Board Assurance Framework
	BaNES	Bath and North East Somerset
	BAPM	Bristih Association of Perinatal Medicine
	BIRD	Bath Institues for Rheumatuc Diseases
	BMM	Black Maternity Matters
	BNSSG	Bristol, North Somerset, and South Gloucestershire
	BSW	Bath and North East Somerset, Swindon & Wiltshire
	BTS	British Thoracic Society
C	**C.Difficile or C.DIff**	Clostridioides difficile
	CABG	Coronary Artery Bypass Graft
	CDC	Community Diagnostics Centre
	CFS	Chronic Fatigue Services
	Coach House	The Coach House is the core internal team responsible for delivering the training of the Bath Improvement System tools, routines and behaviours
	COHO	Community – onset Health Assoicated
	COPD	Chronic Obstructive Pulmonary Disease
	CPR	Cardipulmonary resuscitation
	CQC	Care Quality Commission
	CQUIN	Commissioning for Quality and Innovation
	CRANE	Cleft Registery and Audit Network
	CRIS	Clinical Record Interactive Search
	CRM	Cardiac Rhythm Management
	CRN	Clinical Research Network
	CT	Computerised Tomography
	CVDPrevent	National Audit of Cardiovascular Disease – Prevention in Primary Care
D	**DAU**	Day Assessment Unit
	DIPC	Director of Infection Prevention and Control
	DNACPR	Do Not Attempt Cardipulmonary Resuscitation
	DNA	Did Not Attend
	DSU	Day Surgery Unit
E	**E.coli**	Escherichia.coli
	ED	Emergency Department
	EPR	Enhance Recovery Pathway
	ESAC	Elective Surgical Ambulatory Care
	ESR	Electronic Staff Record

	ESN	Epilepsy Specialist Nurse
	EVAR	Endovasular Aneurysm Repair
	ExCEL	Excellent Care at Every Level
F	**FFFAP**	Falls and Fragility Fracture Audit Programme
	FFT	Friends and Family Test
	FICare	Family Integrated Care
	FLF	Family Liaison Facilitator
	FLS-DS	Fracture Laison Services – date base
	FTSU	Freedom to Speak Up
G	**GIRFT**	Getting It Right First Time
	GP	General Practice
	GWH	Great Western Hospital (Swindon)
H	**HES**	Hospital Episode Statistics
	HOHA	Hospital – onset Healthcare Associated
	HQIP	Healthcare Quality Improvement Parternship
	HSIB	Healthcare Safety Investigation Branch
	HSMR	Hospital Standardised Mortality Ratios
I	**IBD**	Inflammatory Bowel Disease
	ICB	Integrated Care Board
	ICS	Integrated Care System
	ICU/ ITU	Intensive Care Unit / Intensive Therpay Unit
	IM&T	Information & Technology
	IPC	Infection Preventation and Control
	IPCC	Infection Preventation and Control Committee
	IQICC	Improving Quality in Crohn's and Colitis
	IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
	IVOS	Intravenous Oral Switch
K	**KPI**	Key Performance Indicators
L	**LeDeR**	Learning from lives and deaths or people with a learning disability and autistic people
	LFPSE	Learning from Patients Safety Events
M	**MAU**	Medical Admissions Unit
	MBRRACE-UK	**M**others & **B**abies**: R**educing **R**isk through **A**udits & **C**onfidential **E**nquires
	MDT	Multi-Disciplinary Team
	MEWS	Maternity Early Warning Systems
	MEOWS	Maternity Early Observation Warning Systems
	MI	Myocardial Infarction
	MINAP	Myocardial Ischaemia National Audit Project
	MRI	Magnetic Resonance Imaging
	MRSA	Methicillin-Resistant Staphylococcus aureus
	MSSA	Methicilli-sensitive Staphylococcus aureus
	MVPP	Maternity Voices Partnership Plus
	MVLR	National Audit of Mirtal Valve Leaflet Repairs
N	**NACAP**	National Asthma and COPD Audit Programme
	NACEL	National Audit of Care at the End of Life
	NAD	National Audit of Dementia
	NAIF	National Inpatients Falls

	NatSSIPs	National Safety Standard for Invasive Procedure
	NBOCA	National Bowel Cancer Audit
	NBT	North Bristol NHS Trust
	NCAA	National Cardiac Arrest Audit
	NCAP	National Cardiac Programme
	NCAP	National Clinical Audit of Psychosis
	NCCR	Neonatal Critical Care Transformation Review
	NCO	Neonatal Community Outreach
	NCOS	Neonatal Community Outreach Service
	NDA	National Adult Diabetes Audit
	NDFA	National Diabetes Foot Care Audit
	NDISA	National Diabetes Inpatient Safety Audit
	NEIA	National Early Inflammatory Arthritis Audit
	NELA	National Emergency Laparotomy Audit
	NEWS	National Early Warning Score
	NEWTT	Newborn Early Warning Trigger and Track
	NHFA	National Heart Failure Audit
	NHFD	National Hip Fracture Database
	NHS	National Health Service
	NHSE	Natonal Health Service England
	NHSR	NHS Resolution's
	NICE	National Institute for Health and Care Excellence
	NIHR	National Institute for Health and Care Research
	NIVS	National Immunisation and Vaccination System
	NLCA	National Lung Cancer Audit
	NMCRR	National Mortality Case Record Review
	NMPA	National Maternity and Perinatal Audit
	NNAP	National Neonatal Audit Programme
	NNU	Neonatal Unit
	NOA	National Obesity Audit
	NOD	National Ophthalmololgy Database
	NOGCA	National Oesophago-Gastric Cancer Audit
	NPCA	National Prostate Cancer Audit
	NPDA	National Paediatric Diabetes Audit
	NPID	National Pregnancy in Diabetes Audit
	NVR	National Vascular Registery
O	**OGD**	OesophagoGastro Duodenoscopy (Endoscope)
	OHCAO	Out-of-Hospital Cardiac Arrest Outcomes
	OPU	Older Persons Unit
	OPAU	Older Person's Assessment Unit
	OT	Occupational Therapy
P	**PALS**	Patient Advise and Liaison Service
	PCI	Percutaneous Coronary Interventions
	PD	Parkinson's Disease
	PICANet	Paediatric Intensive Care Audit
	PMRT	Perinatal Mortality Review Tool
	POMH-UK	Prescribing Observatory for Mental Health UK
	PPH	Postpartum Haemorrhage
	PROMs	Patient Reported Outcome Measures
	PSCT	Patient Support & Complaints Team

	PSII	Patient Safety Incident Investigation
	PSIRF	Patient Safety Incident Response Framework
	PSIRP	Patient Safety Incident Response Plan
	PSP	Patient Safety Partners
Q	**Q1/Q2/Q3/Q4**	Quarter 1, Quarter 2, Quarter 3 & Quarter 4
	QI	Quality Improvement
	QIPs	Quality Improvement Projects
	QSIR	**Quality Service Improvement & Redesign**
R	**RCA**	Root Cause Analysis
	RCEM	Royal College of Emergency Medicine
	RCP	Royal College of Physicians
	ReSPECT	Recommended Summary Plan for Emergency Care Treatment
	RNHRD	Royal National Hospital for Rheumatic Diseases
	RUH	Royal United Hospital
S	**SDEC**	Same Day Emergency Care
	SDM	Shared Decision Making
	SFT	Salisbury NHS Foundation Trust
	SGLT2	Sodium-glucose cotransporter-2
	SHMI	Summary Hospital Level Mortality Indicator
	SHOT	Serious Hazards of Transfusion UK National Haemo vigilance Scheme
	SJRs	Structured Judgment Review
	SLT	Speech and Language Therapy
	SSNAP	Sentinel Stroke National Audit Programme
	SUS	Secondary User Service
T	**TARN**	The Trauma Audit & Research Network
	TAVI	Transcatheter Aortic Valve Implantation
	TBC	To Be Confirmed
	TC	Transitional Care
	TCP	Transitional Care Pathway
U	**UKSHA**	UK Health Secuirty Agency
V	**VTW**	Venous Thromboembolism
	VESPER	**V**ascular **E**ndothelium in **S**ystemic sclerosis associated **P**ulmonary hypertension to improve **E**arly and **R**apid diagnosis
W	**WHO**	World Health Organisation
	WTE	Whole Time Equivalent

About the Quality Account

The Quality Account is our annual report to the public about the quality of the services we deliver as a health care provider. The Quality Account describes our approach to consistently improve the quality, safety and experience for the people we provide care.

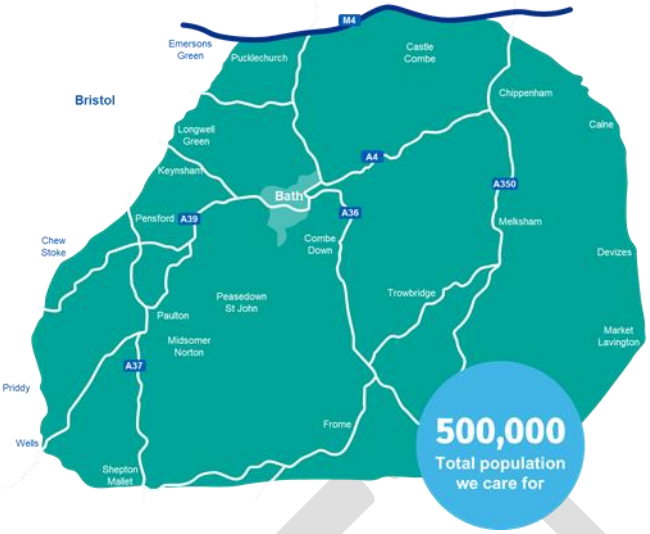
Each year, our Quality Account is both retrospective and forward looking. We look back at the year just passed and present a summary of our key quality improvement achievements and challenges. We look forward and set out our quality priorities for the year ahead, ensuring that we maintain a balanced focus on the three key domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Our quality priorities are chosen following a process of reviewing what our data is telling us, reviewing the services we provide, consultation with our key stakeholders and most importantly through listening to the feedback we receive from patients and carers.

About our hospital

The local area we cover



Our hospital sites

- **Royal United Hospitals Bath**
  Combe Park, Bath
- **Community birth centres**
  Chippenham
  Frome
- **Community maternity units**
  Trowbridge
  Paulton
- **Sulis Hospital Bath**
  Peasedown St John

We have **540** hospital beds

and **17** theatres

We provide care for **500,000** people in our local area

We support **4,100** births a year

We treat over **4,100** cancers per year

The RUH in numbers (2023/24)

586,608 outpatient appointments

98,602 A&E attendances

4,175 babies born

540 beds

3,566 operations performed

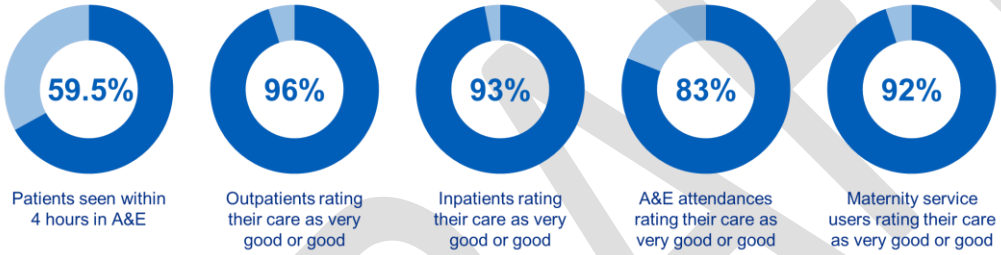
164,571 diagnostic tests

6,442 members of staff

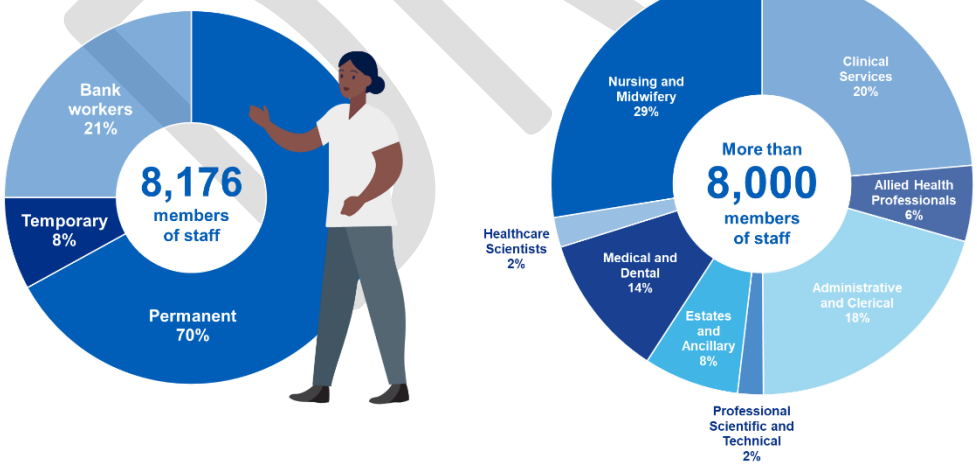
£555.1m total income

60% staff survey response rate

Operational (2023/24)



Data source: RUH operational data and RUH Friends and Family Test (FFT) patient feedback (2023/24)

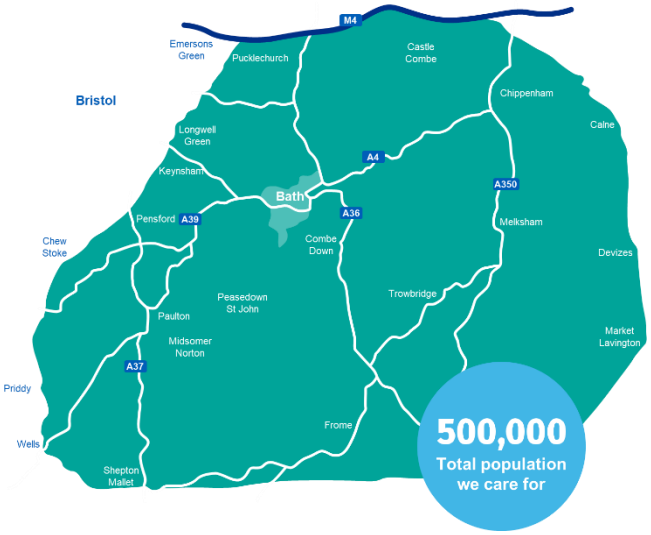


Part 1

Introduction

About our hospital

The local area we cover



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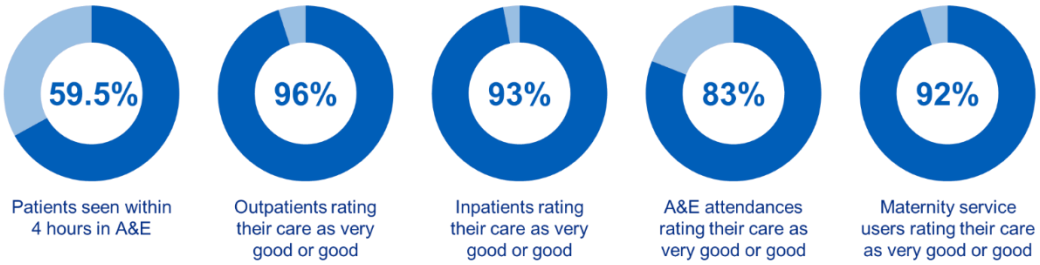

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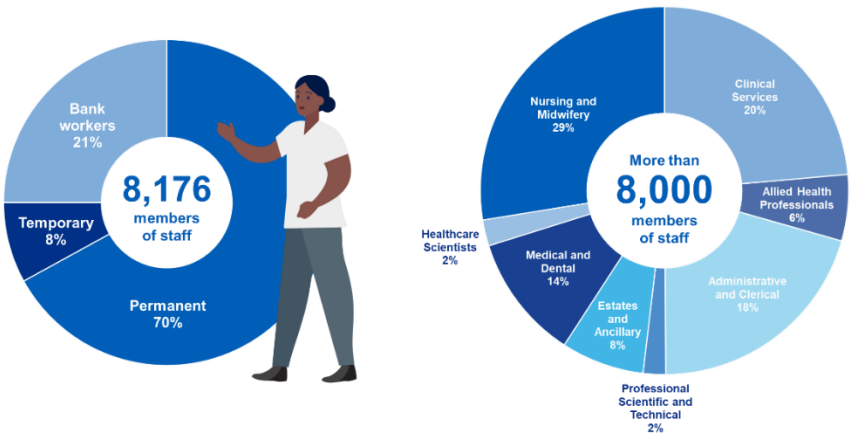
Staff 2023/24



Chief Executive's introduction

DRAFT

Welcome to our 2023/24 Quality Accounts, our annual report to the public about the quality of the services we deliver as a health care provider.

This document will not only review our previous year's progress against the three domains of quality - patient safety, clinical effectiveness and patient experience – but it will also set out our direction of travel for the coming year.

At the RUH, everything we do is against the backdrop of our vision, 'the RUH where you matter', and our values; Everyone Matters, Working Together, Making a Difference. In July 2023, we published our Trust Strategy, which deepened our commitment to our people by setting out our road map, describing the steps we will take to become the organisation we aspire to be.

The quality of the care we deliver concerns the whole Trust and its people. For the people we care for, making sure that we continuously improving by listening to feedback. For the people we work with, ensuring that the conditions are right to deliver outstanding care every day. And for the people in our community, having faith that their local hospital is there for them when they need it and is making a positive contribution in the community it serves.

As ever, our quality priorities reflect the areas where we believe we can have the most impact and are agreed in collaboration with our partners. In 23/24 our chosen priorities were:

- Health inequalities in maternity
- Reduce length of stay in NICU
  Dedicated day surgery unit
- Family Liaison Officers

We've made progress in all of these areas, including improving the quality of our data to better understand how health inequalities in maternity relate to our local population. We also introduced Family Liaison Officers to our Medical Assessment Unit and Older Person's Acute Unit.

Our Day Surgery Unit, which opened in June 2023, is a shining example of staff-led change using our Improving Together methodology and continually listening to feedback from patients and their loved ones to make improvements.

Thanks to our dedicated and skilled team, the unit has transformed into a six day a week service, which now sees 40 -50 patients each day. This is so much better for our patients as they continue their recovery in the comfort of their own home.

Staff have described how, by listening to patients, they have made the day to day running of the service smoother. Their willingness to make change has seen staff arrive before 7am to be ready to welcome patients and working on Saturdays so patients receive the right care at the right time.

I'm so impressed with how our staff have paid attention to what matters to the people we care for throughout their stay in the Day Surgery Unit. The next steps will be increasing paediatric surgery capacity, which along with a refurbished play room donated by the charity Time is Precious, will further increase our focus on the experience of our youngest patients.

As we look ahead to 2024/25, our proposed priorities will focus on improved learning from patient safety events and developing our safety culture, as well as communication with our patients, carers and families. We will also continue to embed the Patient Safety Incident Response Framework, which describes a new national approach to responding to patient safety incidents.

I confirm that to the best of my knowledge the information in this Quality Account is accurate.

Cara Charles-Barks
Chief Executive

June 2024

Part 2

Our priorities

2.1 Quality Priorities

During 2023/24, the Trust continued to embed the vision of 'The RUH, where you matter' into everything we do for the people we care for, the people we work with and the people in our community. Our people group goals (Fig 2.1) describe the outcomes we want to see for each people group and how we are delivering these outcomes through our culture and values, our improvement system; Improving Together, and our enabling initiatives.

Fig 2.1 Trust Strategy

Improving Together is our improvement system and enables us to deliver our strategy by:

- Alignment of priorities – using the strategic planning framework from board to ward we focus on linked priorities, helping us achieve our goals more effectively.
- Empowerment – colleagues will know they are empowered to make changes in their team. Every member of RUH staff will be supported to develop and improve their skills to be able to identify and adopt improved ways of working.
- Developing our culture – by empowering each and every member of staff to have a voice and supporting our leaders to adopt compassionate and enabling leadership approaches.
- Improving quality – by adopting an evidenced based continuous improvement approach to better understand and continually improve the services we offer.
- Stopping doing things that do not add value to the people we care for, the people we work with and the people in our community.

Each year as part of the annual business planning cycle the Trust reviews where we currently are with achieving our goals and sets out the priorities for year ahead. The cascade of priorities to our frontline teams helps our staff understand the part they and their team play in achieving the strategy. The priorities for 2023/24 were (Fig 2.2);

Breakthrough Goals;

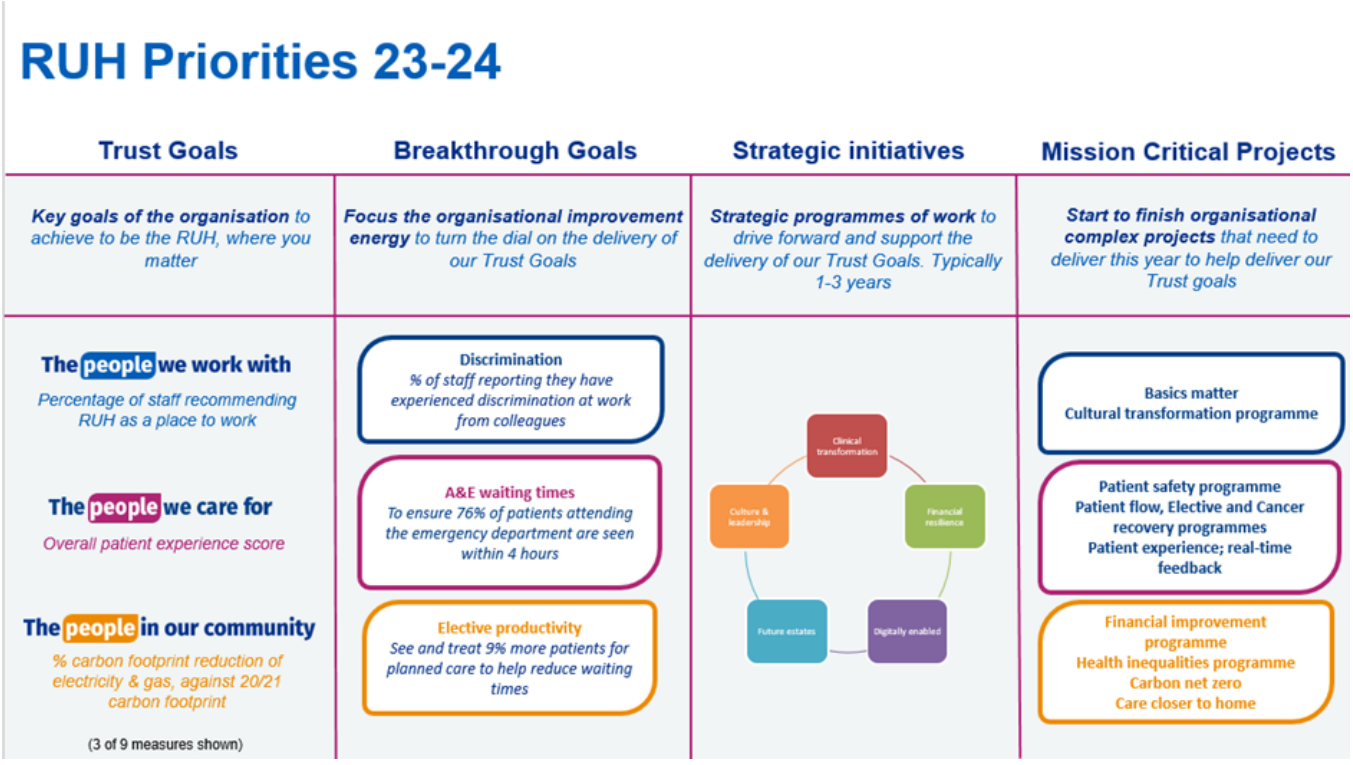
1. Percentage of staff reporting they have experienced discrimination at work from colleagues (People we work with)

2. To ensure 76% of patients attending the Emergency Department are seen within 4 hours (People we care for)

3. To see and treat 9% more patients for planned care to help reduce waiting times (People we care for)

Several strategic projects were initiated in 2023/24 to enable delivery of the Breakthrough Objectives for example re-establishing our Day Surgery Unit, increasing Same Day Emergency Care (SDEC) capacity and the cultural transformation programme. Whilst the focus has been on delivering the Breakthrough Goals, work continues to deliver the Trust strategy in other areas; most significantly moving the Trust to the new national Patient Safety Incident Response Framework (PSIRF) and the Transformation Programme to help achieve financial balance.

Fig 2.2 Trust Priorities 23/24



QI Capability and Capacity

The Trust continues to strengthen its Quality Improvement (QI) capability with 228 staff completing Module 1 of the Improving Together QI Champion course, which contains the fundamentals of QI and how to run an Improvement Huddle in their area. 116 staff have completed all three modules, which, in addition to improvement huddles, includes A3 thinking (a step-by-step approach to breaking down a problem, identifying root cause and testing ideas to address the problem) and standardising the way we work. 137 managers have also attended training on the fundamental principles of Improving Together. In the latest NHS staff survey, 450 more staff said they are able to make improvements happen in their area, which is great for staff morale and patient experience.

Our accredited QI offering, Quality Service Improvement & Redesign (QSIR), continues to be successful with 25 staff completing cohorts 14 and 15 during 2023/24. Three of the QSIR projects have contributed to last year's Quality Account Priorities namely Dedicated Day Surgery Unit (DSU).

2.2 Quality Account Priorities 2023 – 2024

Choosing our Quality Account priorities is important to us and our aim is to ensure that the chosen priorities are ones which will make a real difference the people we care for. In developing our quality priorities we 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 Bath and Northeast Somerset, Swindon & Wiltshire (BSW) Integrated Care Board (ICB) to determine the priorities.

Throughout the year, the Quality Account Priorities and the progress against them continued to be monitored through the Trust Quality and Safety Group, which is chaired by the Chief Medical Officer in addition to our Governor Quality Working Group. Looking back at 2023/24 – What did we say we would do?

Looking back at 2023/24 – What did we say we would do?

Health Inequalities in Maternity

RUH Maternity have committed to increase our understanding of how nationally reported health inequality statistics relate to our local population. Maternity health inequalities have been identified relating to ethnicity, age and deprivation including the continued gap in mortality rates (MBRRACE-UK, 2022).

This priority included two main work streams with the aim of reducing health inequalities for our local populations. Firstly, improving data quality to increase understanding and support targeted quality improvement projects. Secondly, increasing staff knowledge and awareness of the structural and other bias's that exist within maternity healthcare to improve equity and personalisation of care for mothers and babies. This supports the Three-year Delivery Plan for Maternity and Neonatal (2023) to reduce inequalities for all in access, experience, and outcomes.

What we said we would do	What we did
Improve data quality of birth outcomes, in particular smoking and breastfeeding rates where there are known issues	Improved documentation compliance in recording smoking at the time of delivery and breastfeeding at discharge. 100% compliance achieved for recording breastfeeding status in January 2024. Qualitative data collation by Inclusion Midwife to understand the care experience for black/brown and women and the barriers they experienced. No clear themes have been identified thus far However, the work has identified some challenges and therefore the work continues over a longer period of time to gain further information/insights to inform quality improvement work which will be monitored via the Health Inequalities work stream.
Identify three key birth outcomes for priority and complete a 'deep dive' into the differences in these outcomes	Improvement in data capture regarding ethnicity of birthing people was required prior to commencement of this aim. Previous challenges with EPR limited data capture, 100% ethnicity now recorded since September 2023 , deep dive commenced into differences birth outcomes to identify 3 key priorities

What we said we would do	What we did
Develop health inequalities work stream within maternity which reports into the divisional work stream	Health inequalities working party meeting monthly to review insights, measures and ongoing QI, ensuring project drivers align to service need.
Develop cultural competency QI champion clinicians	Maternity services have sought to improve the structure support and governance to underpin the QI agenda in alignment to the trust-wide PSIRF movement. This has led to the service development of a monthly QI hub, and quarterly QI meet supported by 'coach-house' Trust Wide Quality Improvement team. Maternity staff have attended the Black Maternity Matters (BMM) programme, a 6-month training programme to become black maternity champions. A further cohort of 8 attended in March 24.
Roll out cultural competency training to all maternity staff	We have supported all staff who work in perinatal services to attend anti-racism training. The trajectory of compliance since launch in September 2023 is improving, with 3-year target compliance set at 90% by September 2026, currently 63%. Compliance trajectory set to achieve 90% by June 2025.

What we said we would do	What we did
Implement a minimum of three QI projects related to outcome data within clinical practice	9 improvement projects to address health inequalities are underway; • Anti-racism training implementation • Inclusion book club launched to promote discussion about health inequalities within maternity care • Additional digital interpreting services • Increasing clinician awareness of ingredients in medicines, which may have cultural or religious implications • Phonetic names project to ensure correct pronunciation of names • Capillary re-fill service review project as a potential alternative to assess perfusion alongside 'colour' element of APGAR score at birth • Silk bonnet availability for curly hair to prevent hair damage caused by friction whilst sleeping • Understanding barriers to accessing maternity care • Improving ethnicity data quality and data dashboards

How we will continue to work with this priority:

Analysis of birth outcome data, broken down by ethnicity and area of deprivation, will now be possible due to improved ethnicity data capture. We will also continue to engage with lesser-heard groups to increase qualitative data to understand how national health inequalities data compares locally. Triangulation with other maternity feedback will also drive QI projects and enable personalisation of care. Qualitative interviews regarding experience of care for women racialized as black or brown are moving to an 'opt out' offer rather than an 'opt in' to maximise data capture opportunities.

The service plans to move the health inequalities meeting to bi-monthly recognising the small numbers of women booking who are racialized as black meaning a longer period needed to

assess significance of outcome comparisons. The service aims to move towards a blended integrated model where the Health Inequality agenda feeds into the existing structures as part of 'business as usual' e.g. QI hub, feedback triangulation group and clinical audits.

Maternity leaders have a continued desire to provide an anti-racism training programme and incorporate cultural competency training within in-house mandatory training/training needs analysis. The next BMM cohort is due to commence training March 2024 with 8 maternity and neonatal local leaders attending, to promote and support embedding of QI projects into services.

Reduced Length of Stay in Neonatal Unit

Reducing length of stay for our neonatal preterm population within the Neonatal Unit (NNU) is a priority; we understand the impact neonatal care has on a family. Getting It Right First Time (GIRFT) (2022) discharge rates for babies 27-33 weeks at the RUH are in the upper quartile, meaning that there is the opportunity to discharge babies home earlier than we currently do.

Parents receiving care on a neonatal unit are at risk of greater levels of stress, separation anxiety, longer term mental health conditions and financial burden, to mention a few. The impact not only effects parents and carers but the wider family, inclusive of siblings and grandparents. In striving for optimal long-term outcomes for babies, the development of close and loving relationships with their carer's, facilitated by zero separation is paramount.

What we said we would do	What we did
Revision of Transitional Care Pathway (TCP); To ensure appropriate and timely discharge of babies in a safe and effective way	• Updated and ratified TCP guideline removing mandatory 5-day stay for babies bases solely on gestation. Eligible babies can now be discharged earlier from day 3 following weight and satisfactory feed assessment • Additional babies brought under TCP to ensure expert neonatal input and support for families nursed together • Audit service provision and measure impact in care • Collect parent feedback of care received within TCP and act on information gained.

What we said we would do	What we did
Integrate Allied Health Professionals (AHP) into neonatal care	• All recommended AHP in post; Dietetics, Speech and Language, Physiotherapy, Occupational Therapy and psychology. Minimum 0.2 Whole Time Equivalent (WTE) each. This optimises feeding, growth and nutrition in addition to improving care and risk of comorbidities associated with sick and preterm babies • Mitigate gaps in provision to BAPM AHP framework with multi-disciplinary team specialist interest group ensuring education across wider team and support for implementation of quality improvement measures.
Family Integrated Care (FICare) is a model of care that integrates families as partners in the NNU care team, research shows it can reduce length of stay with decrease parent stress, fewer nosocomial infections, improve infant growth and breastfeeding rates, and improve patient safety	• We have continued to build on our existing FICare offer for families • Enhanced FICare provision for families with free parking, meals and fold down beds for families to stay alongside their baby on the unit • Working towards Silver Bliss Baby Charter Accreditation assuring quality of care • Enhanced our virtual unit tour with additional information for families to orientate and alleviate anxiety of unknown. • UNICEF Baby Friendly level 3 accreditation

What we said we would do	What we did
Ensure discharge process is proficient with early identification of babies, timely introduction of parent teaching and seamless transition to home.	• NCO Discharge Liaison Nurse appointed on secondment for 6 months to assess and improve discharge process • Advanced Neonatal Nurse Practitioner designated lead role for discharge • Establish regular neonatal community outreach, family integrated care and discharge working party meetings • Collected data and analysed areas for improvement • Work is underway to improve discharge processes.

How we will continue to work with this priority:

Working to expand our Neonatal Community Outreach Service

Neonatal Community Outreach Service (NCOS) provides additional specialist nursing care for babies and their families in the community following discharge home from neonatal unit care. NCOS provision facilitates the opportunity for infants to be discharged home earlier with the knowledge that they can continue to receive expert-led neonatal care provision for common clinical needs and supervision, this facilitates a smooth transition from the hospital to home.

The RUH Neonatal Outreach service is well established within both the unit and the wider community.

National Requirements

The BAPM Service and Quality Standards for Provision of Neonatal Care in the UK (2022), recommends that additional nursing staff are required to support parents at home which must be resourced to achieve the national benchmark of reducing separation of mother and baby; and that neonatal outreach service provision should be available 7 days a week. BAPM have established a working party to development a framework for NCO services

The development of neonatal outreach services supports the Neonatal Critical Care Transformation Review (NCCR) recommendations and commitments made in the NHS Long Term Plan (2019) to improve the safety and effectiveness of services and experience of

families. The GIRFT Neonatology Report 2022 recommends expanding neonatal outreach services across all neonatal services to support earlier discharge home of neonates from neonatal units and transitional care (TC).

The current staffing provision for the service is not in line with neighbouring outreach provision within Local Neonatal Units in the South West Neonatal Network. This was highlighted in a report produced by the South West Neonatal Network (*Developing and Enhancing Neonatal Outreach Services within the South West Operational Delivery Network 2022*). This care cannot be provided by other community health professional as health visitors are not adequately trained to provide specialist care for these vulnerable babies and their families and this is recognised nationally.

We will

- Review current outreach service to consider flexibility of the current workforce to offer to offer more babies increased levels of care in the home
- Strive to provide a 7-day neonatal community service
- Seek to meet and build upon national recommendations for NCOS, joining national leaders in this area by providing oxygen therapy, gastric tube feeding, phototherapy, and antibiotic treatment in the home
- Ensure our NCOS has designated audit and service improvement capacity so we can continue to evolve the service based upon parent and carer feedback ensuring sustainability of quality and high standards of care.
- Continue to provide individualised care for our families based upon their multi-cultural holistic needs

Dedicated Day Surgery Unit

Introduction

Day Surgery services reduce length of stay for patients compared to those cared for in in-patient settings (Department of Health 2020). The dedicated Day Surgery Unit was opened in June 2023, providing a 6 day-a-week service. The protected day-case area consists of 33 trolley spaces, to ensure surgical elective activity continues reducing cancellation rates. Quality, patient safety and experience are improved by the dedicated skilled workforce and improved theatre efficiently.

What we said we would do	What we did
Increase the number of trollet spaces by reducing inpatients beds	The refurbishment included increasing from 27 to 33 trolley spaces to increase activity.
Expanded elective day sugery theatre list	By introducing 3 times a week paediatric lists on DSU from 1st April 2024 we will increase paediatric capacity by approximately 16 cases a week. To improve the experience of those attending the hospital as an emergency, the Trust has created an Emergency Surgical Ambulatory Care (ESAC) pathway to reduced waiting times. We have reviewed the British Association of Day Surgery (BADS) day case procedures and are now performing more operations as day cases which historically would have been inpatients.
Update advise cheets to improve communication and patient outcomes	We are improving out communication in both pre and post operative phases. Surgeons progressing the move towards including post op advice within the discharge summary. Up to date pre and post op information folder completed for staff use

What we said we would do	What we did
Identify way to improve our service and patient experience, for example a designated waiting area, reconfiguring the estate to provide cubicles.	Newly refurbished waiting area for patients to be able to sit, to enable faster discharges and reduce the waiting times in theatre. New playroom added for children. Works completed for an additional 5 trolley spaces with walls in between to improve privacy and dignity for all patients.
Expand our working week to include routine weekend working Mon-Sat, with a view to including Sunday.	DSU is now fully operational Monday – Saturday.
Review the establishment to support the new way of working.	New establishment for DSU agreed and fully recruited to, including paediatric trained nursing staff.
Staff education specific to Day Surgery pre-operative and post-operative care, to improve patient outcomes and staff wellbeing	Information folder renewed for pre and post op nursing guidelines. Staff working towards nurse competencies set out by BADS. Paediatric trained nurses commenced in April 2024, including a Band 6 (Sister/Charge Nurse) who will work closely with the adult trained nurses to increase paediatric knowledge and skills. Regular surgical audit days used to educate and share information with staff.

How we will continue to work with this priority:

The team continue to work in partnership with patients via their feedback to improve patient experience.

Family Liaison Officers

Why is it important?

A Family Liaison Facilitator service has recently been introduced to MAU and OPAU.

A Family Liaison Facilitator (FLF) service has been introduced to Medical Assessment Unit (MAU) and Older Peoples Assessment Unit (OPAU).

The primary role of the FLF service is to provide regular non-clinical communication to patients/ family members/carers during a hospital admission, and to facilitate completion of the FFT through patient and family/carer feedback we know this service has made a significant positive difference and as such we aim to expand the service.

Promoting safe discharges is one of the Trust's 5 patient safety priorities.
It is proposed that the FLF service provide a Trust wide service and in certain clinical areas provides a regular follow up 'non-clinical' telephone/ video call service to all patient's and/or their families within 48 hours of a patient's discharge.

This telephone/ video call service will allow 'live' feedback about the patient's discharge and the patient's/families experience of discharge. This information will be pivotal in improving the quality of our services, ensuring they are patient and person centred.

What we said we would do	What we did
Provide a consistent FLF Discharge Follow Up Service for all patient's discharged from OPAU and MAU	We have consistently undertaken follow up calls on patients discharged from OPAU and MAU within 48 hours of leaving the hospital. We will expand the service to cover Trust wide.
Record the checklist responses for each Discharge Follow up.	The follow up calls are all logged on a centrally held FLF database. The FLF team will resolve any clinical issues by connecting patients/families to the appropriate clinical team as required. A monthly report is provided to the Divisional leadership team to make improvements.

What we said we would do	What we did
Aduit the data from the discharge checklist responses and feedback to the divisional patient experience / and or patient safety services	We will continue to learn through audit to improve the outcomes and experience of the people we care for. There has been a decline in complaints and concerns related to discharge since the Discharge follow up calls were implemented.

How will we know we are making a difference?

- Through positive feedback and evidence that the teams are learning and improving services based on patient/family/carer feedback
- There is a decrease in concerns and complaints about discharge related concerns
- There is a decrease in patient safety events relating to discharge

2.3 Looking forward to this year 2023/24

Proposed Quality Prioritises 2024 – 2025

Quality Account Priorities 2024/25

- Improve Learning from Patient Safety Events
- Developing Our Safety Culture
- Improving communication access with patients, thier carers and families

Improving Learning from Patient Safety Events

Why is it important?

The Trust has formally transitioned to the new Patient Safety Incident Response Framework (PSIRF). PSIRF embeds patient safety incident response within a wider system of continuous improvement and prompts a significant cultural shift towards systematic patient safety management.

Patient safety event responses are conducted for the sole purpose of learning to identify opportunities to improve systems and reduce risk. Engaging with those affected by a patient safety event improves our understanding of what happened, and therefore the opportunity to prevent a similar incident in the future. Engaging and involving those affected by events fosters a culture of openness and transparency thereby resulting in the increase of recording of events and support for improvement work.

What will we do in 2023/24

- We will trend and theme our patient safety data to ensure that we develop high impact learning to our highest causes of patient safety events.
- We will ensure that our quality governance structure and processes are effective at supporting improved learning.
- We will increase the learning for our teams at the bedside or the patients' home whilst ensuring a restorative approach to learning.
- We will publish guidance on how we involve patients and their families in our learning following a patient safety event.
- We will publish guidance on how we involve and engage staff involved in patient safety events to maximise learning.

How we will know we are making a difference

- Improving evidence of learning from patient safety events.
- Improving evidence that our staff and the people we care for our actively involved in learning.
- Positive evaluations that our revised quality governance structures and processes are supporting learning.
- Assurance that the quality metrics are telling us our patient safety event themes to maximise the opportunities for timely learning.
- Guidance published for staff on the principles of how to positively involve patients and their families in our response to patient safety events.
- Evidence that our processes maximise the learning for clinical teams across the Trust ensuring a restorative approach to learning.

- Guidance published for staff on the principles of how to positively involve staff in our response and learning patient safety events.

How progress will be monitored

- Delievery Group – Quality and Safety Improvement Group
- Oversight Group – Trsut Qualuty and Safety Group
- Asuurance will be provide quartley to the Quaility Governance Committee

Board Sponsor

- Chief Nursing Officer
- Chief Medical Officer

Developing Our Safety Culture

Why is it important?

The Trust is committed to creating the right foundations that foster a 'just and restorative culture' to improve safety and learning for staff and patients. This is facilitated by supporting a psychologically safe environment where people feel able to raise concerns, confident that they will be listened to with a focus on improvement and opportunities to learn.

What will we do in 2023/24

- We will develop a training plan and trajectory to support all our staff to undertake level 1 Patient Safety Training and identified cohorts of staff to undertake level 2 Patient Safety Training.
- We will provide patient safety training to our Non-Executive and Executive Directors, to support their strategic oversight of patient safety.
- We will deliver a culture series of lectures from key national speakers on topics like Civility, Learning from Excellence, Compassionate Leadership, and Human Factors to raise awareness and support our safety culture ambitions.
- We will revise our patient safety intranet pages and the way we communicate to increase accessibility for our staff and to raise the profile of patient safety in the Trust.
- We will undertake a baseline assessment of our safety culture and then plan repeated assessments at appropriate intervals to assess the impact of our interventions

How we will know we are making a difference

- Patient safety culture assessment completed and improvement themes identified.
- Patient safety training needs analysis completed leading to a training delivery plan and compliance trajectory.
- Culture series lectures delivered and evaluated positively
- Revised and refreshed patient safety intranet pages.

How Progress will be monitored

- Delivery Group – Patient Safety Event Oversight Group
- Oversight Group – Trust Quality and Safety Group
- Assurance will be provided quartely to the Quality Governance Committee

Board Sponsor

- Chief Nursing Officer
- Chief Medicial Officer

Improving communcations access with patients, their carers and families

Why is it important?

Since 1st August 2016 all organisations that provide NHS care have been legally required to follow the Accessible Information Standards (AIS). The standards set out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communications support of patients, service users, carers and parents with a disability, impairment or sensory loss. Communication remains in the top three reasons for patient to complain or raise concerns.

This priority supports work being undertaken by the Patient Experience Team to improve communication.

What will we do in 2023/24

- We will seek accredited for the Communication Access UK.
- We will implement targeted training for staff and volunteers to improve communication access skills and confidence.
- Aligned to our Patient Experience Strategy we will develop a set of improvement actions detailing how we are going to address feedback on how we can improve communication with the people that access our services.

How we will know we are making a difference

- Positive evaluation from staff and volunteers will have undertaken the communication access training.
- Accreditation with the Communication Access Standards.
- Reduction in complaints or feedback relating to communication access.
- Successful completion of a range of improvement actions to improve communication.

How progress will be monitored

- Delivery Group – Improving Patient Carer Experience Group
- Oversight Group – Patient Experience Group
- Assurance will be provided quarterly to the Quality Governance Committee

Board Sponsor

- Chief Nursing Officer.

2.4 Statements of assurance from the Board of Directors

Mandatory statement 1

1. During 2023/24 the Royal United Hospitals Bath NHS Foundation Trust provided and/or subcontracted eight relevant health services across three clinical divisions: Medicine, Surgery and Family and Specialist Services.

    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 2023/4 represents 100 % of the total income generated from the provision of relevant health services by the Royal United Hospitals Bath NHS Foundation Trust for 2023/4

Mandatory statement 2

During 2023/24, 50 national clinical audits and 2 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 96% 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 2023/24, 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%
Medical and Surgical Clinical Outcome Review Programme (National Confidential Enquiry into Patient Outcome and Death)	Yes	100%
National Audits		
Case Mix Programme (Intensive Care National Audit & Research Centre)	Yes	100%
Adult Respiratory Support Audit (BTS)	Yes	100%
BAUS Nephrostomy Audit	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
Breast and Cosmetic Implant Registry (NHS Digital)	N/A	Not relevant to RUH
British Hernia Society Registry	N/A	BHS did not collect data in 2023/24
Cleft Registry and Audit Network (CRANE) Database (Royal College of Surgeons)	N/A	Not relevant to RUH
Elective Surgery (National PROMs Programme) (NHS Digital)	Yes	100%
Emergency Medicine QIPs - RCEM: Care of Older People	No	Not participated to date, but under review
Emergency Medicine QIPs - RCEM: Mental Health (Self Harm)	No	Not participated to date, but under review
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP) Fracture Liaison Service Database (FLS-DB)	Yes	93.6% (target 80%)
Falls and Fragility Fracture Audit Programme (FFFAP): National Inpatient Falls (NAIF)	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD)	Yes	100%
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	Yes	100%
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE-UK)	Yes	100%
Mental Health Clinical Outcome Review Programme	N/A	Not relevant to RUH
National Adult Diabetes (NDA) - National Diabetes Foot Care Audit (NDFA)	Yes	100%
National Adult Diabetes (NDA) National Diabetes Inpatient Safety Audit (NDISA)	Yes	100%
National Diabetes Audit - National Pregnancy in Diabetes Audit (NPID)	Yes	100%
National Diabetes Audit – National Diabetes Core Audit	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): COPD Secondary Care	Yes	100%

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Pulmonary Rehabilitation	N/A	Not relevant to RUH
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): Children and Young People's Asthma Secondary Care	Yes	89% to date due to unavailability of some notes
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Cardiovascular Disease – Prevention in Primary Care (CVDPrevent)	N/A	Not relevant to RUH
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia (NAD)	Yes	100%
National Audit of Pulmonary Hypertension	Yes	100%
National Bariatric Surgery Registry	N/A	Not relevant to RUH
National Cancer Audit Collaborating Centre – National Breast Cancer Audit	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	All patients within the Trust who meet the NCAA scope
National Adult Cardiac Surgery Audit	N/A	Not relevant to RUH
National Congenital Heart Disease Audit (NHFA)	N/A	Not relevant to RUH
National Cardiac Audit Programme (NCAP)- National Heart Failure Audit	Yes	Between 95% - 100% compliance for the year
National Cardiac Audit Programme (NCAP) National Audit of Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Audit Programme (NCAP) Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme (NCAP) – National Audit of Percutaneous Coronary Interventions (NAPCI) (Coronary Angioplasty)	Yes	100%
National Audit of Mitral Valve Leaflet Repairs (MVLR)	N/A	Not relevant to RUH
The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	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

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
National Comparative Audit of Blood Transfusion programme - 2023 Audit of Blood Transfusion against NICE Guidelines Quality Standard 138	Yes	100%
2023 Bedside Transfusion Audit	Yes	100%
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 (NMPA)	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Obesity Audit (NOA)	N/A	Not relevant to RUH
National Ophthalmology Database (NOD) Audit - National Cataract Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
Perinatal Mortality Review Tool (PMRT)	Yes	100%
National Prostate Cancer Audit (NPCA)	Yes	100%
National Vascular Registry (NVR)	N/A	Not relevant to RUH
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	N/A	Not relevant to RUH
Paediatric Intensive Care Audit (PICANet)	N/A	Not relevant to RUH
Prescribing Observatory for Mental Health (POMH) Use of medicines with anticholinergic (anti-muscarinic) properties in older people's mental health services	N/A	Not relevant to RUH
Prescribing Observatory for Mental Health (POMH) Monitoring of patients prescribed lithium	N/A	Not relevant to RUH
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion Scheme (SHOT)	Yes	100%
Society for Acute Medicine Benchmarking Audit	Yes	100%
The Trauma Audit & Research Network (TARN)	N/A	The TARN Dashboard has been unavailable since June 2023 following a security alert. However, data has been collected

Clinical Audit / National Confidential Enquiries	Participation?	% cases submitted
		locally and a new national audit via NHS England will be launching soon and training has now commenced on this.
UK Cystic Fibrosis Registry	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	N/A	Not relevant to RUH
UK Renal Registry National Acute Kidney Injury Audit	N/A	Not relevant to RUH

The reports of 34 national clinical audits were reviewed by the provider in 2023/2024 and Royal United Hospitals Bath NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Audit of Cardiac Rehabilitation (NACR) (2022 data)

Compared to the national average, the Trust scored well for the majority of the key performance indicators (KPI). The KPI where the Trust performed well included admitting patients with heart failure to a cardiology ward and providing them with access to specialist heart failure care; the number of patients that were discharged on sodium-glucose cotransporter-2 (SGLT2) inhibitor medication and the number of patients discharged with a discharge plan. However, some coronary artery bypass graft (CABG) patients and myocardial infarction (MI)/percutaneous coronary intervention (PCI) patients waited for longer than expected. The Trust has experienced some restrictions around the provision of Phase 3 cardiac rehabilitation classes. This has been addressed by an increased use of home-based Phase 3 programmes.

National Audit of Care of the End of Life (NACEL) Round 4, (2022/23 data)

The audit showed that the Royal United Hospitals continued to perform well either above (for 5 indicators) or in line (for 3 indicators) with the national average. Areas where the Trust performed better than the national average included communication with families and others, involvement in decision making, individualised plans of care and workforce/specialist palliative care. The Trust also scored well for staff confidence and support and care and culture. The Trust will continue to measure performance by participating in further planned national audits and will plan to take part in a NACEL Quality Survey.

Sentinel Stroke Audit (SSNAP) State of the Nation Report

The audit shows that the Trust continues to perform well and has shown further improvement in performance for SSNAP. The overall trust performance is Level B, and the Trust aims to

continue to improve, with a focus on learning to consistently improve access to the ASU within 4 hours, timeliness of thrombolysis and information given at discharge.

National Dementia Care (NAD) Round 5 Audit (2022-23 data)

Improving dementia care is a key national priority and this is an ongoing audit with the RUH having so far participated in each round of the audit. This latest reported round shows the RUH performed well for Discharge Planning within 24 hours and our median length of stay was 16 days compared to a national average of 10 days. Nearly all patients were assessed for pain, had a 'This is Me' document completed which indicates that a high proportion of patients had their care personalised. All patients had access to finger and snack foods.

However, the Trust performed less well, compared to the national average, for combined delirium screen (all patients who had screen either within or more than 24 hours) although the Trust percentage was slightly improved from the Round 4 hospital results, published in 2019 for patients with a diagnosis of dementia discharged from hospital between April and June 2018. The Trust also performed less well for pain re-assessment. Improvements include collaborative working between the Older Persons Consultants and the Orthopaedic teams to improve pain assessment and carer communication during hospital admission. improvements to carer communications during hospital admission. Currently the Trust has also completed Round 6 and the results and plan for Round 7 this year are awaited.

National Emergency Laparotomy Audit (NELA)

The National Emergency Laparotomy Audit (NELA) commissioned by HQIP (the Healthcare Quality Improvement Partnership) aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy. NELA is an ongoing audit and the RUH has remained a good performer throughout each round of audits. In the latest published national report (Year 8) which refers to data from 2022, the RUH has been highlighted as the only trust in the country to be a positive outlier for low mortality rates.

The latest data shows that we continue to perform better than the national average in the majority of areas other than for Care of the Elderly reviews which is the focus for improvement for 24/25.

Fracture Liaison Service Database

The Trust performed well against the national standards for the identification of fragility fractures. Patients were assessed by the Fracture Liaison Service within 90 days and falls assessments were completed. The Trust also performed better than the national average for performing dual energy X-ray absorptiometry (Dexa Scans) within 90 days. However, improvement is required for meeting standards for patients starting strength and balance programmes by 16 weeks following fracture; the proportion of patients recommended drug

therapy who were reviewed by 16 weeks following fracture and adherence to prescribed anti-osteoporosis medication at 12 months post fracture.

National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) Round 4 (2020-2022 data)

The Trust was in line or did better than the national average for the majority of standards and in scored 100% for the following standards: input from paediatrician with expertise in epilepsy or neurologist, input from epilepsy specialist nurse (ESN), evidence of descriptions and frequency of episodes, individualised epilepsy document or a copy clinic letter that includes care planning information and evidence of discussion of being given service contact details. However, improvement is required for 11 standards. In particular, the Trust had no input from clinical psychologist, educational psychologist, psychiatrist, neuropsychologist, counselling, mental health professional, youth worker. This is also a national problem; we are working in partnership with other trusts to determine how we can address this. The Trust has also been successful in obtaining funding for a 2-year epilepsy nurse pilot and part of that work will be carried out by the new ESN.

The reports of 63 local clinical audits were reviewed by the provider in 2023/24 and the Royal United Hospitals Bath NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided.

Dermatology Surgical Site Audit

The correct lesion identification in a clinic as well as an operating room is crucial to help prevent wrong-site surgery. An audit was undertaken during 2022/23 to identify areas of good practice and / or areas for improvement. Following the results of the audit, a new and improved protocol based on the *British Association of Dermatologists* (BAD) National Safety Standard for Invasive Dermatology Skin Procedure (NatSSIPs) was introduced. The re-audit showed that compliance had risen significantly and the majority of the standards were green. The location description was more specific and consistent and there was less abbreviation. Surgical site identification compliance had increased from 25% to 97%. There was no delay in the outcome form and all the World Health Organisation (WHO) checklist forms had been completed. All the consent forms had identified the surgical site. However, there were still some improvements to be made to the identification of the laterality and medical staff were reminded that taking a good orientation picture with surgical site identification (circle) can help ensure the surgical site including its laterality. The local protocol has improved practice and this will continue to be monitored with regular re-audit.

Abdominal aortic aneurysm (AAA) surveillance programme prior to and following endovascular intervention Audit

The Vascular Studies Unit is a specialist ultrasound diagnostic service which provides regular ultrasound surveillance to patients with an abdominal aortic aneurysm (AAA) and following endovascular aneurysm repair. All patients with an asymptomatic abdominal aortic aneurysm (AAA) should be offered surveillance with ultrasound and those who have had an endovascular repair should be offered enrolment into a surveillance imaging programme. The audit found that nearly all applicable patients were offered surveillance and nearly all patients who had an endovascular repair were enrolled onto a surveillance imaging programme. The majority of patients were on the correct schedule for the size of their aneurysm. Improvements following the audit included identification of all 'lost to follow up' patients who were subsequently contacted and returned to the correct surveillance pathway. Other actions included all surveillance patients having a new event created on CRIS and placed on the electronic waiting list. Where patients are sent to North Bristol Trust (NBT) for further intervention this should be clearly added to the new event on CRIS. A meeting is planned with North Bristol Trust to review processes to ensure that all patients undergoing an EVAR in the locality are returned to the RUH for surveillance. This will be re-audited to ensure that the changes have improved the surveillance process.

Stroke Service Audit 11

Following stroke there is a high incidence of visual problems. This can cause significant impairment and become a barrier to effective rehabilitation. Therefore, it is essential that there is orthoptic input into the care and management of stroke patients, alongside efficient communication within multidisciplinary teams. The National Institute for Health and Care Excellence (NICE) guidance for stroke rehabilitation recommends that stroke survivor inpatients should have a specialist orthoptist assessment as soon as possible. If this cannot be done before discharge, the patient should be offered an urgent outpatient appointment. During the period of this audit, 91 stroke inpatients were referred. The audit showed that 52 of these patients were able to be seen as inpatients. Although the aim is to see all patients before discharge, 39 patients were discharged before being assessed due to clinical capacity, and therefore returned as outpatients. Most of the inpatients were referred within 1 week of their stroke. For patients seen as outpatients, 18% of appointments were within 4 weeks of referral. Although not all the aims have been met, the average number of days between date of referral and orthoptic appointment for inpatients has reduced from 2021, and more patients were seen prior to being discharged. To improve the service, the communication process was refined and closer working with the appointment centre and bookings team will help to ensure that all outpatient referral appointments are made within 4 weeks. Closer collaboration of the stroke and orthoptic team will ensure that appropriate cover is in place to facilitate the referral process prior to discharge. A dedicated orthoptic stroke lead has now been appointed. This audit will be repeated on an annual basis to ensure the changes are continuing to make a positive difference.

Get it on time: An audit of the timely administration of Parkinson's medication at the Royal United Hospital (RUH) June – August 2023

It is essential that people with Parkinson's disease (PD) get their medication on time to manage their symptoms. Delayed and missed doses in hospital can result in a deterioration in their symptoms and increase the risk of complications. This is the second cycle of an audit that was conducted in 2022 and which measured compliance with the National Institute for Health and Care Excellence guidelines (NICE) which states that patients with PD should have their medication within 30 minutes of the expected time. The first audit found that 62% of Parkinson's medication doses were delivered on time. This re-audit identified that overall, 68% doses were administered on time which shows a slight increase in compliance. Furthermore, 18% were more than 30 minutes late, 7% were more than 30 minutes early and 7% were missed. Prescriptions that had timings written in the special instructions, but not appropriately scheduled on the electronic system were less likely to be administered on time. There was a substantial variation by time of day and by ward. The most common reasons for missing medication were: "patient refused", "patient unable to swallow or drowsy" and "medication unavailable".

The audit findings were reviewed by medical, nursing and pharmacy teams who identified areas for improvement and collaboratively developed an action plan. The key actions included modifying the electronic prescribing system to highlight Parkinson's medications as "Time critical", educating prescribers on re-scheduling medicine administration, updating the "First 24hrs" bundle for inpatients with PD and increasing awareness that Parkinson's medication is always available at the RUH. This plan is currently being implemented and will be followed by a further audit cycle in July 2024.

Bloods tests and delays prior to paediatric chronic fatigue service (CFS) clinic appointments

The Paediatric Chronic Fatigue service (CFS) at the RUH is a tertiary referral service for paediatric patients with chronic fatigue and long covid. The National Institute for Health and Care Excellent (NICE) guidelines recommend that a particular set of blood tests should be carried out. The results of the blood tests and the ensuing assessment should be included within the referral proforma. The audit showed that in 32% cases the referral proforma that was provided was not used; nearly half of the proformas received had at least one of the requested blood tests omitted; a total 75% proformas had an omission and the majority of those resulted in a delay in the patient being given an appointment. As a result of these findings key actions included amending the proforma to indicate the 'required' elements of the form, increasing the availability of the proforma; clarifying guidance on the relevance of required blood tests and standardising the assessment of referrals. A further audit is planned to be undertaken.

South West LeDeR 'Call to Action' Audit

LeDeR is a programme that focuses on learning from lives and deaths for people with a learning disability and autistic people. The Royal United Hospitals participated in a regional audit together with Salisbury NHS Foundation Trust (SFT) and Great Western Hospitals NHS Foundation Trust (GWH). This audit was coordinated by BSW ICB.

Results of the audit showed that, compared to the other two participating trusts, the RUH had more Recommended Summary Plan for Emergency Care Treatment (ReSPECT) forms in the notes/transferred from community and most had a ceiling of care documented. For those with a ReSPECT form in place, most had a rationale recorded. Where a person with learning disabilities had a Do not attempt cardiopulmonary resuscitation (CPR) (DNACPR) in place, the person had other co-morbidities recorded. The RUH involved patients in ReSPECT discussions more than the other trusts. However, the audit found more patients did not have a capacity assessment documented in the situation where a patient lacks capacity for a specific decision. Mainly there were 'blank' responses around accuracy of learning difficulty diagnosis, reasonable adjustments documented, flag for patient additional needs. The majority of patients did not have a hospital/health passport. An action plan for improvement is in place to be rolled out through 2024/25 as part of the larger strategic priority at the RUH. Actions include: reviewing and expanding eLearning, assessing training needs and developing educational resources, further scrutiny and audit of ReSPECT forms, making the forms more user friendly and regular reporting to the Vulnerable People Assurance Committee.

Use of MEOWS Charts (Maternity Early Observation Warning System) and NEWTT Charts (Newborn Early Warning Trigger and Track) in Post Natal Period Audit

The recognition of severely ill women either in pregnancy or the postnatal period remains a challenge to all involved in their care. It is recommended that routine use of a MEOWS (Maternity Early Observation Warning System) chart is used as it improves the recognition of and reduces the delay in treatment of Sepsis if a deviation from the normal occurs. This audit is now only conducted in the birthing units as E-Observations (e-obs) have been commenced on the postnatal ward at the RUH. In addition to auditing the MEOWS charts, the NEWTT charts were also examined. Results from the audit showed good compliance with the total of red/yellow scores added correctly and documented responses to triggers. NEWTT charts were completed accurately. However, MEOWS charts were not completed at each postnatal contact. All staff will be reminded of the importance of completing these charts at each postnatal contact and the results of the audit will be cascaded to all staff. It is planned to continue re-auditing MEOWS and NEWTTs monthly until MEWS charts (Maternity Early Warning Score) are introduced to the birthing units.

Mandatory statement 3

The number of patients receiving relevant health services provided or subcontracted by Royal United Hospitals Bath NHS Foundation Trust in 2023/24 that were recruited during that period to participate in research approved by a research ethics committee was 3,775.

Throughout the year around 350 studies are open to recruitment or in follow-up across a wide range of clinical specialities and departments. A large proportion of these research studies are national collaborative studies and support relationships with local and national research funders, Universities, NHS organisations and commercial partners within the life sciences industry.

The RUH has grown a strong portfolio of research that 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 April 2023 – March 2024

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
Dr Raj Sengupta	Rheum	IDEAL - PGfAR	Total awarded - £2,546,536.60 £49,390 to RUH	NIHR
Paul Minty	RUH	Paul Minty HEE-NIHR pre-doctoral bridging award (2023/24)	£14,943.50	NIHR
Dr David Murphy and Dr Ali Khavandi	UoBath/RUH	MICRO-FIT – Mircovascular coronary rehab for improving treatment	£195,000	Heart Researc h UK
Prof O'Callaghan	RUH	To Study the Epidemiology of Tuberous Sclerosis Complex	£135,592.63	BURP charity
Dr Jess Ellis	RUH	Utility of a Novel imaging biomarker for the identification of excess cardiovascular risk in auto-immune rheumatic diseases	£15,000	BIRD Charity
Charlotte Gollins	RUH	Effectiveness of Sequential Lines of Biologic and Targeted Small Molecule Therapy in Psoriasis	£62,000	British Skin Foundat ion

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
Dr Lunt /Jerome Condry	UoBath/RUH	Inflatable Prone Repositioning Device, from Manufacturable Prototype to Marketable Product	£357,687	NIHR I4I Product Development Award
Mary Cramp	UWE	Inspiring students into Research Scheme	N/A	NIHR Insights Scheme
Neil McHugh	UoBath/RUH	CARP – Early Care Pathways for Psoriatic Arthritis - Now called TULiPS	£150,000	NIHR Programme Development Grant
Dr Joseph Page	RUH	Assessing the Vascular Endothelium in Systemic sclerosis associated Pulmonary hypertension to improve Early and Rapid diagnosis (VESPER)	£20,000	BIRD
UoBath, UoPlymouth and Mandy Slatter	UoBath, UoPlymouth /RUH as co applicant	Pharmacy research priorities in the South-West: Engaging and Involving healthcare professionals	£2,000	Engage and Involve Grant
Dr David Murphy and Dr Ali Khavandi	UoBath/RUH	MICRO-FIT – Mircovascular coronary rehab for improving treatment	£195,000	Heart Research UK

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
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Charlotte Gollins	RUH	Effectiveness of Sequential Lines of Biologic and Targeted Small Molecule Therapy in Psoriasis	£62,000	British Skin Foundation
Dr Lunt /Jerome Condry	UoBath/RUH	Inflatable Prone Repositioning Device, from Manufacturable Prototype to Marketable Product	£357,687	NIHR I4I Product Development Award
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Neil McHugh	UoBath/RUH	CARP – Early Care Pathways for Psoriatic Arthritis - Now called TULiPS	£150,000	NIHR Programme Development Grant
Dr Joseph Page	RUH	Assessing the Vascular Endothelium in Systemic sclerosis associated Pulmonary hypertension to	£20,000	BIRD

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
		improve Early and Rapid diagnosis (VESPER)		
UoBath, UoPlymouth and Mandy Slatter	UoBath, UoPlymouth /RUH as co applicant	Pharmacy research priorities in the South-West: Engaging and Involving healthcare professionals	£2,000	Engage and Involve Grant
Dr David Murphy and Dr Ali Khavandi	UoBath/RUH	MICRO-FIT – Mircovascular coronary rehab for improving treatment	£195,000	Heart Researc h UK
Prof O'Callaghan	RUH	To Study the Epidemiology of Tuberous Sclerosis Complex	£135,592.63	BURP charity
Dr Jess Ellis	RUH	Utility of a Novel imaging biomarker for the identification of excess cardiovascular risk in auto-immune rheumatic diseases	£15,000	BIRD Charity
		Total	**£952,223.13**	

Mandatory statement 4

The Royal United Hospitals NHS Foundation Trust income in 2022/23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the value of the funding attributed to this framework was fixed for the year.

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 2023/24.

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 2023/24 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) 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:

- 99.9% for admitted patient car
- 100% for outpatient care and
- 99.0% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100.0% for admitted patient care;
- 99.9% for outpatient care; and
- 99.0% for accident and emergency care.

HES data as presented in Dr Foster has been used to generate this data and for GP Practice codes both blank and defaulted V81 codes (the patient does not have a registered GP practice recorded) have been counted as invalid.

Mandatory statement 9

The Royal United Hospitals Bath NHS Foundation Trust Information Governance Assessment Report overall score for 2023-24 is assessed as 'Standards Met'. The Trust recognises the challenges presented by the ever-changing cyber threat landscape require enhanced controls to achieve this standard which is achieved by continued investment to ensure the confidentiality, integrity and availability of data for all services undertaken.

Mandatory statement 10

The Royal United Hospitals Bath NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the 2023/24 financial year.

Clinical Coding have not had an external audit last year however they have done as internal data and security and protection toolkit and the results are published externally as part of this exercise.

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 2023/24 1364 of the Royal United Hospitals Bath NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 376 in the first quarter (Q1).

- 322 in the second quarter (Q2).

- 330 in the third quarter (Q3).

- 336 in the fourth quarter (Q4).

Mandatory statement 27.2

By April 2024, 142 case record reviews and 13 investigations have been carried out in relation to 148 of the deaths included in item 27.1. In 2 cases, a death was subjected to both a case record review and a serious investigation or a Patient Safety Incident Investigation (PSII) as the Trust transitions to the Patient Safety Incident Response Framework. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 9 SJRs and 2 investigations in the first quarter;
- 23 SJRs and 4 investigations in the second quarter;
- 45 SJRs and 2 investigations in the third quarter;
- 65 SJRs and 4 investigations in the fourth quarter.

Mandatory statement 27.3

We have adopted the Royal College of Physicians' National Mortality Case Record Review (NMCRR) 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

Table 1. below details all SJRs completed for patients who died during 2023/24, even if the SJR was completed after the expiry of that period.

Table1: Structured Judgment Review Completed 2023/24

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.24	156	0	2	17	78	59
Ongoing Care	4.02	133	0	4	28	62	39
Care During	4.21	47	0	0	5	27	15
Return To Theatre	3.33	6	0	1	2	3	0
Perioperative Care	3.88	32	1	1	6	17	7
End Of Life	4.24	129	0	2	17	58	52
Overall	4.06	153	0	4	30	72	47
Patient Record	3.89	153	0	3	61	39	50

Whilst the Trust is unable to calculate the avoidability of a death, the person undertaking the Structured Judgement Review 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: 2 (0.5%)

Q2: 1 (0.3%)

Q3: 0 (0%)

Q4: 1 (0.3%)

Mandatory statement 27.4

In relation to the SJRs that have been completed, the care problems identified included End of Life Care, Communication and Documentation. All have been subjected to a second, more detailed review, to establish if the threshold for a serious incident had been met. In each quarter, the majority of SJRs report that either that the care was good/excellent, or that no additional learning has been identified.

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 1 case which was escalated for serious incident investigation following a Structured Judgement Review (SJR)

Q1: 1 (0.3% of patients who died during 2023/24)

Q2: 0 (0%)

Q3: 0 (0%)

Q4: 0 (0%)

The learning identified from the incident included:

· Recognition and escalation of deteriorating patients.

Mandatory statement 27.5

The RUH Patient Safety Programme for 2022-2025 identified five patient safety priorities which reflect themes identified within incidents and complaints:

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

These priorities continue to be the focus of thematic reviews and work plan development in adherence to the transition to the Patient Safety Incident Response Framework (PSIRF).

Mandatory statement 27.6

The PSIRF programme is a new approach to investigating and learning from safety events. Its impact in improving patient safety will be assessed over the coming months as it becomes embedded.

Mandatory statement 27.7

108 SJRS and 0 investigations were completed after 31/03/2023 which related to deaths which took place before the start of the reporting period.

Mandatory statement 27.8

4 SJRs representing 0.09% of the patient deaths before the reporting period, experienced care problems likely to have contributed to death. This number has been estimated using the same methodology as set out above.

Mandatory statement 27.9

9 representing 0.6% of the patient deaths during 2022/23 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.5 Reporting against core indicators

Mandatory statement 12 – Summary Hospital Level Mortality Indicator (SHMI)

The following data is for the latest reporting year December 2022 – November 2023

Table 2: Summary Hospital Level Mortality Indicator

Measure	Dec 22 – Nov 23	Nov 21 – Oct 22	Feb 21 - Jan 22	National Average	National Best	National Worst
Value	0.98	1.3	1.04	1.00	0.72	1.26
Banding	2	2	2	2	3	1

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 Chief Medical Officer, monitors these indicators on a regular basis, and we use the Dr Foster Intelligence System to monitor mortality and clinical effectiveness.

Mandatory statement 18 – Patient Reported Outcomes Measure (PROMS)

Please note that in 2021, significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.

NHS Digital endeavour to update this linkage process and resume publication of this series as soon as they are able but unfortunately are unable to provide a timeframe for this. Further information can be found by clicking here.

Mandatory statement 19 - Readmissions

The following table shows the Emergency Readmission within 30 days of discharge from hospital during the latest reporting year 2021-2022.

Table 3: Emergency Readmission Rates

	RUH Performance					
	2022 – 23	2021 – 22	2020 - 21	National Average	National Best	National Worst
0-15 year old	13.0	13.3	12.9	12.8	3.7	19.0
16 years or over	13.6	14.3	14.3	14.4	6.2	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 2021/22 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 Chief Medical Officer. When individual diagnostic groups are outside of the expected range for readmissions a review is undertaken to understand what may be contributing to this and an improvement cycle commenced to improve outcomes

Mandatory statement 20 – Responsiveness to personal needs of patients

Measure	Latest reporting year	RUH	National Best	National Worst
Overall, how was your experience while you were in hospital	2022	8.3	9.2	6.6

Ranking compared to previous year about the same

Mandatory statement 23 – Venous Thromboembolism (VTE)

NHS Digital have paused the collection and publication of this data to release NHS capacity to support the response to coronavirus (COVID-19). Click Here to find out more information including a full list of collections and releases affected on the NHS England website under the heading COVID-19 and the production of statistics.

Mandatory statement 24 – Clostridium Difficile (C. diff)

The following table shows the measure of Hospital onset, Healthcare Associated C.Difficile Infections.

Table 4: Hospital Onset, Healthcare associated C.Difficile infections

Measure	RUH Performance			National Average	National Best	National Worst
	2022 - 23	2021 - 21	2020 - 2021			
Rate per 100,000 bed days for specimens taken from patients age 2 years and over	24.6	17.8	17.0	20.3	0.0	76.6

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/charge nurses are undertaking regular audits of documentation and feeding back to staff
- Keeping a focus on antimicrobial stewardship
- Ensuring that all patients with Clostridioides 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.

Mandatory statement 21 – Staff recommending the Trust to friends and family

The following table shows the following measure: “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation”

Table 5: Staff recommending the Trust to family and friends

RUH					
2023	**2022**	**2021**	**Best**	**Average**	**Worst**
71.03%	68%	73.6%	89.5%	64.04%	39.2%

The Royal United Hospitals Bath NHS Foundation Trust (RUH) 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 RUH consistently scores above the national average for Acute Trusts on this measure, revealing that people employed here feel confident about the quality and safety of the care / treatment the Trust provides. The organisation continues to build on its strong foundation of quality improvement (Improving Together), which is supplemented by a robust behaviour, values and culture support package, aiming to help colleagues to thrive, develop and give more of their energy and attention to the direct care of patients. The Trust has invested in its People and Culture function to ensure employees can be as effective and productive in the clinical settings as possible, providing safe and inclusive working environments, refreshed recognition standards and ensuring the basics are in place. This sits alongside an increased focus on change management, compassionate leadership and civility and kindness, all of which aim to improve patient outcomes / experience by keeping staff as healthy and fulfilled in work as possible.

Mandatory statement 25 – Patient Safety Incidents

The following graphs show the number of reported patient safety incidents for the last 3 years and the percentage of patient safety incidents causing significant harm.

Figure 2.3: SPC chart for reported patient safety incidents

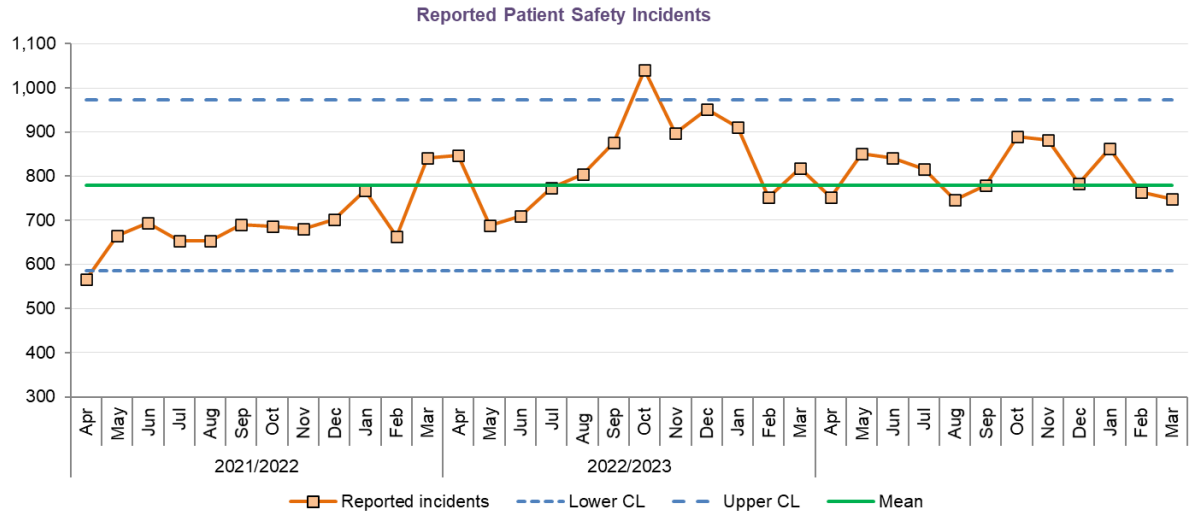
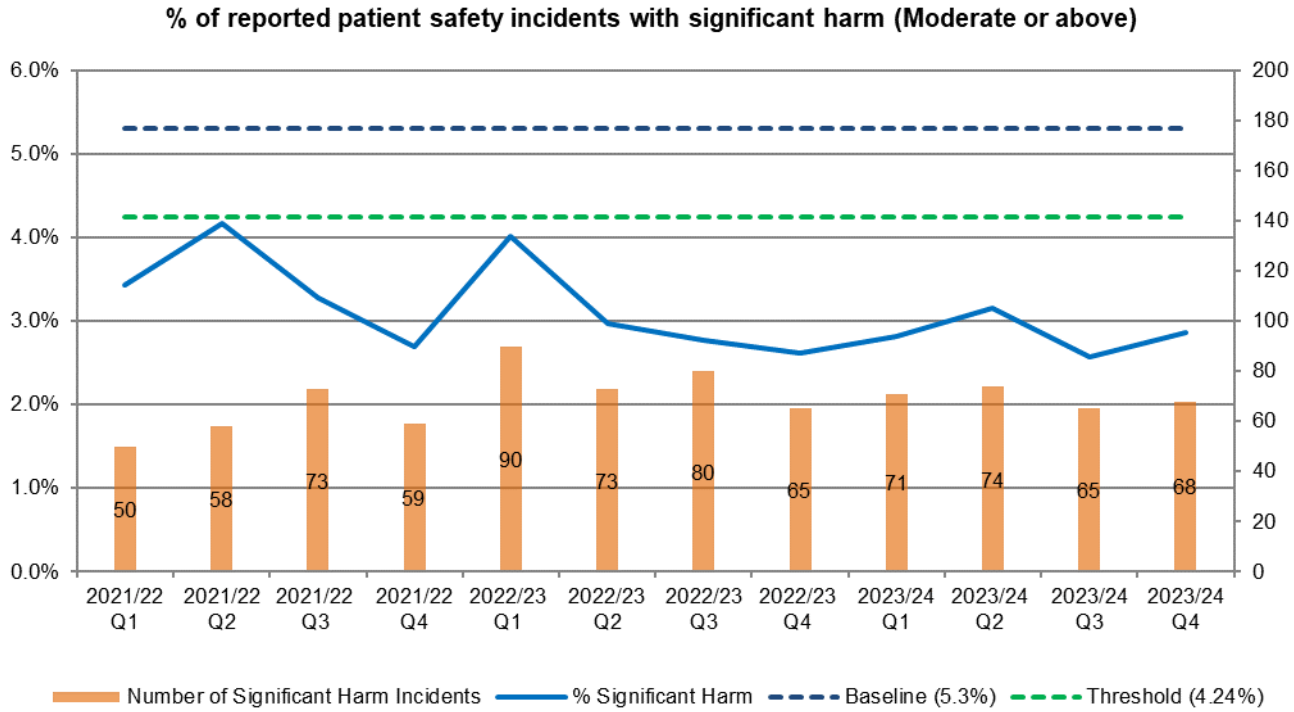


Figure 2.4: Percentage of reported patient safety incidents with significant harm



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 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 providing a key focus on the learning from incidents.

As the Trust transitions into the Patient Safety Incident Response Framework (PSIRF) the focus is more on identifying emerging themes, trends and system functioning in order to better learn from safety events and make improvements to the quality and safety of patient care, thereby reducing harm to patients. The five Trust patient safety priorities are Infection Prevention & Control, Falls, Discharge, Medication and the Deteriorating Patient. Working groups for each priority are actively developing their work plans based on emerging themes and monitoring the impact of improvement work. Other emerging themes such as nutrition/hydration and tissue viability have been identified and working groups are in place to manage and monitor the impact of improvement work.

The following are examples of improvements made following thematic reviews of incidents. In August 2023, a cohort review and thematic analysis of Major Postpartum Haemorrhage (PPH) was undertaken due to an identified rise in PPH rates with the Trust reporting to be above the national average for rate of PPH <1500ml per 1,000 births. A retrospective review of 22 case notes was completed across 6 months and assessed 1 year of demographic data looking at the modifiable factors which may have impacted upon the resulting incurrence of PPH > 1500mls.

The internal review made 5 recommendations with 1 immediate action. The action stated that “it is recommended that it is ensured the initial oxytocic for an actively managed third stage is given at the birth of the anterior shoulder. This is to mitigate the risk of postpartum haemorrhage within an active management of the third stage of labour.”

Following the cascade of information via safety briefs, quality boards, quality hot spots, and safety catches, and the continued work towards the longer standing recommendations within the report, there has been a declining trajectory in PPH >1500ml rates for the period between October and December 2023.

An investigation was also undertaken into a cluster of never events relating to wrong site surgery – removal of incorrect skin lesion. This identified the need for improvements in the process of assessing and communication of skin lesions sites for removal. A standard operation process document has been developed outlining a standardised process for consent, checklists, imaging with site marking, Anatomy Mapper tools and consistent terminology, verification and communication throughout the patient journey.

Part 3

Other information

- **Patient Experience**
- **Patient Safety**
- **Clinical Effectiveness**

3.1 Patient Experience

Modular theatre

The elective orthopaedic ward (Philip Yeoman) is a dedicated (ring fenced) ward at the RUH for elective orthopaedic surgery only. As a direct result there are reduced infection rates, shorter length of stay and fewer cancellations due to bed availability.

To meet demand, a modular theatre has been built on the Sulis site to reduce waiting times and improve outcomes. To date 706 patients have received their surgery in the modular theatre.

The theatre is run by a dedicated RUH team with visiting RUH surgeons working in collaboration with the Sulis teams who provide pre and post operative care.

Community Diagnostics Centre (CDC)

The Community Diagnostic Centre at Sulis began providing diagnostics services in the Spring of 2023. The CDC provides services, such as X-rays, MRI and CT scans, blood tests, ultrasounds, and endoscopies, in the community and away from the large hospital setting. These services provide greater convenience for local patients, and support staff to see more people in need of investigative care.

The CDC is a fantastic addition to our local NHS services as we become much more focused on prevention, and helping people to live longer, happier, and healthier lives, in which any potentially serious conditions can be spotted at the very earliest opportunity. Another advantage of carrying out more diagnostic care in the community is that staff at the Trust should have more time to focus on patients with more pressing and complex needs. The community centres provide an additional level of resilience to the local health and care system, with appointment cancellations during times of high demand or unexpected events becoming less likely.

Improving Patient and Carer Experience

Patients tell us that they appreciate the importance of staff kindness and understanding and especially that they are treated as an individual.

We also hear that we need to improve how we communicate with patients and provide information in a way they can understand and at the right time for them. We know that feeling heard and valued has a positive impact on patients' experience of the hospital.

In partnership with patients, families and the local community, the Trust developed a patient and carer engagement and experience strategy, which aligns with the Trust goal for the 'people we care for'. The strategy supports staff to work with patients and their families/carers to develop and design new services, improve existing services, and improve overall patient and family experience.

Patients, families, and the local community helped develop our three commitments to improving patient experience. These are:

- We will involve and engage with you in a purposeful, meaningful, and inclusive way

- We will listen, hear, and act on what you tell us to improve your experience
- We will communicate with you in a clear and understandable way at the right time.

This year, in working towards achieving these commitments we have focused on the following:

Patient Safety Partners (PSP)

In May 2023 we recruited Patient Safety Partners to be actively involved in developing improvements in patient safety and the quality of care we provide at the RUH. The PSPs, who are volunteers, ensure that the voices of patients, carers, families and hard to hear groups are represented in how we learn from patient safety events.

Patient representatives

Patient representatives bring a unique perspective to our Boards, Committees and Groups. People who have experience of being a patient or a patient's carer/family member are 'experts by experience.' We believe these experiences empower patients to be meaningfully engaged in discussions around quality, service improvement and design. For example, the RUH has recruited patient representatives to the Medicine Divisional Board, Dementia and Strategy group and the Palliative and End of Life Care steering group.

DrDoctor

DrDoctor is a patient engagement platform that helps the hospital to communicate effectively with patients. This is part of our ongoing commitment to provide the right care at the right time.

The RUH has partnered with DrDoctor to introduce video consultations, digital appointment reminders and digital letters. Patients tell us they find video consultations more convenient than attending the hospital. Patients do not have to allow significant extra time before and after appointments, only needed to take minimal time off work, have a more comfortable and shorter waiting experience, have a less stressful experience, and feel it to be safer/easier where their condition reduced their ability to travel.

Patients receive up to three text and/or email reminders about their upcoming hospital outpatient appointment. This reduces non-attendance (DNAs), the reduction in unused clinic slots due to DNAs means more patients can be seen sooner, booking teams do not need to rearrange appointments due to non-attendance, and personalised messages support empowerment of the patients' own care.

Switching from printing and posting appointment letters to digital has improved patient experience, saved money and promoted environmental sustainability. Patients receive their letters faster and they are more readily accessible on the patient portal. Patients view and download their letters online with the option as well to receive letters in their preferred way.

Call for Concern

Call for Concern provides patients, their families, carers, and advocates with access to 24/7 rapid review from a critical care outreach team if they are worried about the patient's condition. A pilot has commenced on 3 wards with a plan to roll this out Trust wide. This service is known nationally as "Martha's Rule".

The Critical Care Outreach team, a team of specialist nurses, provides the service at the RUH. They are available 24 hours a day to help support ward staff in the care of acutely ill patients. They can offer advice over the telephone or see the patient on the ward to review their condition.

Bob's Boxes

Bob's Boxes were introduced to improve the experience of inpatients who are registered blind/partially sighted. Bob was a patient who was diagnosed with a serious eye condition and lost all vision when he was 67. We learnt from Bob how stays in hospital could feel lonely and isolating. With the support of Bob's family, the Trust has created boxes with contents to support patients who have visual impairment. The content includes a magnifying glass, radio, talking clock, memo recorder, non-slip plate pad, non-slip cup holder, plate/bowl guard and velcro-dots for call buttons.

Involving patients in planning future services

Our aim is to continuously improve patient and family experience and strengthen the patient voice in every service across the hospital. The RUH is committed to ensuring that the Trust's priorities reflect what patients, their families/carers and the local community tell us is important to them. This year we have involved members of the local community in developing the Vulnerable People Strategy, which will be launched later this year.

We are committed to creating opportunities for patients, and their families and carers, with lived experience to be involved and work with staff in developing and improving the service, we provide.

This year, the Patient Experience Team supported 73 teams to collect patient and carer feedback (via questionnaires, telephone interviews and focus group meetings) and to use the information to improve their service. This is an increase from the 60 teams supported the previous year.

Some of these projects were nominated for the Improving Patient Experience Awards 2023-24, which provided an opportunity to celebrate the good practice:

The winner of this year's award was the Trauma Assessment Unit for the work they have done to perform hand surgery in their procedure room which has resulted in reducing waiting times for patients.

Patients have fed back positively, saying, "staff were very informative of the procedure which made me feel calm and relaxed throughout". "I was treated extremely well, and every step of the

process was explained as it was happening". "I was given clear and detailed information regarding the procedure, including the benefits and risks"

3.2 Patient Safety

Patient Safety Incident Response Framework

The Trust launched the new National Patient Safety Incident Response Framework (PSIRF) on the 1April 2024. The framework sets out a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This is a significant change to how staff work and respond to patient safety events and the Trust is developing documentation and training to support effective implementation. The National Reporting Learning System has also been replaced with the Learning From Patient Safety Events (LFPSE) system. The Trust has actively engaged with this transition.

The Trust has taken the following actions to improve the quality of its services and reduce the rate of patient safety incidents that have resulted in severe harm or death by:

- Regular oversight by the Board of the Board Assurance Framework and application of the Board approved risk appetite and risk tolerances which has enabled a focus on risks outside of tolerance.
- Monitoring ward to board reporting on key patient safety and experience indicators and reporting these monthly to Board via the Integrated Performance Report.
- Reviewing a significant proportion of deaths in hospital through the Trust's Medical Examiners, Learning from Deaths Process and Mortality Review Group. Specific consideration has been given to how we monitor and capture patient safety risks (ensuring close alignment to our PSIRF processes) and our policies for both audit/effectiveness and mortality were updated accordingly.
- Preparations for the community Medical Examiner roll-out have been continued to progress, and our Medical Examiners are now operating within the majority of our local GP surgeries. We are still awaiting formal notification of when the community Medical Examiner roll-out will become statutory (anticipated for September 2024).
- Approval and initiation of the Patient Safety Incident Response plan to transition to the Patient Safety Incident Response Framework.
- Weekly review of all reported patient safety events of concern to agree the appropriate level of review and identify any immediate actions to mitigate identified risk.
- Establishing a Patient Safety Event Oversight group to ensure that themes and learning from patient safety events reports are maximised and inform safety improvement work.
- Establishing a Quality and Safety Improvement group to ensure improvement work reflects the insights from patient safety event reports and to oversee the delivery of improvement aligned to our patient safety priorities.

- Our Risk Management System, Datix, provides a range of quantitative data to support analysis across services and wards to provide assurance that we have effective systems for the monitoring of patient safety events.

- Improving the voice of patients, families, and carers in the management of patient safety events by; recruiting patient safety partners and incorporating patient engagement into the process for managing patient safety events as part of our PSIRP.

- Refreshing our Patient Experience strategy and ensuring that patient feedback provides insight to the quality and safety of our services and informs improvement.

Deteriorating Patient

Over 2023/24 continued spreading message of 'Be Curious' to support early identification of patient deterioration based on increase in National Early Warning Scores, as well 'soft signs 'of deterioration. Compliance with competition of electronic alerts which support early identification of sepsis and deterioration from other causes increased from 78% to 88% over 2023/24. 62% wards achieved compliance over 90%.

Improved patient outcomes have been demonstrated in 2023

- Hospital mortality data (HSMR) showed a reduction with no difference between weekend and weekday admissions.

- Reduction in mortality from infective causes, better than national average.

- Since June 2023, decreased incidence of hospital acquired Acute Kidney Injury, reduced mortality from AKI as well as decreased length of stay.

<u>Specific Interventions in 2023/24</u>

- In 2023 the new National Maternity Early Warning Score (MEWS) tool was implemented across all the maternity areas, RUH being one of the first trusts to implement the new national tool, which will also help to identify any deteriorating mothers earlier.

- Critical Care Outreach Team implemented Call for Concern, a process whereby patients or family members can contact Critical Care directly if they are concerned.

- The hospital at night team continued to be developed with new appointments to increase senior capacity at night.

- Throughout 2023, a small project team developed immersive training in patient safety priorities, producing 4 virtual reality 360 videos, reflecting key messages for each of the priorities including the deteriorating patient. These are being rolled out to all staff available for all staff and have been exceptionally well received:

    - Great way to learn-makes you feel like you're part of the whole experience in real time'

- ‘This was a really great experience as a student. It really showed me how things are missed easily and what to do next time’
- ‘This type of learning helps more with topic absorption. You can easily remember the things shown and the lessons taught’.

Plans for 2024/25

The trust has been selected to be part of the initial phase of the national implementation of Martha’s Rule, similar to Cause for Concern allowing patient and family access to outreach if concerned.

RUH is also participating in a national research project, Respond, using human factors and supportive tools to increase early identification of deterioration following emergency surgery.

Infection Prevention & Control

The RUH can demonstrate adherence to Trust values and public accountability in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection alongside the 10 criteria and related guidance. A detailed analysis of all these criteria are contained with the annual Director of Infection Prevention and Control (DIPC) report.

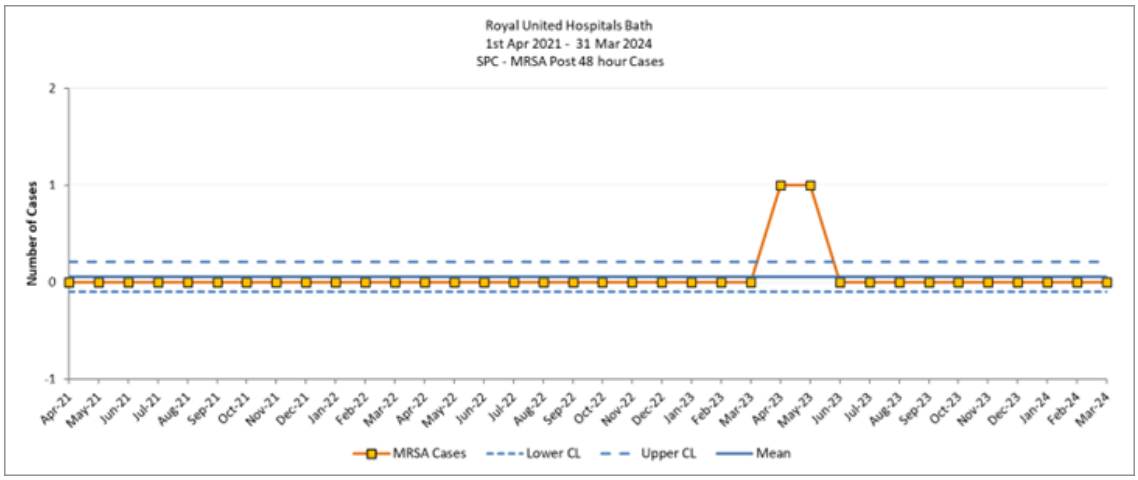
The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework (2023) remains the responsibility of the organisation and all registered care providers must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the 10 criteria outlined in the Act. There are areas of partial compliance to the Board Assurance Framework (BAF) these elements have been added to the Trust risk register and or the estates work plan where improvements can be realistically delivered. There are no areas of non-compliance.

The RUH is required to report to UKHSA on the following organisms:

- Methicillin-Resistant Staphylococcus Aureus (MRSA)
- Methicillin-Sensitive Staphylococcus Aureus (MSSA)
- Gram negative Bloodstream Infections
- Clostridioides difficile (C. difficile)

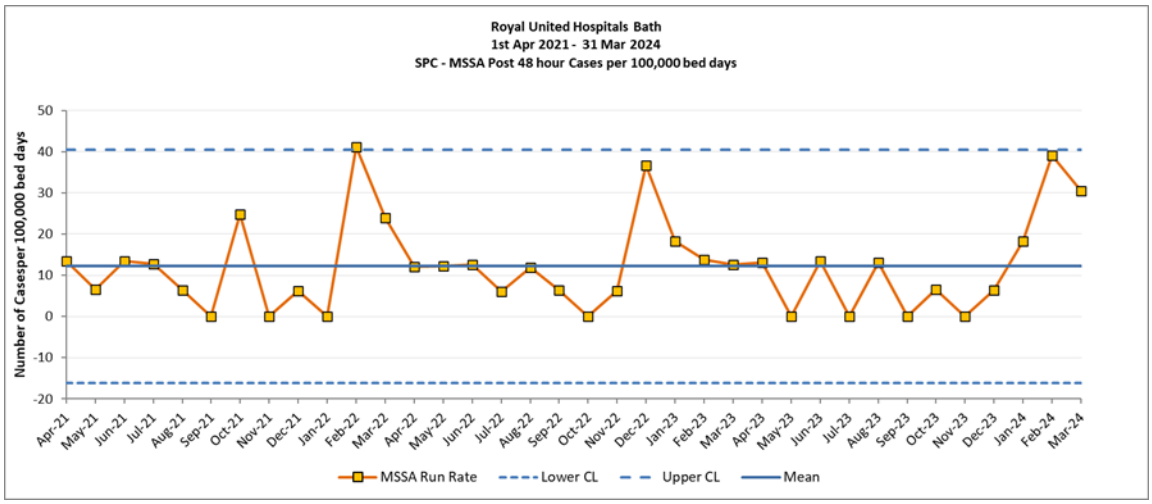
Methicillin-resistant Staphylococcus aureus (MRSA)
There were 2 hospital onset health care associated (HOHA) and 1 Community onset healthcare associated (COHA) cases of MRSA bacteraemia (this case was an ongoing infection). All cases have undergone a root cause analysis (RCA) and were presented and discussed at Infection Prevention and Control Committee (IPCC).

Figure 2.5: SPC Healthcare associated MRSA bacteraemia data 2021 – 2024 per 100,00 bed days



Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteraemia
The Trust reported 22 HOHA cases in 2023/24, there was no trajectory/threshold set.

Figure 2.6: SPC Healthcare associated MSSA bacteraemia data 2021 – 2024 per 100,00 bed days



Gram Negative Bloodstream Infections
Whilst the thresholds set have been exceeded during 2023/24, there has been a 8.5% reduction in the Trusts Escherichia. coli (E.coli) rate since 2022/23 and a 21% reduction in the Klebsiella

rate. This is contrasted by a 25% increase in the Pseudomonas rate (n=15), 3 cases above the threshold of 12.

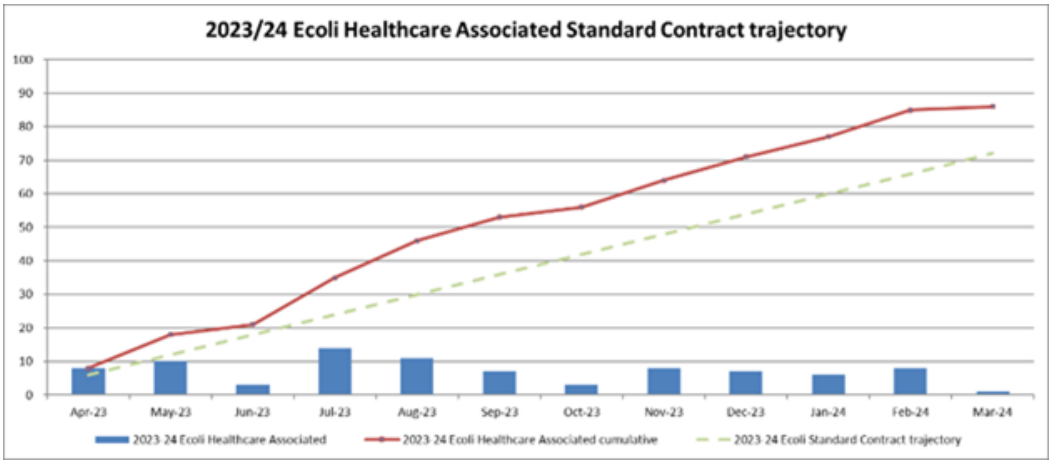
Escherichia. coli (**E.coli)**
90 cases have been reported against a threshold of 72 for 2023/24.

The RUH has seen an overall decrease in cases of 4% from 2022/23 case numbers.

Table 6: Gram negative thresholds for 2022/23 and 2023-2024

Infection	Threshold for 22/23	Final Numbers 22/23	Threshold for 23/24	Final Numbers 23/24	Difference in final Numbers 22/23 and 23/24
E.coli	76	94	72	90	**-4**
Pseudomonas	17	12	12	15	**+3**

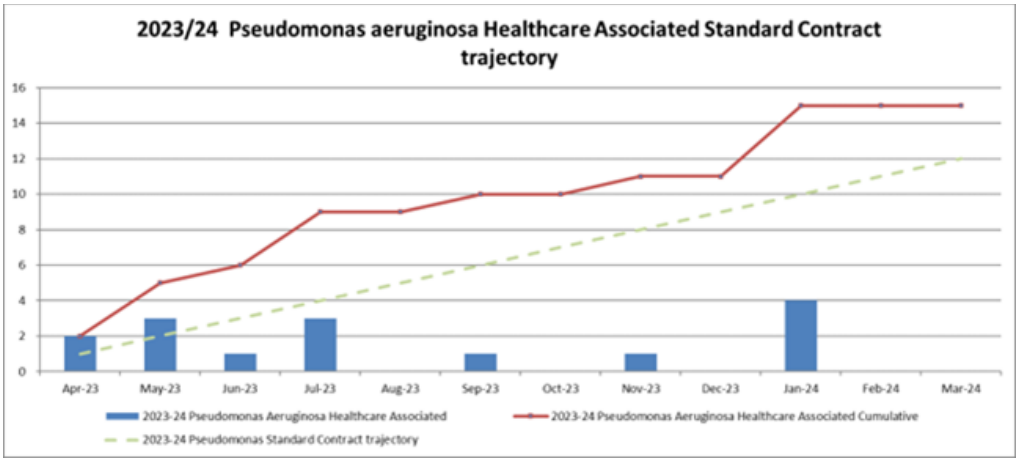
Figure 2.7: Total number of C. difficile cases April 2023 -March 2024



Pseudomonas Aeruginosa infection

15 cases have been reported against a trajectory of 12 for 2023/24. The RUH do identify as an outlier when more than three cases are reported, overall low numbers of Pseudomonas are reported overall. Spikes are seen within several organisations throughout the year, but do not appear to be associated with any seasonal changes.

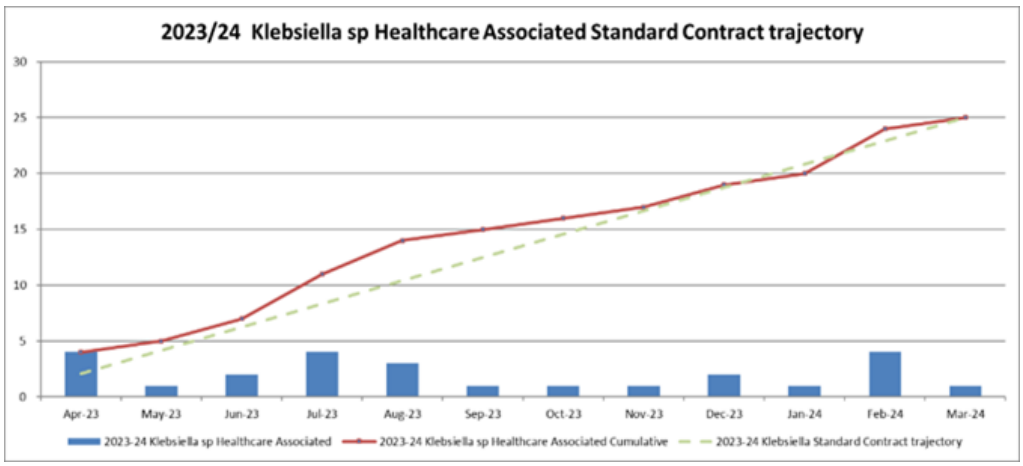
Figure 2.8: All Pseudomonas against trajectory for 2023/24



Klebsiella infection

27 cases have been reported against a trajectory of 25 for 2023/24. National data demonstrates this infection can be linked to dehydration. Hence there has been a hydration project within the Southwest to address this inequality in the population.

Figure 2.9: All Klebsiella against trajectory for 2023/24

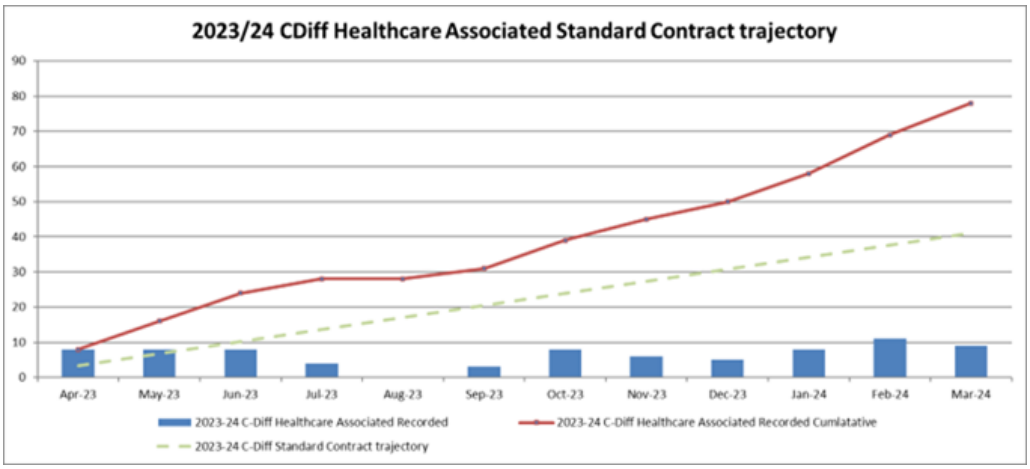


Clostridioides difficile (C. difficile)

The threshold for RUH apportioned cases of *C. difficile* for 2023/24 was set at 41 cases, with 77 being reported at the end of March 2023. This was 36 cases over the threshold. There were 5 more cases reported in 2023/24 than in 2022/23 with equates to a 6.9% increase in cases.

C. difficile root cause analysis is linked with Datix incident reporting for all HOHA cases. COHA cases are investigated using the same RCA tool, but only added to Datix if harm is identified. None of the 77 cases were classed as preventable or had lapses in care. There were lessons learnt for improving the care once a diagnosis has been made. All actions have been implemented by divisions, closed on Datix and discussed at IPCC. The increase in the number of cases overall is of concern and is reflected in the numbers nationally. NHSE have collaborated with the Southwest IPC network to review the increase in *C. difficile* numbers. There is no straightforward explanation for the increase in rates.

Figure 2.10: Total number of *C. difficile* cases April 2023 -March 2024



Key improvement for 24/25

- Focus on patient hand hygiene during an admission to prevent ingestion of not only C. difficile spores, but other infections too. This will be supported by the nutrition and hydration groups and a review of the products provided to cleanse patients hands at the bedside.

- Focus on appropriate timely sampling and not obtaining samples as a result of administering aperients.

- The IPC and divisional work plan for 2024/25 will be to promote the hydration project. This project aims to improve the fluid intake of our patients in the Trust. This will not only prevent urinary tract infections, but it will also prevent constipation, improve cognitive ability, improve skin integrity, improve mobility, and prevent falls.

Freedom to Speak Up (FTSU)

The Trust appointed new guardians in June 2023, one lead Guardian working in a full time capacity and a secondary Guardian working on an ad-hoc capacity with whom staff can raise concerns.

Freedom to Speak Up encourages staff and provides an opportunity to raise patient safety concerns in a supportive environment. Building a more open culture, in which leadership encourages learning and improvement, leading to safer care and treatment, improved patient experience and staff wellbeing.

Key highlights from 2023-24

As of January 2024, FTSU is provided under the leadership of the Chief Executive's Office. The FTSU policy is being updated, and the FTSU Strategy for 2024-2027 is being written, the FTSU champion role is being formalised and eLearning mandatory training module has been updated following staff feedback.

During 2023/24 there were 148 issues raised to FTSU as shown in table x.

Table 7: Number of FTSU issues raised.

2023/24	Q1	Q2	Q3	Q4
Total	45	40	24	39

Themes were:

- Patient safety /Quality
- Worker Safety/Wellbeing
- Inappropriate attitudes and behaviours
- Bullying and Harassment

Future plans for 2024-25

- Finalise and update FTSU Policy
- Finalise FTSU Strategy 2024-2027
- Finalise and update confirmed FTSU Champions and start a promotional/communications campaign to highlight this
- Finalise protected time for secondary Guardian
- Finalise and update confirmed FTSU Champions and start a promotional/communications campaign to highlight this
- Finalise protected time for secondary Guardian

3.3 Clinical Effectiveness

Commissioning for Quality and Innovation (CQUIN)

CQUIN indicators contribute to the Trusts' quality improvement programme and support the delivery of the 'quality pillar', Trust priorities and financial sustainability.

CQUIN is a payment framework introduced to make a proportion of acute healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. For 2023/24 all goals are nationally defined, with no variations possible between the Trust and its commissioners.

CQUIN assessments and achievement

Each CQUIN indicator contains a mandatory set of reporting requirements that will be used for performance monitoring. Some of these indicators will be measured using routinely collected national data. Others will require local data to be submitted to the national CQUIN collection.

CQUIN 2023/24 compliance:

Table 8 below sets out the Trust's annual compliance for the schemes that require a submission in 2023/24. Not all schemes are linked to a financial incentive. Schemes linked to the financial incentive are indicated in bold.

Table 8: CQUIN Compliance

Indicators (indicators that are linked to financial inestive in BOLD)	Threshold	Q1	Q2	Q3	Q4
CCG1: Flu vaccinations for frontline healthcare workers (Immform)	Minimum: 75% Maximum: 80%	Whole period reporting in Q4	Whole period reporting in Q4	Whole period reporting in Q4	61%
CQUIN02: Supporting patients to	Minimum: 70% Maximum: 80%	62.03%	52%	Not currently available	Not currently available

Indicators (indicators that are linked to financial inestive in BOLD)	Threshold	Q1	Q2	Q3	Q4
drink, eat and mobilise (DrEaMing) after surgery					
CQUIN03: Prompt switching of intravenous to oral antibiotic	Minimum: 60% Maximum: 40%	22%	16%	9%	8.91%
CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions	Minimum: 10% Maximum: 30%	49.15%	37.5%	44%	63%
CQUIN11: Achieving high quality Shared Decision Making (SDM) conversations	Minimum: 65% Maximum: 75%	Written update	91%	Written update	89%

Indicators (indicators that are linked to financial inestive in BOLD)	Threshold	Q1	Q2	Q3	Q4
CQUIN12: Assessment and documentation of pressure ulcer risk	Minimum: 70% Maximum: 85%	70.52	20%	27%	48%
CQUIN04: Compliance with timed diagnostic pathways for cancer services	Minimum: 35% Maximum: 55%	19.09	22.52	Late submission not admissible to national portal 39%	33%
CQUIN05: Identification and response to frailty in emergency departments	Minimum: 10% ,Maximum: 30%	17.89%	19.26%	35%	67%
CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge	Minimum: 0.5% Maximum: 1.5%	3.76%	3.10%	3.70%	Q4 data not available yet but the Trust YTD aveage referral rate at Jan 2024 is 4.64%

Indicators (indicators that are linked to financial inestive in BOLD)	Threshold	Q1	Q2	Q3	Q4
Medicines Service					
CQUIN10: Treatment of non small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Minimum: 80% Maximum: 85%	90%	64%	93%	86%

Overview

Flu vaccinations for frontline healthcare workers

The CQUIN specified flu vaccination uptake statistics are reported via ImmForm, taken from our local point-of-care system, Vaccination Track. This is reporting 61% compliance.

The regional and national NHS England teams have been monitoring this year's data via Foundry, which collates vaccination data from various NHS reporting software (like NIVS). Unlike ImmForm, Foundry does not consider whether staff have received the vaccination elsewhere (for example, their GP)) but will still match it against the Trust's Employee Staff Record (ESR) profiles. Foundry often gives a higher vaccination record as a result. Foundry is reporting 64.4% for the total Trust staff population and 64.8% for Frontline staff in April 2024.

Supporting patients to drink, eat and mobilise (DrEaMing) after surgery

Due to demands on the ward it has not been possible for data collection to be undertaken in Q3 and Q4.

Prompt switching of intravenous to oral antibiotic

Compliance is defined as achieving 40% or fewer patients still receiving IV antibiotics past the point at which they meet the switching criteria. The lower % = better performance. Several

actions to improve and embed good practice were undertaken such as presenting to senior surgical nursing team, teaching sessions to junior doctors and IVOS reminder on workplace.

The Medical Division accounts for the highest non-compliance in Q4. Compliance by ward has been analysed, one ward has initiated an improvement cycle to improve compliance.

The Surgical Division has improved the IVOS rate in Q4 and work continues to maintain compliance.

Recording of and response to NEWS2 score for unplanned critical care admissions
A continuation of the CQUIN from 2022/23, this scheme encompasses a broader remit in 2023/2024 which includes evidence of management plans and time of clinical and senior clinical response in line with RCP guidelines. The improvements are linked to: the roll out of call for concern and the implementation of the resuscitation huddles

Achieving high quality Shared Decision Making (SDM) conversations
The initiative has sustained high satisfaction responses from patients across two quarters.

Assessment and documentation of pressure ulcer risk
The CQUIN is based on the initial pressure ulcer risk assessment being carried out within 6 hours of admission and then if found to be at risk, the subsequent care plan and its elements being implemented. A steady improvement in each of the CQUIN criteria has been noted. The Tissue Viability Team continue to offer pressure ulcer prevention training, and support with ward based training sessions.

Compliance with timed diagnostic pathways for cancer services
This CQUIN relates to the following pathways:

- **Colorectal:** Endoscopy capacity is planned to increase in the summer 2024 following expansion of the existing recovery space. Furthermore, from Q2 there are plans to move the straight to test colonoscopy service to Sulis hospital to provide greater capacity in the pathways which will help move closer to routinely delivering colonoscopy within 14 days of referral.

- **Prostate:** There are no specific changes to the pathway planned, focus is to aim to achieve 28 days through the current pathway.

- **Lung:** Increased ring-fenced CT capacity is planned to reduce the waiting time.

- **Oesophago-gastric:** Endoscopy capacity is planned to increase in summer 2024 following expansion of the existing recovery space. Continued use of nasal OGD to better manage total endoscopy capacity.

- **Gynaecology**: Employment of a Gynaecology Cancer Diagnostic consultant is supporting a reduction in waiting time to first appointment.

- **Head & Neck:** Current radiology and consultant capacity make improving against this target very challenging.

Identification and response to frailty in emergency departments
The uplift in identification follows the introduction of the compulsory identification tool within the ED nurses triage bundle by the Frailty Flying Squad Lead Advanced Clinical Practitioner. The Trust has moved from being a national outlier, only identifying 1% of patients within 30 minutes, and only 41% of all frailty admissions, to 92% identification within 30 minutes of arrival just within Q4.

Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
A continuation of the CQUIN from 2022/23, The Trust continues to lead in our rate of referrals via the Discharge Medicines Service. The Trust's rate of referrals is considered to be higher than the data published by NHS England and the Trust lead is working with NHSE to review the process.

Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway
The Trust has achieved an overall performance against the CQUIN target for 2023/24 of 83% which is within the expected range.

2024/25 CQUINs
The CQUIN scheme will be paused during 2024/25 pending the outcomes of a wider review of quality incentives. During the pause NHS England have made available a list of non-mandatory indicators that can be used by systems if they wish to operate a 'CQUIN-like' scheme locally in 2024/25. Whether to use these will be for local negotiation between commissioners and providers. Currently there is no proposal for the Trust to undertake this.

ExCEL Ward and Outpatient accreditation programme

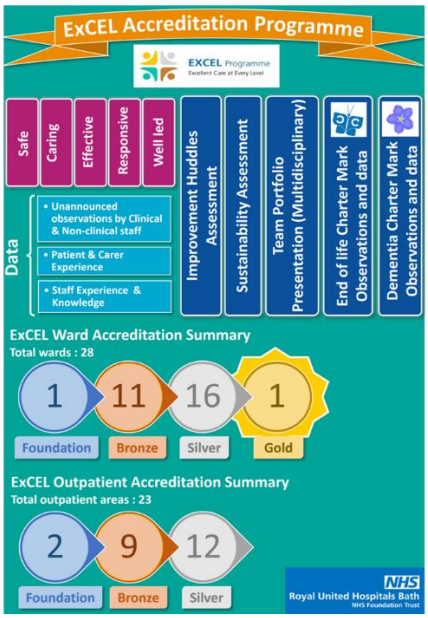
The ExCEL (Excellent Care at Every Level) Ward and Outpatient Accreditation programme is designed to acknowledge and incentivise high standards of care and reduce variation in practice at ward and departmental level within the RUH. It provides assurance that the Care Quality Commission (CQC) standards are adhered to and helps assess the quality and safety of our services.

Wards and departments are assessed against a number of Key Performance Indicators (KPI) for quality and safety, using information gathered from information routinely collected, such as the Nursing and Midwifery Peer Audit Programme, and observations of care, staff and patient interviews. The indicators used within the programme are developed in consultation with clinical staff and reflect CQC requirements and Trust priorities.

The assessment takes a tiered approach with wards and departments being assessed at Foundation level initially, followed by Bronze, Silver and Gold. Progression through each level is recognition of increasing performance over a sustained period of time. Silver and Gold level includes a charter mark for End of Life care and Dementia care. In 2024, the first clinical area has been assessed and achieved Gold level which is a huge step in the programme and recognition of the exceptional standard of care provided. The dedication and drive of the multidisciplinary team on Helena ward is recognised and they have embraced this assessment that took place over a number of months.

The accreditation programme increases knowledge of key standards of quality and safety that wards and outpatients should adhere to. Where these standards are not met, support is provided to the wards and outpatient departments to improve performance so that they can achieve the necessary requirements for accreditation and improve the quality and safety of the services they provide.

ExCEL Accreditation infographic



Compliance with the Care Quality Commission

The Trust is compliant with the registration requirements of the Care Quality Commission (CQC) and is registered with no conditions applied.

During 2023-24 the Trust received inspections of the Medicine, Surgery and Maternity core services and Radiotherapy.

Medical care (including older people's care) inspection

The CQC undertook a focused unannounced inspection of the Medicine core service in July 2023. The inspection covered the Safe and Well Led Key Lines of Enquiry. The CQC published the inspection report on 18 October 2023 giving a rating of 'Requires Improvement' for Medicine

The CQC inspection report praised the outstanding programme provided by the Trust for its international nurses in terms of education and pastoral care. The Trust was promoted as a great place to work and to advance careers which led to a successful retention rate of international nurses. The CQC found the service had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The CQC recognised the skills and abilities of our leaders to run services and they were seen as visible and approachable for patients and staff. The Trust had a vision for what it wanted to achieve, and a strategy created in partnership with relevant stakeholders. The CQC also noted the positive culture for reporting and managing patient safety incidents and the work being carried out to further improve safeguarding.

However, the CQC identified a number of improvements that the Trust needs to make in order to comply with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). These include improving monitoring of risks to patients, such as through the completion of fluid charts, improving governance and risk systems to monitor the quality and safety of services, ensuring the appropriate recording of controlled medicines, and ensuring the premises and equipment are properly maintained. An improvement plan was put in place following the inspection, and progress in implementing the actions from this plan is being reviewed through the Trust Quality and Safety Group on a quarterly basis.

Maternity inspection

The CQC carried out a short notice announced inspection of Maternity in November 2023, looking at the Safe and Well led key lines of enquiry, as part of the CQC national maternity inspection programme. The inspection report was published on 27 March 2024 and the service retained its 'outstanding' rating. Inspectors found examples of outstanding practice relating to the Trust's commitment to continuously improving services, patient experience and the supportive environment provided for staff. The development of a maternity and neonatal communication plan to improve engagement with staff was noted as 'outstanding practice', as was the Maternity Development Panel, which supports staff to develop their own projects and ideas to further improve the care we provide for our community. The CQC also noted that the service ran a forum with doulas, antenatal workers, hypnobirthing teachers and other professionals working with women and birthing people in the community to open channels of communication and to work collaboratively on providing personalised care and support.

Community Birth Centres in Frome and Chippenham were also included in the inspection, with both centres receiving an overall 'good' rating. Inspectors recognised the community teams' commitment to continually learning and improving services, including several initiatives to tackle health inequalities and the ongoing quality improvement projects facilitating women and birthing people's choice of birth place.

Radiotherapy

The CQC carried out an announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the radiotherapy service on 21 February 2024. The Trust is awaiting a copy of the final inspection report from the CQC. The Trust is not rated for this inspection and the CQC does not publish IR(ME)R reports on their website although they may include some details from the inspection anonymously in an overall annual report.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

Surgery

The CQC undertook an unannounced inspection of the surgical core service on 20 March 2024. This was a focused inspection carried out under the new CQC Single Assessment Framework which looked at elements of safe, effective, caring and well-led. The Trust awaits the draft report.

Annexes

Letters of Assurance

The following were all invited to comment and provide assurances on the content of the Royal United Hospitals Bath NHS Foundation Trust Quality Account 2023/23:

- BaNES Swindon and Wiltshire Integrated Care Board
- Bath and North East Somerset (BaNES) Council Overview and Scrutiny Committee
- Wiltshire Council Overview and Scrutiny Committee
- Healthwatch BaNES
- Healthwatch Wiltshire

Copies of the responses received have been attached in this Appendix, along with a Directors' Responsibilities Statement which has been signed by the Chair of the Hospital and the Chief Executive.

Annex 1 – Statement from Healthwatch Bath and North East Somerset

Annex 2 - Statement from Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Annex 3 - Statement from Wiltshire Council Health Select Committee

Annex 4 - Statement of Directors responsibilities for the Quality Account