Quality Account
2017-18

This Quality Account covers the period 1 April 2017 to 31 March 2018 2017-18
Part 1: Chief Executive's Statement

The Board of Directors is committed to providing services of the highest quality, that are patient centred, accessible, support recovery and maintain good health. We work closely with service users, their carers, our partners in other agencies and third sector colleagues to deliver integrated care in the right place and at the right time by staff with the right skills.

The Trust values: Everyone Matters, Working Together, Making a Difference are at the core of everything we do for our patients, and represent our aspiration for the type of hospital we strive to be.

The Trust identifies a series of quality priorities each year, and I am pleased to report that we made substantial progress against our quality priorities for 2017/18 as described in the accounts below.

The Trust is also proud to have been nominated for a number of awards in 2017/18 which reflect the commitment of our staff to the highest quality of care. This has included:

- The Eye Unit being nominated for the Macular Society Awards for Excellence in the Clinical Service of the Year category;
- The “Frailty Flying Squad”; a pioneering specialist team of doctors, nurses and therapists at the Trust, was shortlisted for a national nursing award in the Care of Older People Category;
- The Trust has been shortlisted in four categories for the finals of the Health Services Journal Patient Safety Awards 2017, recognising our work in patient safety improvement methodologies and innovative multidisciplinary training methods; and
- Three of our staffs’ innovation projects made the final stages of the British Medical Journal Awards.

Technology will transform the way that care is delivered in the future. In 2017/18, we introduced several new elements to our electronic patient administration system, including new processes for prescribing medicines, ordering radiology and pathology tests and a new system for our Emergency Department which allows better integration with other systems across the Trust. These upgrades will allow our staff to work in a more seamless manner, and improve the quality of care experienced by our patients.

Like many other acute trusts this year, we have been facing huge pressures on our Emergency Department with increasing admissions and an aging population, as well as experiencing the impact of reduced capacity within local adult social care, which has meant many of our older patients have remained in hospital for longer while awaiting care packages in the community. We remain committed to delivering high quality safe care to our patients at all time, and we recognise the impact that periods of continued pressure have both on our patients and staff. I would like to take this opportunity to thank our staff for their dedication and support throughout the year.

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

Signed:

James Scott
Chief Executive
22 May 2018
Part 2: Priorities for Improvement and statements of assurance from the Board of Directors

2.1 About Royal United Hospitals Bath NHS Foundation Trust

The Royal United Hospitals Bath NHS Foundation Trust (the Trust) primarily provides healthcare services to around 500,000 people across Bath and North East Somerset, Western Wiltshire, Mendip and South Gloucestershire. We deliver healthcare from a number of locations including operating a busy district general hospital on the north western side of the City of Bath and the Royal National Hospital for Rheumatic Diseases (RNHRD) in the centre of Bath, as well as services in multiple community locations.

The Trust provides around 760 beds, a comprehensive range of acute services, including medicine and surgery, services for women and children, accident and emergency services, and diagnostic and clinical support services. These services are provided by the approximately 5,200 staff employed by the Trust.

The Trust, in partnership with local Universities and Colleges, also plays a significant role in education and research. Doctors, nurses and many other healthcare professions have been with us as students and have stayed with us as qualified staff. This focus on learning supports innovation and improvement in the excellent care provided for our patients.

2.2 Why are we producing a Quality Account?

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

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

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

For 2017/2018 we set 4 quality account priorities under the categories of safe care, effective care and patient experience. This Quality Account will explain why we chose these priorities and will summarise how we have performed against them and any improvements we have made.

2.3 How do we improve Quality?

The Trust has a clear ambition to be recognised for delivering the highest quality of care. To achieve this patient safety and quality have to be at the heart of everything we do, with our staff able to provide safe and compassionate care to every patient, every time.

At the RUH we are developing our staff to have core quality improvement skills and knowledge through the use of practical tools in the delivery of service improvement and redesign. Our aim is to build an organisational culture of continuous quality improvement where we support all our staff to have the right skills and tools to support them to make changes. In order to achieve this, our goal is to become a learning organisation in which every member understands and is committed to the part they can play in delivering quality, every day.
We have continued to develop and build on our approach of how we support and develop our staff in spreading quality improvement and service improvement knowledge and skills across the organisation to support our quality strategy. We have two different systems to deliver this knowledge.

- **Quality Service Improvement Redesign (QSIR) course** which is a quality improvement training programme: designed and developed by NHS Improving Quality (NHSIQ) – Advancing Change and Transformation (ACT) Academy. A consultant and senior nurse, who are both quality improvement leads within the RUH, are accredited associate members of the NHS Improvement QSIR teaching faculty which enables them to deliver the QSIR training within the Trust. This course is available to any member of staff across the organisation that is involved in delivering quality or service improvements. It aims to develop core quality improvement skills and knowledge, which staff can practically use within their chosen projects. A comprehensive 4 day course or one day introductory course are available. To date the Trust has delivered the QSIR Practitioner training to over 100 staff and supported over 50 improvement projects. This has increased the capability within the trust to deliver successful change, and those staff members who are trained QSIR practitioners are now supporting other staff members with their projects.

- **The second approach** is Flow coaching, which teaches staff how to apply team coaching and improvement skills along one patient’s journey in order to improve patient flow through a healthcare system. Following successful trials at Sheffield Teaching Hospitals NHS Foundation Trust and South Warwickshire NHS Foundation Trust, the Health Foundation has expanded the programme and established a Flow Coaching training centre at the RUH. This presents a unique opportunity for providers across the West of England to participate in the training programme being delivered during 2017. The Trust has six fully trained flow co-coaches and from January 2017 has been delivering training for a local cohort of staff each planning to undertake a programme of improvement across a patient journey.

To support these programmes and our aim of building an organisational culture of quality improvement, the RUH has established a Quality Improvement Centre (QIC), which brings together teams from Patient Experience, Audit, Risk and Litigation as well as Patient Safety and Quality Improvement. These teams offer a wide range of skills including leadership, stakeholder and staff engagement, clinical and nursing, training, research, education, clinical audit, project management, data analysis and administrative support. Individuals and teams from all parts of the trust are supported by the QIC. The teams within the QIC work with patients, carers and members of the public as well as staff from all parts of the hospital on specific projects to improve the quality of care provided to patients and their relatives / carers.

Finally, the work we are doing on our quality improvement journey is supported by our Trust values; Everyone Matters, Working Together, Making a Difference, which set out values and behaviours which truly make a difference to our patients, carers and staff and guide us as to how we can work together and how we can keep improving.

### 2.4 Patient Safety Priorities 2017/18

The Trust is committed to providing safe and compassionate care and we have established a culture of improving patient safety through our patient safety priorities. The Trust patient safety priorities are set out in our patient safety triangle and consist of our 5 top patient safety priorities and 4 executive sponsored patient safety priorities.
Each patient safety priority has an established clinical leader, and an executive sponsor, who are responsible for setting the work-plan with agreed process and outcome measures. These are reported to Quality Board, which is chaired by the Medical Director, and to the Board of Directors.

The Trust actively participates, contributes and is leading some of the work aligned to the West of England Academic Health Science Network (WEAHSN). The RUH is fortunate to host the WEAHSN Network. The WEAHSN is managed by a Partnership Board which includes representatives from the other AHSN member organisations. The WEAHSN patient safety collaborative is chaired by our Chief Executive and the Director of Nursing and Midwifery is the Trusts representative which helps to ensure we can align the Trust’s patient safety priorities to national priorities and we benefit from collaborative working.

For 2017/18 the 5 Safety Priorities were:

- **Falls**

  In June 2017 a multidisciplinary Trust wide falls improvement programme was launched, aimed to ensure staff implement the falls prevention pathway. The improvement programme included a revised electronic falls risk assessment, introduction of a post fall assessment including SWARM (a rapid multi-disciplinary review after a patient has a fall to ensure all interventions are in place, to keep the patient safe), introduction of Enhanced Observations and a standardised process to review cognitive impairment and record the patients lying and standing blood pressure.

  The programme has achieved a 10% reduction in In-patient falls compared to 2016/17 as illustrated in table 1 and a 40% reduction in the number of patients who fall more than once as illustrated in table 2.

Table 1.

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of patients who fell more than once</th>
<th>Reduction (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2016 – February 2017</td>
<td>58</td>
<td>-</td>
</tr>
</tbody>
</table>

Executive Sponsors

1. Director of Nursing & Midwifery
2. Medical Director
3. Chief Operating Officer
<table>
<thead>
<tr>
<th>Period</th>
<th>Number of patients who fell more than once</th>
<th>Reduction (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2016 – February 2017</td>
<td>58</td>
<td>-</td>
</tr>
<tr>
<td>September 2017 – February 2018</td>
<td>35</td>
<td>40%</td>
</tr>
</tbody>
</table>

Table 2.

- **Clostridium difficile**

The Trust has been working to reduce the incidence of Clostridium difficile infection by using a number of strategies which are part of an overarching improvement plan. These strategies include improvement in antimicrobial stewardship, environmental cleanliness, prompt specimen collection and accurate documentation. The Infection Prevention and Control Team have also focused on increasing the number of staff who have received training in infection control over the last two years with an aim to reach the 90% attendance target. Progress against the improvement plan is monitored by the Trust Infection Prevention and Control Committee.

In January 2018 NHS Improvement were invited to revisit the Trust to support with the Clostridium difficile reduction work programme. The visiting team provided positive feedback and their recommendations will be used to further reduce infection rates.

The trajectory for Trust attributed Clostridium difficile infections was 22 cases in 2017/18. During the year there were a total of 31 cases reported however in 12 cases there was agreement by the Commissioners that these cases would not be counted within the trajectory as there were no lapses in care and are therefore not counted in the year-end total, resulting in 19 actual cases. At the time of writing this report there is another case awaiting agreement by Public Health England for removal from the trajectory.

- **Acute Kidney Injury (AKI)**

Over 2017/18, the AKI steering group have focused on decreasing the incidence of AKI occurring during a patient’s hospital admission. The focus has been on increasing awareness through continued education, as well as active improvements to keep a close monitor of a patients urine output when patients are recovering from an acute illness, and if they require investigations and medications that increase the risk of an AKI when they are unwell. Several improvements have been implemented which are now established and have resulted in decrease from 48% to 36% in the incidence of patients developing AKI during their time in hospital.

Work has also been undertaken to ensure adequate information is relayed back to the GP following identification of an AKI.

- **National Early warning Score (NEWS)**

The aim of the National Early Warning Score (NEWS) work stream is to ensure that NEWS is reliably and accurately used when monitoring adult patients’ vital signs, for example blood pressure, pulse and respiratory rate, that care is appropriately and reliably escalated and correct actions are taken to ensure optimal care for the patient.
The focus for the NEWS work stream has been on the completion and accuracy of NEWS reporting with the aim to achieve 95 per cent compliance in recording and accuracy of NEWS in all adult patients at the Trust. A key aspect has been developing the cascade trainer model and over 100 cascade trainers have trained over 80% of nursing and therapy staff. Measurement of recording and accuracy Trust wide demonstrates a sustained NEWS recorded 98 per cent and NEWS accuracy 90 per cent. A Deteriorating Patient proforma has been developed by joint working with the Sepsis and AKI working group under the umbrella of the Deteriorating Patient work plan. This will be launched as part of the Deteriorating Patient campaign, planned for April 2018, which will further align the work in these 3 areas. A NEWS e-learning package is being developed and a model for a combined Deteriorating Patient team/ Champion role in all wards and departments.

- **Sepsis**

This is also a CQUIN and Quality priority. See Part 3, review of services, clinical effectiveness and National CQUIN schemes for 2017/18 for details.

### 2.5 Quality Account Priorities 2017/2018 and 2018/2019

Choosing our Quality Account priorities is important to us and our aim is to ensure the chosen priorities are ones which will make a real difference to our patients.

We engage with our staff, the Governor Quality working group, the Trust’s Council of Governors, the Patient and Carer Group, the Board of Directors, and our Clinical Commissioning Groups to determine the priorities. We agreed 4 priorities and for each priority, we outline below why it is important to us as a Trust and for our patients, and identify specific indicators we aim to achieve and how progress will be measured. Our priorities for 2018/19 focus on improving pathways of care and ensuring we are continuously listening and learning and making improvements as a result of our patient feedback. The Governors Quality working group and Patient and Carer group were particularly keen to endorse and support taking forward learning from patient feedback as a priority.

The next two sections will set out our progress against the 4 Quality Account priorities chosen for 2017/2018 and describe the 4 priorities agreed for 2018/2019. The Quality Account priorities and the progress will continue to be monitored through Quality Board, which is chaired by the Medical Director.

### 2.6 Priorities for improvement – looking back over last year

**Overview 2017-18**

<table>
<thead>
<tr>
<th>Priority</th>
<th>Aim</th>
<th>Achieved</th>
<th>Part achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 1</td>
<td>To further promote a system of identification and proactive management of patients who are identified as having the presence of frailty</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Priority 2</td>
<td>Management of jaundice in babies</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Priority 3</td>
<td>To continue to improve the experience of patients and carers at discharge</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Priority 4</td>
<td>To continue to improve sepsis management</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Priority 1: To further promote a system of identification and proactive management of patients who are identified as having the presence of frailty

What: We said we would do:

- Launch the revised Medical Assessment Proforma incorporating frailty score and Comprehensive Geriatric Assessment (CGA).
- Roll out CGA documentation to all Older Persons wards.
- Ensure CGA is present on the letter that is sent to the patients’ GP on discharge, from the wards where this has been implemented, if the score is 5 or more.
- Implement a direct admission pathway from the Emergency Department to the Assessment and Comprehensive Evaluation unit for individuals that need minor intervention and short-term rehabilitation.
- To reduce harm and improve the experience of frail people in the hospital setting.

By When: April 2018.

Outcome: Did we achieve what we said we would? Yes

As at the end of February 2018:

- 82% of patients aged 75 and over with a frailty syndrome admitted under Medicine are screened for frailty.
- 96% of patients with a frailty score of 5 or more had CGA completed on discharge summary.

Why is it important?

People who have frailty are at a much greater risk of falling, confusion, disability, admission to hospital and long-term care depending upon its severity. However frailty is not static, it can get worse, but it can also get better. This is one of the reasons that it is vitally important that frailty is assessed whenever an older person comes into contact with a health professional.

Identifying frailty and assessing the severity of the condition helps the health care professional to holistically plan the patient’s immediate and ongoing care needs, and to promote the patient’s independence wherever possible. There is also a need to treat frailty as a long term condition in its own right and ensure we take a more comprehensive approach to the geriatric assessment.

Although not an inevitable part of ageing, frailty is related to the ageing process and is a long term condition in the same sense as diabetes or asthma. It is a term used to describe how our bodies gradually lose their in-built reserves, leaving us weaker and more vulnerable to dramatic changes in our health and wellbeing from minor influences such as an infection.

The frailty pathway, which incorporates the Rockwood frailty score and the Comprehensive Geriatric Assessment (CGA) have the potential to reduce harm and improve the experience of older people. The Comprehensive Geriatric Assessment ensures individuals level of mobility and independence are assessed on admission to ensure a seamless and safe transfer back to community.
What we did?

The first step was to implement the recording of frailty score if above 5 and completion of CGA on each patient’s discharge summary, across the Older Persons wards. During Quarter 1 (April – June) 2017/18 a roll out plan to implement the CGA across the Older Peoples Unit (OPU) was designed and led by a group of doctors, nurses, physio and occupational therapists, as demonstrated in the table below:

Table 1:

<table>
<thead>
<tr>
<th>Roll out plan for CGA &amp; CGA on discharge summary</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embed practice on ACE and Combe Wards</td>
<td></td>
<td>Implement on Midford and Waterhouse wards</td>
<td>Focus audits on Cheselden ward – this is a marker of embedding practice across the Older peoples Unit</td>
<td>Implement on Forrester Brown Ward</td>
</tr>
</tbody>
</table>

To monitor progress retrospective case note audits were conducted by clinicians. A total of 117 case notes were audited in September, October and November 2017 and the results are presented in the table below:

Table 2:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Screened for Frailty Target 75%</th>
<th>CGA on discharge summary Target 75%</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE</td>
<td>100% (31/31)</td>
<td>70% (14/20)</td>
<td></td>
</tr>
<tr>
<td>Midford</td>
<td>50% (15/30)</td>
<td>63% (5/8)</td>
<td></td>
</tr>
<tr>
<td>Combe</td>
<td>97% (28/29)</td>
<td>89% (23/26)</td>
<td></td>
</tr>
<tr>
<td>Waterhouse</td>
<td>78% (21/27)</td>
<td>65% (11/17)</td>
<td></td>
</tr>
<tr>
<td>Combined</td>
<td>81% (95/117)</td>
<td>75% (53/71)</td>
<td></td>
</tr>
</tbody>
</table>

Progress has been monitored on a monthly basis and reported to Quality Board on a quarterly basis.
Additionally a direct admission pathway has been established, between the Emergency Department (ED), Medical Assessment Unit and the Assessment and Comprehensive Evaluation Older peoples Unit (ACE). This reduces the number of transfers that each patient has whilst in hospital. The ACE co-ordinator actively seeks patients from ED and MAU transferring them back to ACE. Weekly performance is monitored through the Frailty Big Room meeting.

The implementation of the Frailty Flying Squad- a team of specialist therapists, nurse practitioners and a geriatrician has significantly increased ED to ACE transfers (bypassing MAU) from a median of 4 to 8 per week, since November 2017. This has peaked at 15 per week.

A further quality improvement project formulated by the Frailty Big Room, has resulted in the first patient directly admitted to ACE from a paramedic crew in March 2018.

How we will continue to work with this priority?

- Work will continue with the wards that are already using the comprehensive geriatric assessment to embed its use.
- We will also work with other adult wards to introduce the comprehensive geriatric assessment
- The Therapy team leads to monitor the use of the comprehensive geriatric assessment and increase its use
- The comprehensive geriatric assessment and frailty scoring tool (Rockwood Frailty Score) will be added to the RUH electronic patient record on 1st May 2018.
- We will continue to establish and embed the direct patient admission pathways to ACE.

What this priority means for patients?

The comprehensive geriatric assessment helps the doctors and therapist to produce a holistic plan of care for patients over the age 75, which can be tailor made to their individual requirements. This helps to promote the patient’s independence whilst in hospital, it can help to reduce the time the patient stays in hospital and can support the patient where appropriate to be discharged to their own home.
Priority 2: Management of jaundice in babies

What: We said we would do
Support a change in practice in the jaundice pathway to improve quality and experience for our mothers and babies through the use of non-invasive subcutaneous bilirubinometer screening in the community in place of serum blood testing at the hospital.

By When: April 2018

Outcome: Did we achieve what we said we would? Yes

Of the 4800 babies born within RUH Maternity Services 502 were screened in the community for suspected jaundice with the transcutaneous bilirubinometer (TSB). 61 (10.45%) were subsequently readmitted and treated in the period between April 1st 2017 and March 31st 2018. On average for the years 2015-2017 the number of babies readmitted and treated for jaundice were 118. The time and cost implications for staff is thus immeasurable. The introduction of TSB has not only reduced the volume of ward attenders for screening but has also significantly reduced readmissions to the acute unit for medical treatment of jaundice; this is most likely due to earlier screening with the TSB which enabled midwives to closely monitor these babies and implement earlier feeding plans without medicalising babies.

The introduction of bilirubinometers has:

- Reduced the number of babies required to be seen on Mary ward by a Midwife and junior neonatal doctor demand on Mary ward and the neonatal unit
- Released staff to deliver care – midwives, doctors and nurses
- Reduced cost in laboratory testing - using the point-of-care device saves time compared to measuring a serum bilirubin and reduces costs.
- Provided a smoother pathway for families and avoided the stress, anxiety and costs associated with testing in the hospital setting
- Reduced unnecessary hospital readmissions.

Why is it important?
Jaundice is one of the most common conditions that can affect new-born babies. It is estimated six out of ten new-born babies develop jaundice, this increases to eight in ten babies if born prematurely.

Neonatal jaundice is a normal physiological transition and usually harmless, typically resolving on its own after 10–14 days. In some babies however, there can be excessive levels of unconjugated bilirubin which if left untreated can cause death in new-borns or lifelong neurological impairment. Early recognition of neonatal jaundice by clinicians is paramount so that if treatment is required, it can commence with immediate effect.
Prior to April 1st 2017 the only way to diagnose jaundice in the new-born was for the baby to attend hospital where serum bilirubin levels were tested from a blood sample taken from the new-born’s heel. A family would spend up to 4-6 hours on the postnatal ward awaiting the result, either to be sent home with a feeding plan, or to be admitted for jaundice treatment.

NICE 2016 Neonatal Jaundice guideline states:

“Use a transcutaneous bilirubinometer (TSB) to measure the bilirubin level - if a transcutaneous bilirubinometer is not available, measure the serum bilirubin”

All babies with suspected jaundice were temporarily hospitalised, with families spending up to 6 hours on Mary ward whilst awaiting blood test results, when only a proportion required medical intervention. As a trust with four standalone birth centres, set within a large geographical area, it was imperative to provide a test that was deliverable in an equitable manner to all parents. It was hoped that the TSB’s would reduce emotional stress and extensive travel for parents and subsequently release clinical time in the acute unit.

What we did

The aim was to support a change in practice in the jaundice pathway to improve quality and experience for our mothers and babies through use of non-invasive subcutaneous bilirubinometer screening in the community in place of serum blood testing in the acute unit by April 2018.

A bilirubinometer is a handheld, portable and re-chargeable jaundice meter that is held against the forehead or sternum of the infant after a calibration with a ‘reflectance checker’ (colour pad). It allows a quick, non-invasive estimate of jaundice levels. It allows a single measurement of bilirubin or an average of up to 5 measurements.

Our aims for 2017/18 were:

- To reduce the need for babies and families to attend the hospital
- To reduce unnecessary blood tests
- To be able to detect jaundice earlier
- To provide more appropriate clinical care more quickly
- To reduce unnecessary admissions to the post-natal ward or Neonatal Unit (occasionally babies were admitted to the neonatal unit as the jaundice diagnosis was delayed in the community)

Benefits:

- Earlier and more accurate detection and treatment of jaundiced babies.
- Appropriate clinical care. The right babies in the right place at the right time.
- Reduction of women and babies transferring to an acute unit for further investigations.
- Reduction in stress and anxiety for families.
- Associated cost savings for these care pathways to families and Trust

In line with NICE recommendations and as part of the CQUIN to reduce term admissions to the neonatal unit this quality improvement was taken to the RUH innovation panel by a senior midwifery sister undertaking the RUH ‘Leading for Quality’ in house training. Funding for 5 bilirubinometers was obtained from the Innovation Panel and charitable funds. These were implemented in all 4 stand-alone birthing centres and on Mary Ward.
What this priority means for families

Non-invasive testing reducing possible pain for the neonate and stress for the family. Testing performed at home or in a local stand-alone birth centre.

Immediate result:

- Reduction of stress, anxiety and costs associated with testing in the hospital setting.
- Eliminate unnecessary hospital attendance.

How we will continue to work with this priority

We will continue the work already in place based on reducing risk factors to neonatal jaundice and identifying which babies are at risk. This includes:

- Improving communication and support with early and regular feeding patterns
- Proactively encourage mothers to express milk, whose babies are in the at risk groups.
- Data collection and audit will continue to monitor new pathway and assess if there is a reduction in babies requiring treatment for jaundice.
- It will be important to obtain staff and family feedback to obtain a view on the service change and quality improvement. This is planned for 2018-19.
- Analysis of the financial savings achieved.
Priority 3: To continue to improve the experience of patients and carers at discharge

What: We said we would do

- Improve the overall discharge experience for patients;
- Reduce delays when patients are waiting to leave hospital by having clear guidelines and plans in place;
- Provide a more timely discharge from hospital for patients who have had certain medical interventions and procedures.

By When: April 2018

Outcome: Did we achieve what we said we would? Yes

- We reduced the amount of time that patients had to wait in hospital after simple day case surgery.
- We launched the Home First discharge pathway
- We supported the rapid discharge home of patients nearing the end of their life with the Enhanced Discharge Service

Why is it important?

Significant improvements had been made in the discharge processes at the Trust during the previous 12 months. It was therefore decided to continue with this focus on patient discharge to continue to embed and build upon the processes already established.

Delays in discharging patients from hospital prolonging their stay within the clinical environment, can impact on patient safety, the quality of care and the patient’s experience. Criteria Led Discharge is a generic term which relates to criteria being agreed by the medical teams for the discharge of patients from hospital, which nurses, physiotherapists and occupational therapist can use to speed up the discharge process. There has been a national drive to implement Criteria Led Discharge within the NHS, in an attempt to reduce the time that patients wait to be discharged home. Reducing the patient’s length of stay gives us an opportunity to improve the patients experience and their journey through the hospital whilst also ensuring a more timely discharge from hospital.

What we did:

Criteria Based Discharge

The introduction of the discharge planning checklist on the Millennium electronic patient record (computer system) has provided some structure around the discharge planning process. Additionally this has enabled the capture of data to inform areas to consider for inclusion within the programme of Criteria Led Discharge.

During the last 12 months we have introduced Criteria Led Discharge to our surgical short stay unit and the Chair Port (an area with reclining chairs for patients undergoing day case procedures). We have provided training for staff within the unit to enable them to confidently discharge patients, when a medical review is not required.
With executive sponsorship the team contributed to the national Criteria Led Discharge collaborative, initiated by NHSi. This allowed networking opportunities with other Trusts across the country, and the chance to showcase the work undertaken at the RUH.

We have worked with patients to collect their experience of being discharged from the Surgical Short Stay Unit and the chair port. This has informed our practice. The overall feedback has been positive as patients no longer have to wait for medication to be prescribed and dispensed or a final review by one of the medical teams.

Home First

Home First (HF) is a collaboration between the RUH and BaNES, Wiltshire, Somerset and South Gloucestershire community partners. It was launched in May 2017 and is becoming more embedded in the hospital discharge pathways. It is the name of the discharge pathway for patients who

- are medically fit but need additional support at home
- can go home to a usual place of residence (home/ residential home)
- are safe between visits and have no night needs

The aim is for patients to be discharged the following day and visited in their home within hours of discharge by a community therapist. The therapist will assess the patient’s needs and set up a re-ablement care plan for the patient. Examples of benefits are:

- Assessment of daily living activities in an environment familiar to the patient
- More accurate assessment of patients’ long-term care needs
- Increased independence
- Improving patient flow through hospital aiming for a decrease in length of stay
- Reduction in risks associated with prolonged hospital stay
- Help to avoid patients having to make major life decisions about long-term residential or nursing care at a point of crisis in the acute hospital environment

This initiative recognises that for some patients whose clinical needs have been met and who need some extra support with their day to day living, the best place to undertake the assessment of those needs is within their own home environment. In order for this to work efficiently it is essential that patients are discharged as early in the day as possible and certainly before lunchtime.

Alongside the Home First pathway is Home First transport. It is a transport solution with capacity to support up to 20 of our weekly Home First patients discharged. Home First transport is to be used when friends and family or Age UK (BaNES) are not able to take a patient home. All Home First transport patients have left the ward by 11:00. Having access to Home First transport supports consistency and momentum for Home First discharge pathway and helps to deliver Home First to its maximum effect.
Table 1 below demonstrates the numbers of patient taken home each month with Home First transport.

Table 1:

<table>
<thead>
<tr>
<th>Month</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home First Transport:</td>
<td>0</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>50</td>
<td>60</td>
<td>50</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

CHC Fast Track and End of Life Care

Choice and preferences for care are integral to the service improvement around discharge planning. In the last year the Trust discharge project board workstream for Continuing Health Care (CHC) Fast Track and End of Life Care supported:

- Development of a guidance and electronic checklist to support patient centred discharge planning in end of life care
- Review of patient and carer information leaflet ‘Discharge to Preferred Place of Care’
- Review of the bundles of information for each CCG on the Trust intranet, to support discharge through CHC Fast Track
- A Supportive Care Model, using the stages of decline for end of life care, to support proactive and coordinated patient centred care

Developing new models to support discharge planning

The Trust has worked with partner CCGs to support improvements in discharge planning to preferred place of care at the end of life. An example is the Enhanced Discharge Service.

Enhanced Discharge Service (EDS) with Dorothy House Hospice Care (DHHC) supports patients from Wiltshire, BaNES (from June) and Somerset (from Nov). The EDS supports rapid discharge home to preferred place of care in the last 4 weeks of life, with a package of care through the DHHC hospice at home service. The care package can be for up to 24 hours of care. The EDS initiative has supported ‘same day’ or ‘next day’ discharges for 93 patients, from April 2017 to February 2018. Average length of stay on EDS has been 14 days for these patients.

The EDS has enabled a discharge to assess model for patients nearing the end of life and requiring a package of care at home. In the last year EDS has supported patients to be discharged home rapidly for care at the end of life, without completion of CHC Fast Track application.
Table 3:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients supported with rapid discharge home with Enhanced Discharge Service</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

What these different discharge initiatives mean for our patients

**Criteria Led Discharge**

- The majority of patients leaving hospital post simple day surgery procedures, within 90 minutes of them returning to the ward without requiring admission to a bed.
- Those patients that have required a bed are able to be discharged on the same day once they have met the established criteria.

**Home First**

- Medically fit patients who are fit to go home but require some additional help at home, have been supported to go home and have their therapy assessments within their own environment, which provides a more accurate assessment of long term care needs.

**Enhanced Discharge Service**

- Through the Enhanced Discharge Service and Dorothy House Hospice, a number of patients approaching the end of their life have been supported to have a rapid discharge home to preferred place of care in the last 4 weeks of life, with a package of care provided for by Dorothy House Hospice.

**How we will continue to work with this priority**

- Criteria Led Discharge: We will continue to work with elective orthopaedics to introduce Criteria Led Discharge as part of their enhanced recovery program. Work is underway within cardiology and gynaecology to implement the principles of Criteria Led Discharge. Once these pathways have been established we plan to explore other opportunities to introduce Criteria Led Discharge.
- Home First: We will continue to increase the number of Home First referrals and discharges and consider widening criteria to include delirium and non-weight bearing/fracture patients. We also aim to promote weekend discharges for Home First.
- End of Life Care and CHC Fast Track: Continue to work with partner organisations to streamline the CHC Fast Track process.
**Priority 4: To continue to improve sepsis management**

<table>
<thead>
<tr>
<th>What: We said we would do</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Deliver new Sepsis teaching to 2000 clinical staff</td>
</tr>
<tr>
<td>- Spread improvement work trust wide</td>
</tr>
<tr>
<td>- Screen 90% of at risk patients for sepsis</td>
</tr>
<tr>
<td>- Administer antibiotics within an hour to 80% of patients with sepsis</td>
</tr>
<tr>
<td>- Implementation of electronic recording of patients observations</td>
</tr>
<tr>
<td>- Develop patient information leaflets which are readily accessible to the public</td>
</tr>
<tr>
<td>- Present patient stories to the board</td>
</tr>
</tbody>
</table>

**By When:** April 2018

**Outcome:** Did we achieve what we said we would? **Partially**

- 2000 clinical staff received the training
- 76% of at risk patient were screened for sepsis
- 89% of antibiotics within 60 minutes for patients with Sepsis
- The national sepsis patient information leaflet is being used however a local leaflet is being developed
- Trust Board have heard patient stories about sepsis

**Why is it important?**

Sepsis is a serious condition which is common. In 2017 data was published showing that it affects more than 260,000 people every year with 44,000 people dying each year.

The recognition and early treatment of sepsis therefore remains a key focus for all health care providers. It is a national priority being driven by NHS England and a national CQUIN for 2017/18 and 2018/19.

Sepsis remains a key trust objective and one of the top 5 Trust Patient Safety priorities.

Over the last 3 years significant improvements have been made in identification and management of patients with Sepsis admitted to the RUH and our aim is to spread this improvement trust-wide, to improve outcomes for all patients, including children and maternity patients.

**What we did**

**Teaching**

Over 2000 clinical staff have received updated Sepsis training about the new NICE guidelines in 2017/8, through a number of methods. These include routine face to face training on core skills, simulation training and taking the training to staff on the wards in the form of the ‘Bath Tea-Trolley training. The ‘Bath Tea- Trolley training’ methodology has been acknowledged nationally and the approach was shortlisted in the Patient Safety Care Awards and HSJ Awards as well as the BMJ Awards in 2018.
Spreading our improvement work

The Sepsis team has 2 specialist nurses, enabling support to be available over an increased period of time, including evening and some weekends. The nurses focus on education and raising awareness as well as the management of patients with sepsis. They play a vital role in embedding the screening and management tools and continually seek to develop processes to further improve our management.

Emergency Admission Screening:

By March 2018 85% of adult patients at risk of sepsis were screened on admission to the Emergency Department.

Screening for children admitted at risk of sepsis has been developed over 2017 and by March 2018 has become well established with 80% of these children screened.

Inpatient Screening for Sepsis

Screening has been spread across the trust and shown significant improvement from 20% of inpatients screened to 75% of inpatients over 2017, however this is under target. Screening has also been introduced into maternity and paediatric practice with similar improvements. Since November 2017 over 90% of at risk paediatric inpatients have been screened.

Deliver 80% of antibiotics within 60 minutes for patients with Sepsis

Overall in 2017, 89% of patients with Sepsis received antibiotics within an hour from diagnosis

Specific improvements over 2017/18 are:

- Antibiotics administered within an hour to inpatients with Sepsis has improved from 29% to 80% patients
- 100% of mothers with sepsis have received antibiotics within an hour since October 2017. All have recovered well and none have required admission to critical care.
- Development of the paediatric action proforma has improved management of children with sepsis and all notes are reviewed to identify areas for learning and improvement, which has resulted in improved processes.

Patient involvement and information

Patient information leaflets from the UK Sepsis Trust are available on all wards and over 2017/18 an RUH specific leaflet has been developed which is being finalised using patient support. The Trust Sepsis Lead has also supported development of a patient support group in Bath, which held its first meeting in February 2018

Patients were involved in the World Sepsis Day event in September, with one giving a presentation on their experiences of sepsis.

A patient story was played to the Trust Board and the staff involved attended and were thanked by the Board of Directors for their exceptional care.

The story was of a gentleman who had deteriorated on the ward, several days after abdominal surgery and the change in his condition was picked up very early by the staff who followed the sepsis protocol exactly.

What this priority means for our patients

The nationally reported mortality rate for patients with sepsis is 20-30%. At the RUH the mortality figure is 16% for inpatients diagnosed with sepsis, and 18% for those patients admitted with sepsis.
Earlier diagnosis and prompt management of sepsis will also have resulted in a significant decrease in serious side effects from Sepsis.

**How we will continue to work with this priority**

- Continue to embed the screening and management tools in all areas
- E learning is being developed and will be available from August 2018.

### 2.7 Priorities for Improvement 2018/19 – Looking forward to this year

#### Priority 1: Transitional Care:

**What is the priority?**

Keeping mothers and their babies together on the postnatal ward and avoiding separation caused by unnecessary admission of babies to the Neonatal Unit.

**Why is it important?**

Some babies born a few weeks before or after the date they were expected or who are smaller in weight, need to be admitted to the Neonatal unit where the necessary services and staffing models are in place and as such babies are able to stay with their mums on the postnatal ward which can reduce the risk of harm caused by separation, and at the same time support early bonding and feeding.

**How are we going to achieve this?**

By providing services, clinical pathways and staffing models that keep mothers and babies together.

**How are we going to measure our achievements?**

Reduce the percentage of babies born a few weeks before or after the expected date of delivery admitted to the neonatal unit from 11% to 9% by March 2019.

**What it means for our patients?**

- Improved patient experience for both mother and baby
- Reduced harm caused through the separation of mother and baby
- Promotes early bonding and establishes feeding.

#### Priority 2: Reducing the waiting time for diagnostic tests

**What is the priority?**

Reducing the time taken to get diagnostic invasive procedures for inpatients who are not on wards that specialise in those procedures. This priority will look specifically at patients who are waiting for cardiac angiograms – a procedure to look at the arteries of the heart and also those waiting for endoscopies – where a camera is placed into the stomach.

**Why is it important?**

Patients can wait a long time to have some invasive diagnostic tests; this is especially the case if they are not being cared for on a ward that specialises in that clinical condition. Concentrating on these patients, who are waiting for either an angiogram or an endoscopy, we will be able to improve the timeliness of the test and reduce the total time that the patients spends in hospital waiting for the test.
How are we going to achieve this?

Patients waiting for cardiology and gastroenterology procedures would be selected
• Patients would be moved to their specialty wards i.e. the cardiac ward or the gastroenterology ward as early as possible
• Consultants and Medical Nurse Practitioners would be proactive in the management of ensuring these patients were in the correct beds
• Treatment would begin in a more timely manner

How are we going to measure our achievements?
• Reduction in the number of cardiac and gastroenterology patients not on a ward of that specialty
• The pathway for patients waiting for an inpatient angiogram who are not waiting on the cardiac ward will be improved with 100% of patients transferred to the cardiac ward within 48hrs.
• Patients waiting for an inpatient endoscopy who are not on the gastroenterology ward will receive their scope within 24 hours of the request.

What it means for our patients?
• Improved patient experience
• Improved timeliness of the test
• Reduction in the total time that patients spend in hospital waiting for a test.

Priority 3: Ensuring our patients with a fractured neck of femur go to theatre within 36 hours of admission

What is the priority?
The timing of treatment for patients who have sustained a fracture to their neck of femur (hip) remains one of the biggest challenges to a health care system. It is recognised that it is not only the time a patient takes to get to surgery that is important, but that the patient has to be medically as well as possible (medical optimisation), with the anaesthetic, surgical and theatre team being appropriately experienced. When planning any emergency care it is not always possible to predict the number of cases which can present, so any system which is set up must have the flexibility to adapt to the peaks and troughs of admissions.

Why is it important?
The timing of surgery is an early marker of a patient's progress following a hip fracture.

Patient who receive surgery within 36 hours are more likely to have improved outcomes post operatively. These include:
• Reduced Mortality
• Reduced length of stay
• Reduced complications including chest infections, pressure ulcers, change of residence and other surgical complications.
How are we going to achieve this?

The surgery does not stand alone. For the pathway to be safe and effective, timely surgery includes:

- Review and redesign of the patient pathway to reduce duplications and avoid unnecessary delays
- Expertise in diagnosis
- Ensuring that the patient is well enough to receive an anaesthetic and have an operation through medical optimisation

How are we going to measure our achievements?

Reduced mortality rate
Reduced length of stay of patients who have a broken hip
Reduced complications post-surgery, including chest infections, pressure ulcers, change of residence and other surgical complications

What it means for our patients?

- Improved experience
- Reduced time between admission and having hip fracture surgery
- Improved patient safety through early mobilisation reduces the risk of a blood clot forming in a vein (venous thromboembolism- VTE) and tissue damage

Priority 4: We will listen to patients and carers and use their feedback to improve services

What is the priority?

We will actively collect, use and share patient and carer experience feedback to improve services, quality of care and patient, family and carer experience.

Why is it important?

Using patient and carer experience feedback will:

- Develop a culture of continuous learning
- Improve patient and carer experience
- Improve services to meet the needs of patients and their carers

How are we going to achieve this?

We will be taking the following actions:

1. Pro-actively collect patient and carer experience feedback through a variety of real-time and post-discharge methods. E.g. national patient surveys, Friends and Family Test (FFT).
2. Develop the RUH electronic data entry system - eQuest to enable feedback to be collected and recorded electronically through the Trust website.
3. Support teams and individual staff to collect and analyse patient and carer experience as part of service review and service improvement projects.
4. Identify learning from patient experience feedback and use the information to improve services and patient experience. We will share the results, analysis and learning from this feedback across the Trust and the wider community.

23
How are we going to measure our achievements?

- Overall year on year improvement in national patient experience survey results
- Increase in service improvements made as a result of complaints. This information will be included in our quarterly patient experience reports.
- Increase in the number of services that have proactively collected and used patient feedback to improve patient, family and carer experience.

What it means for our patients?

- Improve patient and carer experience;
- Continuous development of hospital services to meet patients’ needs.

2.8 Statements of assurance from the Board of Directors

Mandatory Statement 1

During 2017/18 the Royal United Hospitals Bath NHS Foundation Trust provided and/or subcontracted eight relevant health services across three clinical divisions; Medicine, Surgery and Women & Children’s.

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.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Royal United Hospitals Bath NHS Foundation Trust.

Mandatory Statement 2

During 2017/18, 37 national clinical audits and 5 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 97% national clinical audits and 100% national confidential enquiries of the national clinical audits and 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 2017/18, 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.

<table>
<thead>
<tr>
<th>Clinical Audit / National Confidential Enquiries</th>
<th>participation?</th>
<th>% cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme: Perioperative diabetes</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Clinical Audit / National Confidential Enquiries</td>
<td>Participation?</td>
<td>% cases submitted</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Preview Programme: Acute Heart Failure</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Chronic Neurodisability</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Child Health Clinical Outcome Review Programme: Young People’s Mental Health</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme: Cancer in children, teens and adults</td>
<td>N/A</td>
<td>Eligible to take part, but no cases identified</td>
</tr>
<tr>
<td><strong>Acute</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Fractured Neck of Femur</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Major Trauma Audit 2986</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Intermediate Care (NAIC)</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Yes</td>
<td>97% (up to November 2017)</td>
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<tr>
<td>Pain in Children</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Procedural Sedation in Adults (care in emergency departments)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Blood and Transplant</strong></td>
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<td></td>
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<tr>
<td>National Comparative Audit of Blood Transfusion programme</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td>Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
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<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Head and Neck Cancer Audit (HANA)</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td>National Audit of Breast Cancer in Older Patients (NABCOP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Clinical Audit / National Confidential Enquiries</td>
<td>Participation?</td>
<td>% cases submitted</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Oesophago-gastric Cancer (NAOGC)</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td>Prostate Cancer</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td><strong>Heart</strong></td>
<td></td>
<td></td>
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<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Adult Cardiac Surgery</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Congenital Heart Disease – Paediatric cardiac surgery (CHD)</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
<tr>
<td>Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td><strong>Long term conditions</strong></td>
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<td></td>
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<tr>
<td>Endocrine and Thyroid National Audit</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td>Inflammatory Bowel Disease (IBD)</td>
<td>No</td>
<td>Database is being purchased to allow future participation in the audit</td>
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<tr>
<td>National Chronic Obstructive Pulmonary Disease Audit programme (COPD)</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td>National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
<tr>
<td>National Diabetes Audit – Adults (Footcare, Inpatients &amp; Core)</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
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<tr>
<td>Clinical Audit / National Confidential Enquiries</td>
<td>Participation?</td>
<td>% cases submitted</td>
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<tr>
<td>------------------------------------------------</td>
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<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK)</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
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<tr>
<td><strong>Older People</strong></td>
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<tr>
<td>Falls and Fragility Fractures Audit Programme (FFAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td>Sentinel Stroke National Audit Programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>UK Parkinson's Audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
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<tr>
<td>Elective Surgery (National PROMS Programme)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Bariatric Surgery Registry (NBSR)</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
<tr>
<td>Neurosurgical National Audit Programme</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
<tr>
<td><strong>Urology</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAUS Urology Audits: Cystectomy</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
<tr>
<td>BAUS Urology Audits: Nephrectomy</td>
<td>Yes</td>
<td>160 cases (2014, 2015, 2016 ongoing)</td>
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<td>BAUS Urology Audits: Percutaneous nephrolithotomy</td>
<td>Yes</td>
<td>33 cases (2014 – 2016 ongoing)</td>
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<td>BAUS Urology Audits: Radical prostatectomy</td>
<td>Yes</td>
<td>74 cases minimum (2014 – 2016 ongoing)</td>
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<td>BAUS Urology Audits: Urethroplasty</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
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<tr>
<td>BAUS Urology Audits: Female stress urinary incontinence</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
<tr>
<td>Clinical Audit / National Confidential Enquiries</td>
<td>Participation?</td>
<td>% cases submitted</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<td>------------------</td>
</tr>
<tr>
<td>Women’s &amp; Children’s Health</td>
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<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>National Maternity and Perinatal Audit (NMPA)</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td>National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)</td>
<td>Yes</td>
<td>100%</td>
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<tr>
<td>Paediatric Intensive Care (PICANet)</td>
<td>N/A</td>
<td>Not relevant to RUH</td>
</tr>
</tbody>
</table>

The reports of 35 national clinical audits were reviewed by the provider in 2017/18 and the Royal United Hospitals Bath NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- **Sentinel Stroke National Audit Programme (SSNAP).** The audit monitors performance across ten domains which include efficiencies with treatment, therapy input and discharge processes. Each of the domains receives an overall score, and is categorised into a level (A-E) as a way of grouping and comparing against other teams. This is ranked with A being the highest performing and E being the lowest. The audit findings from April to July 2017 show continued improvement with the audit standards. The total indicator level has risen from C to A, with performance rising to A for the overall patient-centred level and also improving from C to A for the team-centred level. Areas where further improvement is required include the percentage of patients directly admitted onto the Stroke Unit and patients being screened for nutrition and seen by a dietitian by discharge. It is anticipated that compliance with the audit standards will be improved by expanding the hours of Medical Nurse Practitioner coverage and ring-fencing the fifth trolley in the hyperacute bay. A new nursing lead for domain 2 of SSNAP is also proposed.

- **National Heart Failure Audit Report.** The audit identified a number of areas of good practice where performance is better than the national average. This includes admitted patients receiving an echocardiogram, input from Consultant Cardiologist, patients being admitted onto the Cardiology Ward, angiotensin-converting-enzyme inhibitor (ACEI) / Angiotensin receptor blockers (ARB), Mineralocorticoid Receptor Antagonists (MRA) and Beta Blocker on discharge. However, there were some areas for improvement which included patients receiving input from specialist referral to Heart Failure nurse and cardiology follow up. In order to address the shortfall dedicated heart failure follow up clinics are commencing which should resolve the deficiency in referrals to follow ups.

- **Third Patient Report of the National Emergency Laparotomy Audit (NELA).** The RUH is specifically mentioned within the Quality Improvement section of the report for managing to sustain quality improvement gains. The RUH performed better than the national average in 6 of the 9 key standards. There were 3 standards where the RUH was below the national average. These were patient arrival in theatre in timescale appropriate to urgency, preoperative review by a consultant surgeon and consultant anaesthetist when risk of death is greater than or equal to 5% and consultant surgeon and consultant anaesthetist present in theatre when risk of death is greater than or equal to 5%. Since August 2015 a multi-disciplinary working group have driven reliable implementation of the laparotomy bundle. This includes a 6 part bundle of care (now NELA standards). Since April 2017 over 80% of RUH
patients undergoing emergency laparotomy have received all parts of the care bundle. This has resulted in a decreased mortality rate from 10% to 6.5%. There has also been a decrease in length of stay for these patients by 2 days since relaunch of the bundle in August 2015. Many parts of the bundle have improved since the 3rd report and are now over 90% compliant, with improved time to theatre. Consultant surgeon and anaesthetist in theatre is now 70%, a slight improvement from the 3rd report. The Trust has a pathway in place that the case is discussed with the consultant if the risk is high and any support required is provided. All patients are discussed with an intensive care consultant regarding their postoperative intensive care and also with the consultant surgeon. This has not been captured in the NELA data collection in the past but is being captured in the most recent data collection from December 2017.

- National Audit of Dementia: The Trust performed better than the national average for Governance (involvement of hospital leads & Executive Board), discharge planning (looking at evidence of discussion about destination and support), assessment on admission, staff communication, carer communication and carer rating of patient care. The Trust was below the national average for nutrition. This looked at how hospitals organise and monitor nutritional needs for patients with dementia including protected mealtimes, the provision of appropriate foods and allowing carers to visit at all times. Key actions taken include the support for open visiting at mealtimes and these principles are included within the Welcome Guide. Discussions have been held with the Patient and Carer Experience Team to look at ways in which involvement of carers can be promoted. The governance processes for reporting on complaints will be reviewed so that key themes can be filtered to monitor whether there are any key issues being raised for patients with dementia.

- Royal College of Emergency Medicine (RCEM) Moderate & Acute Severe Asthma: The Trust performed better than the national average for ten standards and worse for five standards. An asthma trolley has been introduced in High Care with guidelines and equipment including a peak flow meter and spacer. Asthma Care continues to be taught as part of the Emergency Department Teaching programmes for both doctors and nurses. Asthma care for children and adults is planned to be re-audited in Autumn 2018.

- National Physiotherapy Hip Fracture Sprint Audit. 77% of patients were mobilised the day after their surgery compared to 68% nationally. Patients went straight home following discharge in 64.7% of cases compared to 48.6% of patients nationally. On average, patients received 93 minutes of therapy time in the first week following surgery compared to 118 minutes nationally. Innovative therapy and nursing posts have been developed to enhance access to routine therapy.

- The reports of 120 local clinical audits were reviewed by the provider in 2017/18 and the Royal United Hospitals Bath NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- Falls in Older People Audit: Overall, the completion of the falls care prevention care plan was graded as amber and could be improved. Specific areas for improvement included printing the name of the member of staff completing the care plan, time of completion of the care plan, falls prevention reassessment completed within the last 24 hours and discussion of risk of falls and preventative measures. This audit was part of the launch of the falls improvement programme. The standards will continue to be monitored by the Falls Steering Group on a monthly basis. Since this audit was undertaken, the falls prevention care plan has been amended and a post falls and SWARM care plan developed and introduced. The implementation of the revised documentation is just one part of the Falls Improvement Programme to reduce the number of falls across the Trust. A peer based audit is now undertaken to encourage ownership by the ward staff.
• Quality of Acute Oncology Service (AOS) Referrals; The audit results showed that most staff are aware of the correct method of referral and most of the referrals are relevant for AOS. However many staff are referring via bleep and these are not always recorded. There are still some inappropriate referrals or some that do not have a clear reason for referral to AOS. There are a large number of referrals/bleeps asking for advice about new diagnoses and this makes up a large amount of unrecorded workload. It is anticipated that changes to the referral system on millennium (our patient record system) so referrers have to include a reason for referral, more information about fitness, and level of input they want from AOS, will improve the quality of referrals. New guidelines for the referral of new diagnoses of Cancer of Unknown Primary and site-specific cancers will be provided. The quality of the AOS referrals will be re-audited in 2018 to assess the impact of these changes.

• Implementing the WHO safety checklist for invasive procedures in the Emergency Department; Compliance with the use of the WHO safety checklist in invasive procedures in the Emergency Department has increased from 42% for the period between December 2016 and March 2017 to 64% between June and August 2017. Recommendations that were implemented following the initial audit which contributed to the improved compliance included updating the various invasive procedures documentation, including paediatric sedation, publishing these results to the department, and including the audit in registrar and nursing departmental teaching. Further recommendations following the re-audit include continuing to educate emergency department staff and discussions with intensive care to consider altering the rapid sequence induction (RSI) safety checklist to include the WHO safety checklist.

• Risk Assessments and Nursing care plan - (Nursing and Midwifery monthly peer audit programme). The audit showed that whilst patient identifiers are well documented and the majority of the care plan sections were completed (for example falls and pressure ulcers) there were not always responses to individual questions within the care plan sections. Audit findings are disseminated to the wards through the Heads of Nursing, matrons and senior sisters and also published through audit posters on the wards. The Nursing Plan of Care document is currently being reviewed and updated to better reflect documentation requirements.

• Enhanced recovery process for elective caesarean; Two thirds of elective caesarean lists are currently in the afternoon and this can make it more difficult for the enhanced recovery process to be implemented. There are clear requirements for improved pre-operative processes to ensure minimisation of fasting and optimisation of pre-operative hydration (e.g. sugary drink). There is also a need for improved post-operative processes to allow earlier mobilisation, catheter removal and discharge. The plan is to change all elective lists to the morning as part of the first test of the enhanced recovery process. Internal processes will be developed within the Birthing Centre and Maternity wards to improve peri-operative practice in line with Enhanced Recovery After Surgery (ERAS) recommendations. Staff education about the ERAS process is taking place in Maternity. Patient information leaflets are also being developed to improve pre-operative preparation and information sharing.

• Picture Archiving and Communication System (PACS) audit into the use of marker balls in pelvic X-rays for patients with suspected neck of femur fracture. Current practice shows compliance with radiology guidelines has significantly improved in practice after our interventions since cycles 1 and 2 of the audit. Compliance has increased from 20% to 74%. As a result of the audit the teaching sessions were delivered at radiographers’ Continuing Professional Development (CPD) sessions and aide memoirs were developed and displayed in the Emergency Department and Radiology departments. Results of the previous audit cycle were also presented at the orthopaedic multi-disciplinary audit meeting. Further teaching of radiographers at their CPD sessions may help to increase compliance further, and it is
planned to introduce aide memoirs in the radiology department to remind radiographers of the policy at the time of obtaining the images.

**Mandatory Statement 3**

The NHS has a clear mandate from government that it should be committed to research at the heart of clinical activities. Trusts are charged with incorporating research to their plans and strategies. It is well evidenced that research active hospitals have better outcomes for all patients, regardless of whether or not they are directly involved in research.

It is the ambition of the RUH to give as many patients as possible the opportunity to be involved in research and to have access to treatments that would otherwise not be available to them.

The number of patients receiving relevant health services provided or sub-contracted by the Royal United Hospitals Bath NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 2185.

This represents an increase compared to the previous year of over 20%. As well as increasing the number of patients participating in research in 2017/18, there has also been an improvement in other research metrics around efficiency of opening new studies and achieving individual study targets. At the time of publication, there are 300 trials open with patients being treated or attending follow up visits, representing a caseload of over 3,000 patients receiving care or treatment as part of a research study.

Research initiated and run by our own consultants, allied health professionals and nurses remains a priority and continues to flourish. Many of these projects are in collaboration with the Universities of Bath, Bristol and West of England. Our researchers hold Professorships and lectureships in those institutions from clinical areas as diverse as Anaesthesia, Rheumatology, Chronic Pain Management, Ageing, and Parkinson’s Disease.

The following grants were awarded to Trust researchers in 2017/18:

**RUH Grants awarded 2017-2018**

<table>
<thead>
<tr>
<th>Awarded to</th>
<th>Study</th>
<th>Amount and detail</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Raj Sengupta</td>
<td>COMPASS - Can outcome measures predict AS Severity</td>
<td>£54,664.28 - Novartis</td>
<td>April 17</td>
</tr>
<tr>
<td>Dr Raj Sengupta</td>
<td>Whiteswan – Grant for AxSpa interface</td>
<td>€66,489.04 Euros - UCB</td>
<td>June 17</td>
</tr>
<tr>
<td>Sally Tedstone</td>
<td>Does Osteopathic treatment of infants with tongue function difficulties improve breastfeeding outcomes</td>
<td>£29,887 – General Nursing Council</td>
<td>June 17</td>
</tr>
<tr>
<td>Name</td>
<td>Project Description</td>
<td>Funding Details</td>
<td>Date</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Professor Neil McHugh</strong></td>
<td>Nail Psoriasis data project</td>
<td>£35,000 – Abbvie</td>
<td>July 17</td>
</tr>
<tr>
<td><strong>Sandi Derham</strong></td>
<td>Clinical Academic Careers Programme: Transitional Award</td>
<td>£9,981.75 – Health Education England</td>
<td>October 17</td>
</tr>
<tr>
<td><strong>Dr Raj Sengupta (co-applicant)</strong></td>
<td>Do non-steroidal anti-inflammatory drugs reduce the appearance of sacroiliac joint bone marrow oedema on MRI in Spondyloarthritis</td>
<td>£8,750 – Arthritis Research UK</td>
<td>November 17</td>
</tr>
<tr>
<td><strong>Dr William Tillett</strong></td>
<td>IMPAIR – A study to assess impairment of physical function and radiographic change in psoriatic arthritis</td>
<td>£134,113.00 – Celgene</td>
<td>November 17</td>
</tr>
<tr>
<td><strong>Professor Candy McCabe</strong></td>
<td>A multi-centre study to explore the feasibility and acceptability of collecting outcome measure data for Complex Regional Pain Syndrome clinical trials using a new core outcome measures (SUVA)</td>
<td>£74,000 (100,000 swiss francs) – SUVA</td>
<td>October 17</td>
</tr>
<tr>
<td><strong>Professor Grey Giddens</strong></td>
<td>Drill guidance system in orthopaedic surgery</td>
<td>£638,702 NIHR i4i</td>
<td>January 18</td>
</tr>
<tr>
<td><strong>Dr Emily Henderson</strong></td>
<td>A phase 3 trial of Rivastigmine to prevent falls in Parkinson's Disease</td>
<td>£2,386,400.99</td>
<td>February 18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>£3,429,566.02</td>
<td>2017/18</td>
</tr>
</tbody>
</table>

Grant awards made in 17/18 total almost £3.5million, the most successful year to date, an increase of over £3million compared to 16/17 and demonstrating the commitment and growing expertise of RUH researchers. These larger prestigious awards also validate the improving national and international reputation of the RUH as a centre of research excellence.
Mandatory Statement 4

A proportion of the Royal United Hospitals Bath NHS Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Royal United Hospitals Bath NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/. There were no local CQUINs in 2017/18. This year, it is anticipated that the Trust will receive £4.7m in CQUIN payments out of a possible £5.6m, which represents 83 per cent achievement. In the previous year, 2016/17 the Trust achieved 93 per cent achievement, £5.1m out of a possible £5.5m.

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 2017/18.

Mandatory Statement 6 was removed from the regulations in 2011

Mandatory Statement 7

The Royal United Hospitals Bath NHS Foundation Trust has participated in the special reviews or investigations by the Care Quality Commission related to the following areas during 2017-18:

- 12 – 16 March 2018: A local system review in Wiltshire commissioned by the Secretaries for State for Health and for Communities and Local Government, looking at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old.

The Royal United Hospitals Bath NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- The Trust will review the findings and recommendations of the report once published by the Care Quality Commission.

Mandatory Statement 8

The Royal United Hospitals Bath NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data*:

Which included the patient’s valid NHS number was:

- % for admitted patient care 99.8
- % for outpatient care 99.9
- % for accident and emergency care 99.1

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

- % for admitted patient care 100
• % for outpatient care 100
• % for accident and emergency care 100

*Based on Provisional April 2016 to January 2018 SUS Data at the Month 10 Inclusion Date

**Mandatory Statement 9**

The Royal United Hospitals Bath NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 92% and was graded as level 2, satisfactory (Green).

**Mandatory Statement 10**

The Royal United Hospitals Bath NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission or any equivalent body.

**Mandatory Statement 11**

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

• Continue to use and develop the Data Quality Assurance Framework implemented during 2015/16 as a way of assessing the quality of information reported to the Board. This process assigns a confidence rating to key performance standards based on the outcome and frequency of data quality audits.

• Continue to incorporate Data Quality in the Internal Audit Programme, ensuring that the quality of information remains a high priority for the Trust.

• Continue the work of the Data Quality Steering Group, which meets regularly to oversee data quality within the Trust. The group monitors data quality issues and receives the outcomes of audits and external data quality reports to support resolution of issues and improvement work. The meetings are attended by staff from the information department and staff working in operational roles as well as finance and IM&T to make sure that the Trust maintains high quality and accurate patient information to support patient care.

2.9 Performance against national core set of quality indicators

**SHMI**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Reporting Year</th>
<th>RUH Performance</th>
<th>National Average</th>
<th>National Best</th>
<th>National Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHMI</td>
<td>2017/18</td>
<td>1.01</td>
<td>1.00</td>
<td>0.73</td>
<td>1.25</td>
</tr>
<tr>
<td>% of Patient Deaths with Palliative Care Coding</td>
<td>2017/18</td>
<td>22.1%</td>
<td>31.4%</td>
<td>59.5%</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

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 "expected" range based on statistical methodology. There are three bandings applied, with a banding of two indicating that mortality is within 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 expected range, and the latest published figures are in line with the previous time period. Because of this no specific improvement actions have been identified, however the Trust is committed to continuing to reduce mortality as measured by both SHMI and HSMR (Hospital Standardised Mortality Ratio) indicators. The Trust performance against HSMR is detailed in section three of the Quality Accounts.

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

### PROMS

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Reporting Year</th>
<th>RUH Performance</th>
<th>National Average</th>
<th>National Best</th>
<th>National Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groin Hernia - EQ VAS</td>
<td>2017/18</td>
<td>* -1.529</td>
<td>-0.241</td>
<td>3.273</td>
<td>-6.507</td>
</tr>
<tr>
<td>Groin Hernia - EQ-5D Index</td>
<td>2017/18</td>
<td>* 0.058</td>
<td>0.086</td>
<td>0.135</td>
<td>0.046</td>
</tr>
<tr>
<td>Hip Replacement Primary EQ-5D Index</td>
<td>2017/18</td>
<td>* 0.448</td>
<td>0.445</td>
<td>0.537</td>
<td>0.310</td>
</tr>
<tr>
<td>Hip Replacement Revision EQ VAS</td>
<td>2017/18</td>
<td>* *</td>
<td>7.165</td>
<td>13.834</td>
<td>1.527</td>
</tr>
<tr>
<td>Hip Replacement Revision EQ-5D Index</td>
<td>2017/18</td>
<td>* *</td>
<td>0.291</td>
<td>0.239</td>
<td>0.382</td>
</tr>
<tr>
<td>Hip Replacement Revision Oxford Hip</td>
<td>2017/18</td>
<td>* *</td>
<td>13.503</td>
<td>16.508</td>
<td>10.256</td>
</tr>
<tr>
<td>Knee Replacement Primary EQ-5D Index</td>
<td>2017/18</td>
<td>* 0.341</td>
<td>0.324</td>
<td>0.404</td>
<td>0.242</td>
</tr>
<tr>
<td>Knee Replacement Revision EQ VAS</td>
<td>2017/18</td>
<td>* *</td>
<td>3.499</td>
<td>7.525</td>
<td>2.034</td>
</tr>
<tr>
<td>Knee Replacement Revision EQ-5D Index</td>
<td>2017/18</td>
<td>* *</td>
<td>0.273</td>
<td>2.970</td>
<td>1.570</td>
</tr>
<tr>
<td>Knee Replacement Revision Oxford</td>
<td>2017/18</td>
<td>* *</td>
<td>12.360</td>
<td>13.875</td>
<td>8.615</td>
</tr>
<tr>
<td>Varicose Vein Aberdeen Varicose Vein</td>
<td>2017/18</td>
<td>* *</td>
<td>-8.248</td>
<td>2.117</td>
<td>-18.076</td>
</tr>
<tr>
<td>Varicose Vein EQ VAS</td>
<td>2017/18</td>
<td>* *</td>
<td>0.081</td>
<td>6.272</td>
<td>-4.954</td>
</tr>
<tr>
<td>Varicose Vein EQ-5D Index</td>
<td>2017/18</td>
<td>* *</td>
<td>0.092</td>
<td>0.155</td>
<td>0.810</td>
</tr>
</tbody>
</table>
The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

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

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

The reporting periods shown are the latest available from NHS Digital.

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

Historically the Trust scoring against this measure has been within expected range (above national average) for the majority of areas. Because of this, no specific improvement actions have been identified.

There are three different measures included in PROMS, the EQ VAS, EQ-5D Index and Oxford hip and knee scores. The EQ-5D Index is a combination of five key criteria concerning general health and EQ VAS is the current state of the patient's general health marked on a visual analogue scale. The Oxford Hip and Knee scores relate specifically to the patient's condition and therefore are a particular area of focus for the Trust when monitoring PROMS results.

The Trust will continue to review performance against PROMS measures when more recent data becomes available.

Re-admissions

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Reporting Year</th>
<th>RUH Performance</th>
<th>National Average*</th>
<th>National Best*</th>
<th>National Worst*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr 17 - Nov 17</td>
<td>Apr 16 - Mar 17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient readmitted to a hospital within 28 days of being discharged</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-15 years old</td>
<td>2017/18</td>
<td>8.00%</td>
<td>10.80%</td>
<td>8.80%</td>
<td>1.00%</td>
</tr>
<tr>
<td>16 years or over</td>
<td>2017/18</td>
<td>9.20%</td>
<td>8.60%</td>
<td>7.90%</td>
<td>2.00%</td>
</tr>
</tbody>
</table>

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

Published data from NHS Digital for the most recent time periods was not available at the time of reporting, and so in order to provide more up to date information the performance above has been taken from a different source. This data has been taken from Dr Foster Intelligence, a tool used by the Trust to monitor patient outcomes using data submitted by the Trust. National Comparison figures have also been taken from Dr Foster 2016/17 based on non-teaching Acute Hospital Trusts.

Due to the time it takes to publish the data we are only able to include figures from April to November of this year for the latest time period.
The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this indicator, and so the quality of its services by:

The adult (16 or over) readmission rate has seen a small increase in the period April – November 2017 compared to the annual rate seen in 2016/17, while the children’s rate has reduced. Re-admission rates published by Dr Foster are reviewed at our monthly Clinical Outcomes Group meeting that is chaired by our Medical Director. The paediatric service provides open access as a safety net and therefore would expect to have a percentage of children returning to hospital.

Responsiveness to personal needs of patients

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Reporting Year</th>
<th>RUH Performance</th>
<th>National Average</th>
<th>National Best</th>
<th>National Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsiveness to the Personal needs of Patients</td>
<td>2016</td>
<td>69.0%</td>
<td>68.4%</td>
<td>68.1%</td>
<td>85.2%</td>
</tr>
</tbody>
</table>

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

The data shown is published by NHS Digital using patient responses to the National Inpatient Survey. The list of patients was provided by the Trust using the methodology and criteria specified for the survey. In order to protect the confidentiality of responses the survey is analysed by an external company, and so this data cannot be calculated internally. Responses for the 2017 National Inpatient Survey have not yet been released; therefore the latest available surveys have been included. These relate to the 2016 and 2015 inpatient surveys.

The overall score uses the results of a selection of questions from the Inpatient Survey looking at a range of elements of hospital care.

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

The results for the National Inpatient Survey 2016 were presented to the Board of Directors in June 2017. The Care Quality Commission (CQC) compared the Trust responses to 76 questions against all other Trusts and whether the RUH is performing ‘better’ ‘about the same’ or ‘worse’ than the national average. Generally the Trust performed “about the same” as other Trusts and was not in the worst performing categories for any questions. The Trust scored ‘better’ than average on one question ‘If you brought your own medication with you to hospital, were you able to take it when you needed to? (Trust score 8.2/10) This is a new question and therefore there is no comparative data from last year.

Areas for improvement have been identified where the Trust scored slightly below the national average and these have been assigned to leads to identify and support improvements. The areas related to cleanliness of wards and bathrooms; noise at night from other patients; using the same bath/shower as patients of the opposite sex and explaining how patients would feel after their operation.

Staff recommending the trust to family and friends

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Reporting Year</th>
<th>RUH Performance</th>
<th>National Average</th>
<th>National Best</th>
<th>National Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who would recommend the trust to their family or friends</td>
<td>2017</td>
<td>75%</td>
<td>76%</td>
<td>70%</td>
<td>86%</td>
</tr>
</tbody>
</table>
The Royal United Hospitals Bath NHS Foundation Trust considers that this data is as described for the following reasons:

The data shown is taken from the NHS Staff Survey. The survey is run and analysed by an external company and so this cannot be calculated internally. This is done in line with national guidance. For the past 3 years all staff members were given the opportunity to complete a staff survey to make sure opinions were captured from as many people as possible.

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

The Trust scored above the national average for acute trusts for this measure, and the proportion of staff who would recommend the Trust for treatment to friends and family has remained consistent with last year’s results. Work on embedding the Trust values has continued over the past twelve months, supporting staff to focus on Everyone Matters; Working Together, and Making a Difference within the Trust.

VTE

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Reporting Year: 2016/17</th>
<th>RUH Performance</th>
<th>National Average</th>
<th>National Best</th>
<th>National Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients admitted to hospital who were risk assessed for venous thromboembolism</td>
<td>2017/18</td>
<td>2016/17</td>
<td>2017/18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>79.84%</td>
<td>98.32%</td>
<td>95.09%</td>
<td>100.00%</td>
<td>51.38%</td>
</tr>
<tr>
<td>Q2</td>
<td>79.50%</td>
<td>98.73%</td>
<td>95.19%</td>
<td>100.00%</td>
<td>71.88%</td>
</tr>
<tr>
<td>Q3</td>
<td>87.70%</td>
<td>96.72%</td>
<td>95.25%</td>
<td>100.00%</td>
<td>76.08%</td>
</tr>
<tr>
<td>Q4</td>
<td></td>
<td>97.42%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

Performance is published as quarterly totals. At the time of reporting only data to the end of quarter three of 2017/18 has been published.

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:

Compliance with VTE risk assessment during 2017/18 would appear to have dropped on review of the data, however, the data for VTE risk assessment at the RUH was previously collected from a sample of patients using Safety Thermometer information and this changed in 2017/18 to be collected from all patients. The data was collected electronically, but in the information that was input into the electronic system did not reflect the true compliance , as it required a nurse to document that the assessment has been performed on the paper drug chart by the doctor. Following implementation of the electronic prescribing medication administration system (ePMA) in November 2017, the risk assessment for VTE became electronic and this has resulted in the data being much more reliable and has shown a compliance of over 90%.
**Clostridium difficile (C. difficile)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Reporting Year</th>
<th>RUH Performance 2017/18</th>
<th>2016/17</th>
<th>National Average</th>
<th>National Best*</th>
<th>National Worst*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of C. difficile infection</td>
<td></td>
<td>15.1</td>
<td>17.6</td>
<td>12.9</td>
<td>0.0</td>
<td>82.7</td>
</tr>
<tr>
<td>Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over</td>
<td></td>
<td>8.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

The performance shown for the current reporting period (April 2017 to March 2018) has been calculated internally by the Trust using the data submitted nationally, as published data was not available at the time of reporting. During 2017/18 the Trust has reported 31 cases of Clostridium difficile; however it has been agreed by the Commissioners that no lapses of care occurred in 12 of these cases and are therefore not counted in the year-end total, resulting in 19 actual cases. Another case is being contested as further testing revealed that the patient did not have Clostridium difficile infection.

Rates for both reported and actual are shown in the table.

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

In 2018/19 we will continue to work to the Clostridium difficile improvement plan which includes actions recommended by NHS Improvement following a supportive visit to the Trust. These include implementation of enhanced cleaning, further review of antimicrobial stewardship and gaining assurance that remedial works requests are completed.

**Incidents**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latest Reporting Year</th>
<th>RUH Performance Apr 17-Sep 17</th>
<th>Apr 16-Sep 16</th>
<th>National Median*</th>
<th>National Best*</th>
<th>National Worst*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patient Safety Incidents</td>
<td>2017/18</td>
<td>3200</td>
<td>3501</td>
<td>4630</td>
<td>15228</td>
<td>1133</td>
</tr>
<tr>
<td>Rate of Patient Safety Incidents (per 1000 bed days)</td>
<td></td>
<td>29.3</td>
<td>30.6</td>
<td>41.7</td>
<td>111.7</td>
<td>23.5</td>
</tr>
<tr>
<td>Number Resulting in severe harm or death</td>
<td></td>
<td>23</td>
<td>22</td>
<td>15</td>
<td>0</td>
<td>121</td>
</tr>
<tr>
<td>% resulting in severe harm or death</td>
<td></td>
<td>0.2%</td>
<td>0.6%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

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

The data shown for April 2016 – September 2017 is published by the National Reporting and Learning System (NRLS). This uses incident data provided by the Trust based on national definitions, and figures published are consistent with local calculations. National averages, best and worst figures are based on all non-specialist Acute Trusts, with the National averages being calculated internally using the published data. April – September 2017 is the latest published dataset.
The Royal United Hospitals Bath NHS Foundation Trust intends to take or has taken the following actions to improve this performance, and so the quality of its services, by:

The Trust is supporting a culture of incident reporting, to allow for learning to take place within the organisation and the organisation is actively promoting a pro-active approach to focus on increasing the level of reporting. Following a consultation with junior doctors the Trust is exploring the use of new technology to facilitate the ease with which incidents can be reported, including the use of a mobile app. The Trust will continue to use the routine monitoring of data on incident themes and trends, to evidence quality improvement across the Trust.

2.10 Mandatory Statement 27: Learning from Deaths

Mandatory Statement 27.1

During 2017/18 1438 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: 349 in the first quarter; 356 in the second quarter; 348 in the third quarter; 385 in the fourth quarter.

Mandatory Statement 27.2

The process for selecting patient deaths requiring review and investigation was still being developed over the course of quarter 1 and quarter 2 and in a pilot phase. Consequently we have only been able to report data about this process in Quarter 3 and Quarter 4. This is in line with the expectation from NHSI that Trusts would need to be reporting this information publicly through the Board of Directors by the end of Quarter 3.

By the end of March 2018, 430 case record reviews and 42 investigations have been carried out in relation to 735 of the deaths included in item 27.1.

In 5 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 0 in the first quarter;
- 0 in the second quarter;
- 5 in the third quarter;
- 37 in the fourth quarter.

Mandatory Statement 27.3

The process for selecting patient deaths requiring review and investigation was still being developed over the course of quarter 1 and quarter 2 and in a pilot phase. Consequently we have only been able to report data about this process in Quarter 3. This is in line with the expectation from NHSI that Trusts would need to be reporting this information publicly through the Board of Directors by the end of Quarter 3.

0 of the patient deaths reviewed during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

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

These numbers have been estimated using the Royal College of Physicians Structured Judgement Review (SJR) tool which is used to investigate the care of patients whose death triggers on initial review using a screening tool.

**Mandatory Statement 27.4**

The Trust is at an early stage of carrying out mortality reviews using this new methodology and therefore the number of cases reviewed thus far is limited. We expect to gain greater insights and learning as the work gains momentum.

The piloted use of the Structured Judgement Review process for example highlighted a number of cases where a treatment escalation plan coupled with appropriate community resource would have helped prevention of admission for end of life care.

**Mandatory Statement 27.5**

As stated above the process is at too early a stage of development to be able to take actions from specific learning.

**Mandatory Statement 27.6**

As stated above the process is at too early a stage of development to be able to take actions from specific learning.

We would expect action and impact to be seen in 2018 / 19.

As this is our first part year of this activity, we do not have any carry over activity to report from the previous reporting year. This is reflected in the following mandatory statements (27.7 – 27.9).

**Mandatory Statement 27.7**

0 case record reviews and 0 investigations completed after 31th March 2017 which related to deaths which took place before the start of the reporting period.

**Mandatory Statement 27.8**

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

**Mandatory Statement 27.9**

0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.
Part 3  Other Information

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

This section of our Quality Accounts provides an overview of the quality of care we provided in 2017 / 2018. The information shows our performance against mandated indicators as set out in the guidance from NHS Improvement and also against a number of indicators selected by the Board of Directors in consultation with our Commissioners.

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

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

3.2 Patient Safety

The three patient safety indicators are:

1. Falls
2. Infections
3. Pressure ulcers

Falls

We are confident that the data we use to monitor falls is an accurate way of looking at falls within our hospitals. Falls resulting in harm relates to those categorised as moderate and above. Falls assessments are completed on our electronic patient record system and monitored by our senior nursing team. When a patient suffers a fall it is reported via our incident reporting tool, with all falls being monitored through our falls steering group, with the learning shared across the organisation.

In comparison to the Healthcare Quality Improvement Partnership benchmark of 6.63 falls per 1000 bed days (October 2015) the trust has performed under the benchmark for all falls per 1000 bed days for the last 2 years.
The falls steering group monitors all falls within the Trust. This includes reviewing the results of all root cause analyses conducted to investigate falls that have occurred. This process enables us to learn from incidents, identify themes and trends and look for potential improvements.

During 2017/18 we launched a Trust wide falls improvement programme, which included a revised falls risk assessment, introduction of a post falls assessment, introduction of enhanced observations, a standardised process to review patients on high risk medications and ensuring that all patients have a lying and standing blood pressure. These improvements will continue to be monitored through the falls steering group.

There has also been a successful bid to Health Education England South West Simulation Network for allocation of £25,000 to support falls simulation training by members of the falls steering group.

Each ward has an active falls lead supported by the Quality Improvement Senior Nurses.

Infections

<table>
<thead>
<tr>
<th></th>
<th>RUH Target (National)</th>
<th>2017/18 Total</th>
<th>Have we improved on 2016/17 (actual cases)?</th>
<th>2016/17 Total</th>
<th>Did we achieve in 2016/17 against our national target?</th>
<th>Were we better than the 16/17 national rate in 17/18 (actual cases)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Reported</td>
<td>Actual</td>
<td>Reported</td>
<td>Actual</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>Total infections</td>
<td>22</td>
<td>31</td>
<td>19</td>
<td>40</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Rate per 100,000 bed days</td>
<td>10.9</td>
<td>15.1</td>
<td>8.5</td>
<td>17.6</td>
<td>11.9</td>
</tr>
<tr>
<td>MRSA</td>
<td>Total infections</td>
<td>0</td>
<td>1</td>
<td>About the same</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

The Trust takes infection prevention and control very seriously and there have been a number of actions that have taken place during the last year which have helped to produce an overall improvement in performance against health care associated infection targets.

Targeted education has been provided in areas where infections have occurred and the Infection Prevention and Control Team have undertaken a ‘swarm’ approach where multiple factors are taken into account to identify any specific areas that require attention, for example improvements to the clinical environment or specific training requirements.

The *Clostridium difficile* performance is reported in more detail under the core indicators in section 2.

During 2017/18 there was one Trust attributed MRSA blood stream infection. This was thoroughly investigated using a post infection review and a serious incident root cause analysis investigation. The infection was acquired whilst the patient was in Critical Care Services and actions were identified to reduce the risk of further infections. The action plan has been overseen and monitored by the Surgical Division.

A new ambition was introduced during 2017/18 to reduce healthcare associated Gram negative blood stream infections by 10%. This was a whole health economy target and the Trust is currently working in collaboration with the CCGs to achieve a 50% reduction in these infections by 2020.
Pressure ulcers

<table>
<thead>
<tr>
<th>Category</th>
<th>2017/18 Trust Local Target</th>
<th>2017/18 Total</th>
<th>2017/18 Average per month</th>
<th>Did we achieve in 2017/18 against our local target?</th>
<th>Have we improved on 2016/17?</th>
<th>2016/17 Total</th>
<th>2016/17 Average per month</th>
<th>2015/16 Total</th>
<th>2015/16 Average per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category two</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical device related</td>
<td>34</td>
<td>3</td>
<td>34</td>
<td>3</td>
<td>32</td>
<td>1</td>
<td>32</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>15</td>
<td>1</td>
<td>8</td>
<td>6</td>
<td>0.5</td>
<td>15</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Category three</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Category four</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The 2017-18 target for improvement was a 25% reduction of avoidable category two pressure ulcers on 2016-17 figures. This was achieved. The actual improvement was a 57% reduction.

The 2017-18 target for improvement was a 50% reduction of avoidable Medical Device Related pressure ulcers on 2016-17 figures. This was achieved. The actual improvement was a 60% reduction.

The ambition remains to have a zero tolerance for category 3 and 4 pressure ulcers. There has been one avoidable category 3 pressure ulcer in 2017-18 which is a 66% reduction on last year.

There have been no category 4 pressure ulcers.

The Royal United Hospitals Bath NHS Foundation Trust has a clear pathway for pressure ulcer prevention and regular awareness campaigns to keep pressure ulcer prevention at the forefront of providing quality care.

Where the Trust saw an increase in the number of pressure ulcers further improvement plans were put in place and monitored by the Senior Nursing team and the Tissue Viability Steering group. These actions saw an immediate effect with a decrease in avoidable harms.

All hospital acquired pressure ulcers are investigated to identify any themes and potential learning. These are then used to drive improvement work at local and Trust level.

We are confident that our pressure ulcer data is accurate. Pressure ulcers are recorded on our electronic patient record and our incident reporting system. These are then checked and confirmed by our Tissue Viability team. An annual prevalence was carried out in July 2017 and provided assurance that the incidence data we are capturing is accurate and figures were improving.

3.3 Clinical effectiveness

The four clinical effectiveness indicators are:

1. Sepsis
2. Cancer access targets
3. Summary Hospital-level Mortality Indicator (SHMI)
4. Hospital Standardised Mortality Ratio (HSMR)
Sepsis

<table>
<thead>
<tr>
<th>Sepsis</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>17/18 Q1-Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who met criteria for sepsis screening and were screened for sepsis</td>
<td>90%</td>
<td>81%</td>
<td>79%</td>
<td>77%</td>
<td>79%</td>
</tr>
<tr>
<td>Patients with sepsis receiving antibiotics within 60 minutes from diagnosis</td>
<td>90%</td>
<td>87%</td>
<td>90%</td>
<td>89%</td>
<td>89%</td>
</tr>
</tbody>
</table>

Sepsis is a national priority being driven by NHS England and a national CQUIN for 2017/18 and 2018/19. It includes data for adults, paediatrics, direct admissions and inpatients. The sepsis measures in 2017/18 are not directly comparable with 2016/17 measures.

Over the last 3 years significant improvements have been made in identification and management of patients with Sepsis admitted to the RUH and our aim is to spread this improvement across trust-wide, to improve outcomes for all patients, including children and maternity patients. Our improvement journey is covered in more detail in section 2.6, priorities for improvement.

At RUH we are confident that the information we use for monitoring sepsis is accurate. Information is collected from the patient information system within our emergency department and from patient notes. This is then validated by clinical staff and fed back to staff in the department for monitoring performance and driving improvement.

Cancer access targets

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>2017/18 RUH Total</th>
<th>2016/17 RUH Total</th>
<th>2015/16 RUH Total</th>
<th>2015/16 National Total</th>
<th>2016/17 National Total</th>
<th>2017/18 National Total (Apr-Feb)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two week wait</td>
<td>From GP referral to 1st outpatient appointment</td>
<td>93.0%</td>
<td>94.2%</td>
<td>94.1%</td>
<td>93.3%</td>
<td>94.1%</td>
<td>94.4%</td>
</tr>
<tr>
<td></td>
<td>From GP referral to 1st outpatient appointment - breast symptoms</td>
<td>93.0%</td>
<td>90.1%</td>
<td>83.9%</td>
<td>86.8%</td>
<td>93.2%</td>
<td>93.4%</td>
</tr>
<tr>
<td>31 day wait</td>
<td>From diagnosis to first treatment for all cancers</td>
<td>98.0%</td>
<td>99.9%</td>
<td>99.5%</td>
<td>99.6%</td>
<td>97.6%</td>
<td>97.6%</td>
</tr>
<tr>
<td></td>
<td>From diagnosis to subsequent treatment - surgery</td>
<td>94.0%</td>
<td>99.7%</td>
<td>99.2%</td>
<td>99.7%</td>
<td>95.6%</td>
<td>95.4%</td>
</tr>
<tr>
<td></td>
<td>From diagnosis to subsequent treatment - drug treatments</td>
<td>98.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>96.5%</td>
<td>93.3%</td>
</tr>
<tr>
<td></td>
<td>From diagnosis to subsequent treatment - radiotherapy treatments</td>
<td>94.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>97.6%</td>
<td>97.3%</td>
</tr>
<tr>
<td>62 day wait</td>
<td>From urgent referral to treatment of all cancers</td>
<td>85.0%</td>
<td>88.4%</td>
<td>89.0%</td>
<td>89.7%</td>
<td>82.4%</td>
<td>82.0%</td>
</tr>
<tr>
<td></td>
<td>From referral to treatment from a screening service</td>
<td>90.0%</td>
<td>93.6%</td>
<td>91.3%</td>
<td>96.4%</td>
<td>95.1%</td>
<td>91.8%</td>
</tr>
</tbody>
</table>

The Trust did not achieve the 2 week breath symptomatic target in year following failures in the early part of the year due to challenges with recruitment to a consultant radiologist vacancy. Throughout this time a rigorous clinical triage process has been in place to ensure that patients with any suspicion of cancer did not experience delays. The team have worked on resolving the capacity and recruitment issue and successfully appointed a consultant breast and general radiologist in autumn and also secured additional capacity within the financial year and extending into 2018/19.

The 62 day GP target has been maintained throughout the year despite increased workloads of all staff involved. This was supported by additional short term central funding.

Summary Hospital-level Mortality Indicator (SHMI)

This is reported as part of the core indicators in part 2.
Hospital Standardised Mortality Ratio (HSMR)

<table>
<thead>
<tr>
<th></th>
<th>2017/18 April to December</th>
<th>2016/17 April to March</th>
<th>2015/16 April to March</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Average</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSMR value</td>
<td>100</td>
<td>101.4</td>
<td>112.2</td>
</tr>
<tr>
<td>Were we within expected range?</td>
<td>✔</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td>HSMR value</td>
<td>100</td>
<td>97.4</td>
<td>108.7</td>
</tr>
<tr>
<td>Were we within expected range?</td>
<td>✔</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td>HSMR value</td>
<td>100</td>
<td>116.0</td>
<td>122.1</td>
</tr>
<tr>
<td>Were we within expected range?</td>
<td>✗</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

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

Due to the time it takes to publish the data we are only able to include figures from April to December of 2017.

We monitor HSMR through our monthly Clinical Outcomes Group meeting. This meeting is chaired by our Medical Director, and is attended by clinical and non-clinical staff within the Trust. As part of this any areas of concern are investigated.

We are pleased to note that our overall HSMR values for April to December this year have seen an improvement on 2016/17 and are within the expected range for overall and weekday mortality. Weekend mortality was outside of the expected range but had reduced from the 2016/17 position. The Clinical Outcomes Group will continue to monitor HSMR performance.

3.4 Patient experience

The three patient experience indicators are:

1. Referral to Treatment (RTT)
2. Friends and Family Test (FFT)
3. Emergency Department – Four Hour waiting times

Referral to Treatment (RTT)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Royal United Hospitals Bath NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Target</td>
<td>92.0%</td>
</tr>
<tr>
<td>2017/18 RUH Total</td>
<td>87.8%</td>
</tr>
<tr>
<td>Did we achieve in 17/18</td>
<td>✗</td>
</tr>
<tr>
<td>2016/17 RUH Total</td>
<td>90.4%</td>
</tr>
<tr>
<td>Did we achieve in 16/17</td>
<td>✗</td>
</tr>
<tr>
<td>2015/16 RUH Total</td>
<td>91.7%</td>
</tr>
<tr>
<td>Did we achieve in 15/16?</td>
<td>✗</td>
</tr>
</tbody>
</table>

The Trust has worked hard to balance the unprecedented non-elective demand throughout 2017/18, which has resulted in us being unable to meet the the RTT open pathway access standard.

There have been two main causes:

1. The reduction in outpatient activity related to junior doctor rota changes impacting on high volume specialties and difficulty in recruiting to medical staff vacancies.
2. The impact of Winter nationally and the need to focus on delivery of care for the most urgent and cancer related procedures.

The Trust has made good progress within the medical specialties with most now delivering the access standard. The Trust has been working with Commissioners to manage demand for elective care over the year and developing relationships with our Independent Healthcare partners to support the Winter period and elective care going forward.

We are confident that the recording of RTT pathways is robust and includes a number of daily reports to monitor and manage patient pathways.

Friends and Family Test (FFT)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Royal United Hospital</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017/18 RUH Total</td>
<td>2016/17 RUH Total</td>
</tr>
<tr>
<td>Inpatients Percentage of patients that would recommend the RUH to friends and family</td>
<td>96.9%</td>
<td>About the same</td>
</tr>
<tr>
<td>A&amp;E Percentage of patients that would recommend the RUH to friends and family</td>
<td>97.2%</td>
<td>✔</td>
</tr>
</tbody>
</table>

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

Performance is good and the Friends and Family Test continues to be reported through the Trust Performance and Quality Groups and is on the Trust Scorecard. In addition, the additional comments submitted by patients on the questionnaire are logged and analysed to pick up on any issues raised.

Emergency Department – Four Hour waiting times

<table>
<thead>
<tr>
<th>Measure</th>
<th>Royal United Hospitals Bath NHS Foundation Trust</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients attending the Emergency department waiting a maximum of four hours before a decision is made to treat, admit or discharge - All Types - Including the Urgent Care Centre</td>
<td>95.0%</td>
<td>82.7%</td>
</tr>
<tr>
<td>Patients attending the Emergency department waiting a maximum of four hours before a decision is made to treat, admit or discharge - Type 1 - Emergency Department only</td>
<td>95.0%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

The 4 hour standard has continued to be challenging and it is recognised that support from system partners is required to deliver an improved performance. The urgent and emergency care system has a system wide improvement plan in place, with focus on patient length of stay, in particular those with a stay exceeding 21 days. The trust is receiving support from the Emergency Care Improvement Programme (ECIP) to deliver its improvement programme. The improvement programme is led by the executive Urgent Care Collaborative Board which has responsibility to oversee the improvement plans and actions.

We remain committed to delivering safe and high quality care to our patients, especially during periods of greatest demand and heightened pressure within the Emergency Department, continuing to perform well on quality indicators and remaining one of the top performing trusts in the region for rapid
handover between ambulance and Emergency Department staff; enabling patients to be seen quickly and also free the ambulance crews.

There has been an increased focus this year on alternative pathways to admission to prevent and Emergency Department attendance and or admission ensuring that patients are seen in the most appropriate place for their clinical needs. These pathways include medical ambulatory care, surgical ambulatory care, paediatric assessment unit and gynaecology emergency clinic. Over 30% of the medical take is now routinely cared for through the medical ambulatory care unit.

In November 2017 the Emergency Departments patient administration system was replaced with a system that is linked to the main hospital patient administration system enabling all hospital clinicians to view the emergency episode of care in real time and supporting a streamlined process if the patient is admitted. The Emergency Department team were fully engaged with the build and deployment of the system. Data quality continues to improve. Attendances and waiting times are monitored using these systems, supported by a range of reports which are available to help us monitor and manage attendances and waiting times on a daily basis. Processes are reviewed and audited as part of the trust internal audit programme.

### 3.5 Commissioning for Quality and Innovation (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) is a payment framework which enables Commissioners to reward excellence by linking a proportion of acute healthcare provider’s income conditional on demonstrating improvements in quality in specified areas of care. For 2017/18 all projects have been nationally mandated and applied to all acute trusts.

Each project is led by a clinician, who supports the achievement of the quality indicator milestones and is accountable for the financial performance of the scheme. The following outlines the progress with the 2017/2018 CQUIN quality improvement schemes.

#### National CQUIN schemes for 2017/18

**Staff Health and Wellbeing** (partially achieved)

A continuation of the good practice put in place during 2016/17 this project is comprised of a series of initiatives aimed to improve the support available to NHS Staff to help promote their health and wellbeing.

The scheme was split into three parts;

- Putting in place and delivering initiatives to ensure staff feel supported physically and emotionally by the Trust. This element of the project was assessed against the results of the 2017 staff survey from three questions:
  1. Does your organisation definitely take positive action on health and wellbeing?
  2. Have you experienced musculoskeletal problems (MSK) as a result of work?
  3. Have you felt unwell in the last 12 months due to work related stress?
- Ensuring healthy food is available to staff/visitors and that unhealthy food is not being promoted in outlets across the Trust
- Improving the uptake of the flu vaccination for frontline staff to ensure that 70 per cent were protected by February 2018.

The Trust established a Health and Wellbeing group to support this CQUIN in 2016/17 whose members continue to work towards it’s achievement and also support other wider initiatives to support staff. During the year the group promoted and hosted a range of wellbeing initiatives including the Trust’s Health and Wellbeing festival and other targeted days to raise awareness on issues such as men’s health or available financial support. 2017/18 also saw the continuation and expansion of the
staff physiotherapy service and the launch of additional mental health courses by the Trusts employee assistance programme (EAP).

The Trust has changed suppliers for its pre-packaged sandwiches and savour snacks to ensure they contain fewer calories and saturated fats and all outlets have greatly reduced the volumes of sugar sweetened beverages and high calorie confectionary sold.

The Trust had a very successful flu campaign this year, achieving 71.8% of front line staff receiving the vaccination by the end of February.

This scheme was partially achieved with no payment received for improvements to the staff survey results but full payment for the healthy food and flu vaccine elements.

**Serious Infections (partially achieved)**

A scheme building on two 2016/17 projects aimed at combating the rise of antimicrobial resistance by reducing the overuse and inappropriate prescription of antimicrobials and continuing the Trusts excellent track record in swiftly identifying and treating sepsis.

The sepsis safety programme has been an ongoing priority in the Trust since 2014, commencing as a local CQUIN this work has been built upon by two national CQUINS in 15/16 and 16/17. The project focuses on the rapid detection, via screening, and treatment of patients with Sepsis in the Emergency Department and inpatient settings. As a result of this work we are now identifying patients earlier and administering antibiotics faster.

Over 2000 staff members have been trained in the new NICE guidance and NEWS (National Early Warning Score) and are empowered to act quickly when patients deteriorate.

The other element of the CQUIN sought to incentivise the Trust to reduce the prescription of two specific drugs, carbapenem and piperacillin-tazobactam and its overall antibiotic consumption by one percent.

**Improving services for people with mental health needs who present to A&E (fully achieved)**

The scheme is applicable to Acute Trusts and Mental Health providers, incentivising both organisations to work together and review patients who have attended the Emergency Department for on multiple occasions who may have underlying mental health needs.

Patients have been identified jointly by clinical leads from the RUH and Avon & Wiltshire Mental Health Partnership NHS Trust who would benefit from the creation of a joint care plan which was then created by a multi-disciplinary team, including members from the Emergency Department (ED), community mental health team, local Ambulance Trust and others. Additional activities were also undertaken to review the way these patients notes are recorded when they attend ED and engagement with a wider local group to look at alternatives for patients who need mental health support other than a hospital attendance.

The scheme is anticipated to achieve full compliance with all milestones for both organisations; an initial review of the patients that received care plans demonstrates a reduction in attendances of 40% across the year. This scheme was fully achieved.

**Offering Advice and Guidance (fully achieved)**

The scheme requires Acute Trusts to set up and operate Advise & Guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to hospital.

The RUH has chosen to expand the provision of an existing pilot which enabled GPs to contact a rota’d list of consultants via the telephone. To date this service has been rolled out across Urology, Rheumatology, Paediatrics, Neurology, Gastroenterology, Elderly Care, Diabetes and Endocrine
Medicine, Cardiology, Breast surgery, General surgery, Gynaecology and Dermatology and the Trust received 5886 calls between April 2017 and March 2018 from GPs with queries.

GP satisfaction surveys are carried out regularly with GPs speaking highly of the service and stating that this has helped improve clinical practice in primary care with improved communication.

The CQUIN milestones require lines for specialties receiving 35% of GP referrals, to date the lines cover 58% with plans to expand the service to include an additional 30% during 2018/19. This scheme was therefore fully achieved.

**NHS E-Referrals (partially achieved)**

Over 2017/18 the Trust has been undertaken work to ensure that all services that receive referrals from GPs to be available on the NHS E-Referral system, facilitating the elimination of paper and faxed referrals during 2018/19. All services have been reviewed and those missing have been created on the Trust's directory of service during the year.

Running concurrently with this work the STP launched a project to support both the referral management centres and the CQUIN, with Trusts asked to return referrals which had not gone through the correct process for a given list of specialties, and a timescale for further roll out across the year for Wiltshire and Somerset. The Trust has fully engaged with this work. This scheme was partially achieved.

**Safe and Proactive Discharge (partially achieved)**

This work sought to incentivise the Trust to increase the proportion of patients over 65 discharged to their usual place of residence within seven days. This workstream was included in the Trust's already established and effective integrated discharge service, supported by the Home First programme as the vehicle for delivering a 2.5% increase on 16/17.

The scheme is anticipated to achieve full compliance with all milestones, demonstrating the Trust's continued focus on supporting older people to remain well for as long as possible within the wider health care system. This scheme was partially achieved.

**Medicines Optimisation (fully achieved)**

A scheme agreed with NHS England which is comprised of several projects to deliver changes to optimise cost effective prescribing mechanisms. These projects include; the switching from branded to biosimilar drugs when these become available. Data quality initiatives for standardised medical product names and improved national submissions for IVIG and SACT. A final element required the Trust to explore cost effective dispensing options for outpatients.

The pharmacy team have worked with clinical teams across the hospital to amend prescribing practice when new medicines are approved and put in place additional processes to ensure all appropriate data is captured and reviewed. The Trust also undertook a procurement exercise to select a provider for the pharmacy shop located in the Atrium.

This scheme has delivered a structure for the collection of more robust and reliable data across key clinical areas which will improve patient safety and has made significant savings for the hospital using homecare. This scheme was fully achieved.

**Nationally Standardised Dose Banding Adult Intravenous SACT (fully achieved)**

The second NHS England scheme sought to standardise doses of prescribed chemotherapy to reduce variation in prescribing as part of the national medicines optimisation agenda. The CQUIN built upon a very successful smaller scheme from last year and required the clinical teams to support
the principle of dose banding and then increase the percentage of dose banded prescriptions administered for 48 drugs.

The scheme has achieved full compliance with all milestones across the year with 99% of prescriptions being dose banded by quarter three. This scheme was fully achieved.

**Optimising Palliative Chemotherapy Decision (fully achieved)**

The final project focused on ensuring that in cases where chemotherapy was being used to treat palliative patients a peer to peer discussion had taken place and been recorded. This should ensure decisions to start and continue further treatment should be made in direct consultation with peers and then as a shared decision with the patient.

Over the course of the year the team have reviewed the existing processes for 30 mortality reviews and how two specific groups of patients are recorded. An action plan was then drawn up to ensure that these conversations are consistently recorded. The scheme has demonstrated the Trusts existing excellent practice and is anticipated to achieve full compliance with all milestones.

**Achievements**

The Trust has had a very successful year with regard to CQUIN schemes, both in terms of financial achievement and clinical quality improvements. In terms of financial achievement the Trust will receive 83% of a possible £5.6 million available CQUIN funding. Five scheme achieving 100% of their milestones overall, these are Mental Health in A&E, Advice and Guidance, Medicines Optimisation, Nationally Standardised Dose Banding Adult Intravenous SACT and Optimising Palliative Chemotherapy Decisions.

**3.6 Duty of Candour**

In November 2014, it became a legal requirement for all NHS Trusts to implement the Duty of Candour. This was an important step towards ensuring an open, honest and transparent culture.

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other ‘relevant persons’ (people acting lawfully on their behalf) in relation to care and treatment. It sets out specific requirements that providers mustfollow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. It is important that lessons are learned and improvements made when things go wrong and that the culture of the organisation encourages openness and transparency. The Care Quality Commission (CQC) inspection will check that the Trust has robust systems in place to meet the duty of candour regulation.

To ensure compliance with the Duty of Candour, the Trust has produced a Duty of Candour policy to guide staff. The Trust Risk and Assurance team provide support to staff to ensure they are aware of the process and compliant with the process as per the policy.

Duty of Candour has been incorporated into the Trust’s incident reporting system. Moderate, Severe and Catastrophic patient safety incidents automatically trigger Duty of Candour ‘fields’ which have to be completed by the incident reporter and informs relevant staff of required actions they need to take. Reminder e-mails are automatically populated when Duty of Candour leads fail to complete the actions in a timely manner. Duty of Candour is embedded into the process of investigating incidents and reminders are sent to investigators if the Duty of Candour process has not been completed. The risk team advise staff investigating Serious Incidents of the date the investigation report is signed off and to share the outcomes with the service user or ‘relevant persons’

Every month the Trust continues to randomly select 10 incidents deemed to have triggered Duty of Candour in order to assess against the requirements of the regulation and ensure the correct procedure has been followed.
On a quarterly basis, a review of those incidents for which the reporter has indicated that Duty of Candour is not applicable, is performed. If it is discovered that Duty of Candour should have been implemented, the Duty of Candour action chain is initiated and the reporter of the incident contacted to explain why the previous decision has been overturned.

3.7 NHS staff survey results

A total of 2279 staff responded to the survey, which is 45% of the trust. This is a higher rate than the national average response (44%) for acute trusts but a slight decline on last year’s responses (46%).

KF21 (percentage of staff believing that the organisation provides equal opportunities for career progression or promotion)

![Graph showing KF21](image)

The trust has remained in the same position as last year and is positioned in the top (best) 20 per cent of acute trusts for this measure.

KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months)

*The lower the score the better*

![Graph showing KF26](image)

The Trust score is better than the average score for acute trusts, although there has been a small (not statistically significant) increase since 2016.

3.8 Implementing priority clinical standards for seven day hospital services

The Ten clinical standards for delivering seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of
clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

**Standard 2 – Time to first consultant review**

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

**Standard 5 – Access to diagnostic tests**

Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

**Standard 6 – Access to consultant-directed interventions**

Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

**Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others.**

All patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

The RUH is committed to working towards the implementation of these 4 Significant progress has been made in the following areas to help deliver this:

- Acute medical consultants are available until 7 pm each day and there are plans to recruit further into new posts to help bring this up to 9 pm each day.
- All level 3 intensive care patients are reviewed twice daily by consultants on our critical care unit.
- Ambulatory care has extended opening 3 days a week.
- The Frailty Flying Squad service, designed to enable rapid and safe discharge of the frail elderly from the front door is now a seven day service.
- Each bed holding specialty has introduced daily weekend ward rounds for new admissions.
- Enhanced junior doctor presence on weekends, including a registrar dedicated to discharging patients to help with the flow of admissions into the hospital.
Healthwatch Wiltshire’s Response to Royal United Hospital NHS Foundation Trust Quality Statement 2017/2018

Healthwatch Wiltshire welcomes the opportunity to comment on Royal United Hospital NHS Foundation Trust’s quality account for 2017/18. Healthwatch Wiltshire exists to promote the voice of patients and the wider public with respect to health and social care services. Over the past year we have continued to work with the Trust to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously.

We are happy to see that the Trust has engaged with a variety of people including service users and unpaid carers in the development of their priorities and that Priority 4 focuses on listening to patients and carers and using their feedback to improve services. We are also pleased to see that the Trust reports that they have achieved what they said they would in terms of last years priorities with plans for further improvement work in all priority areas.

It is concerning that targets for falls were not met again this year but we are pleased to see that improvement targets for pressure ulcers are being achieved. We hope to see further improvements this coming year and hope the work of the falls improvement programme and the falls steering group benefits from the additional funding obtained from the HEE Simulation Network.

The Trust has failed to meet the two-week breast symptomatic wait target this year, however we see that this was in part due to recruitment issues and that there were measures in place to ensure patients with suspicions of cancer did not experience delays. A measure of patient experience would be a useful way of gauging the impact of delays like these for this cohort of patients and Healthwatch Wiltshire would be happy to advise and support the Trust with this.

We welcome the work the Trust has done in working with the mental health Trust to review patients who attend emergency departments on multiply occasions. Identified patient have benefitted from the creation of joint care plans by multidisciplinary teams.
These reviews identified opportunities for mental health support other than a hospital attendance. An initial review suggests a reduction of 40% of attendances across the year.

It is positive to note the number of patients who would recommend the Trust’s care under the Friend and Family Test.

Healthwatch Wiltshire looks forward to working with the Trust over the coming year to ensure that the experiences of patients, their families and unpaid carers and staff are heard and taken seriously.
Quality Account Response Form for 2017-18:

Royal United Hospital Bath

Health & Wellbeing Select Committee

We believe that the Royal United Healthcare (RUH) priorities should and do match those of the needs of the local community. The report builds upon the aspirations for the RUH to build an organisational culture of continuous quality improvement. This has been demonstrated through the continued development of staff training and learning development, which is reflected throughout this year’s report.

We welcome this year’s reflection on the performance against the trusts patient safety priority and national priorities and are encouraged to read the actions set out to address those not yet met from last year.

Members also acknowledge the number of national and local clinical audits experienced by the trust, and note the steps already being made to progress those areas not met. The committee will look forward to reviewing these actions in next year’s quality account report.

The committee notes the use of public engagement, specifically priority 4, which will be measured through listening to patients, carers and use this to improve services. Through patient surveys, friends and family’s test. The committee are also encouraged to learn that these will be used to continually improve patient and carer experience at the RUH and meet patient’s needs.

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

Health & Wellbeing Select Committee

Councillor Francine Haeberling (Chair)

Donna Vercoe Senior Scrutiny Officer (scrutiny@bathnes.gov.uk)
18th May 2018
Helen Blanchard
Director of Nursing and Midwifery
Royal United Hospital
Combe Park
Bath
BA1 3NG

Dear Helen,

Quality Accounts 2017/18 for the Royal United Hospitals Bath NHS Foundation Trust (RUH)

NHS Bath and North East Somerset Clinical Commissioning Group welcome the opportunity to review and respond to the Quality Accounts for 2017/18 for the Royal United Hospitals Bath NHS Foundation Trust (RUH).

The account provides an accurate representation of the Trust’s quality programme which highlights the positive aspects of innovative ways of working whilst also explaining where things have not progressed as well as planned or where quality indicators have not been met.

There are robust arrangements in place with the RUH to agree, monitor and review the quality of services, covering the key domains of quality, patient safety, clinical effectiveness and patient experience.

We acknowledge the Trust’s commitment to supporting and developing their staff’s skills and knowledge in quality through training and coaching in order to increase and enhance quality improvement expertise across the organisation.

The Trust has shown an increased focus on their five patient safety priorities in 2017/18. Through the implementation of a Trust-wide falls programme and falls prevention pathway the Trust has been able to begin to demonstrate a reduction in the number of inpatient falls.

Commissioners recognise the work undertaken to reduce the incidence of Clostridium Difficile Infections (CDI) and the support provided to the Trust from NHS Improvement with 19 CDI cases attributed to the RUH for 2017/18 against a target of 22 which is a significant improvement for the Trust. There has been one case of Trust attributable MRSA.

The work undertaken on the early detection of patients with Acute Kidney Injury (AKI) is also notable. However, it is not clear if the objectives for AKI have been fully achieved. We look forward to working with the Trust in 2018/19 to develop a format to fully measure improvement in this area.
The Trust has detailed the work they have undertaken against their four quality priorities for 2017/18 and they have made effective progress against these. It is encouraging to see the quality improvement work on frailty and the notable impact that this has had on patient outcomes in particular with the Frailty Flying Squad.

We acknowledge the work that has been undertaken on management of jaundice in babies and the significant reduction in re-admittance for jaundice treatment.

Commissioners are pleased to note that improving the patient experience at discharge is a priority and that there have been significant improvements in this area through the implementation of various initiatives. However, we would welcome working in partnership with the Trust to continue to focus on this area particularly in relation to the expansion of Home First and Continuing HealthCare Fast Track.

It is disappointing to note that the Trust has not achieved their quality priority to improve sepsis management in 2017/18. However, the range of quality improvement measures which have been implemented is noted and we are encouraged that with continued focus the percentage of patients screened for sepsis will increase.

Other quality improvements of note are the reduction in pressure ulcers and the continued focus on providing patients with the opportunity to provide feedback on their experiences.

It is notable that the Trust has participated in the full range of national and local clinical audits and that this has resulted in actions to improve quality. Commissioners are pleased to see that the Trust has made improvements in the Sentinel Stroke National Audit Programme with the current audit performance available showing the Trust having achieved the highest level of audit standards.

During 2017/18 the Trust has implemented and participated in the national CQUIN (Commissioning for Quality and Innovation) programme. The Trust has demonstrated collaborative working with other providers to implement and meet the required CQUIN targets. Overall, the Trust has performed well against the national CQUIN targets. A key area for 2018/19 is the CQUIN on ‘Reducing the impact of serious infections’ as the Trust has had variable performance during 2017/18.

When reviewing the Trust’s 2017/18 Quality Account, Commissioners note the inclusion of learning from deaths which is a new requirement for this year. Commissioners note that the Trust are in the early phases of completing mortality reviews and this area will continue to be monitored in 2018/19 through the quality contract meetings.

Commissioners acknowledge the priorities for improvement planned for 2018/19 and that these continue to focus on quality improvement initiatives which are across the lifespan of the population. There is limited information provided within the Quality Accounts on how these will be achieved in 2018/19 and we look forward to supporting the Trust in developing more definitive measures of what success will look like for these priority areas.
It is important to acknowledge that the RUH as with many other acute Trusts in England and Wales, have experienced on-going challenges again this year with pressures on the urgent and emergency care treatment. The Trust’s failure during 2017/18 to meet the Referral to Treatment standards and the Emergency Department four hour waiting times standard impacts on patient experience significantly and we look forward to continuing to work collaboratively to identify system wide solutions to manage demand and implement more effective treatment pathways during 2018/19.

It is clear that the Trust has demonstrated numerous areas of effective improvement in patient safety and quality initiatives. The CCG recognises the Trust’s commitment to working in partnership with commissioners, the public and other key stakeholders and we look forward to again working with the Trust in the forthcoming year.

Yours sincerely,

Lisa Harvey

Director of Nursing and Quality
NHS Bath and North East Somerset Clinical Commissioning Group

cc Tracey Cox, Chief Officer, BaNES CCG

Dina McAlpine, Director of Nursing and Quality, Wiltshire CCG
Debbie Rigby, Director of Quality, Safety and Engagement, Somerset CCG
Annex 2: Statement of director’s responsibilities for the quality report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period 1 April 2017 to 31 March 2018;
  - papers relating to quality reported to the board over the period 1 April 2017 to 31 March 2018;
  - feedback from Bath and North East Somerset Clinical Commissioning Group on behalf of all the Trust's local commissioners dated 18th May 2018;
  - feedback from governors dated 26/02/2018;
  - feedback from Healthwatch Wiltshire dated 10 May 2018;
  - feedback from Bath and North East Somerset Council Health and Wellbeing Select Committee dated 14 May 2018;
  - the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27/09/2017;
  - the 2016 and 2017 national patient surveys;
  - the 2016 and 2017 national staff surveys;
  - the Head of Internal Audit’s annual opinion of the trust’s control environment dated May 2018;
  - CQC inspection report dated 10/08/2016;
- the Quality Report presents a balanced picture of the NHS Foundation Trust’s performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.
• The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

...............22 May 2018.Date.............................................................Chairman

...............22 May 2018. Date.......... Chief Executive
Independent auditor’s report to the council of governors of Royal United Hospitals Bath NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Royal United Hospitals Bath NHS Foundation Trust to perform an independent assurance engagement in respect of Royal United Hospitals Bath NHS Foundation Trust’s quality report for the year ended 31 March 2018 (the ‘quality report’) and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Royal United Hospitals Bath NHS Foundation Trust as a body, to assist the council of governors in reporting Royal United Hospitals Bath NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Royal United Hospitals Bath NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge, and;
- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the ‘NHS foundation trust annual reporting manual’ issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’ and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in detailed guidance for external assurance on quality reports 2017/18; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’ and the six dimensions of data quality set out in the ‘detailed guidance for external assurance on quality reports’.

We read the quality report and consider whether it addresses the content requirements of the ‘NHS foundation trust annual reporting manual’ and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2017 to 22 May 2018
- papers relating to quality reported to the board over the period April 2017 to 22 May 2018;
- feedback from Bath and North East Somerset Clinical Commissioning Group on behalf of all the Trust’s local commissioners dated 18 May 2018;
feedback from Healthwatch Wiltshire dated 10 May 2018;
feedback from Bath and North East Somerset Council Health and Wellbeing Select Committee dated 14 May 2018
the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2017;
the 2017 national patient survey;
the 2017 national staff survey;
Care Quality Commission inspection report, dated August 2016
the Head of Internal Audit’s annual opinion over the trust’s control environment, dated May 2017; and
any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the ‘NHS foundation trust annual reporting manual’ to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the ‘NHS foundation trust annual reporting manual’.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’;
the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2017/18 Detailed guidance for external assurance on quality reports for foundation trusts; and

the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP
Birmingham
22 May 2018