Bundle Public Board of Directors 2 November 2022

0 Agenda
- 00.0 - Public BoD Agenda - November 2022 v1.8 - 26.10.22.docx

1 Chairs Welcome and Apologies

2 Written questions from the public

3 Declarations of Interest

4 Minutes of the Board of Directors meeting held in public: 7 September 2022
- 04.0 - Public BoD Minutes Sept 22 v1.docx

5 Action List
- 05.0 - Public BoD Action List for Nov22 v1.docx

6 Governor Log of Assurance Questions and Responses (For Information)
- 06.0 - Governor log of assurance questions v1.1.docx
- 6.1 NED Assurance 2022 - RM Reformat - 28.02.22.pdf

7 CEO Report

Management Board Report
- 7.0- CEO Report 02.11.22.doc

8 Chair's Report

9 Board Assurance Framework Summary Report
- 9.0 - BAF summary report.doc

10 Patient Story

11 Integrated Performance Report
- 11.0 - Integrated Performance Report - Public BoD Cover Sheet - 02.11.22.doc
- 11.1 Integrated Performance Report - Public BoD 02.11.22.pdf

12 Maternity Update
- 12.0 - Maternity Quartley Report - 24.10.2022 v1.0 BoD FINAL.docx

13 Infection, Prevention and Control Annual Reprot
- 13.0 - IPC annual report Oct 22.docx
- 13.1 - IPC Annual Report 2021-22 FINAL.docx

14 Staff Survey Results - Mid Year Review
- 14.0 Staff Survey - Board Paper - November 2022 _.doc
- 14.1 Appendix 1 - Staff Survey Deeper Dive. November 22 Board.pdf

15 Annual Health and Safety Report
- 15.0 Health and Safety Annual Report 2021-22.docx

16 People Committee Update Report
- 16.0 - People Committee upward report.docx

17 Research and Development Annual Report
- 17.0 Research Annual Public Board Report 2122 updated.doc

18 Finance and Performance Committee Chair’s Update Report
- 18.0 - Finance and Performance Committee Chair's Update Report Sept 2022 v2.docx

19 Charities Chair’s Update Report
- 19.0 - Charities Committee Update Report Sept2022.docx

20 Non-Clinical Governance Committee Chair’s August Update Report
- 20.0 NCGC Update Report - Public BoD.docx

21 Non-Clinical Governance Committee Chair’s October Update Report

22 Updated Committee Terms of Reference

- *Finance and Performance Committee*
- *Quality Governance Committee*
- *Audit and Risk Committee*
- *Non-Clinical Governance Committee*

22a.0 - FPC Terms of Reference cover.doc

22a.1 - Finance and Performance Committee ToR - updated Oct 22.docx

22b.0 - Quality Governance Committee Terms of Reference review cover.doc

22b.1 - Quality Governance Committee TOR.doc

22c.0 - Audit Committee ToR review coversheet.doc

22c.1 - Audit Committee Terms of Reference 2022.docx

22d.0 NCGC Terms of Reference Review.doc

22d.1 NCGC Terms of Reference 2022.doc

23 AOB

Royal United Hospitals Bath
NHS Foundation Trust

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS
OF THE ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
WEDNESDAY, 2 November 2022, 14:00 – 16:00
VENUE: Widcombe Social Club, Lower Widcombe Hill, Bath BA2 6AA

Item	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chair's Welcome and Apologies	Alison Ryan, Chair	Verbal
2.	Written questions from the public	Alison Ryan, Chair	Enc.
3.	Declarations of Interest	Alison Ryan, Chair	Verbal
4.	Minutes of the Board of Directors meeting held in public: 7 September 2022	Alison Ryan, Chair	Enc.
5.	Action List	Alison Ryan, Chair	Enc.
6.	Governor Log of Assurance Questions and Responses (For Information)	Alison Ryan, Chair	Enc.
7.	CEO Report • Management Board Report	Cara Charles Barks, Chief Executive	Enc.
8.	Chair's Report	Alison Ryan , Chair	Verbal
9.	Board Assurance Framework Summary Report	Ade Kadiri, Head of Corporate Governance	Enc.
The People We Care For			
10.	Patient Story	Sharon Manhi, Lead for Patient and Carer Experience.	Pres
11.	Integrated Performance Report	Libby Walters, Director of Finance & Deputy Chief Executive	Enc.
12.	Maternity Quarterly Report	Sarah Merritt, Deputy Chief Nurse & Claire Park, Consultant, Obs & Gynae	Enc.
13.	Infection, Prevention and Control Annual Report	Antonia Lynch, Chief Nurse	Enc.
The People We Work With			
14.	Staff Survey Results - Mid Year Review	Alfredo Thompson, Director of People and Culture	Enc.
15.	Annual Health and Safety Report	Brian Johnson, Director of Estates and Facilities	Enc.
16.	People Committee Update Report	Sumita Hutchison, Non-Executive Director	Enc.
The People in Our Community			
17.	Research and Development Annual Report	Richard Graham, Interim Medical Director	Enc.
18.	Finance and Performance Committee Chair's Update Report	Jeremy Boss, Non-Executive Director	Enc.
19.	Charities Chair's Update Report	Jeremy Boss,	Enc.

		Non-Executive Director	
20.	Non-Clinical Governance Committee Chair's August Update Report	Sumita Hutchison, Non-Executive Director	Enc.
21.	Non-Clinical Governance Committee Chair's October Update Report	Sumita Hutchison, Non-Executive Director	Verbal
22.	Updated Committee Terms of Reference: • Finance and Performance Committee • Quality Governance Committee • Audit and Risk Committee • Non-Clinical Governance Committee	Ade Kadiri, Head of Corporate Governance	Enc.
4. CLOSING BUSINESS			
23.	AOB	Alison Ryan, Chair	Verbal
Date of Next Meeting: Wednesday 11 January 2023 **Venue:** Widcombe Social Club, Lower Widcombe Hill, Bath BA2 6AA			

Key: Enc – Paper enclosed with the meeting pack
Pres – Presentation to be delivered at the meeting
Verbal – Verbal update to be given by the presenter at the meeting

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS
HELD IN PUBLIC ON WEDNESDAY, 7 SEPTEMBER 2022, AT WIDCOMBE SOCIAL CLUB, BATH, BA2 6AA

Present:

Voting Directors
Cara Charles Barks, Chief Executive
Jeremy Boss, Non-Executive Director
Antony Durbacz, Non-Executive Director
Richard Graham, Interim Chief Medical Officer
Sumita Hutchison, Non-Executive Director
Adewale Kadiri, Head of Corporate Governance
Antonia Lynch, Chief Nurse
David McClay, Chief Digital Officer
Ian Orpen, Non-Executive Director
Alison Ryan, Trust Chair (*Chair)*
Simon Sethi, Chief Operating Officer
Nigel Stevens, Non-Executive Director
Libby Walters, Director of Finance

Non-Voting
Brian Johnson, Director of Estates and Facilities
Alfredo Thompson, Director for People and Culture

In attendance
Paul Fairhurst, Non-Executive Director
Amanda Fox, Staff Nurse, Ophthalmology
Gemma Gough, Trainee, shadowing Cara Charles-Barks
Erin Houlihan, Matron
Katie Lear, Lead Nurse, Ophthalmology
Sharon Manhi, Lead for Patient and Carer Experience
Nisha Rajcoomar, Trainee, shadowing Cara Charles-Barks
Catherine Soan, Executive Assistant *(minute taker)*
Members of the Public
Staff and Public Governors

Apologies
Anna Mealings, Non-Executive Director
Jocelyn Foster, Director of Strategy

BD/22/09/01 Chairs Welcome and Apologies

The Chair welcomed everyone to the meeting and noted that apologies had been received from those listed above.

The Chair introduced Paul Fairhurst, Non-Executive Director who starts his post on 1st October 2022, replacing Anna Mealings, Non-Executive Director.

BD/22/09/02 Written Questions from the Public

No written questions from the public.

BD/22/09/03 Declarations of Interest

There were no interests declared by members of the Board for items being considered.

BD/22/09/04 Minutes of the Board of Directors Meeting held in Public on 6th July 2022

The minutes of this meeting held in Public on 6th July 2022 were approved.

BD/22/09/05 Action List and Matters Arising

One action (PB578) presented for closure and this was approved.

BD/22/09/06 Governors' Log of Assurance Questions and Responses

The Chair noted that the Governors' Log was a document for information, not for discussion, and would be a regular item on the Public Board agenda going forward.

The Board noted that there was one open question, to which a response was being collated by the deadline of 9th September 2022. The response will be included in the log of assurance circulated in advance of the next meeting.

BD/22/09/07 Patient Story

The Chair welcomed the Lead, Patient & Carer Experience who introduced colleagues from Ophthalmology who presented their work on nurse development that had improved patient experience.

The Board watched a film where a patient spoke about the amazing treatment that they had received by a nurse injector.

The Lead Nurse, Ophthalmology described how the team had introduced nurse led injections releasing doctors from this activity. The clinic gives 150 injections a week which were treated similarly to the 2 week cancer referral as patients can go blind if not seen promptly. In the last year the unit had increased from one nurse injector to six. The Healthcare Assistant role had been developed to assist the trained nurse and to start seeing patients in outpatients to help with the backlog of appointments. The ambition for next year is that Nurses and Optometrists see and treat emergency eye patients directly, preventing A&E attendance.

The Staff Nurse described how her role as nurse injector meant she met patients at the very beginning of their diagnosis, building a relationship with the patient and making them feel like part of the RUH family. The nurse injectors all follow the same routine which was reassuring for patients. She described how nurses come from around the country to learn how to give the injection.

The Matron described how proud she was of the team for their commitment and ambition to revolutionise the department and introduce a training model to attract nurses. She felt that as a Trust we need to think how we can replicate this type of service in all outpatient areas by investing in Nurses and Nurse Practitioners to keep skills in nurse specialties alive.

Another change, was that the unit was seeing patients in clinic who were then being listed for surgery and sent home. They would then come back in for pre assessment, which required a nurse and a room to be allocated. Healthcare Assistants have now been trained to undertake the tests when listed for surgery in virtual clinics. This meant that the patient only has to come back for surgery which is much better for patient experience. Previously the nurse would have 6-8 pre-op assessments a day, due to the change we are now able to offer 25 appointments a day. The Lead Nurse described how hard the team had worked to introduce this change and how proud she was to work alongside them.

The Interim Chief Medical Officer described how he was inspired by the work which had transformed the care for patients, benefited doctors and set a career pathway for other roles. He agreed about the transformation of outpatients and the Matron confirmed she was a member of the Steering Group to support this work. She felt that it was time to rebrand outpatients to treatment centres for example and push the model of what can be achieved in outpatients.

Anthony Durbacz, Non-Executive Director asked the team what they would share with colleagues from their experience of creating change. The Lead Nurse described this as being able to give colleagues confidence, supporting them with change and sharing the positive results from patient feedback.

The Director for People and Culture recommended that the team was nominated for a Team of the Month award.

The Director for Finance congratulated the team on their innovation in making this change which was often hard to make happen. She asked the team if they had any feedback on how making a change such as this could be made easier. The Lead Nurse described some difficulties around getting the necessary IT equipment for colleagues to carry out pre-assessments virtually. The team had to share one laptop and be creative about sharing it.

Nigel Stevens, Non-Executive Director commended the team on their work and enthusiasm and ambition.

Ian Orpen, Non-Executive Director congratulated the team on their fantastic achievement and that this should be identified as a QIPP initiative.

The Chief Nurse commented that the power of clinical leadership enabling a culture of team empowerment was so important. She agreed that the name of 'outpatients' did not showcase everything that happens there.

The Chair thanked the team for their enormous achievement and their energy for making improvements.

BD/22/09/08 CEO Report

The Chief Executive provided an overview of the report and highlighted:

- The Trust's financial position will be discussed in more detail under the Integrated Performance Report.
- RUH had been recognised by the Ministry of Defence's Employer Recognition Scheme Gold Award for veterans and military staff. This award allows us to support our reservist community by introducing supportive HR policies in place for veterans, reserves, Cadet Force adult volunteers and spouses and partners of those serving in the Armed Forces. It is our ambition to have achieved the requirements of the award by March next year.
- The Trust's Freedom to Speak Up service had been shortlisted for a Health Service Journal award. The service had gone from strength to strength with greater recognition and utilisation across the Trust. It was pleasing to see colleagues from the minority communities highlighting concerns, which we are then able to address.
- The Trust's Art at the Heart team won both the 'Creativity for Good' and "ACE Award" at the Creative Bath Awards.
- Every year the CEO and other members of the Executive Team have the privilege of hearing from Doctors in Training on quality improvement, presenting the incredible

work they have been doing over the last year to improve processes for our patients and families. It is a great opportunity to hear from our leaders of the future.

- Management Board received and approved the Breast Radiology Workforce Transformation Business Case, noting the difficulties nationally in recruiting to this sub-speciality, and therefore the importance of identifying and recruiting to alternative workforce models.
- The staff benefits package will be launched in October, and in addition, drop-in sessions are to be set up to support staff through the current cost of living crisis.
- Management Board was informed that both the Trust and Sulis were off plan financially in July. As part of plans to recover the position, it would be important for agency costs to go down as levels of substantive staffing rise. With regard to transformation, weekly reviews of actions and progress are being led by the Director of Finance. Weekly peer reviews of QIPPs are also being held.
- The Trust's Digital Strategy was approved for ratification by the Board of Directors.

The Board of Directors noted the update.

BD/22/09/09 Chair's Report

The Chair provided a verbal update and highlighted:

- The recent recruitment processes for Consultants, the Chief Medical Officer and Non-Executive Director.
- The Trust's excellence with regard to organ donation and recognition. The Trust had scored 100% each year for the past 6 years on the national indicators for identifying potential donors. The Chair of the Trust was proud to Chair the Trust's Organ Donation Committee and was also the Regional Chair. The Trust had facilitated 14 donations, extracting something positive from tragic situations.
- Tissue donation was more of a challenge; the Trust was working hard to improve this and was actually one of the more advanced hospitals in progressing this.

The Board of Directors noted the update.

BD/22/09/10 Integrated Performance Report

The Chief Operating Officer presented the Integrated Performance Report and highlighted:

Performance

July was challenging with another wave of Covid-19 resulting in the highest level of Covid-19 patients in hospital since the start of the pandemic. A quarter of the Trust's beds were occupied by patients with Covid-19. Approximately half of these patients caught Covid-19 when in hospital and that is why we are prioritising the improvements to the ward environment on Acute Stroke, Forrester Brown, Pierce and Haygarth. The Covid-19 peak in July was linked to community prevalence and this led an increase in staff being off sick and closure of some community services. The Trust's spend on agency staff had increased because of the impact of staff sickness. Non Criteria to Reside patient levels reached 138 in July with a very high level of patients waiting to leave hospital to ongoing community services.

Cancer performance in July was positive despite the increase in demand for cancer services in Urology, Breast and Colorectal. The Trust was doing a lot of stay on top of demand and was the strongest for cancer performance last month. However, the Colorectal service in particular was facing challenges in keeping up with demand.

The Chief Operating Officer will bring the completed Winter Plan to Board shortly.

Finance
Trust Pay was over plan by £1.4 million at the end July. Drivers for this overspend were Sulis, the adverse plan linked to agency spend and income and the issue of medical and nursing agency staff and how that links to recovery trajectory and elective capacity. Some of the agency expenditure was linked to Covid-19. It was anticipated that improvement will be seen in month 5 in a non Covid-19 surge.

The Director of Finance advised of the significant financial risks relating to nurse agency costs being more than expected contributing to this was the model for 1.1 care to support patients with mental health needs. This was being addressed to consider what is the best and most efficient future model. Sulis performance had been impacted by Covid-19 prevalence and operational challenges. A weekly data review is taking place to look at quick actions we can take to improve performance.

Workforce
The Chief Operating Officer reflected on the increase in agency spend and how we control this as we recruit more staff. During the pandemic, mandatory training and appraisal compliance had slipped. The divisions were focussed on improving this and the Family and Specialist Services had made some recent improvement.

The Director for People and Culture referred to the Trust's People Plan and ensuring we have the resources in place for staff to undertake their training and receive consistent conversations about career progression.

Quality
The Chief Operating Officer described the challenge around CDiff; the organisation had 22 cases of CDiff this year to date, the target for the year is 42 so this was a challenge. The Trust is an outlier in the South West in terms of rates and we have joined a collaborative review across BSW to take a fresh eyes approach. The Trust was below target for falls and major harm which was positive.

The Chief Nurse commented on the learning from the last Covid-19 outbreak which resulted in 7 wards with bay closures for 2.5-3 weeks. From a retrospective review, we can see the tipping point and have been able to identify some metrics on how to manage the site more effectively. When Covid-19 affects 100 people per thousand of the population we see an impact in hospital, when it affects 150 per thousand, we need to increase the number of Covid-19 dedicated wards. If we can isolate affected patients in side rooms we manage not to transmit the infection. The report identifies 8 deaths from Covid-19 in July and a Serious Incident Review was undertaken on all of those. All patients were aged 61 to 91 and had significant comorbidities, nonetheless this was a sad outcome.

The Chief Nurse confirmed that we had experienced a rise in the number of patients presenting with mental health disturbance which had driven the enhanced care requirement. We are working in collaboration with Avon and Wiltshire Mental Health Partnership to review risk metrics which will tell us whether a patient needs enhanced care and how we accommodate these patients in the acute setting.

The Chair asked if we had volunteers back on the wards and the Chief Nurse confirmed that we do and were working with the League of Friends to increase the number of volunteers as well as the diversity of the volunteer group.

Ian Orpen, Non-Executive Director commented on the cancer performance which was commendable, however, we should be realistic around the scale of the challenge ahead. The Chief Operating Officer acknowledged this and although we had worked hard to generate capacity there was a lot more to do, in Endoscopy referrals are 130% of 19/20 levels. We are undertaking planning for next year to bring in more efficient operating.

The Chief Executive stated that we had seen an increase in referrals to the Colorectal team following the awareness generated by Dame Deborah James, she asked what the timeframes were to make a step change. The Chief Operating Officer advised of his regular meetings with the Cancer Lead where attention is given to the trajectory for the Colorectal cancer pathway. We have had 500 referrals in the past month but the aim is to get on top of the current surge by January, but with more attention given to how we manage capacity challenges in the long term.

The Director of Finance referred to the significant investment the Trust has made in nursing and asked whether we had any assurance around achieving safe staffing within the investment we have already made. The Chief Nurse responded that the international recruitment plan had not yielded as expected and we have therefore not recruited to establishment. However, 50 international nurses were expected to start this month which is an improvement on recent months. The Divisional Directors of Nursing were discussing the level of control for approving agency nursing to ensure it is the right decision and there are no other options available to us.

Anthony Durbacz, Non-Executive Director referred to the trajectory for international nurses and if the upward trajectory was continuing. The Director for People and Culture responded that we were will be back on target by January/February next year.

Sumita Hutchison, Non-Executive Director commented that the Trust's turnover rate had increased and was higher than the target, she asked if this was of concern. The Director for People and Culture responded that turnover was back to pre-pandemic levels which was healthy, during the pandemic, turnover was low as people were not changing their job. Turnover in nursing was not a concern but the turnover of Allied Health Professions, especially Pharmacy needed more analysis. Anecdotally, the Director for People and Culture was hearing that people are reassessing life in general after the pandemic.

The Chair was conscious of the levels of exhaustion experienced by staff who have faced endless difficult challenges. She offered the Non-Executive's support if there was anything they could do to help. This was welcomed by the Executive Team.

The Chief Executive added that the Trust will be offering the Covid-19 vaccination in September, followed by the Flu vaccination in October.

The Board of Directors noted the update.

BD/22/09/11 Quality Governance Committee Chair's Update Report

Nigel Stevens, Non-Executive Director provided an overview of the report and highlighted:

- The Committee gained assurance from the briefing provided by Dr Foster relating to HSMR and their positive view of how the RUH approaches HSMR. The Dr Foster team felt the team had a sensible and pragmatic approach.
- The Committee welcomed the triangulation of related standard reports (learning from deaths, serious incidents etc.) to look at themes to identify issues and learning early.

- The Interim Chief Medical Officer referred to learning from deaths. The HSMR compares Trust's, we do have some coding differences relating to Covid-19 deaths compared to our neighbours. Coding flags on specific conditions that we can focus on and take away learning to assure ourselves that patients were not dying unexpectedly.
- The risk of the impact of Aseptic Pharmacy on the delivery of chemotherapy was a serious ongoing issue which the Chief Pharmacist was working on. We had lost staff due to a local unit offering a significant pay rise outside of NHS Terms and Conditions.

Ian Orpen, Non-Executive Director advised of the extensive conversation regarding maternity and the challenges faced but all units. The Chair commented that although the Private Board receive a monthly maternity update, it should also come to Public Board on a regular basis. The Head of Corporate Governance will ensure the next maternity update comes to Public Board.

Action: Head of Corporate Governance

The Board of Directors noted the update.

BD/22/09/12 Safeguarding

The Chief Nurse provided an overview of the report and highlighted:

Adult Safeguarding

The Trust had an un-announced inspection by the CQC 2 weeks ago. The focus of the inspection was across three medical wards, after escalation from a family member. The CQC had issued a letter of intent and identified a number of areas for improvement. The Trust has developed an action plan and a further meeting with the CQC will be arranged as we report against the action plan.

The Adult Safeguarding Annual Report identified a number of achievements and good practice thanks to the dedication and expert work of the team. Adult Safeguarding was an increasingly complex area due to legislation and complexity of patients which had increased during the pandemic. A need to improve discharge processes had been identified and some key work was taking place on communication, provision of medicine and take home information.

The Deprivation of Liberty Safeguards Scheme was changing to Liberty Protection Safeguards which changes to the authorisation of people deprived of their liberty from the Local Authority to us at the RUH. This will require the support of an expert team and a business case had been written to implement this.

The Chief Nurse reported that the Head of Adult Safeguarding was retiring from the Trust this week and a successful appointment has been made to this role. The Trust was also recruiting an Associate Director of Vulnerable People and Safeguarding to support this increasingly complex agenda. The appointment of a Lead for Domestic Abuse for a further year had been made as well as a Mental Health Midwife Specialist. These appointments strengthen medical leadership.

During the pandemic, mandatory training for safeguarding moved to online training but it had recently been reverted back to face to face scenario based training from which the learning had been impactful.

Children's Safeguarding

The Chief Nurse highlighted the increase in children and adolescents presenting with

a primary mental health condition. There is an issue accessing beds in specialist units so they remain in the acute setting which was not ideal for their treatment and they often require one or two mental health nurses per patient.

The Chief Nurse expressed her gratitude to the safeguarding team for the work they have done this year. The Chair advised that the Board Seminar in October will focus on safeguarding.

The Board of Directors noted the update.

BD/22/09/12A People Committee's Chair's Update Report

The Director for People and Culture presented the key highlights of the report as follows:

- The People Committee received a presentation from Dr Gough and Dr Diskin from the Children's Ward on their project work to improve staff experience. This will be shared with colleagues as part of Civility Week commencing on 19th September 2022.
- As part of the Civility Week, Dr Chris Turner from the Civility Saves Lives Campaign is giving a talk on the impact of civility on patient care. The Director for People and Culture will ensure the invitation is extended to the Board of Directors.

Action: Director for People and Culture

- The People Committee heard the story of a junior doctor's real life experience of discrimination, misogyny and incivility at work at the RUH. There were some important messages including that our colleague had to tell her experience nine or ten times before some action was taken. This demonstrates why we have work to do on this agenda.
- The People Committee noted that the Trust had recently undertaken the second stage pilot of the NHS Rainbow Badge accreditation. We are not yet scoring against the framework to achieve a Bronze/Silver/Gold accreditation. The review had highlighted that we have work to do on the way in which we care for transgender patients.
- The People Committee received an update on the digital talent programme which was over halfway through, transforming how we bring people into the organisation. The first benchmark was to reduce the time it takes to bring people into the organisation. As expected with any new process, there had been some teething problems which were being worked through.

Sumita Hutchison, Non-Executive Director advised that the format of the meeting had been refreshed to align the agenda with the People Plan and this had worked well.

The Board of Directors noted the report.

BD/22/09/13 Annual Health and Safety Report

The Director of Estates and Facilities presented the key highlights of the report as follows:

- There had been a reduction in RIDDORS throughout the year.
- The improvement in the compliance of mandatory training was a key area of focus .
- The Health and Safety Committee was performing well against its Terms of Reference although there had been a challenge in terms of attendance which was being managed.
- Key risks identified as:
  - Asbestos, which will be eliminated by the end of the financial year whilst existing control measures remain in place.
  - The absence of electronic records relating to the maintenance of fire safety devices were now in place and fire risk assessments of all clinical areas had now been completed. A Training Needs Analysis was in circulation.

- Designated Nursing Officer (DNO) training on medical gases was being considered, so that clinical colleagues can be trained differently to estates professionals which is an extensive and technical training course.

The Board of Directors noted the report.

BD/22/09/14 Finance and Performance Committee Chair's Update Report

Jeremy Boss, Non-Executive Director provided an overview of the report and particularly highlighted the update from the Medicine Division which had been positive in the respect of understanding the issues relating to spend and how it was being addressed. This provided some assurance to the Finance and Performance Committee.

The Reference Costs data had been submitted to NHSE on the 5th August to compare cost and activity across services.

The Board of Directors noted the report.

BD/22/09/15 Audit and Risk Committee Chair's Update Report

Antony Durbacz, Non-Executive Director advised that the Audit and Risk Committee met on 1st September 2022 and he was therefore presenting a verbal update as follows:

- The Annual Audit Report had highlighted no significant weaknesses but a couple of recommendations were raised.
- The Committee received an overview of Cyber Security and highlighted that the Trust was currently migrating to a new system which would enable us to compare data with other NHS Trusts. Business continuity following a cyber-attack was discussed to look at the consequences of a system going down.
- The Anti-Crime Specialist provided an update on the counter fraud work undertaken since the last meeting. There was concern about the low number of referrals received and the low response rate to the Fraud awareness survey. Some benchmarking followed by a further update was requested.
- We are seeing an increase in audit recommendations from our internal audit programme. 13 new actions had been generated from 4 audits, 1 as a high priority. We still have some outstanding actions to focus on which required the support of Executive's to address them. The Chief Executive advised that the Executive Team review the actions every month and she will ensure this continues going forward.

The Board of Directors noted the report.

BD/22/09/16 Learning from Deaths and Inquest Report

The Interim Chief Medical Officer provided an overview of the report and highlighted:

- All deaths in hospital were reviewed by clinical colleagues to ascertain whether there was any possibility of issues with care contributing to the patient's death.
- 75% of Structured Judgement Reviews (SJRs) completed in the last quarter rated care as either good or very good.
- 8% of SJRs completed in the last quarter rated care as poor or very poor.
- Communication, documentation and delay in tests/procedures were the top 3 root causes of reduced quality of care in patients who die.
- Any learning is communicated back to teams involved.
- There had been a backlog in SJRs but the allocation of SJRs in the clinical teams had been re-emphasised and there was no longer a backlog.

The Chief Executive asked what the process was for communicating themes back to the teams to ensure that action was being taken to review and change processes when necessary. The Interim Chief Medical Officer advised that a random audit process was required to gain this assurance.

Ian Orpen, Non-Executive Director asked how the results of our SJRs compare to other Trusts. The Interim Medical Director advised that this standard had not been adopted by all Trusts and therefore it was difficult to compare data. The process was relatively new and the RUH was ahead of others in its implementation.

The Board of Directors noted the report.

BD/22/09/17 Annual Review of the Trust Constitution

The Head of Corporate Governance presented the Constitution outlining the minor changes to the table of amendments including updated definitions and description of the CCG becoming the ICB. The table also proposed an update to the tenure of Governors to hold office for a maximum of 9 years, but not necessarily consecutively which allowed governors to take a break.

The Chair suggested that the Board review the latest publication of the NHS Foundation Trust Code of Governance in light of changes.

Action: Head of Corporate Governance.

The Director of Estates and Facilities commented that page 10 of the Trust Constitution refers to NHS Improvement, which should be amended to NHSEI.

Action: Head of Corporate Governance.

The Board approved the amendments to the Trust Constitution which would now be presented to the Council of Governors for approval.

BD/22/09/18 Any Other Business

The Chair expressed her thanks to two members of the Board who had left/were leaving the organisation shortly. Dr Bernie Marden had recently left the Trust after 5 years as Medical Director. The Chair expressed her thanks to Dr Marden for his sympathy, warmth, kindness and wisdom, acknowledging amongst all the wonderful work he did for the Trust, his ability to identify with and nurture our young Consultants.

The Chair was also sorry to say goodbye to Anna Mealings, Non-Executive Director who joined the Trust three years ago. Anna Mealings had joined at a time when we didn't have a People Committee, she helped to create and deliver this. Anna brought her OD knowledge, concern for staffing and commercial experience to the organisation and had been a valuable contributor.

Both colleagues will be greatly missed.

The meeting was closed by the Chair at 15:06 hours.

Royal United Hospitals Bath
NHS Foundation Trust

Agenda Item: 5

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY 2 NOVEMBER 2022

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB579	**Quality Governance Committee Chair's Update Report** The Head of Corporate Governance will ensure the next maternity update comes to Public Board.	BD/22/09/11	Sept 22	Oct 22	Item added to the public agenda. **Closed**	Head of Corporate Governance
PB580	**People Committee's Chair's Update Report** As part of the Civility Week, Dr Chris Turner from the Civility Saves Lives Campaign is giving a talk on the impact of civility on patient care. The Director for People and Culture will ensure the invitation is extended to the Board of Directors.	BD/22/09/12A	Sept 22	Oct 22	The Board were invited to the session. **Closed**	Director for People and Culture
PB581	**Annual Review of the Trust Constitution** The Chair suggested that the Board review the latest publication of the NHS Foundation Trust Code of Governance in light of changes.	BD/22/09/17	Sept 22	Dec 22	Although the new draft Code has not yet been formally launched, its provisions will be incorporated within the Trust's Integrated Governance Framework which is to be updated and presented to the Board in December.	Head of Corporate Governance
PB582	**Annual Review of the Trust Constitution** The Director of Estates and Facilities commented that page 10 of the Trust	BD/22/09/17	Sept 22	Oct 22	All references to NHS Improvement have been updated within the	Head of Corporate Governance

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
	Constitution refers to NHS Improvement, which should be amended to NHSEI.				Constitution to read NHSEI. **Closed**	

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**6.0**
Date of Meeting:	**2 November 2022**		

Title of Report:	**Governor log of assurance questions and responses**
Status:	**For Information**
Board Sponsor:	**Alison Ryan, Chair**
Author:	**Roxy Milbourne, Deputy Head of Corporate Governance**
Appendices	**Appendix 1: Governor log of assurance questions August – October 2022**

1.	**Executive Summary of the Report**
The purpose of this report is to provide the Board of Directors with an update on all questions on the "Governors' log of assurance questions" and subsequent responses. The Governors' log of assurance questions is a means of tracking the communication between the Governors and the Non-Executive Directors.	

2.	**Recommendations (Note, Approve, Discuss)**
The report is presented for information.	

3.	**Legal / Regulatory Implications**
None	

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)**
N/A	

5.	**Resources Implications (Financial / staffing)**
N/A	

6.	**Equality and Diversity**
N/A	

7.	**References to previous reports**
September 2022.	

8.	**Freedom of Information**
Public	

Appendix 1: Governor Log of Assurance Questions August - October 2022

Royal United Hospitals Bath NHS Foundation Trust

Date:	**October 2022**
Source Channel	**Governor Quality Working Group**
Date Sent & Responder	Sent to Ian Orpen on the 20th October 2022,response requested 31st October
Question	Since Covid measures were introduced, the Trust has been able to cease using corridors in the Emergency Department to queue patients in and out of the department. Corridors were deemed a risk at the time due to the inability to socially distance, however there are further risks such as no oxygen, suction, patient call bells or emergency bells in corridors. During times of increased pressure on the hospital, such as recently with the internal critical incident, an "out corridor" has been reintroduced, consisting of patients awaiting beds on wards within the hospital. What assurance do the NEDs have that the Trust's winter plan will increase flow out of the ED so that patients don't have to be nursed in an "out corridor".
Process / Action	NEDs in the process of gaining assurance and producing a response.
Answer	
Closed?	Open

Date:	**September 2022**
Source Channel	**Governor Strategy and Business Planning Working Group**
Date Sent & Responder	Sent to Antony Durbacz on 3rd October 2022, Response was requested by end October 2022
Question	With the IT training demonstrating that breaches of data by NHS staff re - people that they have no clinical responsibility for can be repeated up to 300 times with no clinical need, or consequence, can the NED's be assured that systems will be built into the software; and managed so that such breaches can be identified and the person breaching confidentiality will be identified and then subject to appropriate disciplinary procedure.
Process / Action	Response Cirulcated to the Governors on the 25th October 2022
Answer	Access to patients records is controlled by Nationally defined Position/Role based access controls. This attempts to restrict access to the Electronic patient record (EPR) based on role/position. When a user opens a record in the clinical view of the EPR solution this creates a relationship with the patients data, and it records who accessed which record, what they looked at, what they updated, what device they used, dates and times etc. Part of the suite of EPR tools include a solution which allows suitably trained and identified staff to run reports that can see this information. These reports can be scheduled to run daily/weekly/monthly and cover topics such as: • Access by User – everything an identified user has looked at or changed within a given timeframe • Access by Patient (name or Medical record number) – everyone who has looked at or changed anything in the patients record within a given timeframe • Same name as patient – identifies staff looking at their own records • Same family name – identifies staff looking at relatives • Excessive user log ons – Where a user has logged on much more than the average Any of these reports can be run monthly or in an ADHOC manner by the identified staff and have been used as supporting evidence in a number of cases where staff had breached Trust Information Governance policies
Closed?	Open

Date:	**August 2022**
Source Channel	**Staff Governors**
Date Sent & Responder	Sent to NEDs on 30th August 2022, response requested by 9th September 2022.
Question	Despite all efforts taken by the Trust to date, there is relevant evidence that our WRES data demonstrates increasing levels of racial hate/abuse towards our staff and patients who have protected characteristics. Our Transgender/Transitioning and or Non Binary staff and patients have also seen a significant hike in hate/abuse towards them both via staff to staff, patient to staff, staff to patient and we and they have been attacked via our social media platforms. This has taken place/escalated over the past 6-12 months. Examples of such abuse are available to view. What assurance do the NEDs have that our staff and patients will be protected and supported by their employer, and that the trust will push more energy into training, education, promoting a zero tolerance to hate of any kind?
Process / Action	NEDs in the process of gaining assurance and producing a response.
Answer	Agreed, whilst we have made progress with our ED&I agenda, our stats do show that our staff with protected characteristics face unacceptable levels of bullying harassment within the workplace. Our Workforce Race Equality data shows this to be at 30.5 % against a 23.9% for white colleagues, which is a consistent trend. This is also mirrored in part by our Workforce Disability Data. • We have increased representation within FTSU, which has encouraged more staff to speak up. Recognising a lack of black and ethnic minority staff speaking up in September 2020 led to increasing the diversity in the FTSU team which has increased cases from Black and ethnic minority staff over the last 18 months from 1% to 19%. Currently our data shows that 17% of FTSU cases are raised by black and ethnic minority staff. FTSU has had an increase in white ally staff speaking up against racism in the organisation • In January 2022 Cara, our Chief Executive Officer released a statement in January 2022 saying “Here at the RUH, we have a zero-tolerance approach to discrimination, victimisation or harassment based on a person's sexual orientation, gender identity and other protected characteristics….I am calling on all of us to work together as an organisation to share the opportunities we have to stand by our commitment and speak up against discrimination so that we can make a difference to our LGBTQ+ colleagues, patients and wider community and create a sense of belonging here at the RUH.” • We have four networks in place and these are being refreshed and relaunched. As part of this commitment to addressing the above we signed up to take part in the second phase pilot of the NHS rainbow badge accreditation, designed initially at Guy’s and St Thomas’. LGBT+ people experience a range of health inequalities throughout their life course which mean they are more likely to need to access healthcare services. These health inequalities are often exacerbated by the barriers that people face when accessing services to treat or support them. This includes things such as a lack of understanding and training on how to properly treat or care for the person, or discrimination or a perception of potential discrimination based on sexual orientation or trans status. We have also received feedback that whilst some actions taken recently show support of the LGBTQ+ community, there is a risk of tokenism in our intentions, due to the lack of co-ordinated meaningful action and staff feeling unsupported in the area. The Rainbow Badge Accreditation gives us a well-established, evidence based framework to aspire to and results in a clear set of actions to improve the experience of both our colleagues and our community when accessing services at the RUH. The recent review into ED&I, and the rainbow badge accreditation process have given us a clear platform for action to improve the experience for colleagues at the RUH. The documents outlined a number of necessary Strategic actions that require Executive and Board level commitment and action, in order to be successful. One key note was the need to increase capacity and skills of the team who currently support the ED&I agenda, if we are to move at pace. A new Head of ED&I has recently been appointed. Another recommendation was the embedding of a zero tolerance approach to acts of clear discrimination, this will supported by clear education and training. As an organisation, we are focused on supporting all colleagues with protected characteristics, this is reflected in the KPI’s set out in RUH People Plan which is regularly reviewed by Non-Executive Director.
Closed?	

Report to:	Board of Directors	Agenda item:	7.0
Date of Meeting:	2nd November 2022		

Title of Report:	Chief Executive's Report
Status:	For Information
Board Sponsor:	Cara Charles-Barks, Chief Executive
Author:	Helen Perkins, Senior Executive Assistant to Chair and Chief Executive
Appendices	None

1. Executive Summary of the Report

The purpose of the Chief Executive's Report is to highlight key developments within the Trust, which have taken place since the last Board of Directors meeting.

Updates included in this report are:

- Overview of current performance, encompassing quality, finance, people and performance;
- Independent Investigation into East Kent Maternity Report
- Update from Management Board Held on 26th October 2022;
- Updates regarding areas of recognition, ongoing developments and new initiatives;
    - Staff Deaths
    - NHS Pastoral Care Quality Award
    - Nursing Times Workforce Award
    - Member of the Florence Nightingale Foundation
    - Infection Prevention and Control Works
    - RUH Researching 'Super Rehab' to Improve or Reverse Chronic Illness
    - Breast Cancer Awareness Month
    - Black History Month
    - New Parking Provider Contract
    - Over 10,000 Listens for New Patient Information Podcasts Offering Help with Rheumatic Diseases
    - HCA Takes Starring Role in BBC Healthcare Video
    - Senior Management Changes
- RUH Membership;
- Annual General Meeting;
- 2022 Governor Elections;
- Consultant Appointments;
- Use of Trust Seal;
- Update on Consultant appointments

2. Recommendations (Note, Approve, Discuss)

The Board is asked to note the report.

3. Legal / Regulatory Implications

Not applicable

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
Strategic and environmental risks are considered by the Board on a regular basis and key items are reported through this report.	

5.	Resources Implications (Financial / staffing)
Not applicable	

6.	Equality and Diversity
Not applicable	

7.	References to previous reports
The Chief Executive submits a report to every Board of Directors meeting.	

8.	Freedom of Information
Private	

9.	Sustainability
Not applicable	

10.	Digital
Not applicable	

CHIEF EXECUTIVE'S REPORT

1. Performance

Operationally, the Trust has struggled with urgent care given the combined impacts of an increase of COVID cases and a knock on impact of getting patients home once they are medically fit. This has led to continued issues offloading ambulances in September and October. The Executive Team and I are completely focussed on maximising the safety of patients within the RUH but also in the community calling ambulances and we are revising our approach given this challenging context. We also declared a Critical Incident in recent weeks in which we urgently requested additional support from the community to get patients home. In November Ward 4, a community hospital ward, will open as a combined system project which will provide valuable capacity for patients not needing acute care.

Regarding elective care, the Trust delivered 10% more activity than it did before COVID in September which is a fantastic effort by all our teams and makes a huge difference to patients. Year to date we are now delivering 6% more elective care than before COVID despite the many challenges we face. Our cancer performance remains strong although rising demand for colorectal cancer pathways is requiring us to ensure we maximise capacity to see these patients promptly.

2. Quality

The Care Quality Commission (CQC) carried out an unannounced, targeted inspection of Medical Care on 22nd August 2022 due to concerns received by the CQC about the safety and quality of the medicine core service. Following the visit the CQC issued a Letter of Intent, notifying the Trust of possible urgent enforcement action due to serious concerns identified in relation to safeguarding. An action plan was returned to the CQC addressing the areas of note which include:

i) Rationale for restricting movement through swipe access on ward main entry and exit doors;
ii) Plans to improve training compliance for safeguarding training including staff understanding of restriction and restraint;
iii) The CQC also requested evidence of systems or processes to ensure all patients' best interests are assessed and the Trust is compliant with the provisions of the Mental Capacity Act 2005.

The Trust submitted an action plan to the CQC, they have subsequently informed the Trust that they will not pursue enforcement action. The Trust has commenced addressing the areas identified in the report. A full written report will be presented to public Board of Directors when the finalised CQC report is issued to the Trust.

The Nursing and Midwifery team have enhanced their Quality Assurance Framework which provides assurance relating to quality and safety of services from Ward to Board. This framework formalises and standardises the way in which Senior Sister/Charge Nurses, Matrons and Divisional Directors of Nursing have oversight of quality, safety and performance at ward/department level.

The ExCEL – Excellent Care @ Every Level Accreditation Programme is continuing to be rolled out with OPAU achieving Bronze accreditation in October.

3. Finance

The BSW system has set a breakeven financial plan for 2022/23 as required and within this some organisations are planning a deficit and others a surplus. The RUH is planning a deficit of £19.3 million. The actual position at the end of Month 6 was a deficit of £14 million which is £1.4 million worse than planned. The position improved by £800,000 in the month due to additional income associated with an increase in elective work. There is a continuing focus on delivering additional elective capacity to address the elective backlog. The Trust is continuing to experience pressures in pay costs, particularly in emergency care medical and nursing staffing. There is a financial recovery plan in place to ensure these costs pressures are brought back in line with plan. Of the full year savings plan (of £14.8 million), £12.7 million of schemes and opportunities have been identified.
The key risks to the delivery of the financial plan are ensuring we maintain elective capacity which require reducing the number of patients with no criteria to reside; managing vacancies and temporary cover of workforce gaps; delivering the savings plan; and managing the impact of inflationary pressures especially in respect of utilities.

4. People

With the launch of the Trust's new vision of 'You matter' we have introduced our own on-line discount and Health and Well-being platform, with 1353 activations to date and have held our first Equality Diversity and Inclusion conference aligned to Black History Month, welcoming colleagues from Public Health alongside external speakers.

Staffing levels remain at the heart of the True North objective for 2022-23, to support achieving this we continue with our international recruitment, for which we have received an National Pastoral Care Award. Trac also continues to deliver improvements in recruitment timeframes and the Digital Talent Programme continues to drive wider changes across its six workstreams. The Locum's Nest pilot has proved successful with over 75% of shifts being filled and a further nine month extension has been commenced.

We are continue to work hard to support staff with increasing costs of living, introducing weekly bank pay and moving the pay-date in response to staff feedback and we are working hard with clinical divisions to support our colleagues as we see increasing sickness absence and turnover. We are using A3 improving together methodology to ensure we can understand and address all the root causes.

5. Independent Investigation into East Kent Maternity Report

Background

In February 2020, NHS England and NHS Improvement (NHSE/I) commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. This followed concerns raised about the quality and outcomes of maternity and neonatal care. Dr Kirkup published his report on 19 October, Reading the signals: Maternity and neonatal services in East Kent – the report of the independent investigation.

Findings

The investigation reviewed 202 cases where the families involved asked to participate and where their care fell within the scope of the investigation.

The investigation found a clear pattern where those responsible for the services often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor, both as care was given and in the aftermath of injuries and deaths.

Investigation Findings

The investigation found that the individual and collective behaviours of those providing the services were visible to senior managers and the trust board in a series of reports throughout the period and lay at the root of the pattern of recurring harm. At any time during this period, these problems could have been acknowledged and tackled effectively and eight clear separate opportunities were identified when that could have happened. The investigation's assessment of the clinical outcomes found that:

- Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the investigation team, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.

Accountability

The report states that the issues were systemic throughout the organisation and individual clinicians are not at fault. The report is clear that a series of failings at board level meant opportunities to identify and rectify failures were missed.

Areas for Action

The investigation did not seek to make multiple detailed recommendations, instead it identifies four broad areas for action, based on its findings with much wider applicability. These are:

1. Monitoring safe performance – finding signals among the noise, therefore focus on:
    a) Effective monitoring to outcomes
    b) Meaningful measure
    c) Data show graphically to identify variation, trends and outliers – this must be national and mandatory
2. Standards of clinical behaviour – technical is not enough
    a) Compassionate – never lose sight and address if occurs
    b) Professional behaviour and compassionate care must be embedded into professional development
    c) Reasonable and proportion sanctions to address poor behaviour
    d. Listening to patients must be re-established
3. Flawed team working – pulling together in different directions
    a) A strong basis of team working in maternity and neonatal care with common goals and shared understanding
    b) National guidance of different care pathways
    c) Teams to train together
    d) Evaluate the changed patters of working and training for junior doctors
4. Organisational behaviour – look for good while doing badly
    a) Balance of incentives for organisations need to be changed. There is a need for openness, honesty, disclose and learning
    b) Legislation to oblige public bodies and officials to make all their dealings with families honest and open
    c) Review the regulatory approach to failing organisations

In making its recommendations, the report is clear that the first step in the process of restoration is for all concerned to accept the reality of what has happened and the damage caused to families. Therefore, recommendation 5 states the Trust must accept the reality of the findings, acknowledge the unnecessary harm that has been caused and embark of a restorative process addressing the problems identified in partnership with families and the public.

RUH are undertaking a benchmark assessment against these recommendations which will be presented to Board of Directors in December 2022.

6. Update from Management Board Held on 26th October 2022

This was the first meeting of the new, streamlined Management Board, which has now been renamed the Trust Management Executive. The Chief Executive provided a detailed summary from the recent NHSE CEOs meeting, highlighting the Centre's perspective and advice in respect of current challenges. There was also an update on the progress of the Outline Business Case for the work on the Sulis Hospital site. The main focus of the meeting, however, were a detailed discussion about the Finance Strategy and the steps that need to be taken to set the Trust onto a more sustainable financial footing, and to help inform the subsequent Board session. The other key item was a workshop session on the causes and impacts on the hospital of current operational pressures, particularly in relation to ambulance handover delays and flow through the hospital. An improvement event is to be held in the coming days, involving all key internal and external partners, to identify and implement urgent actions to address the issues.

7. Staff Deaths

I am very sad to let you know that two of our Registered Nurses sadly died this month. I would like to extend my sincere condolences to their family, friends and work colleagues. Both staff members were cared for at RUH and I'd like to thank staff from William Budd ward, the Palliative Care team and the Spiritual Centre for the compassionate care given to their colleagues. Both colleagues were exceptional nurses who touched the lives of so many, both of them leave an amazing legacy of care and compassion behind them.

8. NHS Pastoral Care Quality Award

I am delighted to inform you that RUH has been awarded the NHS Pastoral Care Quality Award by NHS England/Improvement. The awarded is bestowed to Trusts who deliver high standards of pastoral support to international nurses which includes prioritising the wellbeing of internationally educated Nurses and Midwives, ensuring they have tailored support during recruitment and beyond. I am so pleased that we now have over 400 International Nurses and that over 97% remain at the RUH, many of whom are progressing their nursing careers. I'd like to thank the entire team for their excellent work.

9. Nursing Times Workforce Award

The RUH has been nominated and shortlisted for the Nursing Times Workforce Award in the category of Best Employer for Diversity and Inclusion for the project 'Connecting Cultures'. The winners will be announced on the 22nd November 2022.

10. Member of the Florence Nightingale Foundation

I'm pleased to advise that RUH has now become a member of the Florence Nightingale Foundation. This entitles Nursing and Midwives, including students to access leadership and development courses and provides opportunities to join networks to influence with wider Nursing and Midwifery agenda.

11. Infection Prevention and Control Works

We are committed to improving our Estate, as such, work has commenced to create 23 new en suite facilities across 4 of our wards which will enable us to isolate patients with infection more effectively whilst making it much more comfortable for patients. The work is scheduled to be completed by March 2023.

12. RUH Researching ‘Super Rehab’ to Improve or Reverse Chronic Illness

This September the Cardiovascular research team at the Trust shared an update on how an innovative lifestyle intervention, called Super Rehab, could become an effective new treatment option to save lives and reduce hospital procedures, while also cutting costs to the NHS.

Super Rehab is all about testing the impact of a high-level, well-resourced one-to-one support programme for patients with heart disease. It offers more than just advice, providing a tailored diet and exercise programme personalised to the individual with support to make sure the changes are practical and can become part of a daily routine. Super Rehab is being offered to patients earlier in the evolution of their forms of heart disease than other rehab programmes, aiming to halt its progression, help patients feel better, and potentially even reverse the disease process and turn the clock back.

Working in partnership with the University of Bath, and with support from RUHX, the hospital's charity, RUH experts have already seen that this approach can be life-changing. If a CT scan shows that a patient is at risk of developing cardiovascular disease, or at risk of a heart attack, they will be offered the chance to join the Super Rehab programme. The research is starting with two studies, one for coronary heart disease and one for atrial fibrillation, involving just under 100 patients across both studies. Patients are offered Super Rehab in addition to standard treatments, and the research team are collaborating with researchers at the University of Oxford to track the impact using the very latest heart imaging techniques and industry partners for heart rhythm monitoring, alongside blood tests and fitness tests.

13. Breast Cancer Awareness Month

Jessica Parsons, 36 and a mum of two, has been cared for at the Trust since being diagnosed with cancer in June. After finding a lump when breastfeeding her daughter, she was diagnosed with metaplastic squamous cell carcinoma, a rare type of breast cancer accounting for less than 2% of breast cancers. As Jessica comes to the end of six rounds of chemotherapy during October's Breast Cancer Awareness Month, she is working with the RUH to spread the message that it is important to check your breasts no matter what your age. Jessica has been sharing her experience and encouraging others to check themselves regularly, and has been interviewed by local radio and featured in local and national press.

14. Black History Month

Throughout October the Trust is celebrating Black History Month. This year’s theme is ‘Actions not words’. In line with our vision, we are committed to making sure that every member of our staff and all of our patients and visitors feel as though they matter from the minute they come into contact with us.

However, we acknowledge we are not always getting this right. Our evidence shows that where this is definitely the case is the experience of our ethnically diverse colleagues, who are more likely to experience bullying and harassment by patients and families as well as other staff members and more likely to experience discrimination by their line manager than that of a white team member. We are committed to the RUH becoming a more inclusive place to work and seek treatment and believe race equality is an essential part of delivering great care.

Progress in this area includes work to develop a race equality programme, introducing positive action recruitment programmes and development programmes and a development

of a zero tolerance policy. We held our first ever Black History Month conference on 19th October 2022 where were joined by speakers including Yvonne Coghill, Director – WRES Implementation in NHS England, and as a Trust we committed to actions for change.

15. New Parking Provider Contract

As part of the hospital's new contract with Saba UK, in October all current pay stations have been replaced with new, easier to use payment machines, and more payment options are available. New barriers have been introduced to the main patient and visitor car park to improve traffic flow and give people the option to pay before they leave. Automatic Number Plate Recognition (ANPR) cameras log the time a vehicle has entered the car park and on leaving, all visitors need to do is enter their car registration number into a payment machine to find out how much they need to pay.

Parking for blue badge holders will remain free of charge and free parking will remain in place for those patient groups who need to make frequent visits to the RUH. There have been some changes to parking charges, the first in ten years. Money raised will be used to cover the cost of the car parking contract as well as maintenance, lighting and staffing costs. The model is not designed to raise profit but any additional money that is raised will go back to the RUH.

16. Over 10,000 Listens for New Patient Information Podcasts Offering Help with Rheumatic Diseases

In October Bath Institute for Rheumatic Diseases (BIRD) celebrated over 10,000 listens of its Podcast Library which provides information to patients, families and carers on advances in treatments, therapies and how to live well with the symptoms of different rheumatic diseases. Thirty-six podcasts have been produced since 2020 on individual rheumatic diseases such as Lupus, Osteoarthritis, Rheumatoid Arthritis and Osteoporosis as well as podcasts on Self-Management and wellbeing. Each one features experts in the field of rheumatology from the Royal National Hospital for Rheumatic Diseases (RNHRD), part of the RUH. The aim of the podcasts is to provide patients with a better understanding of their condition, the medications or treatments available and to improve patient knowledge and confidence. Speakers range from Consultants, Specialist Nurses and Physiotherapists to patients sharing their own experiences.

17. HCA Takes Starring Role in BBC Healthcare Video

Healthcare Assistant and Apprentice Nurse Becky Chapman gave up her time to film with the BBC Bitesize website and the Open University for a special feature about jobs in healthcare. The film was shared by the BBC in September – in the video Becky talks about her experience of working as an HCA as well as her work on a local farm where she has her own sheep and a horse. Becky's video is available to watch here https://bbc.in/3Qcqtax

18. Senior Management Changes

Andrew Hollowood has been appointed at the Trust's new Chief Medical Officer following an interview process held on the 5th and 6th September 2022.

Andrew was appointed as a Consultant Oesophagogastric cancer surgeon to University Hospitals Bristol and Weston (UHBW) NHS Foundation Trust in 2006, having trained in the South West and completed his training in Japan. He has over twenty years' experience of working in the NHS and has undertaken many leadership roles.

Andrew recently held the position of Deputy Medical Director of UHBW and is currently the Site Medical Director in Weston. Andrew brings with him a wealth of experience in the

delivery of major change and has been responsible for the design of the new model of working for Weston General Hospital.

Andrew starts at the RUH in mid-November. In the interim period, Professor Richard Graham, Deputy Medical Director will act into the role.

19. RUH Membership

We are always actively seeking new members to help us shape the future of the hospital and as a member of the Trust you can influence many aspects of the healthcare we provide.

By becoming a Member, our staff, patients and local community are given the opportunity to influence how the hospital is run and the services that it provides. Membership is completely free and offers three different levels of involvement. Through the Council of Governors, Members are given a greater say in the development of the hospital and can have a direct influence in the development of services. Simply sign up here: https://secure.membra.co.uk/RoyalBathApplicationForm/

20. Annual General Meeting

Our 2022 Annual General Meeting combined with Annual Members Meeting took place on Thursday 29th September 15:00 – 17:00. The meeting was broadcast live online via Microsoft Teams as the original meeting was postponed following the death of Her late Majesty Queen Elizabeth II. The key successes and challenges of the year 2021/22 were reviewed and the Annual Report and Accounts were formally presented. In addition, the Lead Governor presented the proposed changes to the Trust's Constitution which were approved by Members.

A recording of the meeting is available to view on the Trust website (https://www.ruh.nhs.uk/about/AGM/index.asp), alongside the following materials:

- Meeting Presentation slides
- Year in Review 2021/22
- Council of Governors Annual Report 2021/22
- Corporate Report & Accounts 2021/22

A total of 9 questions were asked by the public during the question and answer session, all of which were answered live by the Board of Directors. These can be viewed in the recording.

21. Governor Elections 2022

Voting commenced on 22nd September to elect new Governors for the hospital. All eligible members were sent ballot papers to their home addresses and email address respectively. Everyone was encouraged to use this opportunity to vote for the candidate who would best represent the member's views.

Voting closed at 5pm on Monday 17th October 2022 and the results were announced on Tuesday 18th October 2022. Look out for a "Meet the Candidates" special article in our winter edition of the Insight magazine which is due to be sent to members in late November/ early December.

Following the close of the elections on Monday 17th October, the following candidates have been elected to join the Trust's Council of Governors:

- Nicola James, City of Bath
- Vivienne Harpwood, City of Bath
- Anna Beria, North East Somerset
- Anne Martin, Somerset (re-elected)
- Diana Benham, South Wiltshire
- Narinder Tegally, Staff (re-elected)
- Beas Bhattacharya, Staff

North Wiltshire and Rest of England and Wales constituencies were uncontested and the following candidate was elected unopposed:

- Ramal Royal, Rest of England and Wales

The candidate for the North Wiltshire constituency withdrew from the process for personal reasons. As a result, we will be running a by-election shortly to fill this vacancy.

The full election report is available to read on the Trust's website.

22. Consultant Appointments

The following Consultant appointments have been made since the last report to Board:

- Dr Ovishek Roy was appointed as a Consultant in Gastroenterology on 31st August 2022. Dr Roy currently works at Royal Devon & Exeter NHS Foundation Trust as a Consultant;
- Dr Joseph Keighley was appointed as a Consultant in Radiology on 12th September 2022. Dr Keighley currently works as University Hospitals Sussex NHS Foundation Trust as a Radiology Registrar;
- Dr Laura Rich was appointed as a Consultant in Diabetes on 20th September 2022. Dr Rich is already working at the Trust as a Locum Consultant;
- Dr Samantha Hayward was appointed as a Consultant in Obstetrics & Gynaecology on 3rd October 2022. Dr Hayward is currently working at Salisbury NHS Foundation Trust in the same role;
- Dr Edoardo Ricciardi and Dr Matthew Doe were appointed as a Consultants in Upper Gastro-Intestinal & Emergency Surgery on 20th October 2022. Dr Edoardo Ricciardi is currently working at the RUH as a locum in this role. Dr Doe is working at University Hospitals Bristol and Weston NHS Foundation Trust as a Specialty Training Year 8 in Upper GI Surgical Registrar ST8;
- Dr Daniel White and Dr Deirde Nally were appointed as Consultants in Colorectal Surgery on 20th October 2022. Dr White is works at University Hospitals Sussex NHS Foundation Trust as a Royal College of Surgeons Colorectal Fellow and Dr Nally at Oxford University Hospitals NHS Foundation Trust as a Senior Clinical Fellow.

23. Trust Seal

The Trust Seal was used on the following dates:

- On 27th September 2022 in relation to the construction of a 3rd ultrasound room in the Breast Care Department at the RUH;
- On 30th September 2022 in relation to the sealing of the shareholder agreement between the RUH and Sulis Hospital Bath Ltd.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**2 November 2022**		

Title of Report:	**Board Assurance Framework Summary Report**
Status:	**For Information and Discussion**
Board Sponsor:	**Cara Charles-Barks, Chief Executive**
Author:	**Adewale Kadiri, Head of Corporate Governance**
Appendices	**Appendix 1: BAF Risks Summary Sheet** **Appendix 2: BAF Risks rated ≥20 and key actions**

1. Executive Summary of the Report

The Board Assurance Framework (BAF) is a key mechanism for ensuring that the Board is able to monitor those risks that could prevent the Trust from achieving its strategic objectives. The BAF identifies and scores the risks, and describes the steps being taken to manage, mitigate or avoid their impact.

The purpose of this paper is to provide an update on the content and development of this year's BAF, and highlight actions being taken to address the individual risks.

One of the main aims of the BAF is to help drive the Board's agenda and ensure that sufficient time is spent on issues that are key to achieving the Trust's objectives. It is therefore important that the BAF process is flexible enough to adapt to the Trust's internal and external risk environment.

In summary, the main changes to the BAF since the last report in July are as follows:

- The rating for BAF 5 (failure to maintain patient flow through the hospital…) has been increased from 16 to 20
- The Non-Clinical Governance Committee has asked that the scope of BAF 6 (failure to reduce the Trust's environmental impact and become carbon neutral by 2030) be broadened to include the impact of climate change on the Trust.

2. Recommendations (Note, Approve, Discuss)

The Board is asked to note this update and discuss any potential changes to the risks or their ratings, or to suggest any additional risks.

3. Legal / Regulatory Implications

As the Board's highest level risk register, the BAF is key to evidencing that the Trust meets the requirements of the Care Quality Commission's Well Led framework.

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

The Report sets out all of the Trust's current BAF risks, and the Board has the opportunity to suggest additional risks based on their understanding of the Trust's internal and external risk environment.

5.	Resources Implications (Financial / staffing)
Not applicable	

6.	Equality and Diversity
Not applicable	
7.	**References to previous reports**
The last BAF summary report was presented at the March 2022 meeting	

8.	Freedom of Information
Public	

Board Assurance Framework Review

Background

The Board Assurance Framework (BAF) is a key mechanism for ensuring that the Board is able to monitor those risks that could prevent the Trust from achieving its objectives. In other words, it focuses on the highest level risks facing the organisation – both operational and strategic. The Board and its Committees have been working with executive leads to agree and keep up to date the constituent risks of the 2022/23 BAF, along with the key controls and sources of assurance.

Current BAF risks

The summary sheet in Appendix 1 is a snapshot of the current risks that the Board has agreed could, if not properly managed, prevent the Trust from achieving its strategic goals. The lead directors and committees have agreed and continue to review and challenge the measures that should help to manage these risks, as well as action plans to move from the current rating to the lower target score.

Arguably, once a risk has reached its target rating, it can be removed from the BAF on the basis that it has either been effectively managed or its impact mitigated to such an extent that it could be accepted as part of business as usual. However, it is acknowledged that it will be easier for some of the risks to achieve their targets than others. Indeed, as part of the early thinking around the 2023/24 BAF, the Board is considering whether those long standing risks that are more difficult to shift ought to be treated differently from those that could ultimately be managed off the BAF.

Since the last update to the Board, a number of changes have been made to some of the risks, either by the executive leads or the lead committees:

- The risk rating for BAF 5 (failure to maintain patient flow through the hospital continues to affect performance, safety of care and patient experience) has been increased from 16 (consequence = 4 x likelihood = 4) to 20 (4x5). This is mainly in recognition of the difficulties that the Trust has experienced around Non Criteria To Reside and the lack of capacity within local community and social care services. It is also noted that the work that is currently being done to increase en suite facilities is having the temporary effect of reducing bed capacity.
- The Non-Clinical Governance Committee has asked that the current scope of BAF 6 (failure to reduce the Trust's environmental impact and become carbon neutral by 2030) be broadened to cover the wider impact of climate change and what the Trust needs to do about it going forward. This work is underway and would have been reported to the Committee's meeting that was held yesterday.
- Further work is also being done in respect of BAF 9 (cyber security) to reflect, as much as is possible, the actions that have been taken to better protect the Trust from attack and the risks that still remain. The outcome of this work will also be reported to NCGC.
- BAF 1, 2 and 15 have been updated to reflect the factors that are contributing to risks around the maintenance of high quality services. With regard to BAF 1 (delivery of sub-optimal quality services), reduced staffing levels, more recently seen among Allied Health Professionals, insufficient isolation facilities and the lack of bed capacity are the most recent contributory factors. For BAF 2 (failure to

prevent avoidable healthcare associated infections), unfilled vacancies within the cleaning teams and insufficient bed spacing on some wards are two of the recent issues, while for BAF 3 (sub-optimal maternity services) a key issue is the fact that the BirthRate+ tool has identified the requirement for additional posts for which funding is not currently available.

- The financial risks that are facing both the Trust and the wider BSW system have now been better described. BAF 7 (failure to deliver the Trust's financial plan and develop the longer term financial plan) and BAF 8 (lack of sufficient capital funding prevents the Trust from making the necessary investments in its infrastructure to provide and support safe services for patients) set out the risks facing the RUH, while BAF 11 (Failure of the BANES, Swindon Wiltshire Integrated Care System to deliver its financial plan and failure to develop a plan to return to financial sustainability) relates to the system's position. The focus in both cases is on need for longer term planning to help achieve financial sustainability across the system.

The risk environment

The Board will note that the BAF as a whole reflects some of the key challenges facing the NHS post-pandemic – lack of staffing is a particular theme, as is capacity, both here at the hospital and within the community.

The executive leads and colleagues are actively engaged in managing these risks through a range of immediate actions, including, for example, some specific capital works in respect of BAF2 (Failure to prevent avoidable healthcare associated infection harm), and longer term work with BSW partners in respect of Risks 11, 13 and 14. The Committees will continue to monitor the delivery of these actions, including timescales.

Future work

The BAF is, understandably an agile document. While many of the major risks facing the organisation are unlikely to change in the short term, it is possible that new risks will emerge or that existing risks will need to be managed differently. The lead committees assess their risks at each meeting, and are best placed to respond to changes in the risk environment that require a re-appraisal of how these are managed.

It is also for the Committees to consider whether the risk as set out still accurately describes the issues that the organisation is facing on a particular subject, and the different approach that the Non-Clinical Governance Committee now intends to take in respect of both of its risks reflects this.

As always, the Board is invited to put forward any potential risk areas that they think ought to be considered for inclusion, as well as any changes they wish to suggest to the focus of any of the existing risks. It is intended that discussions leading to the agreement of the 2023/24 BAF will start in December – any early thoughts on what this ought to focus on are welcome.

Conclusion

The BAF continues to reflect the most serious risks facing the organisation at any time and is key to helping the Trust address and manage these. The Board is asked to note this

update, discuss any potential changes to the risks or their ratings, or to suggest any additional risks.

Appendix 1

Royal United Hospitals Bath
NHS Foundation Trust

Ref	Risk Description	Initial Score	Current Score	Target Score	Lead	Lead Committee	Risk Appetite
Strategic Priority 1: Recognised as a listening organisation; patient centred and compassionate							
Risk 1	Delivery of sub-optimal quality services, leading to sub-optimal patient outcomes, care and experience and failure to meet regulatory standards	20	20	12	Chief Nurse	QGC	Minimal
Risk 2	Failure to prevent avoidable healthcare associated infection (HCAI) with reportable organisms, including COVID-19 leading to harm	16	16	12	Chief Nurse	QGC	Minimal
Risk 15	Delivery of sub-optimal quality services, leading to sub-optimal patient outcomes, care and experience and failure to meet regulatory standards – Maternity services linked to staffing levels	20	20	12	Chief Nurse	QGC	Minimal
Strategic Priority 2: Be an outstanding place to work where staff can flourish							
Risk 3	Failure to ensure there are enough people in the organisation to do the job is likely to lead to increased experiences of incivility; discrimination; burnout; exhaustion; higher bank & agency spend ; and poor patient outcomes	20	20	15 (5x3)	Director for People & Culture	People Committee	Open
Strategic Priority 3: Quality improvement and innovation each and everyday							
Risk 4	Failure to achieve the NHS Constitutional emergency, elective diagnostic and cancer targets, which leads to an inability to provide timely care and avoid unduly long patient waits	20	20	15	Chief Operating Officer	F&PC	Cautious
Risk 5	That the failure to maintain patient flow through the hospital continues to affect performance, safety of care and patient experience	16	20	12	Chief Operating Officer	F&PC	Cautious
Strategic Priority 4: Be a sustainable organisation that is fit for the future							
Risk 6	Failure to reduce the Trust's environmental impact and become carbon neutral by 2030	16	16	12	Director of Estates	NCGC	Open
Risk 7	Failure to deliver the Trust's financial plan and to develop the longer term financial plan	16	16	12	Director of Finance	F&PC	Cautious/Open
Risk 8	The lack of sufficient capital funding prevents the Trust from making the necessary investments in its infrastructure to provide and support safe services for patients	20	20	12	Director of Finance	F&PC	Cautious/Open

Risk 9	Cyber-security breaches leading to inability to use digital platforms due to a cyber-attack resulting in potential loss of services across the Trust and loss of data.	20	20	12	Chief Digital Officer	NCGC	Cautious
Risk 10	That the potential medium and longer term benefits of acquiring Sulis Hospital Bath are not achieved	12	12	8	Chief Operating Officer	SOC	Open
Strategic Priority 5: Work together with our partners to strengthen our community							
Risk 11	Failure of the BANES, Swindon Wiltshire Integrated Care System to deliver its financial plan and failure to develop a plan to return to financial sustainability	16	16	12	Director of Finance	F&PC	Open
Risk 13	Non-elective demand exceeds the Trust's ability to cope, leading to reduction in the quality of care and longer waits	20	20	12	Chief Operating Officer	F&PC	Open
Risk 14	Community services are not sufficiently responsive to enable patients to get home promptly, leading to hospital beds being occupied by patients who do not need them. The Trust is then unable to accommodate new patients and patient decompression.	16	20	12	Chief Operating Officer	F&PC	Open

Appendix 2

Key actions being taken to address the highest rated risks (all rated at 20)

Delivery of sub-optimal quality services, leading to sub-optimal patient outcomes, care and experience and failure to meet regulatory standards:

- Bi-annual review of Nursing & Midwifery staffing
- Safer staffing meetings being held twice a day
- Development of an out of hours Senior Nurse rota
- Launch a of a live e-roster to enable staff to raise a 'red flag' regarding staffing levels
- Review and benchmarking of Allied Health Professional roles at the RUH and across the BSW Acute Hospital Alliance

Delivery of sub-optimal quality services, leading to sub-optimal patient outcomes, care and experience and failure to meet regulatory standards – Maternity services linked to staffing levels:

- Continue to work towards Maternity Incentive Scheme and Ockenden compliance
- Bi-annual Midwifery staffing review
- Two safer staffing meetings per day
- Development of an out of hours Midwifery on call rota
- Redo BirthRate+ to calculate staffing levels with the aim of achieving Continuity of Carer requirements
- Running a focussed recruitment campaign for Maternity
- Assessing measures to improve retention rates among midwives.

Failure to ensure there are enough people in the organisation to do the job is likely to lead to increased experiences of incivility; discrimination; burnout; exhaustion; higher bank & agency spend ; and poor patient outcomes:

- Medical establishment review to be completed
- Strategic workforce plans to be completed
- Candidate attraction and recruitment plans to be developed
- Equality, Diversity and Inclusion review to be competed
- Introduction of a Scope for Growth and Succession planning programme
- Trust Education plans to be written
- Review of AHP establishment to be carried out
- Health Education England to assist the Trust in developing its workforce planning process

Failure to achieve the NHS Constitutional emergency, elective diagnostic and cancer targets:

- Plans have been developed and are being implemented to recover the delivery of elective care in line with national guidance

- Plans are also in place to deliver improvements in 62 day performance in relation to cancer care
- The additional capacity provided by Sulis Hospital is being utilised to maintain elective care in the face of significant emergency pressure at the RUH
- Electronic communication aids continue to be used in areas such as Outpatients to minimise the need for patient contact and reduce delays in patient care.

Failure to maintain patient flow through the hospital continues to affect performance, safety of care and patient experience:

- Revising bed model to identify capacity gaps and mitigations for winter
- Confirming the Trust's winter plan
- Engaging sisters and matrons in the revised approach to ward flow

The lack of sufficient capital funding prevents the Trust from making the necessary investments in its infrastructure to provide and support safe services for patients:

- Long term capital planning relating to Sulis Hospital is being developed
- Development of a BSW infrastructure strategy

Cyber-security breaches leading to inability to use digital platforms due to a cyber-attack resulting in potential loss of services across the Trust and loss of data , including exposure of patient and other sensitive information, regulatory intervention and reputational damage:

- Implementing plans to migrate systems off unsupported servers
- Identifying dedicated roles in IM&T/Cyber and data security that require resource
- Accessing and following advice from the Data Protection Officer on compliance with UK GDPR and regulatory standards to help guide progress on cyber security

Non-elective demand exceeds the Trust's ability to cope, leading to reduction in the quality of care and longer waits:

- The Ageing Well Programme across the BSW footprint is implementing a range of interventions to support patients and reduce the need for emergency hospital care
- Expansion of the Trust's same day emergency care services
- Work being done across BSW on reducing demand for emergency care, reviewing 111 call rates, and rolling out rapid responses to rising pressures on the system as they occur.

Community services are not sufficiently responsive to enable patients to get home promptly, leading to hospital beds being occupied by patients who do not need them:

- System-wide approach to winter planning
- Additional investments in discharge services at locality level across BSW
- Understanding of and planning for bed shortfalls during the winter months – interventions are being made to reduce bed gaps

- Innovative and collaborative work is taking place between the Trust and its community partners on different schemes for the delivery of out of hospital support packages.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**11.0**
Date of Meeting:	**26 October 2022**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor:	**Simon Sethi, Chief Operating Officer** **Libby Walters, Director of Finance & Deputy CEO** **Alfredo Thompson, Director for People & Culture** **Toni Lynch, Chief Nurse**		
Author:	**Rhiannon Hills, Deputy Chief Operating Officer** **Tom Williams, Head of Financial Management** **Jenny Turton, Assistant Director of HR** **Rob Eliot, Lead for Quality Assurance**		
Appendices	**Appendix 1: Integrated Performance Report**		

1. Executive Summary of the Report

The report provides an overview of the Trust Operational and Financial Performance as at the end of September 2022, aligned to our True North Pillars and breakthrough objectives agreed for the year.

The slide pack includes an overarching Executive summary with each section providing a more detailed summary on key indicators and measures monitored via the Integrated Performance Report.

Performance

- In September the Trust lost a total of 2,420 hours in ambulance handovers, which is a deterioration on the August position. The causes of this were increased Covid admissions, higher numbers of non-criteria to reside patients and the closure of beds for the IPC improvement works. The COO and CNO are jointly leading an urgent recovery plan to improve the Trust's position on ambulance handovers despite these current challenges. Winter plans are being tracked closely which should mitigate rising winter pressures.

- During September, the Trust had an average of 129 patients waiting who had no criteria to reside and is significantly outside of the system modelling trajectories. Additional capacity, both bedded and home based is due to come on line over the next 3 months – the key change will be the opening of Ward 4 in Bath in October and South Newton in November.

- Despite significantly increased demand, urgent care performance was 71.5% in month against an internal 80% target reflecting improved staffing levels.

- Cancer 62 day performance in August fell to 64.6% but is expected to improve in September and remains one of the best in the region. The key challenge remains around colorectal where very high demand has put strain on services. The Deputy MD and COO are jointly working on supporting recovery in this area – Trust activity remains very high in key diagnostic modalities to support this.

- During September the Trust had no patients waiting longer than 104 weeks.

Recovery plans are in place of key areas of challenge including oral surgery, general surgery and gastro.

- The Trust delivered 110% of costed activity against the Elective Recovery target in month – the best in the region for most recent comparative data available. This means performance YTD is currently at 106%.

Finance

- The RUH delivered a deficit of £13.96 million against a plan of £12.56 million.
- The number of Non Criteria to Reside patients had reduced slightly but remained high, with an average of 129, which was above the planned level. Work is happening across BSW to focus on reducing the number of patients with no criteria to reside at the RUH
- High agency usage continued in the month, due to the continued use of registered mental health nurses. There has been focus on how we care for patients with a need for mental health support and this is now being managed in a more co-ordinated way to reduce the reliance on high cost temporary staffing.
- An increase in elective activity resulted in activity being at 110% of 2019/20 levels in the month, which at 106% year to date is above the 104% target. The improved ERF position has contributed an additional £900,000 of income to the Trust's position and accounts for the majority of the improved position in the month. We are continuing to focus on maximising the amount of elective activity through the second half of the financial year.
- The identification of an increased QIPP remained a significant challenge through the financial year but the gap of identified schemes has reduced by £689,000 in the month. Each service area is focussing on closing their QIPP gap to ensure the target is delivered and this forms part of the recovery plan.
- The RUH was managing £10m of risks in the opening plan which increased by £5m due to operational pressures increasing expenditure rates. £8 million of risks remain and are being managed through the RUH recovery plan, £6m and £2m of potential extra winter costs which are being managed across the system. The recovery plan is focussing on reducing high cost agency usage both in nursing and ancillary staff; managing energy usage; closing the QIPP gap; improving the profitability of elective work and reducing expenditure to managing remaining risks.

Workforce

- Vacancy rate has increased to 5.7%. International nursing recruitment continues. A new Senior Resourcing Manager has been appointed to provide support to the team.
- Turnover has exceeded the target at 1.02% however this has slightly reduced from last month. Rates have now returned to pre-COVID levels and a deep dive into this issue is being led by the Associate Director of Learning and Culture. Its results will be presented at People Committee in December.
- Sickness remains above target at 4.57%, reduced from the previous month, reflecting a continuing drop in COVID cases.
- Agency and nurse spend both continued to exceed target at 3.87% and 8.48% respectively although these are both reductions from the previous month.

- Mandatory training compliance levels, which now excludes bank workers, continue to decrease, and now stand at 85.40%. Information governance compliance has improved fractionally to 75.50%. A contract has been signed for the provision of a new electronic training platform which will make it possible for staff to access training via their mobile devices. The training team is also looking for new ways of taking training opportunities to staff, as against the current reactive approach.

Quality

Data for September shows the Trust is under-performing for the following objective and tracker measures:

- Healthcare Associated Infections
- The Trust remains above trajectory for:
- Clostridioides difficile: 7 cases of Clostridioides difficile reported during September, against an in month trajectory of 3.5. There have been 36 cases year to date against an annual trajectory of 42.

- E coli: 13 cases of E coli infections reported during September 2022, against a monthly trajectory of 6.3. There have been 50 cases year to date against a trajectory of 76.

- COVID-19: There were 33 confirmed nosocomial infections in September and two deaths associated deaths which had COVID-19 recorded on the death certificate.

  A number of actions are being undertaken to reduce Hospital Acquired Infections which include:
- The Cleaning Standards Group commenced to oversee and improve compliance of cleaning standards across the Trust chaired by the Deputy Director of Estates and Facilities and the Deputy Director of Infection, Prevention and Control.
- A catheter care improvement programme is being implemented.
- An improvement plan to improve patient hydration.
- The Trust continues to apply NHSIE guidance underpinned by local risk assessment to reduce COVID-19 spread.

Quality metrics (performing within expected intervals):

- Falls
  The Trust falls per 1000 bed days remains below the national average for a third month, there was one reported fall resulting in moderate harm. A number of actions are being taken to reduce falls which include:
- Enhanced data sets to direct improvement interventions.
- Safety huddles commenced on top contributor wards using Improving Together to drive sustainable improvement on 7 wards.
- Focus on #EndPJParalysis to reduce deconditioning and using appropriate footwear.
- New bed rails guidance launched.
- 'Right footwear, reduces falls' – a working group established to work in

partnership with patients and relatives to ensure people wear appropriately fitted footwear.

- Number of Hospital Acquired Pressure Ulcers
  There were two category 2 pressure ulcers in September. A number of actions are being undertaken to reduce pressure ulcers which include:
- Improvements are focussed on the use of Repose Foot Protection, managing patient non-concordance and patient nutrition.
- A red flag system to ensure all staff are aware of those most at risk is being extended to 3 additional wards.
- 'Wound Warriors' - a series of training sessions based on the principles of wound healing has been launched.

- Patient Experience
- The Trust received 27 formal complaints in September.
- 58% were closed within the required timescale in September.
- PALS had 413 contacts, key themes are: appointment waiting times, communication and information and clinical care and concerns.

- Friends and Family test – 96.51% stated their experience was very good or good against a target of 95%. Positive feedback related to attitudes and behaviours of staff, resources and communication. Negative feedback related to timeliness, communication and resources.
  A number of actions are being undertaken to improve experience which include:
- A review of complaints in Orthopaedics (top contributor).
- Review of letter templates.
- Improving the intranet to ensure patients can access condition specific information.
- Development of Customer Care Training.
- Working in collaboration with an external consultant of one speciality across inpatient and outpatient services to review customer service.
- Developing Customer Care Training for Administration and Clerical staff (in the first instance).

- Maternity
- The Midwife to Birth Ratio is 1:35 against a standard of 1:27. Despite this being higher than required, one to one care in labour was achieved in all but one case (no harm) and the Labour Ward Coordinator has been supernummary for 99% of shifts in September.
- The Maternity Fill rate (for all Maternity Services) is reported as 88.1% (day) and 88.8% (night) for Registered Midwives which is an increase from the previous 3 months.
- The Maternity absence rate (combined vacancy and maternity leave) is 23.26 whole time equivalents (WTE). The vacancy rate is expected to reduce to 16.55 WTE in October.
- Perinatal Mortality rate – there were zero still birth and neonatal deaths in September.

One case was referred to the Healthcare Safety Investigation Branch and one Serious Incident is being investigate. The outcome will feature in future reports.

2.	Recommendations (Note, Approve, Discuss)
The Committee is asked to note the report and discuss current performance, risks and associated mitigations.	

3.	Legal / Regulatory Implications
Trust Single Oversight Framework.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The Integrated Performance Report is linked to the Board Assurance Framework and Risk Register.	

5.	Resources Implications (Financial / staffing)
Operational and financial risks as set out in the paper.	

6.	Equality and Diversity
NA	

7.	References to previous reports
Standing agenda item.	

8.	Freedom of Information
Private	

9.	Sustainability
None identified.	

10.	Digital
None identified.	

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report

October 2022 (September data)

The RUH, where you matter

22/23 Priorities

	Strategy	Trust goals	Breakthrough goals	Trust projects
The people we work with	People plan	There are enough people in this organisation for me to do my job	Recruitment to vacancies	Recruitment transformation project
The people we care for	Clinical strategy Patient engagement strategy	Zero avoidable harm Number of complaints	Reduce hospital acquired infections	Improving patient flow programme Better care better value projects IPC estates plan
The people in our community	Estates strategy Digital strategy BSW Health and Care Model	Delivery of breakeven position Ambulance handover delays Carbon footprint	Reduce the number of patients waiting in hospital (non criteria to reside)	Elective recovery programme Patient safety programme

The RUH, where you matter

Business Rules

	Measure		Suggested Rule	Expectation
Trust Goals, Breakthrough & Key Standards	Driver is **green** for current reporting period		Share success and move on	No action required
	Driver is **green** for 6 reporting periods	6	Retire to tracker measure status	Standard structured **verbal** update, and retire measure to tracker status
	Driver is **red** for current reporting period		Share top contributing reason, the amount this contributor impacts the measure, and summary of initial action being taken	Standard structured **verbal** update
	Driver is **red** for 2+ reporting periods	2	Undertake detailed improvement / action planning and produce full structured countermeasure summary	Present full written **countermeasure** analysis and summary
	More than **6** countermeasure summaries to present	6	Discuss with Exec before Meeting which countermeasure summaries should be prioritised for presentation	Present full written **countermeasure** summary against Exec expectations

The people we work with

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

Month 6

The RUH, where you matter

Executive Summary I

				2021/22				2022/23			
	Performance Indicator	Performing	Outside Tolerance	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
True North	Positive Response Rate: *There are enough staff in this organisation for me to do my job*	>=40.0%	<28.5%			28.9%	35.7%	25.4%	26.6%		

No Making a Difference Survey being run in Q3 - True North for this quarter will reflect National Staff Survey result when available.

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Breakthrough Objective	Trust Vacancy WTE	<=275.2	>301.8	238.6	245.4	223.4	210.9	153.3	166.1	398.9	316.8	322.0	347.3	267.2	307.3
Contextual Information	Substantive WTE on ESR at EoM			4906.8	4936.6	4926.1	4968.6	4966.5	4938.2	4971.4	4985.5	4977.0	5004.5	5007.1	5077.9
Key Standard	Vacancy Rate	<=5.2%	>5.7%	4.62%	4.75%	4.32%	4.08%	2.97%	3.21%	7.41%	5.95%	6.05%	6.47%	4.98%	5.72%
Tracker	Band 5 Nurse Vacancy Rate	<=7.7%	>8.7%	7.93%	8.59%	7.37%	6.55%	6.24%	5.48%	14.75%	10.20%	9.41%	15.69%	14.75%	14.33%
Key Standard	In Month Turnover	<=0.92%	>1.00%	0.86%	0.69%	0.86%	0.85%	0.92%	1.31%	0.97%	0.88%	1.06%	0.99%	1.14%	1.02%
Key Standard	Rolling 12 Month Turnover	<=11.0%	>12.0%	9.83%	9.63%	9.78%	9.86%	10.25%	10.88%	11.00%	11.23%	11.61%	11.81%	12.05%	11.68%
Contextual Information	Bank Use (Staffing Solutions Data)			338.0	357.2	322.7	322.1	258.3	266.3	279.4	281.1	256.8	278.4	261.5	284.3
Contextual Information	Agency Use (Staffing Solutions Data)			118.1	139.5	124.1	132.2	104.3	142.9	122.3	129.9	146.9	138.0	130.9	126.0
Key Standard	Agency Spend as Proportion of Total Pay Bill	<=2.5%	>3.5%	6.06%	4.24%	2.22%	3.60%	3.22%	2.95%	4.26%	3.78%	4.61%	6.56%	5.40%	3.87%
Key Standard	Nurse Agency Spend as Proportion of Registered Nursing Pay Bill	<=3.0%	>4.0%	7.60%	8.43%	7.78%	8.45%	6.58%	8.12%	11.66%	7.09%	9.36%	11.04%	12.08%	8.46%
Key Standard	In Month Sickness Rate (Actual) - Reported 1 month behind	<=3.9%	>4.4%	5.63%	5.31%	5.81%	6.24%	5.50%	6.69%	6.10%	4.66%	5.28%	6.28%	4.57%	
Key Standard	In Month Sickness Rate (Deseasonalised) - Reported 1 month behind	<=4.3%	>4.8%	5.46%	4.99%	5.47%	5.68%	4.67%	6.39%	6.65%	5.26%	5.76%	6.71%	4.90%	
Key Standard	Rolling 12 Month Sickness Rate - Reported 1 month behind	<=4.3%	>4.8%	4.60%	4.69%	4.73%	4.81%	4.87%	5.10%	5.31%	5.38%	5.48%	5.62%	5.59%	
Tracker	Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.10%	1.19%	1.23%	1.22%	1.19%	1.17%	1.11%	1.05%	0.99%	0.98%	0.99%	
Contextual Information	In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.26%	1.43%	1.24%	1.10%	0.95%	1.02%	0.94%	1.04%	0.90%	1.00%	1.05%	

				2021/22				2022/23			
	Performance Indicator	Performing	Outside Tolerance	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tracker	Overall Wellbeing Score	>=3.50	<3.25			3.20	3.21	3.19	3.21		

* Colour coding reflects performance against relevant In Month Target, which may differ from latest month target

Measures requiring focus and a countermeasure summary this month are:

Measure	Executive Summary	Recommendation to Board
Vacancy	The overall vacancy stands at 307.3 WTE, which equates to a vacancy rate of 5.7%. This is above the targeted trajectory if the vacancy rate is to be cut to 4% by the end of the financial year.	Band 5 nurses and Cleaning continue to have highest vacancy rate, this will be support by overseas recruitment work and bespoke recruitment campaigns in cleaning.
Turnover	For the seventh month out of the past eight, in month turnover exceeded target and currently stands at 1.02%. Rolling 12 month turnover is projected to be at or above 12% in the next few months.	A3 work to commence to understand true root causes
Sickness Absence	Although the overall sickness rate in August reduced to 4.57%, reflecting a drop off in Covid cases, it remains above target and the chance of achieving a rolling 12 month sickness rate of 4.3% by the end of the financial year would seem very low.	Focused work continues in hot spot areas, increase in Stress and anxiety being analysed
Agency Spend	Both the agency and nurse agency spend rates have reduced on the previous month, but continue to be well above target	RUH is a regional outlier for off framework agencies. Weekly agency scrutiny at Executive Team meetings focusing on RMNs

Executive Summary II

				National Staff Survey Result					
	Performance Indicator	Performing	Outside Tolerance	2017	2018	2019	2020	2021	2022
Tracker	BME Positive response rate: Organisation provides equal opportunities for career progression or promotion (WRES 7)			40.9%	33.3%	43.6%	47.0%	41.5%	
Contextual Information	Trust Positive response rate: Organisation provides equal opportunities for career progression or promotion (WRES 7)			58.4%	55.7%	57.0%	57.4%	55.7%	

				2021/22				2022/23			
	Performance Indicator	Performing	Outside Tolerance	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tracker	Personal Development Theme Score - BME respondents	>=3.75	<3.50	3.74	3.69	3.00	3.75	3.46	3.49		
Contextual Information	Personal Development Theme Score - All respondents	>=3.75	<3.50	3.71	3.68	3.66	3.63	3.53	3.62		
Tracker	Perceived Fairness Theme Score - BME respondents	>=3.50	<3.25	3.18	3.24	2.70	3.53	3.17	3.13		
Contextual Information	Perceived Fairness Theme Score - All respondents	>=3.50	<3.25	3.39	3.31	3.33	3.35	3.23	3.25		
Tracker	Civility Theme Score - All Respondents	>=4.00	<3.75		3.72	3.71	3.66	3.57	3.57		

No MAD Survey will be run in Q3

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Tracker	BME likelihood of being appointed from shortlisting - comparative ratio to 1 White (WRES 2) - Rolling 3 months	>=1.0	<0.8	0.52	0.51	0.55	0.53	0.57	0.63	0.72	0.66	0.62	0.64	0.63	Not Available
Contextual Information	BME WTE at Band 6 or7			125.3	136.0	137.5	139.8	146.6	145.6	143.4	143.7	143.8	146.8	152.3	153.7
Contextual Information	BME WTE at Band 8A to 9			8.3	8.3	8.3	8.3	8.3	8.3	9.3	9.7	11.6	11.6	11.6	12.6

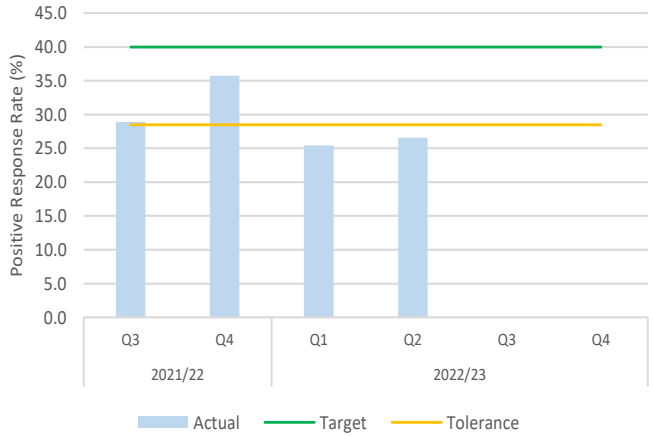
				Last 12 Months											
	Performance Indicator	Latest Month Target	Outside Tolerance	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Key Standard	Appraisal Compliance Rate	>=75.6%	<70.6%	63.04%	62.23%	63.16%	62.48%	59.94%	61.10%	62.66%	66.14%	66.50%	69.65%	71.85%	72.88%
Contextual Information	BME Appraisal Compliance Rate	>=75.6%	<70.6%	67.99%	66.15%	64.49%	62.75%	58.64%	61.05%	64.77%	68.51%	69.09%	71.73%	74.00%	72.95%
Key Standard	Mandatory Training Compliance	>=90.0%	<85.0%	86.60%	86.30%	86.20%	85.60%	85.60%	85.20%	84.90%	85.60%	85.80%	85.70%	85.10%	85.40%
Key Standard	IG Training Compliance	>=95.0%	<90.0%	82.10%	81.70%	81.90%	80.40%	79.50%	77.20%	75.80%	76.70%	77.20%	75.80%	75.30%	75.50%

Measures requiring focus and a countermeasure summary this month are:

Measure	Executive Summary	Recommendation to Board
Training Compliance	Mandatory Training, which now excludes bank, compliance has further fallen and now stands at 85.40%, Information Governance training compliance has fractionally improved to 75.50%. Both rates are considerably below their respective targets of 90% and 95%.	• HRBPs continue to support divisional focus around IG compliance • Business case for new Learning Management Solution approved • Importance of Training compliance being picked up at monthly Performance Review meetings

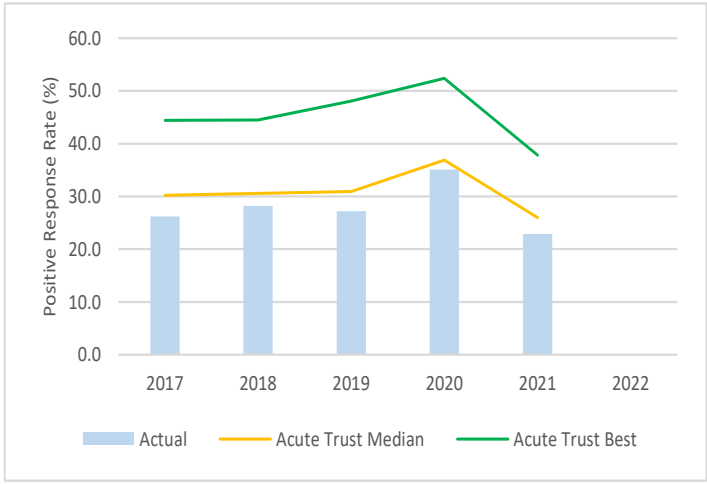
True North | There are enough staff in this organisation for me to do my job

Making a Difference Survey Result



Latest Survey	26.6%

National Survey Results



Latest Survey	22.9%

Is standard being delivered?

'• The percentage who responded positively that there are enough staff in this organisation for them to do their job increased to 26.6% in the Q2 survey. However, despite this improvement, this proportion would still not be sufficient for the Trust to place in the top quartile of Acute Trusts based on the 2021 National Staff Survey results.

What is the top contributor for under/over-achievement?

• Professional clinical staff were least likely to respond positively: Medical & Dental (19.1%); Nursing and Midwifery (20.0%) and AHP (20.5%). Additional Clinical Services had a positive response rate of 41.7%, but this is based on only 24 respondents. In addition, as around half of the I don't know group who had a positive response rate of only 17.4% reporting being Band 2 or 3, it is likely that some of these respondents would fall into the Additional Clinical Services group and lower the positive response rate.
'• Given who is responding less positively, it is unsurprising that Medicine (20.0%), FASS (20.6%) and Surgery (23.4%) are the poorest scoring Divisions.

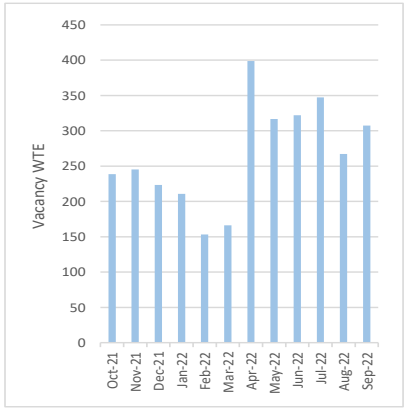
Countermeasure Summary

Countermeasure/Action	Owner
Communication around staffing establishment and plans to be shared as part of vision launch.	HRBPs
FASS: Oncology and Haematology and Breast business cases successful, therefore this supports the increase in workforce establishment for these areas. Currently all vacant posts in other areas across FaSS being recruited to and Pharmacy aseptic and maternity recruitment going well. Recruiting to Nursing safer staffing Trajectory as agreed in April 2022 via a phased implementation plan. Progress monitored via divisional PRM's on a monthly basis	Katy Coulam David Mawdesley.
Develop plans to recruit to establishment plus turnover in 23/24 for overseas nurses	Mandy Rumble

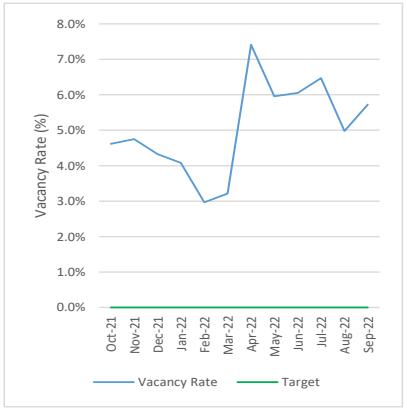
Breakthrough Objective| Reduction in Vacancy WTE

Trust Vacancy Position

WTE

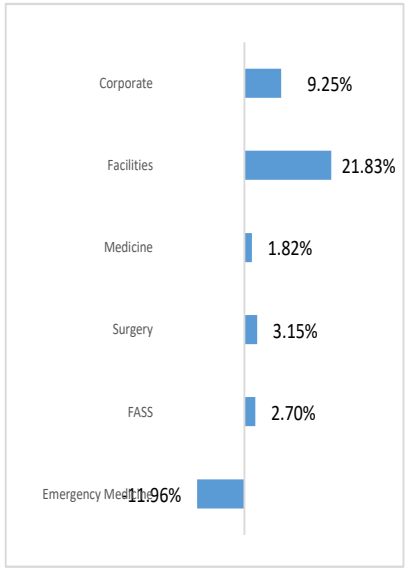


Vacancy Rate

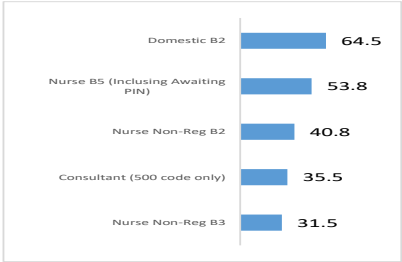


Current Vacancy WTE	307.3	Current Vacancy Rate	5.72%

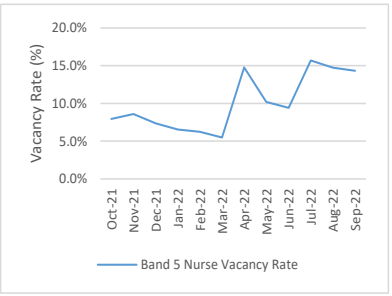
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

• Based on Finance data, vacancies currently stand at 307.3 WTE, which equates to 5.7%. This is above the targeted position for the month given the trajectory outlined to reduce the vacancy rate to 4% by the end of the financial year.

What is the top contributor for under/over-achievement?

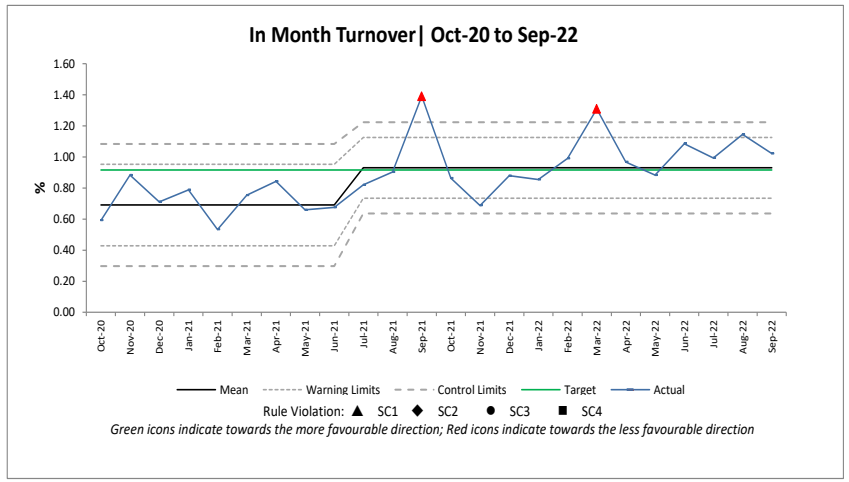
• Facilities has the highest vacancy rate at 21.8%. The vast majority of this relates to the Cleaning & Accommodation directorate and this is reflected in that account code pertaining to Band 2 domestics has the highest vacancy of individual account codes.
• Band 5 nurses has the next highest vacancy at 53.8 WTE, although there are a significant number of international nurses due to start in October (42 arrivals) and November (40 arrivals).

Countermeasure Summary

Countermeasure/Action	Owner
Recruitment drive is continuing in Cleaning – Paid Facebook advert is live for Cleaning Supervisors. Attended Job Centre again in October and exploring the SWAP scheme. Specific resource in recruitment to be allocated to E&F to help process 20 WTE currently in Trac	Holly Hitchcock/Philip Watson Jenny Turton
Specific recruitment campaigns for Pharmacy and Maternity Services and Paeds/NICU Nursing. Paeds have been doing recruitment videos that have proved successful. Maternity Services campaigns include mulitmedia touchpoint, through Google, Facebook and Instragram, RCM Magazine (Sept 2022 issue), Maternity & Midwifery Forum mailing and e-shot. Bid for international Midwives recruitment taking place.	Katy Coulam, Pharmacy Business Manager, Speciality Manager/Rec Midwife/Leads for Maternity Services

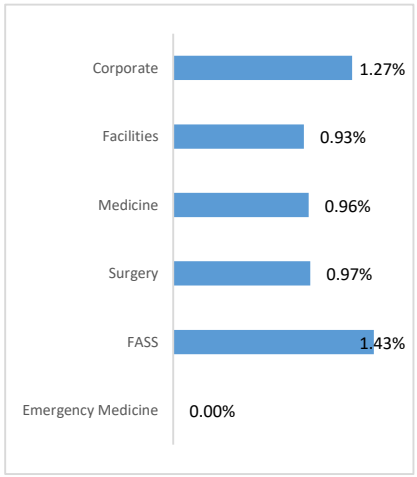
Key Standard| Turnover Rate

In Month Turnover - Trust

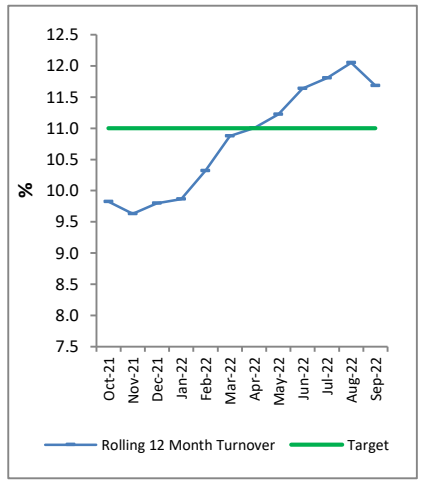


Turnover Rate	1.02%

In Month Divisional Turnover



Rolling 12 Months Turnover - Trust



Turnover Rate	11.68%

Is standard being delivered?

• As it stands, In Month Turnover was 1.04% in September. This means that for 7 out of the past 8 months, turnover has exceeded the target.
'• Turnover in September was, however, lower than that 12 months previously which has resulted in a reduction in the 12 month rolling turnover rate to 11.68%. Nonetheless, based on recent months' turnover and what is due to roll off over the next four months this is not likely to be the start of a downward trend. Rather, a return to 12%+ is quite possible.

What is the top contributor for under/over-achievement?

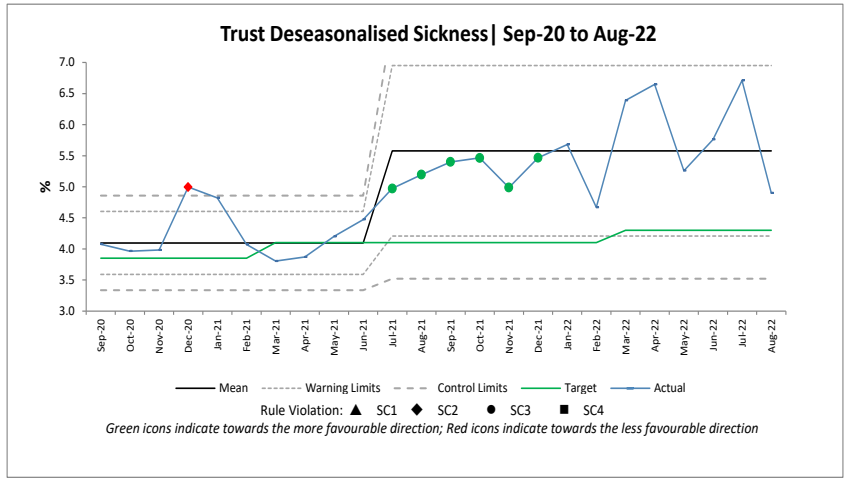
• Only Emergency Medicine (which is a relatively small division) and Medicine, all other main divisions have a rolling 12 month turnover comfortably above the 11% target.
• AHP, Additional Clinical Services and Professional Scientific and Technical staff groups all have a 12 month turnover rate above 14%, with Estates and Ancillary and Administrative and Clerical staff groups also above 12%. Countermeasure summary details specific actions that are taking place to address.

Countermeasure Summary

Countermeasure/Action	Owner
Deep dive into what professions make up AHP vacancy gap	Workforce information
HCA and Admin and Clerical listening events planned November 2022	Helen Back/Ana Gleghorn
Commence A3 looking at turnover, focus on top contributors	Helen Back
3 Leavers in E&F in month. Leaving reasons for Estates and Ancilliary staff are monitored on a monthly basis via E&F Board and exit interviews are being offered with HR for staff who are leaving.	Holly Hitchcock

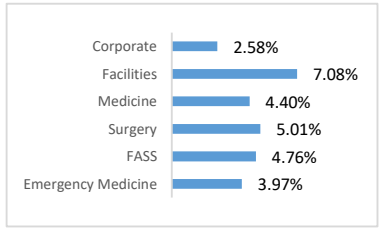
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

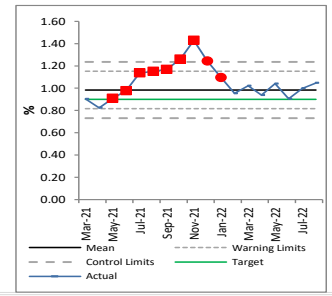


In Month Actual	4.57%	In Month Deseasonalised	4.90%	Rolling 12 Months	5.59%

In Month Divisional Sickness Rates



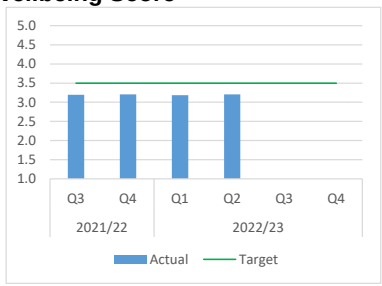
Anxiety, Stress & Depression - Trust



Absence Rate

0.99%

Wellbeing Score



RIDDOR Reporting - Employees

	2021/22				2022/23			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Dangerous Occurrence –release or escape of biological agents	-	-	-	-	-	-		
Exposed to harmful substance/ Work acquired Infection	-	1	-	1	2	2		
Lifting and handling injuries	-	2	2	2	3	1		
Physical assault	-	1	-	-	1	1		
Slip, trip, fall same level	3	3	3	-	3	2		
Struck against	-	1	-	-	-	-		
Struck by object	2	1	-	-	1	-		
Fell from height	-	-	1	-	-	-		
Another kind of accident	-	1	1	-	-	-		

Is standard being delivered?

• Sickness absence rate reduced in August by 1.7 percentage points to 4.57%. This reduction was, however, essentially a reflection of a drop off in the COVID absence rate from 2.77% to 0.95%. The non-Covid absence rate was relatively static, rising 0.1 percentage points on July's position.

What is the top contributor for under/over-achievement?

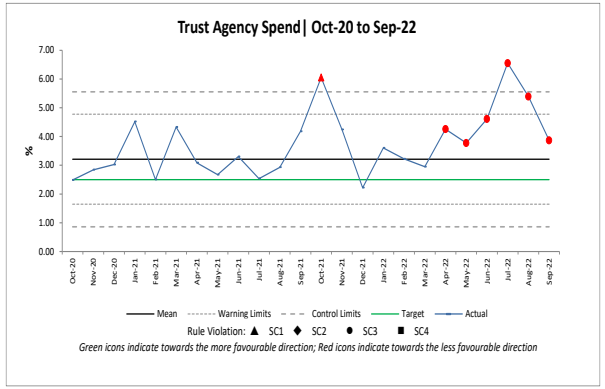
• Chest and Respiratory (which includes COVID) continues to be the main cause of absence (23.24%), despite the reduction mentioned above. The WTE days lost, however, is down from 4467.0 to 1650.5.
'• Anxiety, Stress and Depression is the next most frequently cited reason (22.88%). WTE days lost has been on the increase in the past few months; however the current figure of 1624.9 is well below the high levels that were beginning to be observed at this stage last year.

Countermeasure Summary

Countermeasure/Action	Owner
Deep dive into anxiety stress and depression data	Workforce information
H&WB facilitators continue to support hot-spot areas – drop-in wellbeing session held in E&F	H&WB facilitators
A3 to be completed on Theatres sickness	Helen Back / Lilly Cowan

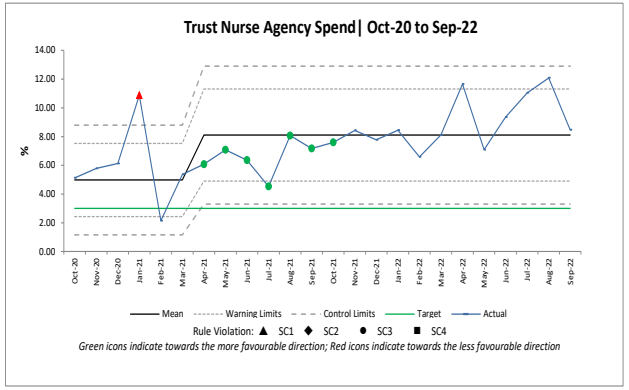
Key Standard| Agency Spend & Bank and Agency Use

Agency Spend as Proportion of Total Pay Bill



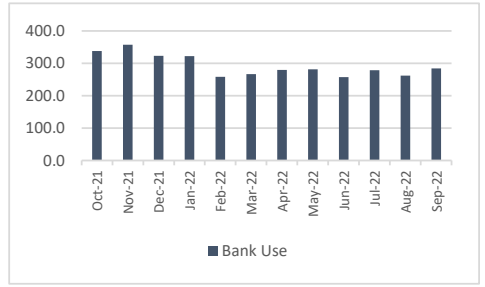
Proportion	3.87%

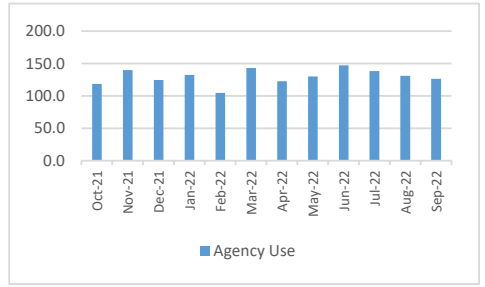
Nurse Agency Spend as Proportion of Total Registered Nursing Pay Bill



Proportion	8.46%

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

- Although Agency spend as a proportion of the pay bill continues on a downward trend, it continues to exceed target at 3.87% and as the sixth successive point above the mean triggers an SPC rule.
- Nurse agency spend has also improved as a percentage on last month's position at 8.46%. Although this data point does not trigger any SPC rules, the current parameters ought to be noted as the target falls below the lower control limit suggesting this target is very unlikely to be realised, especially on a consistent basis.

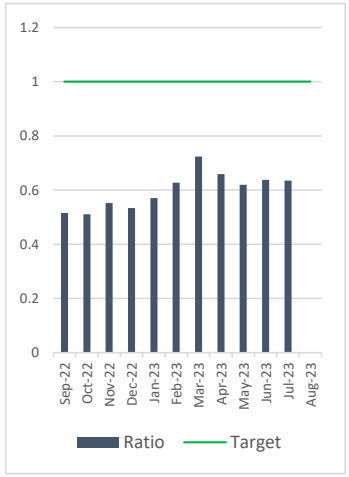
What is the top contributor for under/over-achievement?

- Over 60% of agency spend was related to registered nursing, with a further 20% pertaining to Consultants.
- Nursing & Patient Care, Paediatric Inpatients and COVID-19 Mass Vaccination Programme had the highest nurse agency spend at cost centre level.

Countermeasure/Action	Owner
Recruitment drive in Cleaning should result in a reduction in the agency spend of the department – additional recruitment resource to be allocated to support with processing candidates through Trac As and when new recruits start in Maternity Services and other Clinical areas in which bank/agency spend is high this should result in a reduction in bank/agency spend.	Holly Hitchcock / Philip Watson / Recruitment Katy Coulam/Fass Lead Clinicians and Speciality Managers
Growing the Bank: Auto enrolment onto the Bank at the point of recruitment went live for new joiners from 1st July for Nursing Band 2-7 and Medical Staff	Eugenie Mellon
Weekly pay for Bank workers to commence 4th November – The approach aims to attract and retain valued bank workers by levelling the playing field amongst competitors	Eugenie Mellon
Locums Nest pilot live to trial new ways of working with Medical Locums to improve access to bank opportunities.	Eugenie Mellon
RMN Agency spend remains high in comparison with previous years demand. To mitigate risk a review for the RMN Assessment form and escalation process is underway	Ana Gleghorn

Key Standard| Agency Spend & Bank and Agency Use

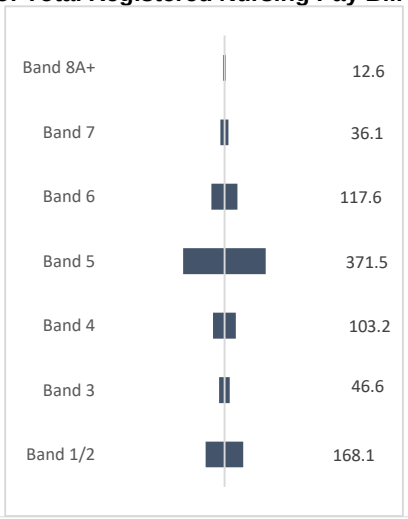
Agency Spend as Proportion of Total Pay Bill



Proportion

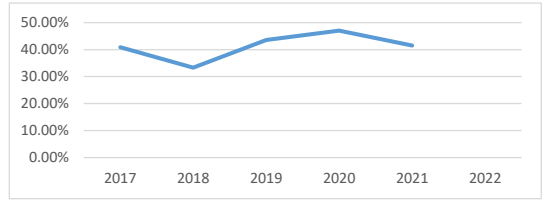
Not Available

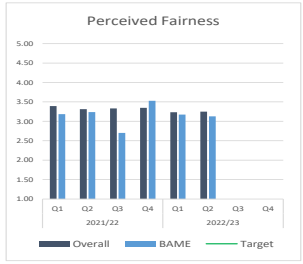
Nurse Agency Spend as Proportion of Total Registered Nursing Pay Bill

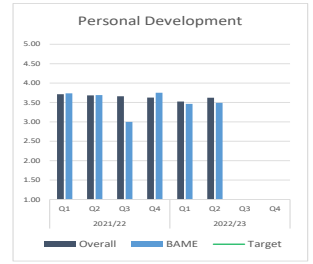


Proportion

Bank & Agency Use – Staffing Solutions Data







Is standard being delivered?

- Our Workforce Race Equality Scheme data shows you are 1.55 times more likely to be appointed from short-listing if you White then Black, Asian and ethnic minority. We are aiming for monthly data to be accessible from Trac as we develop this data.

What is the top contributor for under/over-achievement?

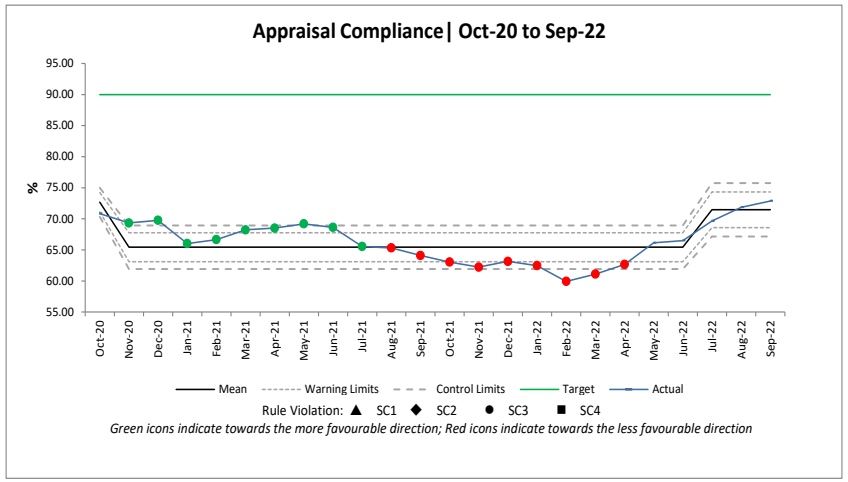
Currently we have an overall figure as derived from our Workforce Race Equality scheme, we are working to replicate this data at a divisional level to be able to ascertain contribution. See countermeasure.

Countermeasure Summary

Countermeasure/Action	Owner
Working with Kineo to develop inclusive recruitment.	Head of ED&I
Development of Divisional level data to understand top contributors	Head of ED&I and workforce
Head of ED&I prioritising positive actions linked to WRES/WDES	Head of ED&I
ED&I recruitment focus group in situ	Head of ED&I
Job description final checks	Hannah McCoid

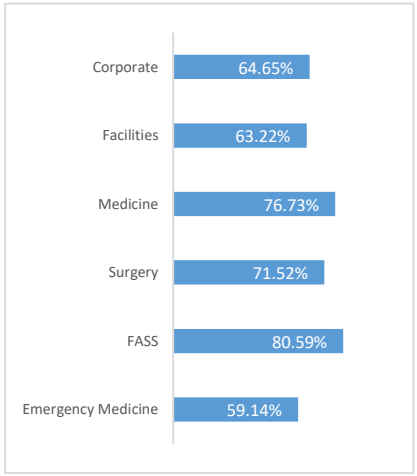
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	72.9%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff	73.0%
M&D Staff	71.6%
Consultants	78.1%
White	73.0%
BME	72.9%

Is standard being delivered?

• The methodology for calculating appraisal compliance has been amended and now excludes staff on maternity leave, long term sick. and career breaks. This has fractionally boosted the compliance rate to 72.88% which is still considerably below the long-term target of 90%.

What is the top contributor for under/over-achievement?

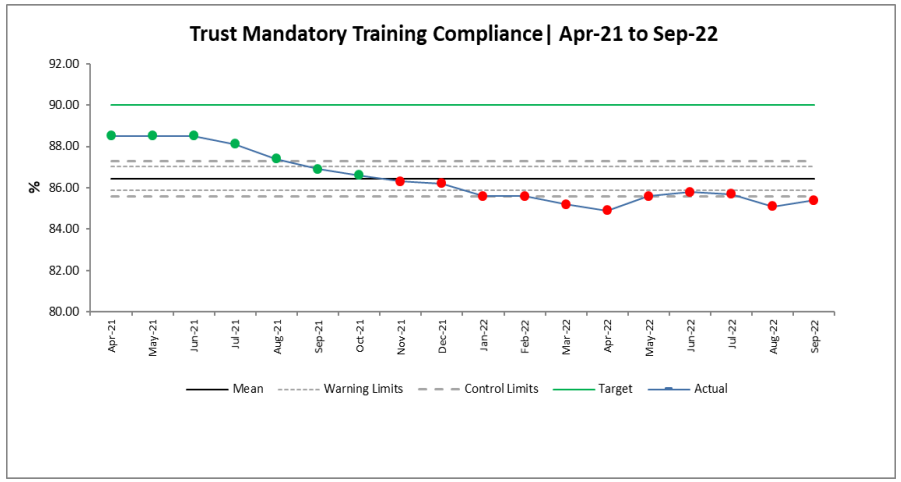
• Appraisal compliance is lowest in Emergency Medicine (59.14%), followed by Facilities (63.22%) and Corporate (64.65%).
'• AfC staff compliance (72.99%) is now fractionally above that of M&D staff (71.59%), reversing the recent trend.

Countermeasure Summary

Countermeasure/Action	Owner
Appraisal recovery plans sent out by the HR Advisor to the areas with the lowest compliance rate. Appraisal compliance flagged at E&F Board and through 1:1 meetings.	Holly Hitchcock / Sam Deere / E&F Managers
FaSS Division a new Appraisal Driver has been drawn up, currently the Division is showing the highest compliance since September 202. Trajectories are currently being worked up to support outstanding appraisals being completed as soon as possible.	Katy Coulam/ FaSS Speciality Managers
Medicine Division appraisal rate has improved by 17% since April 2022 and continues on an upward trajectory. Appraisal set as driver for all specialties where compliance less than 90%	David Mawdesley
Appraisals is a driver for Surgery and has improved by 13% since April 2022. Appraisal compliance being monitored at monthly speciality PRM and Nursing Performance Reviews	Lilly Cowan / Surgery speciality Managers
FTC project post to develop new appraisal platform to be hosted on new Learning Management System being recruited to. Aim new appraisal process for beginning 23/24	Tracy Elvins

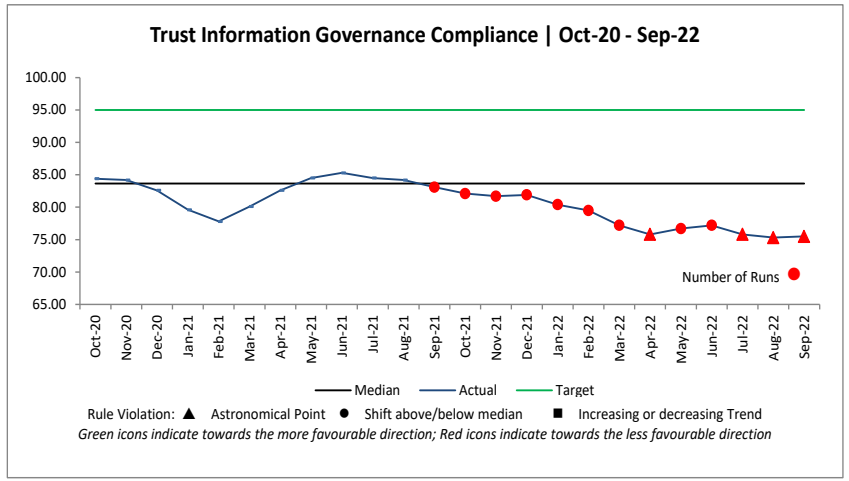
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



Compliance Rate	85.4%

Information Governance Training Compliance Rate - Trust



Compliance Rate	75.5%

Is standard being delivered?

- At 85.40%, Mandatory Training compliance, which now excludes bank, has continued on its downward trajectory and for a second successive month falls below the lower control limit, triggering an SPC rule.
- Information Governance compliance has fractionally improved to 75.50%. However, this continues to be just under 20 percentage points below the Trust's target.

What is the top contributor for under/over-achievement?

- Continuing the trend of the past few months, Facilities and Emergency Medicine have the two lowest compliance rates of the main Divisions for both overall mandatory training and IG training.

Countermeasure Summary

Countermeasure/Action	Owner
Mandatory training compliance flagged at E&F Board and through 1:1 meetings. Training on new Cleaning systems took priority in August 2022	Holly Hitchcock / E&F Managers
FaSS Division a new Mandatory Training Driver has been drawn up to also include Doctors in Training, with a key priority for the Division over the coming months being Safeguarding Adults and Children's training alongside IG training.	Katy Coulam/FaSS Speciality Managers
Addressing via Medicine specialty PRM meetings, highlighting subjects and areas where compliance is low and reviewing improvement on a monthly basis.	David Mawdesley
Being reviewed at Surgery Speciality PRM and New Nursing Performance Reviews	Lilly Cowan / Surgery Speciality Managers
Continued procurement process to support implementation of New learning management system which will ease access and understanding of mandatory training.	Nardina Storey

The people we care for

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Performance Report

Month 6

The RUH, where you matter

Executive Summary: Performance

Royal United Hospitals Bath NHS
NHS Foundation Trust

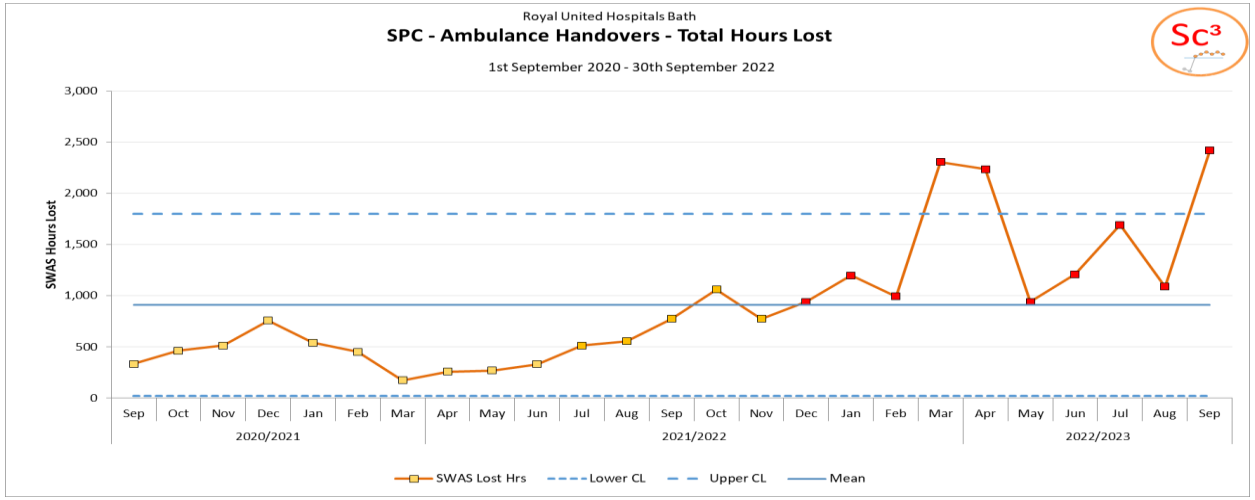
Strategic Goal		Performance Indicator	Target		2021/22						Trend	Movement From Previous Month
			Performing	Under Performing	Apr	May	Jun	Jul	Aug	Sep		
Trust Goals	People in our Community	Ambulance Handover Delays	>=39	<39	729	389	466	685	446	722		
Breakthrough Objectives	People We Care For	4 Hour Performance (Total RUH Footprint, including MIU & Booked)	>=95%	<95%	66.0%	69.0%	66.7%	64.1%	65.2%	61.5%		
	People in our Community	Non Criteria to Reside	<=62	>62	156	128	128	137	135	129		
Key Standards	People We Care For	RTT - Incomplete Pathways in 18 weeks	>=92%	<92%	63.5%	63.9%	62.5%	61.8%	61.1%	59.4%		
		62 day urgent referral to treatment of all cancers	>=85%	<85%	66.7%	69.3%	71.7%	75.4%	62.1%	(LAG 1)		
		Diagnostic tests maximum wait of 6 weeks	<=1%	>1%	32.5%	38.4%	32.2%	33.2%	37.6%	40.8%		

Measures requiring focus and a countermeasure summary this month are;

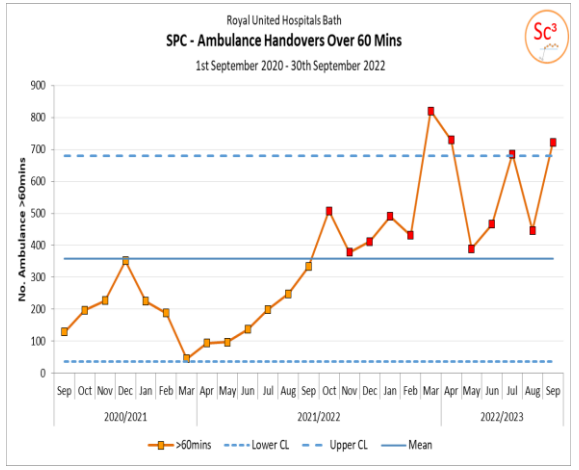
Measure	Change	Executive Summary
Ambulance Handover	↑	In September the Trust lost a total of 2,420 hours in ambulance handovers, which is a significant deterioration on August. ED are continuing to increasing the Pit Stop model into being able to provide Rapid Assessment and Treatment (RAT) service. Flow based challenges are still impacting on the department's ability to release capacity to support new arrivals.
4 Hours	↓	RUH 4 hour performance during September was 63.98%, a slight deterioration on last month. Demand remained above the mean with patients arriving within ED, paediatric attendances being the highest increase of over 200 in month . Urgent care performance 71.5% against an internal 80% target.
Non Criteria to Reside (NC2R)	↑	During September, the Trust had an average of 129 patients waiting who had no criteria to reside, however, in the first two weeks of October, the number of NCtR has increased falling outside of the system modelling trajectories. Additional capacity, both bedded and home based due to come on line over the next 3 months.
Referral to Treatment	↓	During September the Trust had no patients waiting longer than 104 weeks. The number of pts waiting over 78 weeks increased to 184. This continues to be driven by gastroenterology, general surgery and oral surgery.
Cancer 62 Days	↓	Performance in August fell to 64.6%. The largest number of breaches were recorded in Colorectal, Urology and Breast. Colorectal breaches were predominantly due to long waiting times for diagnostics (colonoscopy, CT). Performance is expected to recover in September. Trust 62 backlog had increased slightly by the end of September; 60% of patients are Colorectal.
Diagnostics	↓	September > 6 week performance 40.8% , deterioration of 3.2%. Main issue remains demand for clinically urgent and planned scans for patients on treatment (oncology) coupled with increased demand for dating scans in ultrasound. Recovery trajectories in place to recover to 15% by March 2023.
Elective Recovery	↑	The national target has been updated for 22/23, with Trusts now being asked to deliver 104% elective activity. During September the Trust delivered 110% of costed activity against the ERF target. This means performance YTD is currently at 106%. Strong performance continues in Day cases including endoscopy. Challenges in outpatient procedures are being resolved. Level of uncoded spells a noted issue.

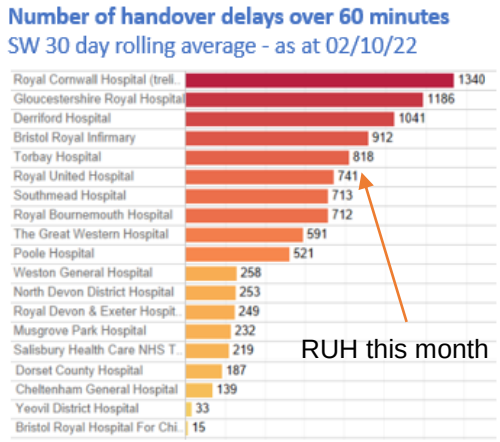
Trust Goal | Ambulance handover delays

Historic Data: hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

In September the Trust lost a total of 2,420 hours in ambulance handovers. This included the Trust having over 1,000 patients waiting more than 30 min to handover.

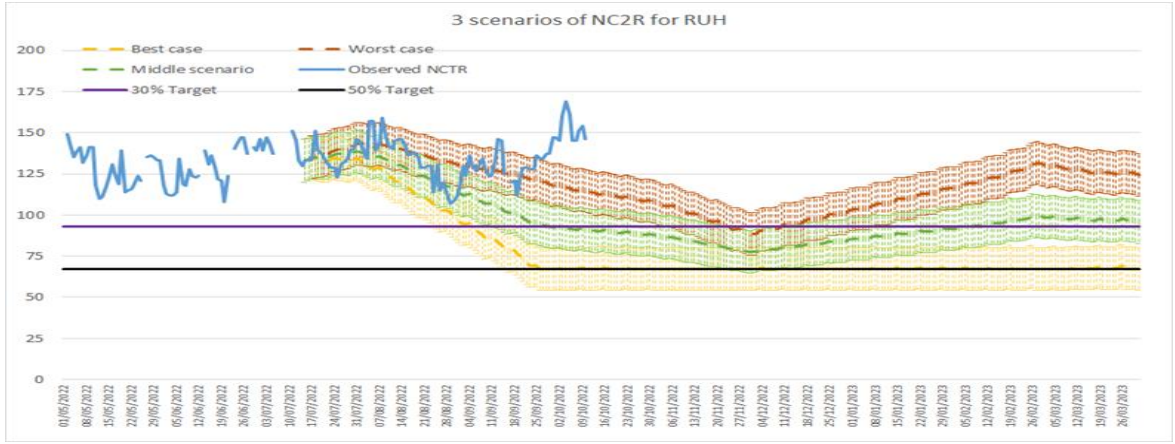
What's the top contributor for under/over achievement?

- The Trust continued to have significant impact on its bed availability, which is limiting the organisation's ability to pull patients out of ED, in turn leading to delays in getting patients into ED.
- Front door group being established to allow closer working with specialities to try and identify how patients, who are suitable, can wait within the assessment units instead of in a full ED or on ambulances. Considerations as part of winter funding to support staffing these areas.
- Continuing the use of ACA to support Trust position and utilising Pit Stop to maintain patient safety when on the back of an ambulance

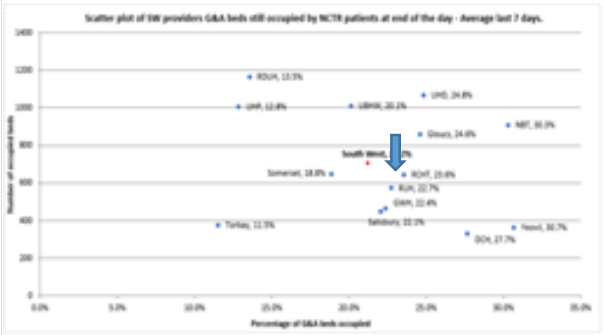
Countermeasures / Actions	Owner	Due Date
Working with Bristol Ambulance to expand scope and hours of ACA	H Cox	Nov-22
Continuing weekly review meeting with SWAST	Prosser	Ongoing
Launching work to increase percentage of pts moved out of ED within 15 minutes of bed being allocated	ED Majors Working Group	In progress
Delivery of winter schemes to further support flow	ED team	Quarter 4

Breakthrough Goal | Non criteria to reside

Historic Data: as of 13/10/22



Supporting data



Is the standard being delivered?

During September, the Trust had an average of 129 patients waiting who had no criteria to reside. This is a reduction from an average of 135 patients in August, however, in the first two weeks of October, the number of NCtR has increased falling outside of the system modelling trajectories

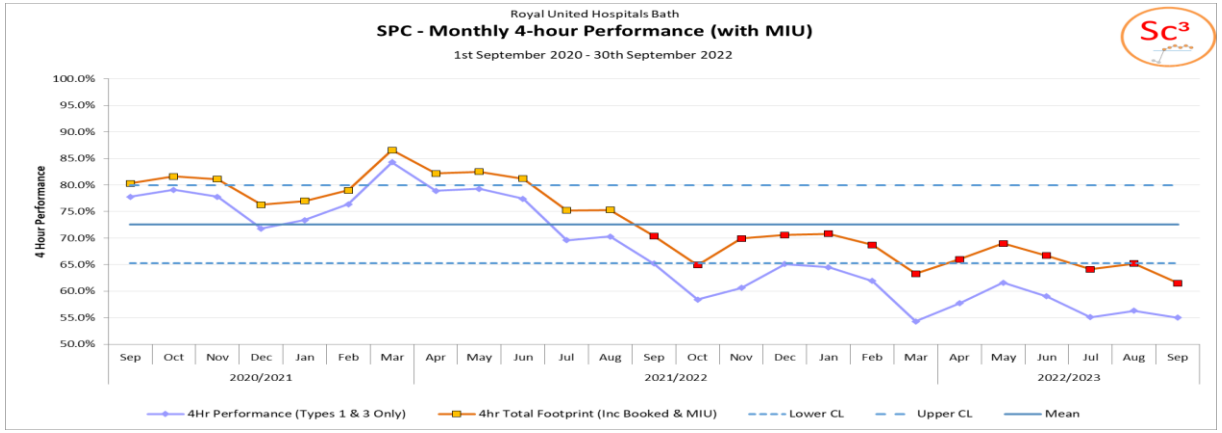
What's the top contributor for under/over achievement?

- The impact of increased covid numbers in hospital and closures of care homes due to covid has impacted on community discharges.
- A lack of home care capacity is impacting discharges from community and hospital beds.
- Higher number of patients being discharged on a pathway 2 increasing demand for bedded care.
- Capacity caps in social care and brokerage impacting on the timeliness of discharge processes.

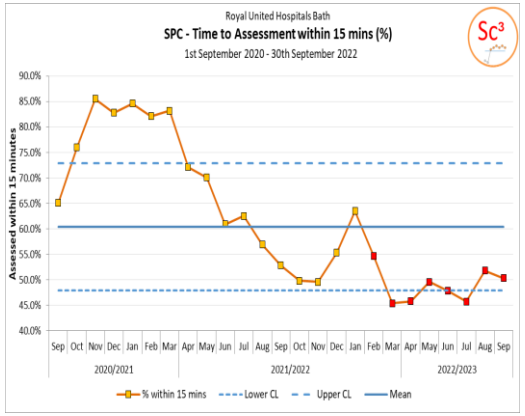
Countermeasures / Actions	Owner	Due Date
Complex discharge list reviews to ensure plans in place	Goddard	On going
Continuing to develop United Care BaNES. Service and recruit to establishment	Dolman-Sellars	Nov-22
Self-funding team launched to support pathways out	Goddard	Oct-22
Ward 4 and South Newton opening to provide addition community beds	HCRG / WH&C	Oct-22
Implementation of winter schemes including a Mobilisation Team, 7-day DLN cover, Increased discharge coordinators and further expansion of Art and Reablement	Project Leads	Quarter 4

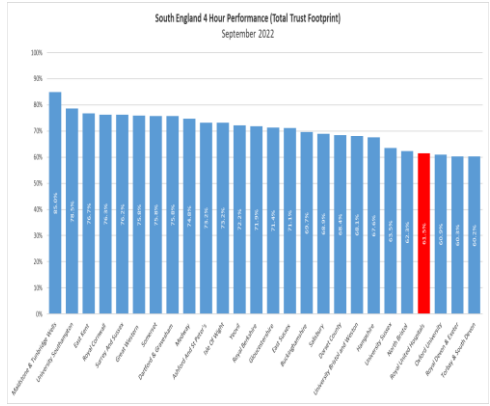
Key Standards | 4 hour Emergency Standard

Historic Data



Supporting data





Is the standard being delivered?

RUH 4 hour performance during September was 63.58%. This is a deterioration in performance since last month.

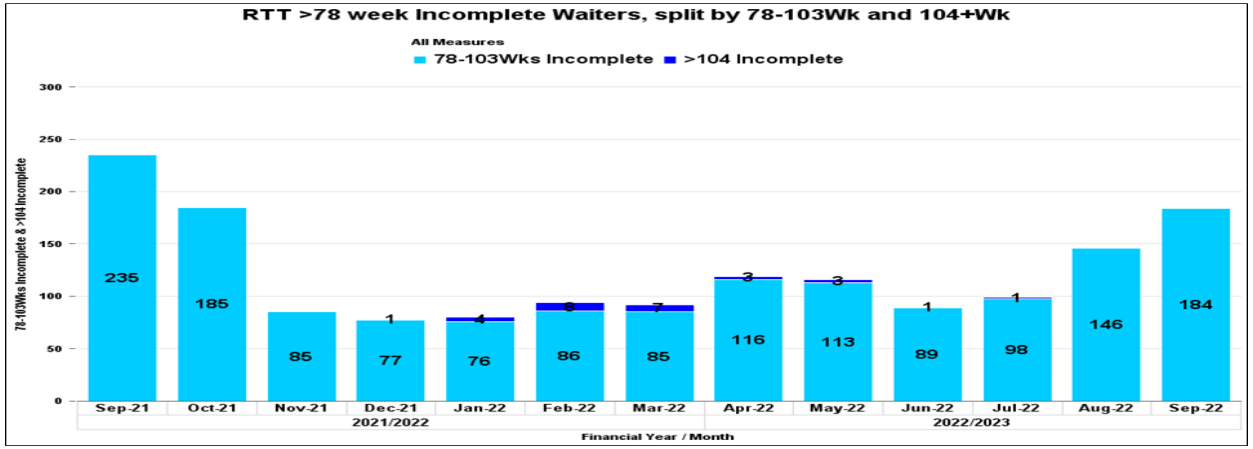
What's the top contributor for under/over achievement?

- Flow within the hospital has continued to remain challenging during September. This has been driven by challenges with the;
  - Non Criteria to Reside that was an average of 129, it peaked at 138
  - COVID numbers have increased in September with an average of 23 beds occupied, although this has increased to 55 in October
- The Trust has continued to see high levels of activity through Urgent Care in September, with an additional 300 attendances per week compared to the beginning of the year. Urgent care performance was 71.5% against a target of 80%. This has been driven by rota gaps (Vacancies and Supernumerary staff).
- Majors performance was 19.27%, against a target of 45%, mainly driven by the challenges with hospital wide flow.

Countermeasures / Actions	Owner	Due Date
Relaunching majors Improving Together huddles and Majors Working Group	Hills, Whittock, Tate	In progress
Launched, although not yet full coverage, RATing within ED to supplement pit stop	Jones, Furse	Quarter 4
Understanding impact of staff being supernumerary while training on Practitioner rota in Urgent Care to discuss mitigations	Cox, Fouracre	Nov-22
Launching pilot for streaming within urgent care	Fouracre	In progress
Review and prepare to launch Winter Schemes to support Flow	ED Team	Quarter 4

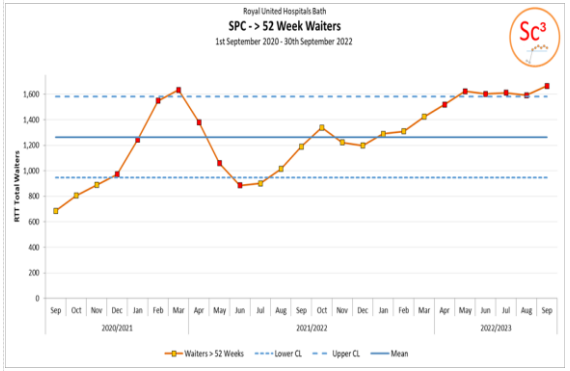
Key Standards | Referral to Treatment

Historic Data

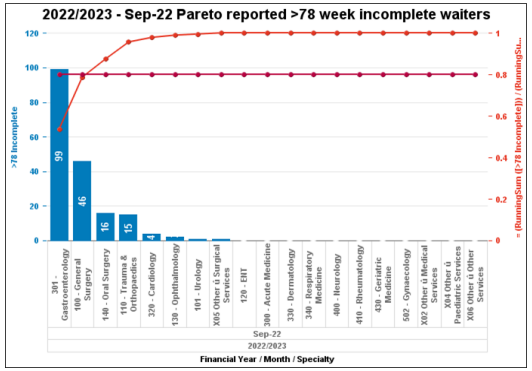


Supporting data

SPC 52+ Waiters



Pareto 78+ (inc. 104+) by Specialty



Is the standard being delivered?

- In September the Trust had 184 patients waiting over 78 weeks but no patients waiting over 104 weeks.
- 52+ Waiters were 4.5% of all RUH Waiters in September, versus National Avg 5.5% in August (RUH 4.4% in Aug, GWH 4.6%, Salisbury 1.9%).

What's the top contributor for under/over achievement?

- Incomplete 78+ Hotspots are General Surgery and Gastro.
- Overall +38 increase in 78+ Waiters mainly due to +41 Gastro

- 52+ Hotspots are Gastro, Oral Surgery, General Surgery and Cardiology.
- Overall, +72 increase in 52+ Waiters. Biggest increases from Cardiology +32, Gastro +33, General Surgery +38. These mask sizeable decreases –21 Oral Surgery and –16 Orthodontics

Countermeasures / Actions	Owner	Due Date
General Surgery patients transferring to Practice Plus	S Roberts	In progress
Locum in post from end of October to support additional activity	B Isaac	Oct-22
Recruitment underway for 1 x replacement General Surgeon and 1 x additional colorectal surgeon	N Lepak	Nov-22
48 additional clinics being provided in Gastro up to end of November. Recruitment in process for Consultant Endoscopist and Locum Gastroenterologist.	N Aguiar/R Weston	Nov-22
Locum in post from end of October to support additional activity	B Isaac	Oct-22

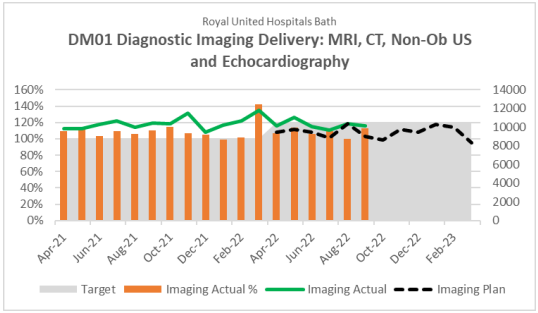
Key Standards | Elective Recovery

RUH In Month Performance Against 2019/20 Activity

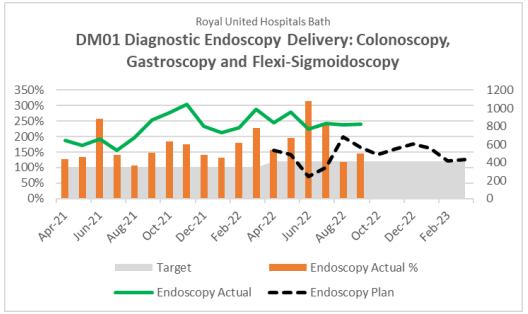
	M6				YTD			
Division	2019/20 £	2022/23 £	Variance £		2019/20 £	2022/23 £	Variance £	
FASS	1,716	2,204	488	128%	10,024	12,334	2,310	123%
Medicine	2,038	2,354	315	115%	12,122	13,886	1,765	115%
Surgery	3,893	3,836	(57)	99%	23,468	22,154	(1,314)	94%
RUH	**7,647**	**8,393**	**746**	**110%**	**45,613**	**48,374**	**2,761**	**106%**

Supporting data

Diagnostic Imaging (DM01)



Diagnostic Endoscopy (DM01)



Is the standard being delivered?

- RTT Stops delivery 91% against target of 110%
- Trust delivered 110% in month against the 104% ERF financial target.

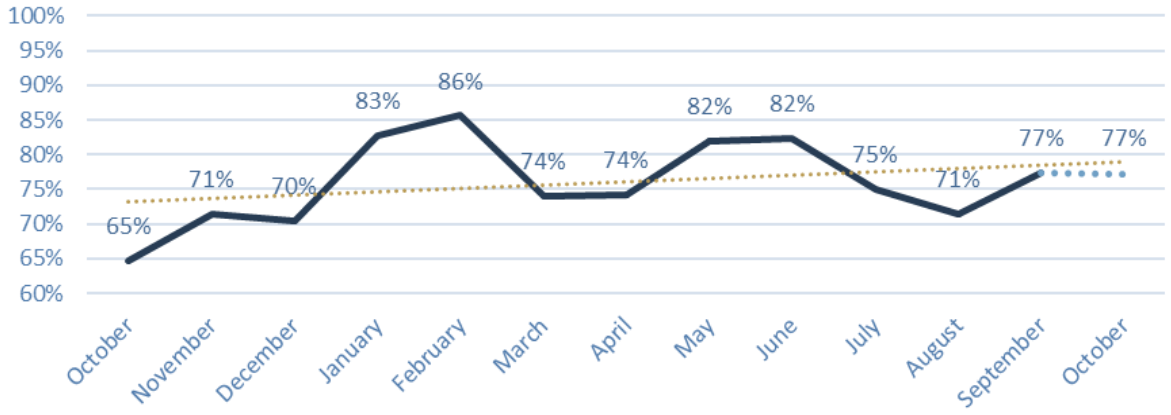
What's the top contributor for under/over achievement?

- Endoscopy volumes continue to be above 2019/20 levels particularly in Colonoscopy and associated 6 week breaches much reduced
- DC activity has continued to be good this month particularly Urology. Oncology continues to be high. IP activity up on August and over 2019/20 overall.
- Orthopaedics lower activity due to loss of beds
- Outpatient news highest volumes all year with notably high volumes in Breast, Orthopaedics, Dermatology and Oncology
- OP Follow Ups continue to be high at 92% of 2019/20, noting NHSE requirement to cap at 75%
- Improvements in ENT OP Procedure recording have increased volumes year to date. OP Procedures up to 83% of 2019/20.

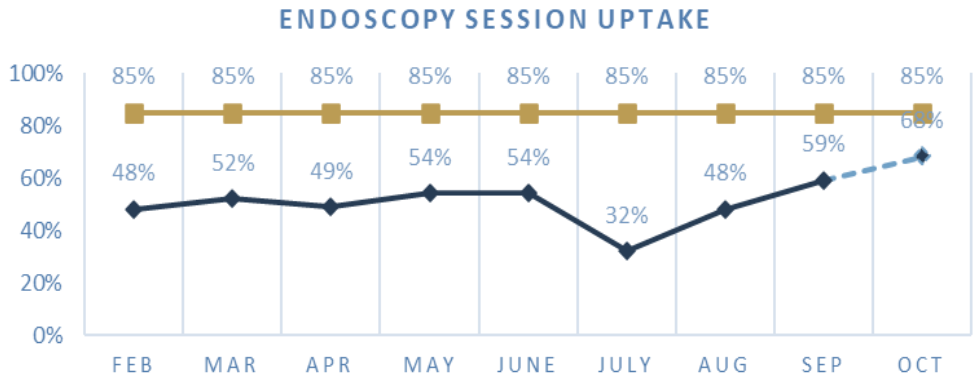
Countermeasures / Actions	Owner	Due Date
Outsourcing of skin cancers to clear BCC backlog	S Roberts	In progress
ENT and Ophthalmology procedure recording recovery plan in place	S Roberts	In place
Recruitment of additional middle grade surgeons in OMFS to allow reduction in insourcing and provide continuity of care at reduced cost	S Roberts	Quarter 3
Ophthalmology recovery plan – additional patients added to outpatient clinics and theatre lists	S Roberts	Quarter 3
Mobilisation of elective recovery programme	Sethi	On going

Key Standards | Sulis

Historic Data: Theatre vacant sessions



Supporting data



Is the standard being delivered?

- Sulis had 74 theatre sessions cancelled from schedule. 22 of 79 session closed The business managed to retain 72% of cancelled sessions.
- Annual leave, consultant availability (inc anaesthetist) and availability of kit caused some session to be closed
- Other sessions closed due to consultant illness and private volumes due to patient choice.

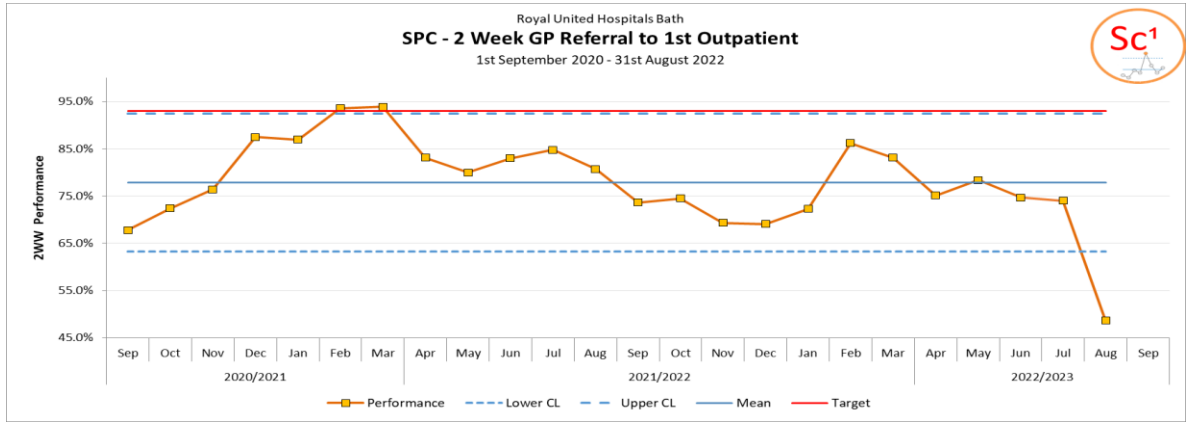
What's the top contributor for under/over achievement?

- Theatre session uptake improved due to consultant availability. Oct 77%
- Endoscopy session uptake improved due to improved scheduling model and increased Urology sessions now established. October tracking high due to enrolling new endoscopist. Currently 59% tracking to 66%.
- Radiology CT volumes recovering from June & July – More activity displaced away from RUH mobile CT. X-Ray volumes increased as we continue to support wider providers (Paulton).

Countermeasures / Actions	Owner	Due Date
NHS RTT and ERS slot management improving viability and attractiveness on ERS system	Milner / Harrison	On going
Increase Urology IPT volumes from RUH to utilise additional Endoscopy sessions.	Harrison	Quarter 3
Review opportunities to increase theatre capacity to accommodate displaced activity – Options include Sunday initiatives	Milner	Quarter 3/4
Review theatre schedule utilization and option for three consultant in single day.	Milner	Quarter 3

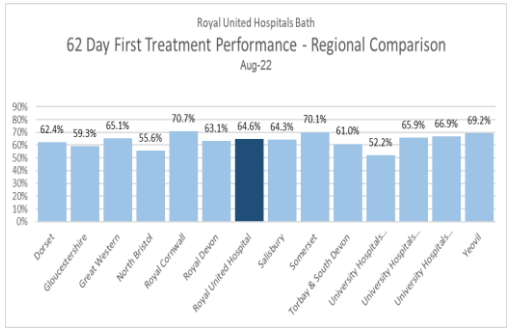
Key Standards | Cancer 2 week wait

Historic Data

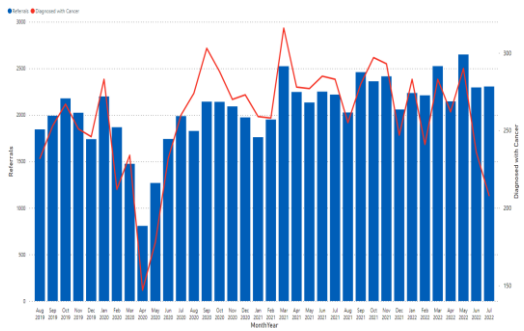


Supporting data

2week wait Regional Comparison



2week wait demand and diagnoses



Is the standard being delivered?

In August performance deteriorated significantly to 48.7%.

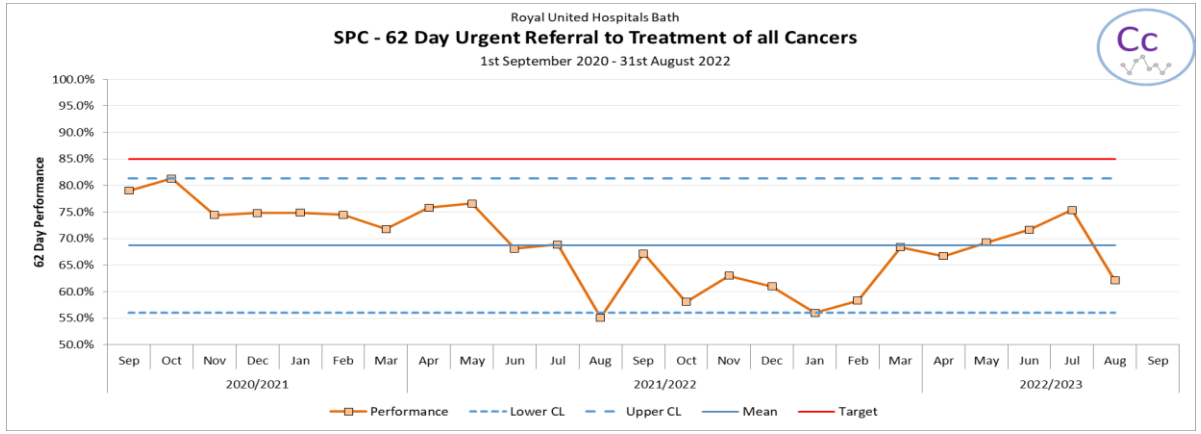
What's the top contributor for under/over achievement?

- Skin breaches were sustained following previous clinician sickness and additional long term sickness and summer annual leave in the team which coincided with a period of high demand.
- Skin performance is expected to improve from September.
- Colorectal demand continued to rise with the service receiving the most referrals ever in one month.
- Waiting times for Colorectal telephone appointments have extended. Recruitment for clinical staff to manage the 2ww pathway continues.
- Gynaecology performance improved significantly in month following several months of lower performance.

Countermeasures / Actions	Owner	Due Date
Gynaecology – Nurse practitioner hours increased	S Fowler	Completed
Colorectal – Permanent nurse practitioner recruited	N Lepak	Completed
Colorectal – Review of current pathway to increase number of patients going straight to test	N Lepak	Nov-22
Colorectal – Review of straight to test criteria, reducing the need for telephone appointments	S Richards B Colleypriest	Nov-22
Skin – Recruiting consultant fixed term for six months	C Croxton	Nov-22

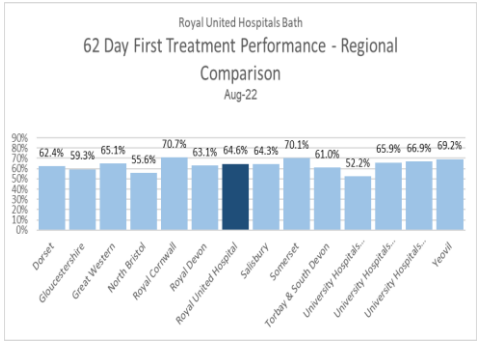
Key Standards | Cancer 62 days

Historic Data

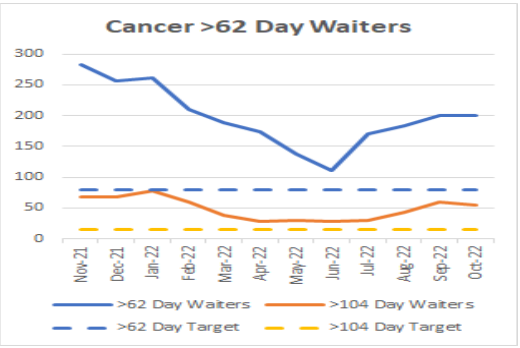


Supporting data

62 Day Regional Comparison



RUH 62 Day Backlog



Is the standard being delivered?

August performance was to 64.6%, a deterioration following significant improvement in June and July. The place the RUH in the middle of other Trusts across the Cancer Alliance and BSW.

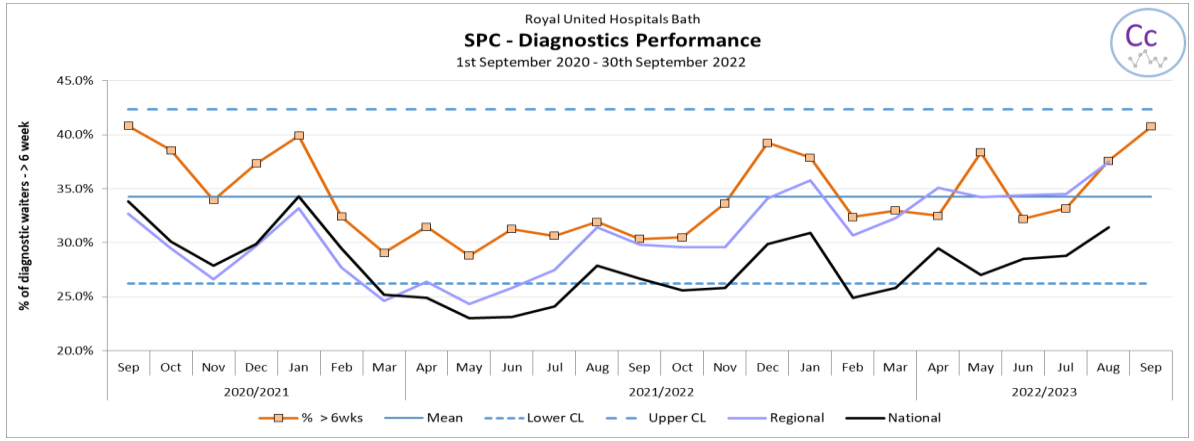
What's the top contributor for under/over achievement?

- Colorectal accounted for the most breaches. Waiting times for key diagnostics was the main contributor, with some patient choice/delays adding to longer waiting times for some patients.
- Urology performance deteriorated slightly. Breaches were impacted by waiting times for MRIs and reporting but also due to patient choice delays in the diagnostic pathway.
- Breast contributed the next largest number of breaches with the biggest contributory factory being waiting times for imaging following surgical clinics. An increase in breast radiology capacity is reducing the imaging waiting times.
- Trust performance is expected to improve in September.

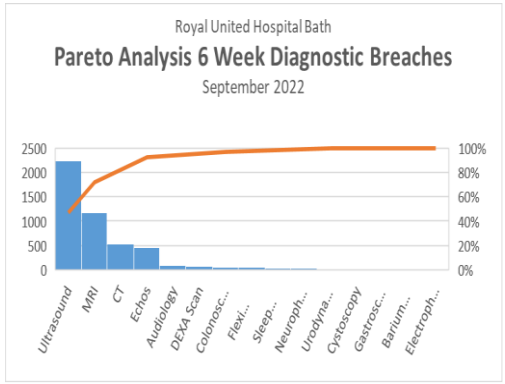
Countermeasures / Actions	Owner	Due Date
Breast – Locum Radiologist appointed	H Wheeler	Completed
Colorectal – Referrals Administrator appointed to support improvement in referral quality/STT rate	N Lepak	Completed
Colorectal – Additional permanent Colorectal Surgeon being recruited – interviews September	N Lepak	Nov-22
Colorectal – STT pathway to be reviewed	Richards / Colleypriest	Nov-22
Urology – Additional LATP lists to mitigate the longer waiting times for MRI reporting	McFarlane	Oct-22

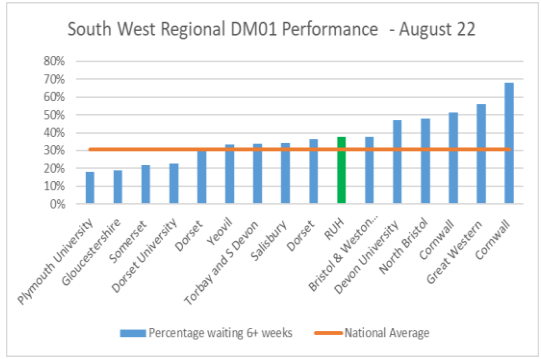
Key Standards | Diagnostics 6 weeks

Historic Data



Supporting data





Is the standard being delivered?

September >6 week performance was 40.8%. This represents a deterioration of 3.2% compared to August 2022.

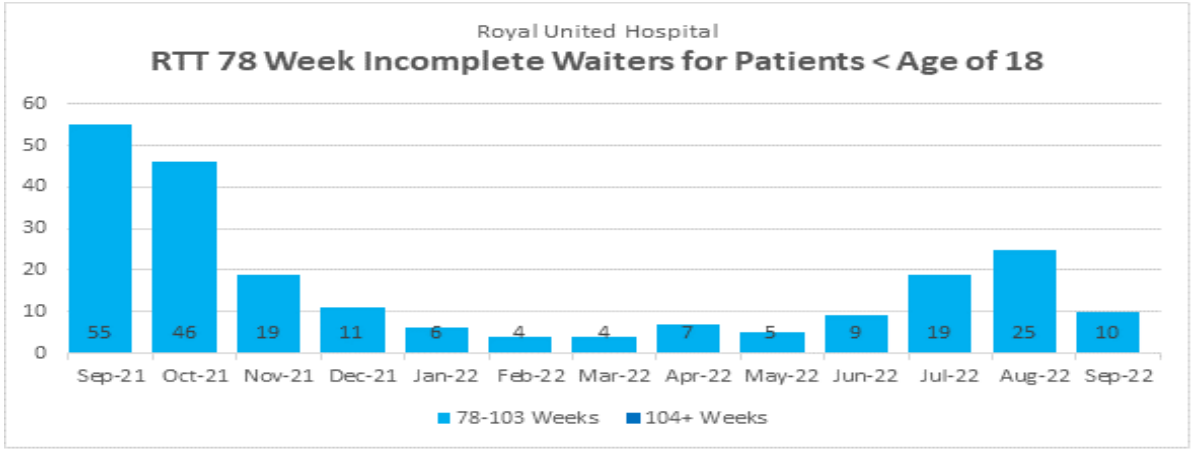
What's the top contributor for under/over achievement?

- Top contributors; Ultrasound, MRI, CT and echocardiography.
- Increase in both clinically urgent and planned scans (on treatment oncology) reducing capacity for routine investigations within Radiology.
- High demand for dating scans in ultrasound moving sonographers away from non-obstetric ultrasounds as well as reduction in Consultant capacity for MSK USS.
- Reduction in uptake of WLIs.
- Transfer of mobile scanner from fully CT to CT & MRI reducing overall capacity for CT until additional scanner available at Sulis.
- Reduction in capacity within DEXA due to vacancies.

Countermeasures / Actions	Owner	Due Date
Mobile scanner to be converted to CT & MRI	N Aguiar	Completed
Clinical triage of 52+ waiters - Endoscopy	J Pegram	On going
Service review commenced within Respiratory labs	Warner-Holt / C Forster	In progress
Action plan and recovery trajectory to be drafted for USS	N Aguiar	Oct-22
All referrals for ECHO to be added to the waiting list	Beech / B Isaac	Quarter 3
Triage process review - ENT & Audiology	K Rye	Nov-22
Transfer Neurophysiology waiters to NBT	C Croxton / J Usher	Oct-22

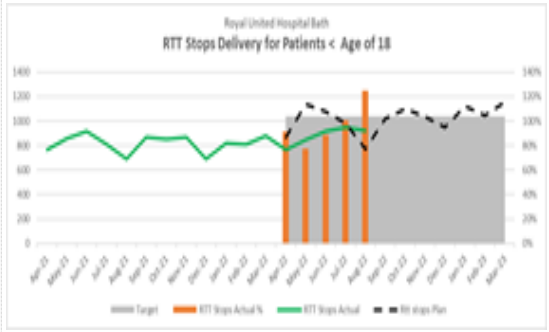
Key Standards | Paediatrics

Historic Data

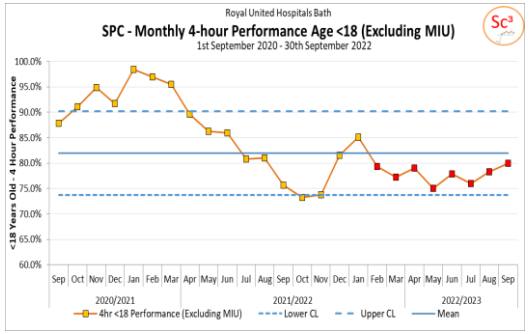


Supporting data

Pareto of 6 week performance



4 hr performance



Is the standard being delivered?

- RTT non-compliant – September reflected 10 paediatric patients over 78 weeks. This is an improvement of 15 patients from August position
- Cancer 2WW non-compliant – In August we saw 5 two week wait referral paediatric patients with 1 patient breaching the standard - performance of 80%
- Cancer Diagnostics non-compliant – In August we diagnosed 7 paediatric patients with 4 being diagnosed within 28 days giving a performance of 57.1%. The breaches were all for patients seen in the breast unit who waiting longer for imaging following assessment in a surgical clinic first. All were diagnosed non-cancer.

What's the top contributor for under/over achievement?

- Oral surgery continue to be the biggest contributors to paediatric waiting over 78 weeks. Work continuing to ensure patients are treated as quickly as possible.
- Waits for ENT paediatric patients requiring sleep studies continue to be lengthy as these are provided by UHBW.

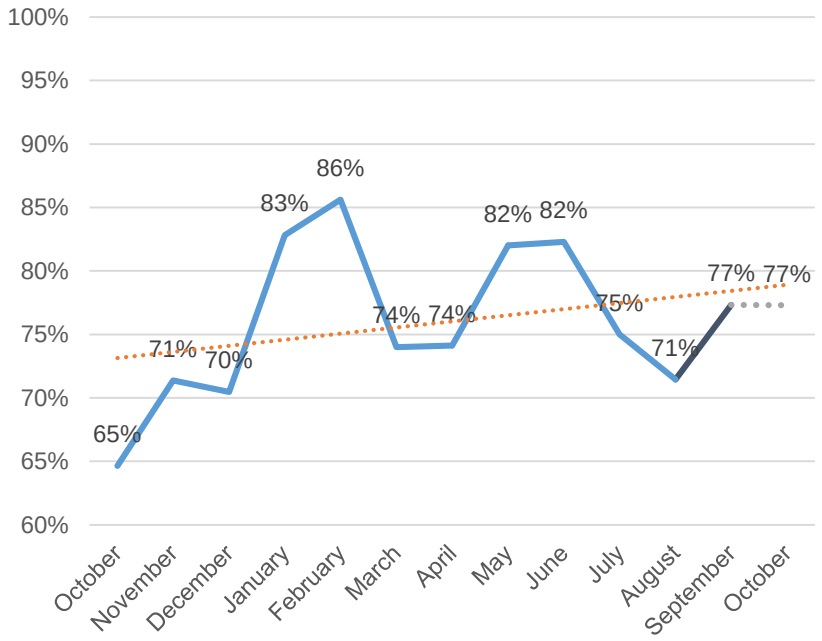
Countermeasures / Actions	Owner	Due Date
Launched new day case recovery area within paediatric ward	Griffiths	Completed
Robust cross divisional PTL management continue on a weekly basis to minimise non-capacity delays in pathways	Dando	In progress
ED paediatric team and PAU working closer together to improve pathways and processes	Gilby / Potter	In progress
Utilise winter funding to increase the number of paediatric nurses to three to support ED during peak periods of demand	Whittock	Quarter 4

Month Position

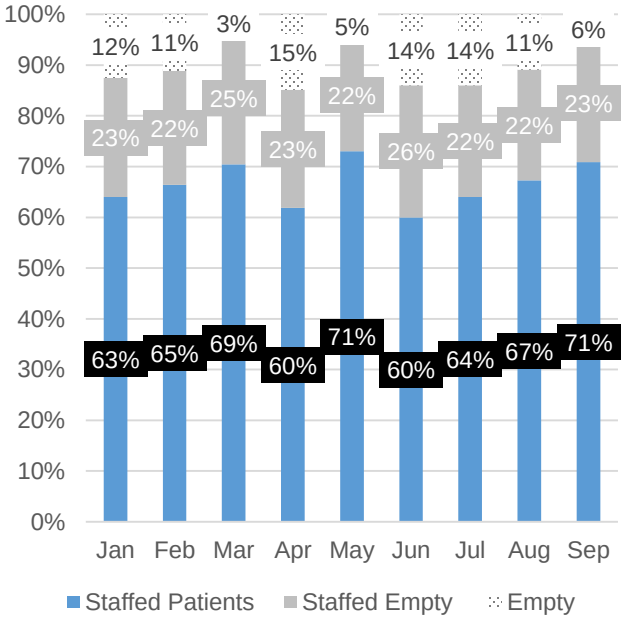
Key Standard | Sulis Hospital - SEPT

SULIS HOSPITAL BATH

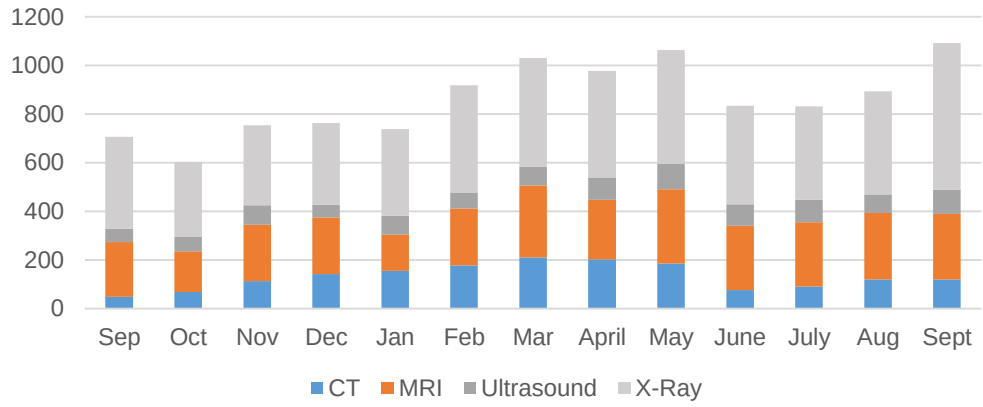
Session Uptake



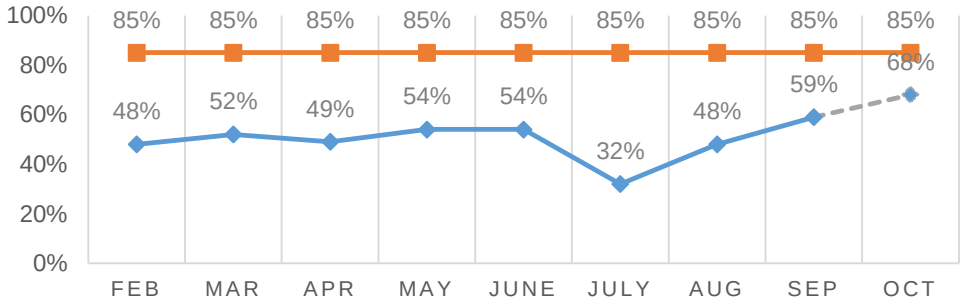
True Utilisation by Time
Mon – Saturday 11hr



Diagnostic Appointment Volumes (MRI,CT,XRAY,US)



ENDOSCOPY SESSION UPTAKE



Data based on four theatres 6 days per week. Utilisation refers to a session which has consultant allocated and one or more patients booked. Includes evening sessions Mon-Friday.

Initial business case objectives

. (CLOSED = left empty CANCELLED = Plan Consultant changed planned SESSION = Half Day)

- 79 theatre sessions cancelled from schedule.
- 22of79 session closed The business managed to retain 72% of cancelled sessions.
  - Closed causes: (2 Annual Leave, 5 No Pts, 2 Consultant Sick, 2 Kit Issues, 2 Staffing, 8 HRH Funeral, 1 Vacant)
- Theatre session uptake improved due to consultant availability. Oct – Tracking at 77%
- Endoscopy session uptake improved due to improved scheduling model and increased Urology sessions now established. Oct tracking high due to enrolling new endoscopist. Currently 59% tracking to 66%.
- Radiology CT volumes recovering from June & July – More activity displaced away from RUH mobile CT. X-Ray volumes increased as we continue to support wider providers (Paulton).

Counter measure/Action (Completed this month)	Owner
NHS RTT and ERS slot management improving viability and attractiveness on ERS system.	
Counter measure/Action (Planned this month)	**Owner**
Increase Urology IPT volumes from RUH to utilise additional Endoscopy sessions.	
Review opportunities to increase theatre capacity to accommodate displaced activity (July/July) – Options include Sunday initiatives. – Staffing is our concern	
Review theatre schedule utilization and option for three consultant in single day.	

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Quality Report

Month 6

The RUH, where you matter

Quality | Executive Summary

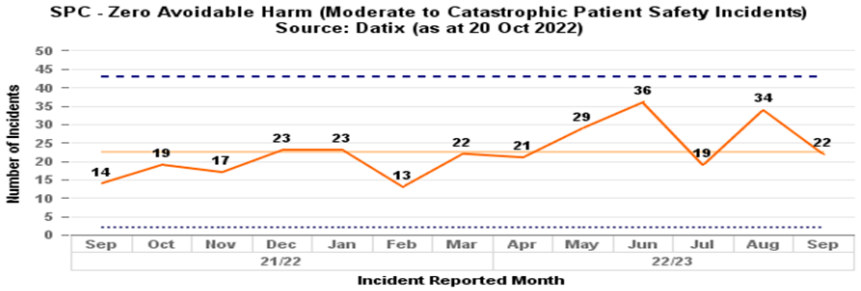
Strategic Goal		Performance Indicator	Description	Target		2021/22							2022/23						Trend
				Performing	Under Performing	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Trust Goals	People We Care For	Zero Avoidable Harm	Reported Patient Safety incidents resulting in significant harm (moderate to catastrophic), excl. rejected			14	19	17	23	23	13	22	22	29	36	19	34	22	
Breakthrough Objectives	People We Care For	Healthcare Associated Infections	MRSA, MSSA, E coli, C diff (Healthcare Onset and Community Onset), Klebsiella spp, Pseudomonas aeruginosa, COVID, Norovrus & Flu	<=11	>11	16	24	18	36	37	44	68	51	26	47	125	37	56	
Tracker Measures	People We Care For	Patient safety incidents - rate per 1000 bed days	Total no of reported patient safety incidents for the Trust, per 1000 patient bed days.	>43	<=43	44	42	43	43	47	44	49	51	41	44	45	48	55	
		Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	6	4	1	3	5	3	2	2	3	2	1	2	1	
		Number of falls resulting in significant harm (Moderate to Catastrophic)		<=1	>=3	1	3	6	6	2	4	2	5	3	7	1	2	1	
		ED time to triage	Percentage of ED attendances triaged within 15 minutes			57.0%	54.2%	53.1%	57.7%	65.7%	57.0%	47.7%	48.1%	51.8%	50.2%	48.2%	54.7%	53.5%	
		Falls per 1000 bed days	Includes all falls			5.9	7.0	8.6	7.9	7.2	6.0	6.9	7.0	6.9	6.5	6.5	6.1	6.0	
		Medication Incidents per 1000 bed days	All Incidents			5.7	6.5	6.3	6.2	6.5	7.9	5.7	5.9	6.0	5.2	5.7	6.6	7.5	
		Number of Patients given medication by scanning device				18.6%	18.0%	19.4%	17.0%	13.2%	14.5%	13.3%	11.6%	14.8%	14.5%	14.3%	14.8%	16.4%	
		Early Identification of Deteriorating Patient				21.3%	18.9%	21.5%	19.6%	17.7%	20.3%	20.3%	19.9%	18.0%	17.7%	19.4%	20.8%	21.0%	
		Number of COVID nosocomial infections				7	10	3	21	18	23	43	31	8	34	110	16	33	
		Number of Hospital Acquired Pressure Ulcers Category 2	Includes Medical Device Related	<=2	>2	2	1	1	5	2	4	3	0	5	5	7	1	2	
		Number of Hospital Acquired Pressure Ulcers Category 3 & 4	Includes Medical Device Related	0	>0	0	0	2	3	1	0	0	0	1	3	0	3	0	

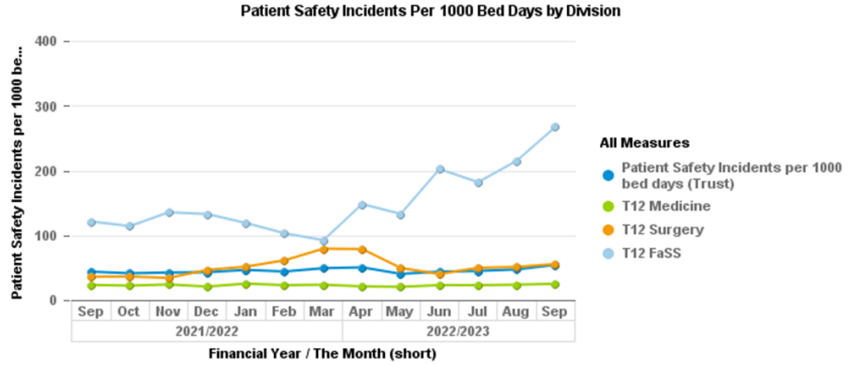
Measures requiring focus and a countermeasure summary this month are;

Measure	Executive Summary
Healthcare Associated Infections	There were 56 Healthcare Associated Infections in September 2022. o There were 7 cases of Clostridioides Difficile reported during September against a monthly trajectory of 3. o There were 13 hospital associated E coli infections reported during September, above the monthly trajectory of 6.3 o There were 33 COVID nosocomial infections for September.

Quality | Avoidable Harm

Historic Performance



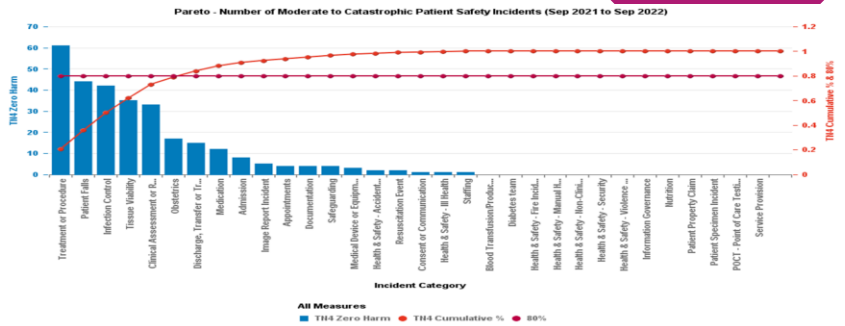


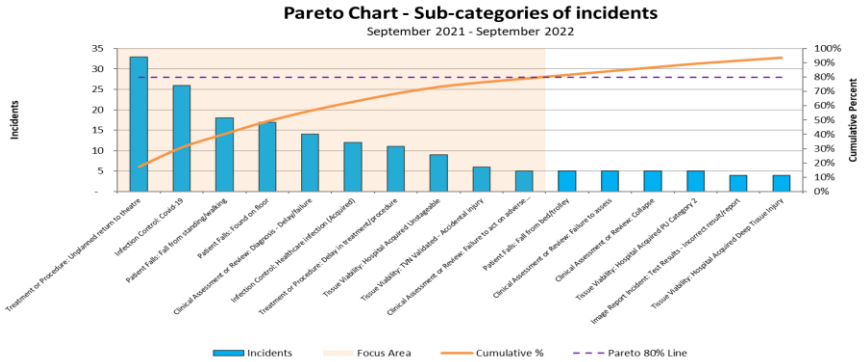
Is the standard being delivered?
In September 2022 there were 22 reported moderate to catastrophic incidents compared to a target of no more than 30 incidents.

What is the top contributor for under/over-achievement?
The top contributors for incidents reported for September 2022 were: Clinical Assessment or Review (n=4), Treatment or procedure (n=3), and Infection Control (n=3).

For Clinical Assessment or Review, the incidents reported were diagnosis – delay / failure (n=2) and collapse (n=2). For Treatment or Procedure, there were 3 unplanned returns to theatre.

The most frequently types of reported incidents between September 2021 and September 2022 are unplanned returns to theatre (n=33), COVID-19 (n=26), falls – from standing / walking (n=18) and falls – found on floor (17).

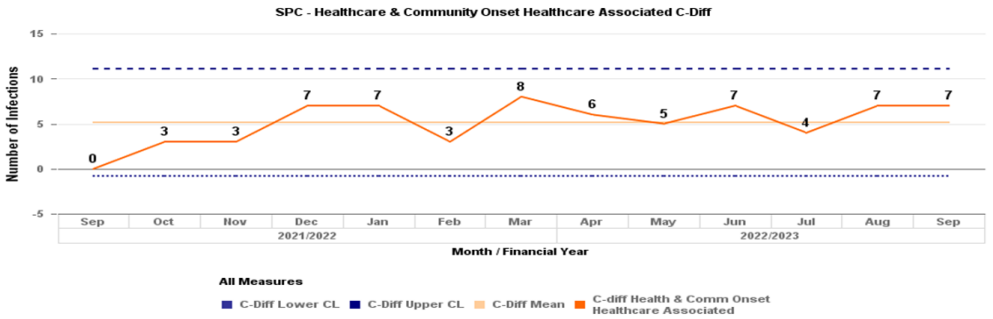


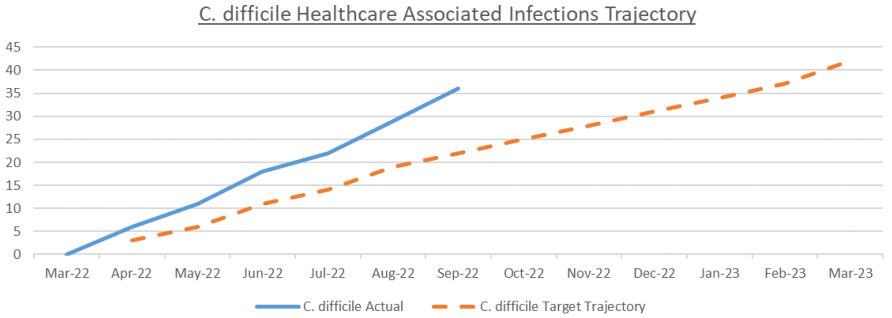


Countermeasure /Action (planned this month)	Owner
Process for review RTT in general surgery confirmed and shared with addition of identification of deterioration and time to RTT	General surgery Governance lead
PSIRF Task and Finish group performing gap analysis and investigating national training packages	Trust Patient Safety Lead
Review of all incidents up to August 2022 to be shared with Divisions in October	Risk Lead
Patient Safety Priorities on project wall awaiting project support.	Transformation Lead
Launch Patient Safety Programme (PSP) with 5 priorities w/c 31 November with film and tea trolley training and cafes	Priority Leads
Outcome and process measures to be developed for each PSP for review at (Patient Safety Steering Group) SSG. To be aligned to Divisional performance measures	Trust PS Lead / Improving Together Lead /Divisional triumvirates

Breakthrough Objective | Clostridioides Difficile

Performance





Is standard being delivered?
There were 7 cases of *Clostridioides difficile* (CDI) reported during September, 5 were healthcare onset infections and 2 were community onset healthcare associated. YTD 36 cases against the trajectory of 42.

What is the top contributor for associated risk factors?
Pulteney ward was placed under a period of increased incidence (PII) in September as there were 2 cases of hospital onset healthcare associated CDI reported. No lapses in care were identified at the post infection review meeting.

Learning: Ribotyping confirmed there was no cross infection between the two cases, with R087 and R014 being detected, the PII will be closed if there are no further cases within 28 days.

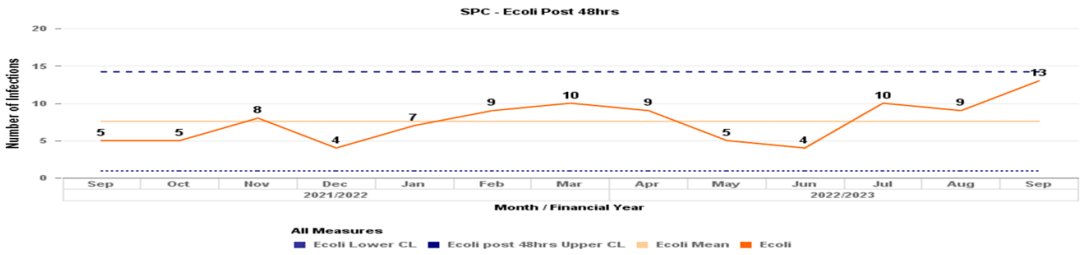
CDI Benchmarking

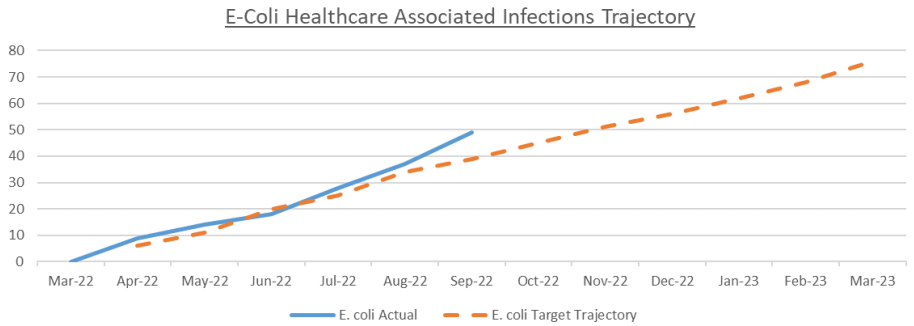
Trust	Rate (Aug 22)	Rate YTD
SW rate	**34.9**	**30.5**
RUH	**39.12**	**32.9**
GWH	17.3	17.61
SFT	28.17	21.36
Gloucester	38.8	37.94

Countermeasure/Action (completed last month)	**Owner**
Cleaning Standards Group established, to be chaired by the Deputy Director of Estates and Facilities to gain enhanced oversight of cleaning standards. First meeting held on the 19 October.	Estates & Facilities
Countermeasure/Action (planned this month)	**Owner**
A thematic review will be undertaken of all of cases reported to date to look for any additional themes and trends.	IPC

Breakthrough Objective | E Coli

Performance





Is standard being delivered?
There were 13 healthcare associated E coli infections reported during September 2022, which is above the monthly trajectory of 6.3 cases per month, with the annual trajectory being no more than 76 infections during 22/23.

What is the top contributor for associated risk factors?
The cases were associated to hepatobiliary (n=4), lower urinary tract infection (n=4), lower urinary infection with a catheter (n=1), gastrointestinal (n=1) and no root cause identified (n=3).

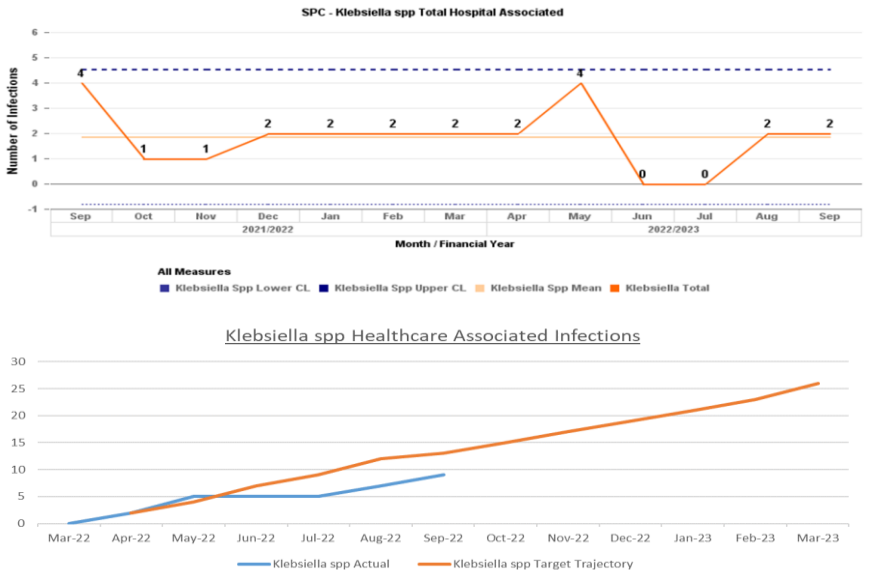
Benchmarking data:

Trust	Rate (Aug 22)	Rate YTD
SW rate	**32.26**	**33.32**
RUH	**50.3**	**43**
GWH	74.97	53.78
SFT	14.08	15.63
Gloucester	23.28	27.6

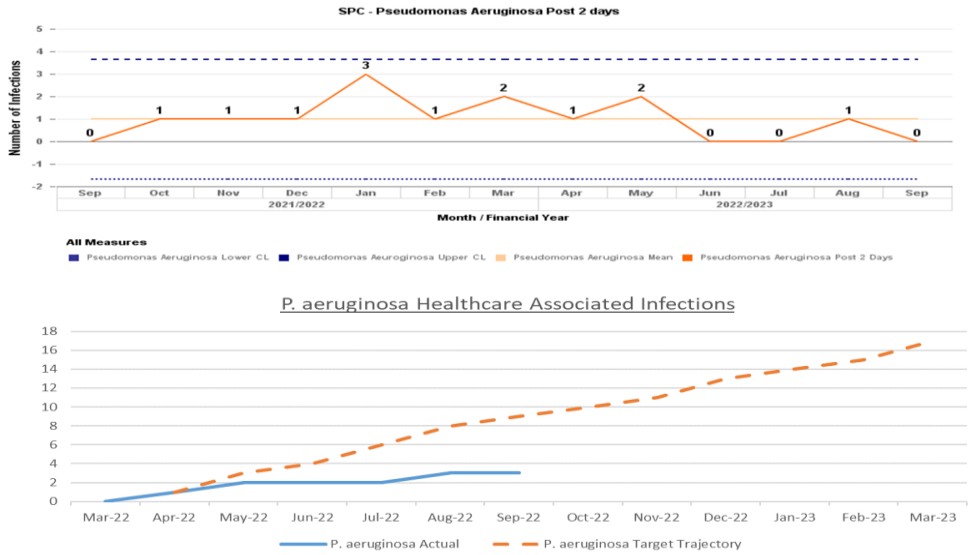
Countermeasure/Action (completed last month)	**Owner**
Improve urinary catheter care, continence care and hydration	Continence team / Matrons
Countermeasure/Action (planned this month)	**Owner**
Promotion of hydration and catheter care during Infection Control Week	IPC
Review the policy for the insertion and management of lines, taking into account the Practice versus Guidelines assessment of cannulation and Peripheral Vascular Cannula (PVC) care/maintenance findings	Training Department / Matrons

Breakthrough Objective | Klebsiella and Pseudomonas

Performance (Klebsiella)



Performance (Pseudomonas)



Is standard being delivered?
There were 2 hospital associated Klebsiella infections reported during September 2022 against the annual trajectory of no more than 26 infections during 22/23.

The cases were associated to: lower urinary tract infection with no catheter (n=1), lower urinary tract infection with a urinary catheter (n=1).

There was 0 *Pseudomonas Aeruginosa* reported during September against the trajectory of 17 for 22/23.

Benchmarking

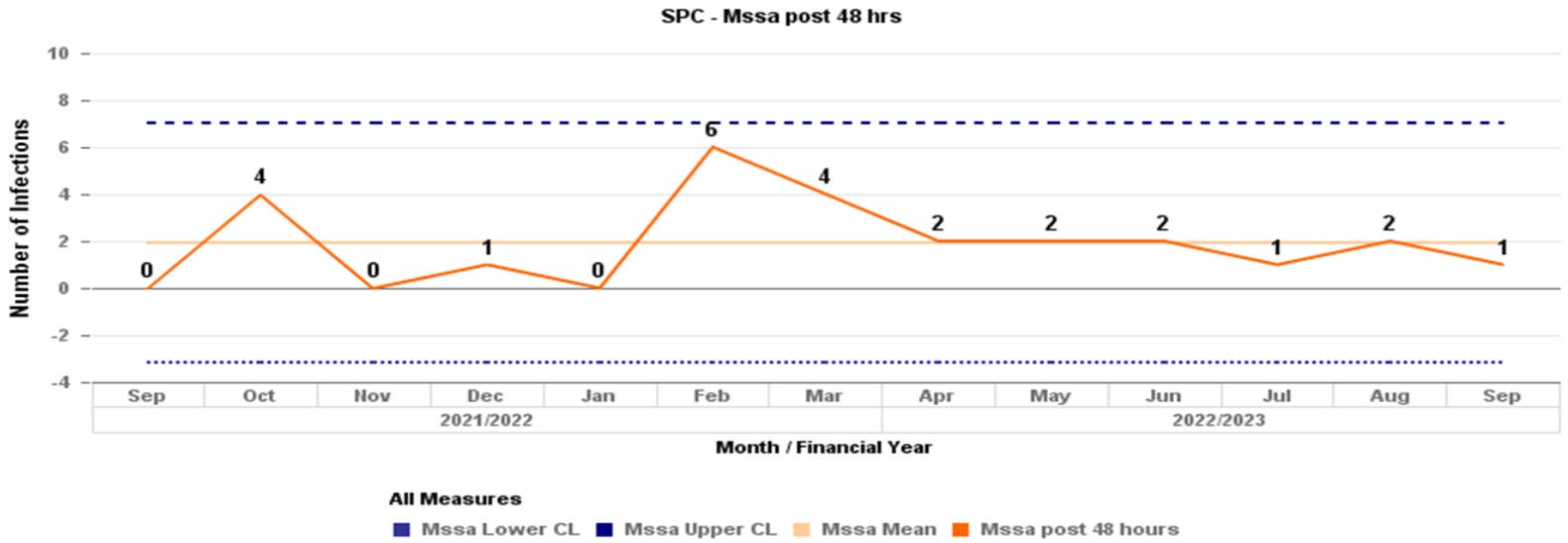
Trust	Klebsiella Rate (Aug 22)	Rate YTD
SW rate	**14.82**	**16.92**
RUH	**11.18**	**7.9**
GWH	11.53	11.69
SFT	0	5.73
Gloucester	11.64	7.01

Countermeasure/Action (completed last month)	**Owner**
Promotion of urinary catheter, continence care and hydration	Continence team / Matrons
Countermeasure/Action (planned this month)	**Owner**
Review the policy for the insertion and management of lines, taking into account the Practice versus Guidelines assessment of cannulation and PVC care/maintenance findings	Training Department / Matrons

Trust	Pseudomonas Rate (Aug 22)	Rate YTD
SW rate	**14.82**	**10.92**
RUH	**11.18**	**7.9**
GWH	11.53	11.69
SFT	0	5.73
Gloucester	11.64	7.01

Breakthrough Objective | MSSA

Performance



Is standard being delivered?
There was 1 hospital onset Methicillin-Susceptible Staphylococcus Aureus (MSSA) blood stream infection during September 2022.

What is the top contributor for associated risk factors?
The case was associated with septic arthritis.

Benchmarking

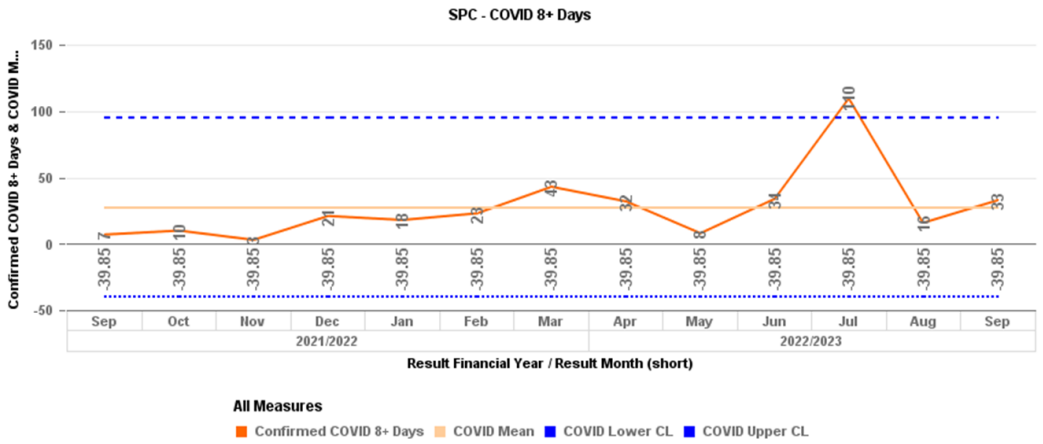
Trust	Rate (Aug 22)	Rate YTD
SW rate	**18.44**	**17.21**
RUH	**11.18**	**11.36**
GWH	34.6	30.49
SFT	21.13	11.36
Gloucester	38.8	21.98

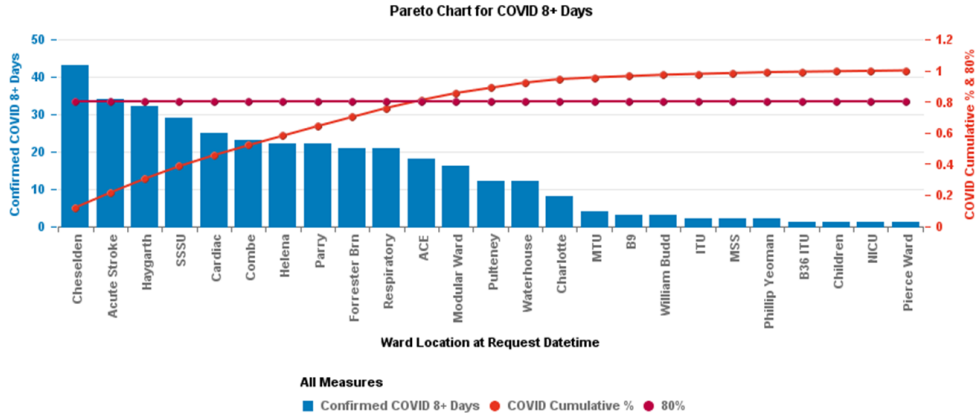
Countermeasure/Action (completed last month)	Owner
Take the Practice versus Guidelines assessment of cannulation and PVC care/maintenance findings through the October Infection Control Committee (ICC) for wider learning	IPC

Countermeasure/Action (planned this month)	Owner
Promotion of line care and skin prep during IPC week and patient safety week	IPC
Review the policy for the insertion and management of lines, taking into account the Practice versus Guidelines assessment of cannulation and PVC care/maintenance	Training Department / Matrons

Breakthrough Objective | Confirmed COVID-19

Performance





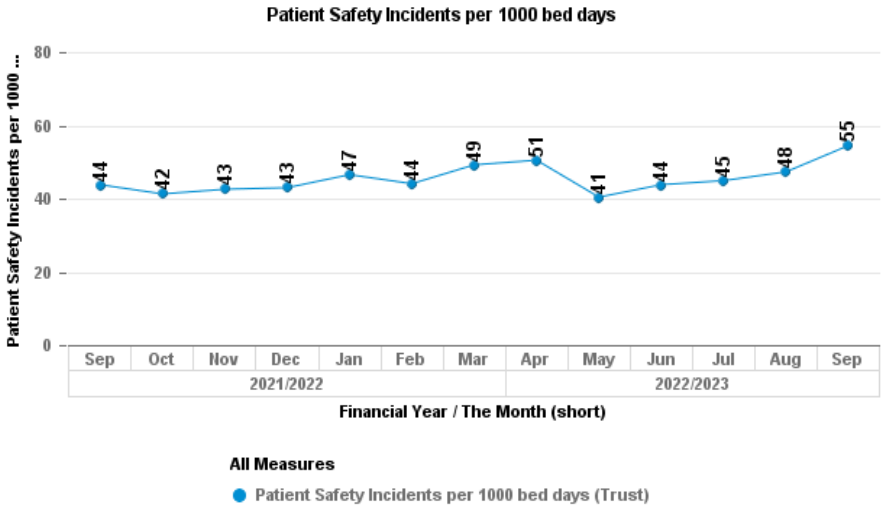
Is standard being delivered?
There were 33 confirmed COVID-19 8+ days infections in September 2022. This was reflective of the increasing community rate and a small number of symptomatic cases being detected on wards as inpatients.

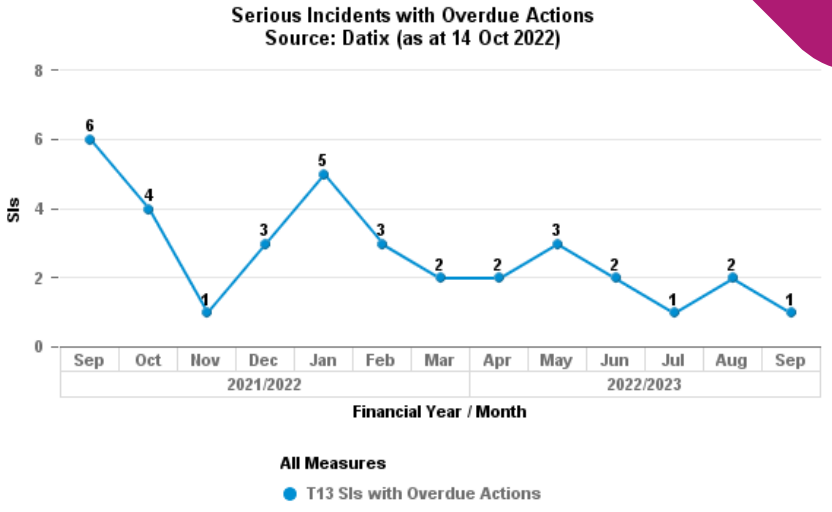
There were 2 deaths in patients who had nosocomial COVID-19 infection and 1 patient with indeterminate nosocomial infection during September 2022 however COVID-19 was not recorded as a cause of death on the death certificate.

Whilst the BANES COVID-19 rate reduced to 37.77 at the end of August 2022, by the end of September the South West rate had increased to 118.88 and the BANES rate had increased to 74.50.

Countermeasure/Action (completed last month)	**Owner**
Mask wearing has been reinstated due to increasing rates.	IPC
Countermeasure/Action (planned this month)	**Owner**
2 cohort areas created to manage increasing COVID-19 demands.	Site Management Team
Contact bays being maintained with exposure testing on days 3 and 5.	IPC

Quality | Tracker Measures

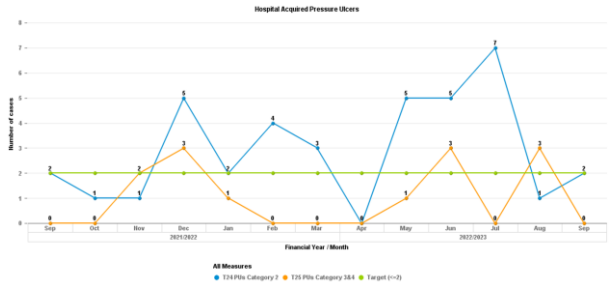


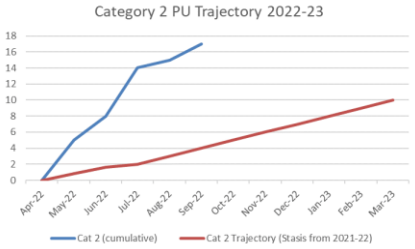


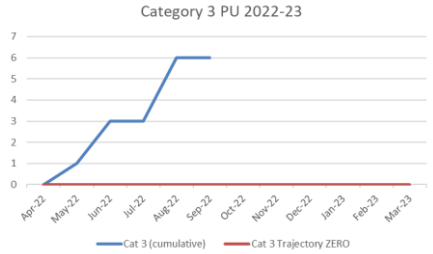
Measure	Top contributor for red/green performance this month	Action
Incident Reporting	The top reported categories of incidents are: admission (including long trolley waits), patient falls, medication incidents and discharge, transfer or transport. The top reporter of incidents are General Surgery followed by Maternity and Acute Medicine.	There has been an increase in incident reporting for September with 55 incidents reported per 1,000 bed days compared to 48 in August and 45 in July. Incident reporting will be promoted through the e-learning training for staff, linked to the launch of the new Patient Safety Incident Response Framework (PSIRF). A working group has been established to agree and roll out new processes to meet the requirements of the PSIRF, published in August 2022.
Serious Incidents	There were 1 Serious Incidents with overdue actions in September 2022.	A report is produced monthly for each Division summarising any overdue actions and these are followed up with the leads for each action. A review is being undertaken into the process of incident review, actions, feedback and learning from incidents. The new processes will be aligned to the Patient Safety Incident Response Framework (PSIRF), published in August 2022. This will include a separate action plan meeting for each Serious Incident following a review of findings from the initial investigation. This will allow better consultation with key stakeholders to ensure that appropriate improvement actions are agreed.

Quality | Pressure Ulcers

Historic Performance

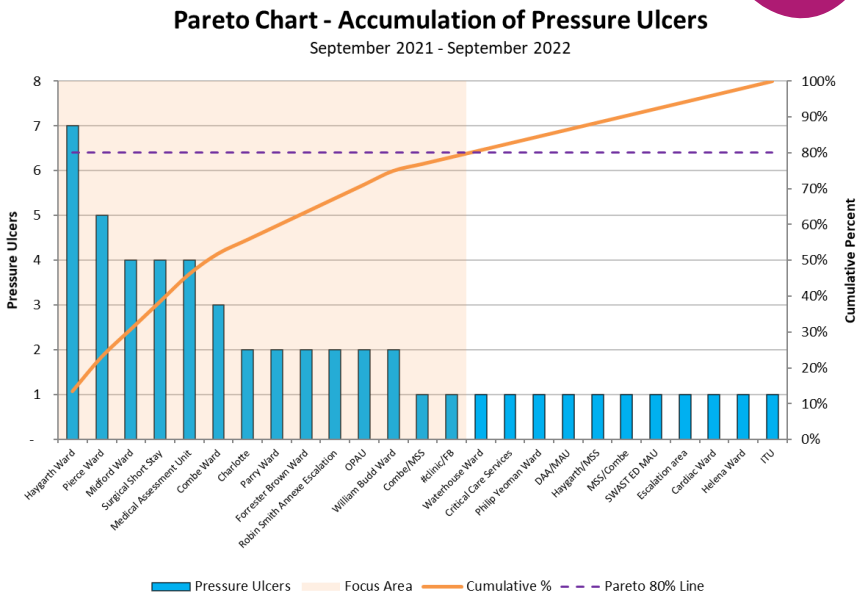






Is standard being delivered?
The ambition for 2022-23 is to have no more than 10 category 2 pressure ulcers, no more than 4 device related pressure ulcers and no category 3 or 4 pressure ulcers.
There were 2 category 2 pressure ulcers in September. The Trust is above trajectory for category 2 and 3 pressure ulcers.
Benchmarking a similar size and demographic hospital indicates the RUH remains a flag ship for prevention despite an increase in pressure ulcer.

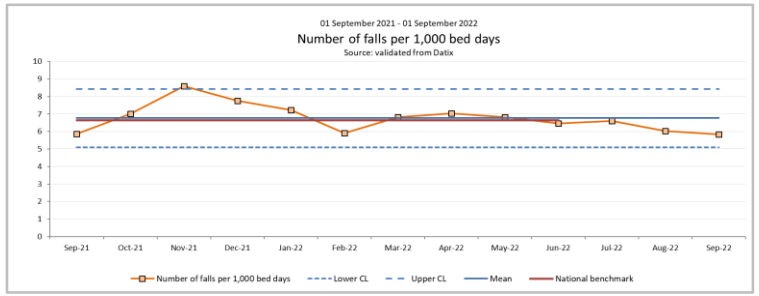
What is the top contributor for under/over-achievement 2022-23
The Pareto chart demonstrates the top 5 contributors for total number of pressure ulcers are: Haygarth, Pierce, Midford, Surgical Short Stay Unit and Medical Assessment Unit.

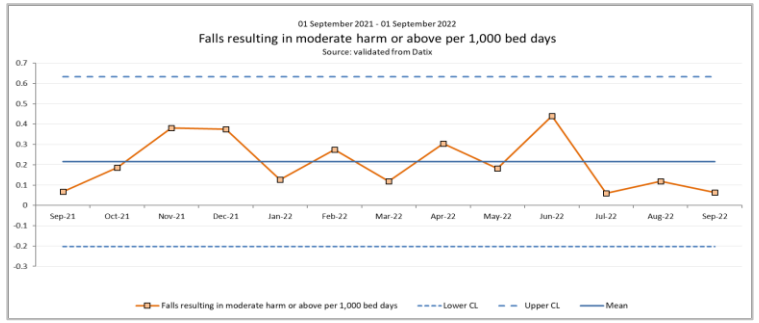


Countermeasure/Action	Owner
Introduce the red flag system to Combe ward; a system to clearly identify those at extreme risk who require regular nursing interventions in the face of reduced staffing levels. Also in use now on Midford, Haygarth and plans for Pierce ward.	TVN Team
Tissue Viability Steering Group: Monitor learning and actions from acquired pressure ulcer investigations. Thematic appraisal of all pressure ulcers to date has identified the top 3 (64%) contributors to pressure ulcer development. Improvements are focussed on the use of Repose Foot Protection, managing patient non-concordance and patient nutrition.	TV Steering group
"Wound Warriors" launched – a series of training sessions across the wards on the principles of wound healing.	TVNs and TV Ambassadors

Quality | Falls

Historic Performance





Is standard being delivered?
There was 1 moderate harm fall in September , against a target of 3 per month: MSS (n=1). Falls per 1000 bed days remain within the expected confidence intervals with a slight decrease in falls for September.

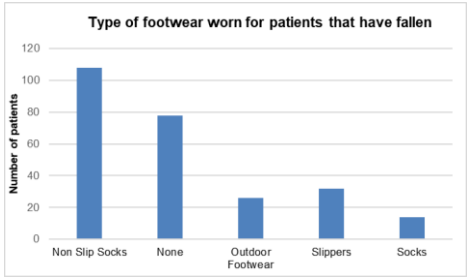
What is the top contributor for under/over-achievement?
Since July, data is recorded on Datix on the location of the fall in the ward, type of footwear and enhanced observation level. Three months review of this data highlights the following:

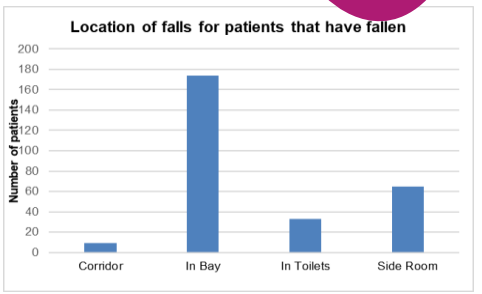
- 62% of falls occur in bays
- 42% of patients wore slipper socks and 30% no footwear

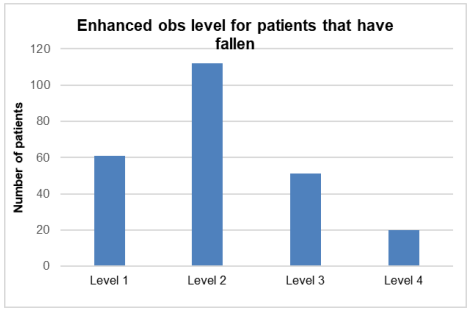
Working with 1 ward - Midford to test use of this data in identifying trends and improvements.

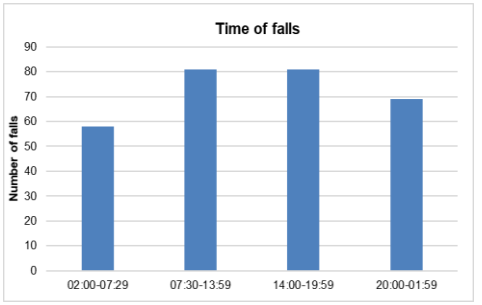
Planned quarterly report for PSSG November.

Further data on falls recorded on Datix









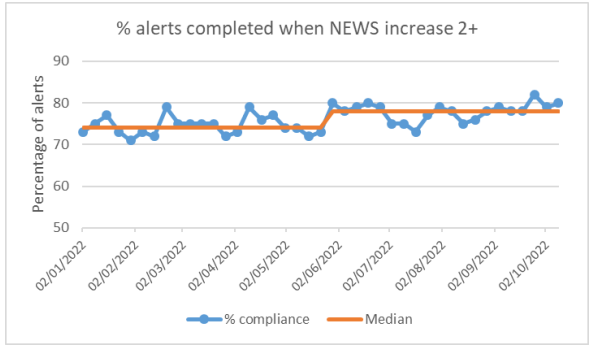
Countermeasure / Action (completed last month)	Owner
Analysis of datix fields for the areas included in the weekly safety huddles – commenced with Midford ward.	QI Team
Launch of Enhanced Observation training video.	QI Team
Falls Awareness Event 20 September including interactive training.	QI Falls lead
Launch of “safe use of bed rail “guidance.	QI Falls lead
Working group being established to develop guidance for appropriate footwear to prevent falls in hospital.	QI Falls lead

Countermeasure / Action (planned this month) October	Owner
Continue work with Midford – use of data in identifying trends and improvements.	QI Team
Develop tracker measure for falls and 1 to 1 support.	QI Team
Audit effectiveness of bed rail guidance.	QI Falls lead
Quarterly Falls Champion update – first session 20 October.	QI Falls lead

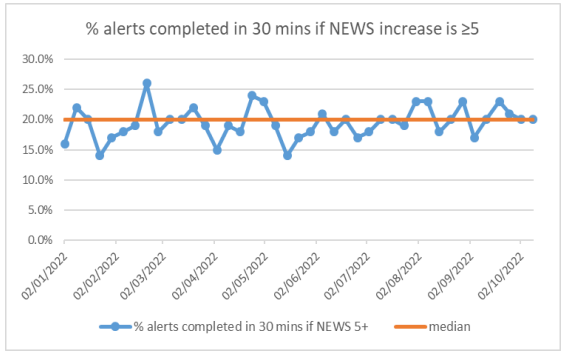
Quality | Deteriorating Patient

Historic Performance

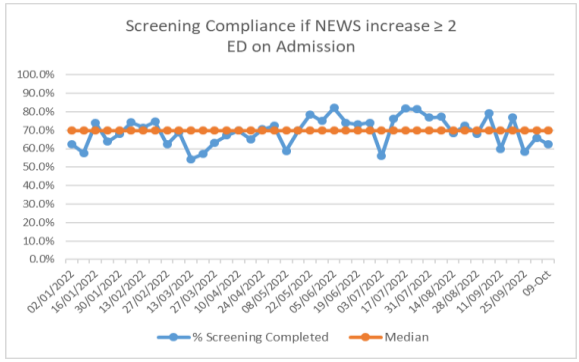
Screening completed if NEWS increases by 2 or more trust wide 2022 (Figure 1)



% alert complete in 30 mins if NEWS increases > 5 trust wide (Figure 2)



Sepsis screening on admission in emergency department (Figure 3)



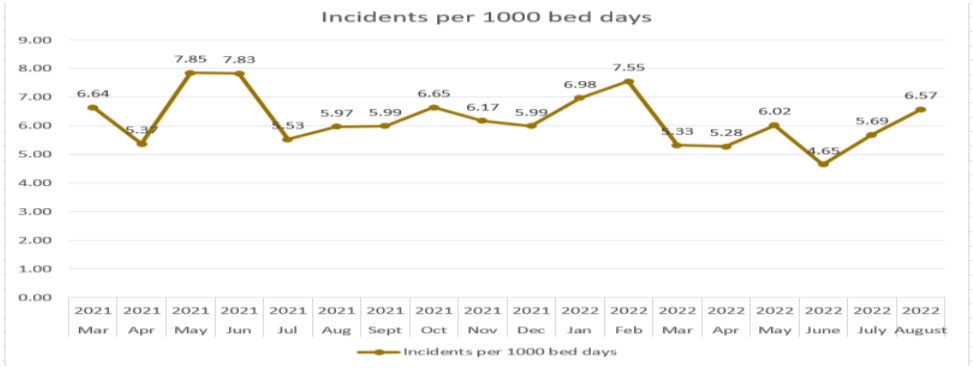
Is standard being delivered?
Trust-wide screening from E-obs for early deterioration based on NEWS increase ≥ 2 for 2022 is 78% (Figure 1). Compliance is slowly increasing.
Compliance with response within 30 minutes of NEWS increase ≥ 5 is 20% (Figure 2) against a target of ≥ 80%.
ED Sepsis screening from electronic recording has decreased to median of 70% (Figure 3) against a target of ≥ 90%, with a decreasing trend.

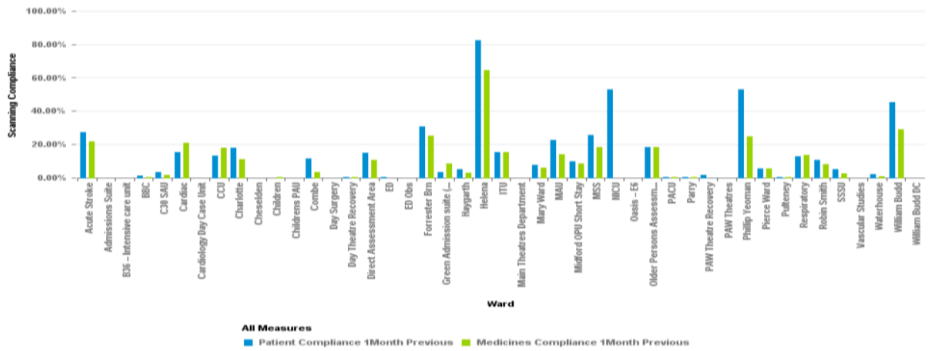
What is the top contributor for over-achievement?
Median compliance for ASU, Cheselden, Helena, Midford, Combe, Parry and Pulteney is ≥ 90%.
Haygarth and Cardiac have achieved >90% compliance for the last 6 weeks.
Forrester Brown and Charlotte have increased compliance to >85%. For last 6 weeks.
Wards with higher screening compliance have compliance within 30 minutes if NEWS 5 or more of 30-70%.

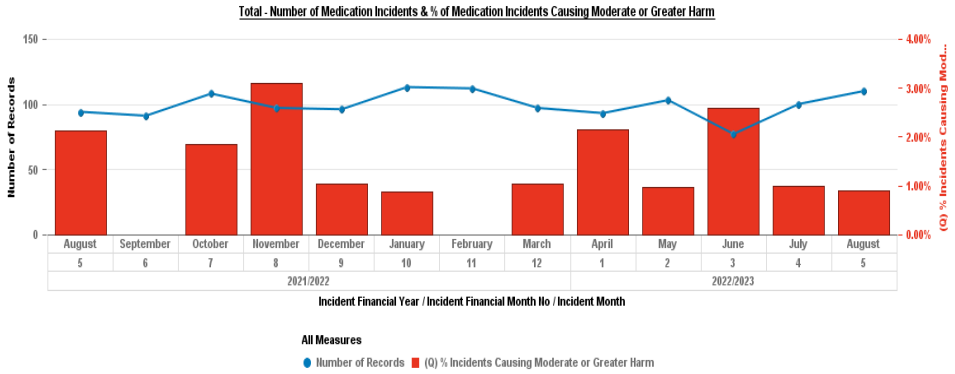
Top contributors to Under achievement
Pierce and SSSU have decreased compliance of 58% and 55% respectively.

Countermeasure / Action (completed last month)	**Owner**
Focused training on highlighted wards.	SKIP team
Review Night Sister role and JD.	Hospital @ Night group
Whiteboard default use by wards.	Digital Nurses
Countermeasure / Action (planned this month)	**Owner**
'Be Curious' tea trolley training with launch of PS Priority campaign.	Consultant Anesthetist/SKIP
ED nurse trainers for sepsis / Acute Kidney Injury deteriorating patient.	ED Education Nurse / SKIP
New E observation deteriorating patient form to go live.	IT/ Digital Nurse Lead
Funding awaited for hand-held devices to start testing in ED.	CNIO / CMO
Restart ward awards system / link to ward accreditation scheme.	Consultant Anesthetist/SKIP
Review availability Cerner options for ward dashboard/escalation.	CNIO
Review CQUIN metrics on unexpected ICU admissions and metrics for response to deterioration	Consultant Anaesthetist/ Critical Care Lead

Quality | Medicines Safety







Subject	Refresher Period (Years)	Current Target	Compliance at Census						Change Since Last Month	No. of Staff Requiring Training	No. of Staff Trained	No. of Staff Not Trained	Due in Next 3 Months
			2021/2022			2022/2023							
			Q2	Q3	Q4	May	Q1	July					
			30/09/2021	31/12/2021	31/03/2022	31/05/2022	30/06/2022	31/07/2022					
AKI Level 2	3	90.0%	77.7%	79.6%	80.2%	80.7%	81.4%	81.2%	▼	4191	3401	790	109
Antibiotic Review Kit (ARK)	once only	90.0%	56.6%	60.7%	61.6%	63.4%	63.3%	65.0%	▲	857	557	300	0
Antimicrobial Stewardship Level 1 *	once only	90.0%	85.9%	87.2%	87.4%	87.9%	87.9%	88.1%	▲	2998	2641	357	1
Antimicrobial Stewardship Level 2	3	90.0%	59.4%	63.2%	63.2%	64.3%	64.0%	64.6%	▲	872	563	309	17
End Of Life Care (Adult)	once only	90.0%	84.2%	83.8%	84.0%	84.3%	83.5%	84.1%	▲	1822	1531	291	0
Insulin Safety	2	90.0%	75.2%	74.4%	71.5%	71.0%	71.3%	70.9%	▼	1841	1305	536	70
Medical Gas Safety	2	90.0%	79.3%	78.2%	77.6%	77.4%	77.3%	77.3%	●	3121	2410	711	107
Sepsis Level 2	3	90.0%	84.8%	85.2%	84.4%	84.6%	84.8%	83.1%	▼	4294	3566	728	304
VTE	once only	90.0%	85.1%	85.8%	85.3%	85.3%	85.1%	85.4%	▲	2895	2472	423	0

Is standard being delivered?

- Barcode scanning: 100% patient + medicine scanning would prevent >1,000 medication errors/month.
- All front line staff should receive adequate training to supply or administer high risk or critical medicines: insulin / antibiotics / oxygen.

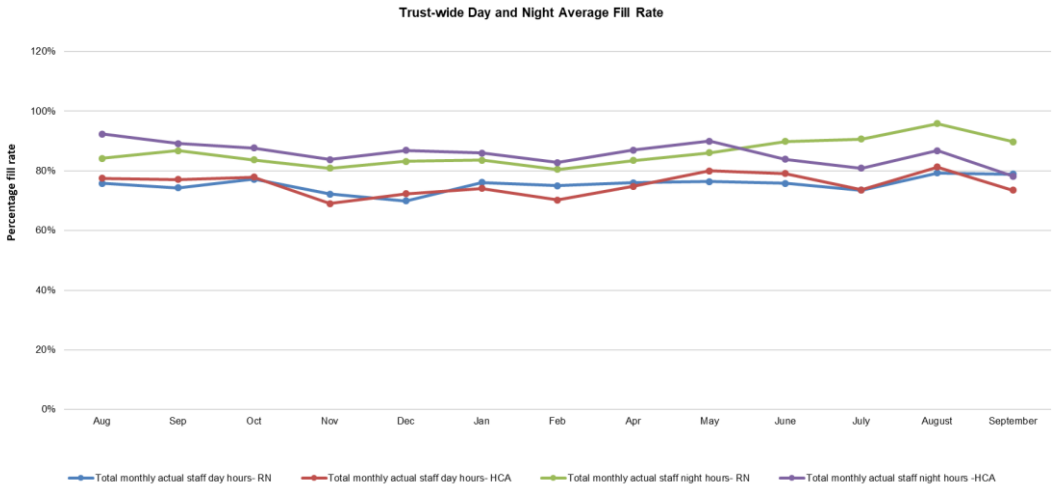
What is the top contributor for under/over-achievement?

- Medication incidents: for information only-reported incidents within normal variation.
- Barcode Scanning: Medicines compliance 10.79%. Helena top contributor (45.74%).
- Medicines training: for information: Declining training compliance across all divisions with key metrics- Antimicrobial Stewardship, ARK level 2, Medical Gas safety, VTE.

Countermeasure /Action (completed last month)	Owner
Approach to Ward Accreditation (Gold / Silver) threshold agreed – to include barcode scanning and incident reporting	Chief Pharmacist / Senior Nurse QI / Head of Quality Assurance
Escalation of medical gas training deficit and incident profile to Divisional Governance Leads.	Chief Pharmacist
Countermeasure /Action (planned this month)	**Owner**
Begin medical gas improvement plan with Medical Gas Committee/Divisional Clinical Governance Leads.	Chief Pharmacist/MGC Lead/CG Leads
Medicines Safety Brief to be shared with Divisional Governance leads on a monthly basis to highlight areas of good practice/for improvement.	Chief Pharmacist

Quality | Safer Staffing

Historic Performance



At a glance for September 2022: Wards with fill rate <=75% (shaded Red) for RN and/or HCA (by Day and Night shifts)

	Day		Night	
Ward / Dept	**RN**	**HCA**	**RN**	**HCA**
Acute Stroke Unit	85%	61%	94%	59%
Cardiac Ward	83%	91%	117%	80%
Charlotte Ward	59%	75%	67%	100%
Cheselden Ward	71%	47%	100%	93%
Children's Ward	87%	46%	87%	60%
Combe Ward	111%	87%	129%	84%
Coronary Care Unit	94%		103%	
Emergency Department	90%	82%	91%	62%
Forrester Brown Ward	71%	63%	85%	82%
Haygarth Ward	70%	82%	96%	84%
Helena Ward	70%	104%	66%	133%
ITU	60%	63%	82%	56%
MAU	67%	76%	90%	75%
Medical Short Stay	101%	81%	100%	87%
Midford OPUSS	80%	80%	104%	74%
NICU	59%	67%	71%	24%
OPAU	94%	85%	93%	85%
Parry Ward	102%	90%	118%	91%
PAW Mary / BBC	88%	63%	89%	60%
Philip Yeoman Ward	91%	80%	97%	56%
Pierce Ward	67%	59%	101%	85%
Pulteney Ward	55%	88%	72%	79%
Respiratory Ward	53%	52%	59%	85%
Robin Smith Ward	81%	69%	77%	68%
SAU	72%	78%	81%	90%
Surgical Short Stay	80%	87%	85%	111%
Waterhouse Ward	94%	60%	102%	75%
William Budd Ward	75%	70%	59%	76%

Is standard being delivered?

Compared to the 90% target, in September 2022:

- The percentage fill rate for registered nurses was 79% for day hours and 90% for night hours
- The percentage fill rate for HCAs was 74% for day hours and 78% for night hours

What is the top contributor for under/over-achievement?

Wards with low percentage fill rate highlighted in the at a glance section above. Key drivers for this position are:

- Vacancy rate and fill rate
- Sickness due to COVID-19 (Isolation & positive cases)
- Variation in e-roster compliance/e-roster knowledge
- Robin Smith are working to dependency and occupancy so as a planned sole elective ward this will impact on their daily planned numbers against establishment

Countermeasure /Action (completed last month)	**Owner**
Light touch establishment reviews completed and work continues to recruit into the new establishments.	ADON for Workforce
Finalise the recruitment dashboard detailing International and Domestic recruitment.	Workforce team
Scoping of an electronic agency authorisation process is complete	ADON for workforce

Countermeasure /Action (planned this month)	**Owner**
Work with Psych Liaison team to revamp the RMN job description, risk Matrix and escalation process. Scoping of a dedicated staff training program commenced.	DDoN – Medicine & ADON for workforce
Scope centralised recruitment, liaising with other Trust where this is in operation, determine the resource needed and the program of activities required. Plan to roll out a centralised approach for HCSW this month.	AD of HR & ADON for workforce
1st Cohort of 4 wards due to go live in November with the additional eRoster training programme.	Workforce Utilization & Safe Staffing Lead
Develop a dedicated support program for Internationally Educated Nurses (IEN) following NMC registration, recruitment into this new team is planned.	IR Lead & ADON for workforce

Patient | Executive Summary

Strategic Goal		Performance Indicator	Description	Target		2021/22							2022/23						Trend
				Performing	Under Performing	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Trust Goals	People We Care For	Number of Formal Complaints		<30	>=30	38	36	44	38	29	32	44	27	28	34	31	33	27	
Tracker Measures	People We Care For	Overall Patient Experience (FFT)	Proportion responding 'good' or 'very good'	>=95%	<95%	96.1%	95.1%	97.6%	96.7%	98.2%	96.6%	95.7%	96.4%	94.5%	93.7%	95.7%	97.1%	96.5%	
		% of Complaints responded to within target		>=90%	<90%	36.4%	47.1%	25.6%	40.7%	42.3%	44.4%	52.4%	61.1%	69.4%	82.4%	52.4%	60.9%	57.9%	
		Number of re-opened complaints		<=3	>3	7	5	1	6	2	3	4	3	3	3	2	2	1	
		PALS Response Time	% of Responses within 2 days			-	-	-	-	-	-	-	79.6%	80.5%	64.0%	72.0%	65.0%	62.0%	
		Number of Compliments				100	118	58	28	44	15	18	15	15	92	36	31	58	
		Number of Family Liaison Service Contacts				-	-	-	27	722	996	1243	858	934	698	357	-	-	

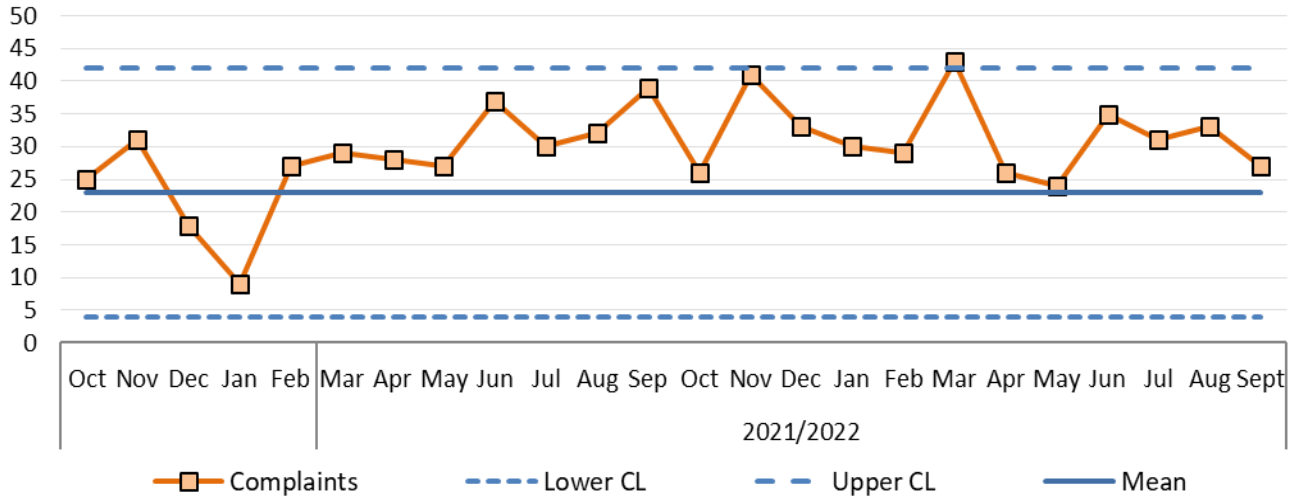
Measures requiring focus and a countermeasure summary this month are;

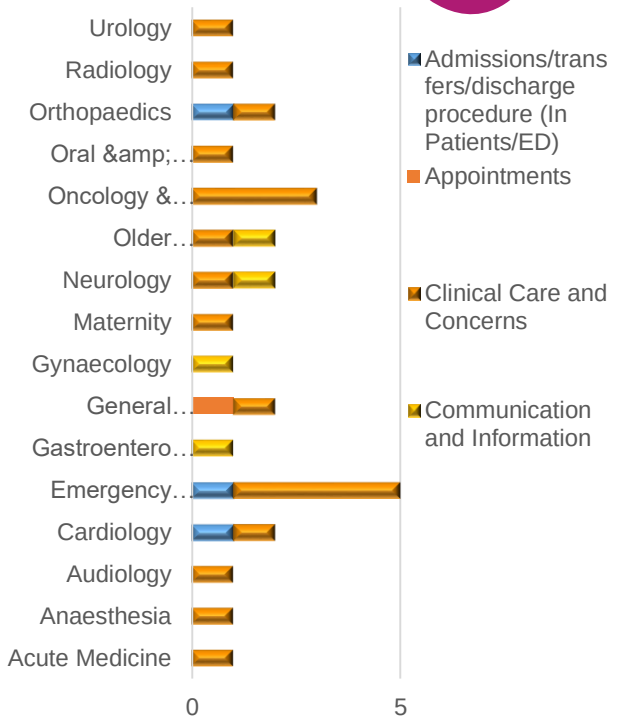
Measure	Executive Summary
Percentage of complaints responded to within target	This measure has shown an decrease in September. Overall**, 58% of complaints closed during September met the required timescale of 35 working days (11/19).** This is an decrease from last month (61% met timescale). Numbers of re-opened complaints remains low. Weekly Divisional Complaint meetings are held with the Head of Complaints and this is helping support ongoing improvements to the response times. The reasons for the timeframe exceptions are varied but predominantly: • Workload of clinicians causing delays in providing statements/investigating • Increased volume over recent months together with the complexity of complaints • Enhanced scrutiny by Executive team delaying sign off. To support improvements to the timeliness of complaint responses, a review of the severity of complaints using the risk matrix has been undertaken. Complaints categorised as low-medium with low frequency will be approved and signed by the Divisional Triumvirate.
PALS response time	The national standard for responding to PALS cases is 5 working days. The RUH standard for responding to PALS cases is 2 working day. The numbers of PALS contacts in September was 413**.** The reasons for the timeframe exceptions are mostly due to: • Workload of clinicians causing delays in responding • The volume, complexity and logging of cases for a small team • A review of the team resources and benchmarking with other Trusts is being undertaken 73% of PALS enquiries were responded to within 5 working days. 62% of PALS enquiries were responded to within 2 working days.

Patient | Complaints

Historic Performance

Number of Complaints – October 2020 to September 2022





Response Rate	Medicine	Surgery	F&SS	Corporate
Completed within timescale	60% (3/5)	57% (4/7)	33% (1/3)	75% (3/4)

Re - opened	Medicine	Surgery	F&SS	Corporate
Complaints re-opened	1	0	0	0

Is standard being delivered?
The Trust received 27 formal complaints in September 2022. This is 12 less than September 2021 and 4 more than the mean average for the rolling 24 months. Underperforming >=34, Performing <30.

What is the top contributor for under/over-achievement?
Clinical Care and Concerns accounted for 70% (n=19) of complaints. Emergency Department (n=4) and Oncology & Haematology (n=3) account for 37% of Clinical Care complaints. Complaints relate to inappropriate care/treatment, co-ordination of medical treatment, error performing a procedure, wait for treatment and test results lost or mislaid.

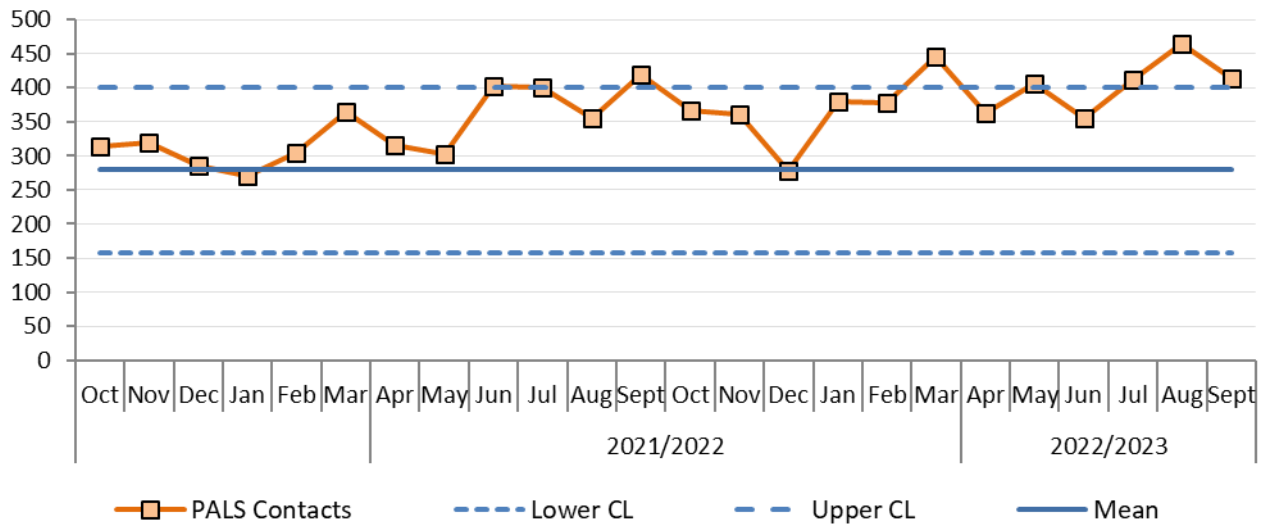
58% of complaints closed during September met the required timescale of 35 working days (11/19). This is a decrease from last month (61%).

Countermeasure /Action (planned this month)	Owner
• **Work towards improvements in response times** by continuing with weekly divisional meetings.	HH
• **Triage system for complaint responses** to be introduced on Monday 17 October. Complaints assessed as low and medium risk will be approved and signed by the Divisional Triumvirate.	HH
• **Monitor implementation of action logs** within the divisions to provide assurance that actions are completed.	HH

Patient | Advice and Liaison Service

Historic Performance

Number of PALS Contacts – October 2020 to September 2022



Is standard being delivered?

Situation report: There were **413 contacts with PALS in September 2022.**

KPI: Performance against 48hr standard resolution timeframe 62% of cases were resolved in 48 hours or less; a further 15% were resolved in 6 days and 7% between 7-14 days. 16% of the complex cases took more than 14 days.

What are the top contributors for under/over-achievement?

Appointments (n=66). The highest number of enquiries related to the length of time patients were waiting for new and follow up appointments 56% (n=37). A further 18% (n=12) were patients requesting to change their appointment date.

Communication and information (n=45). The highest number of contacts were general enquiries/communication 36% (n=16). A further 31% (n=14) concerned telephones not being answered.

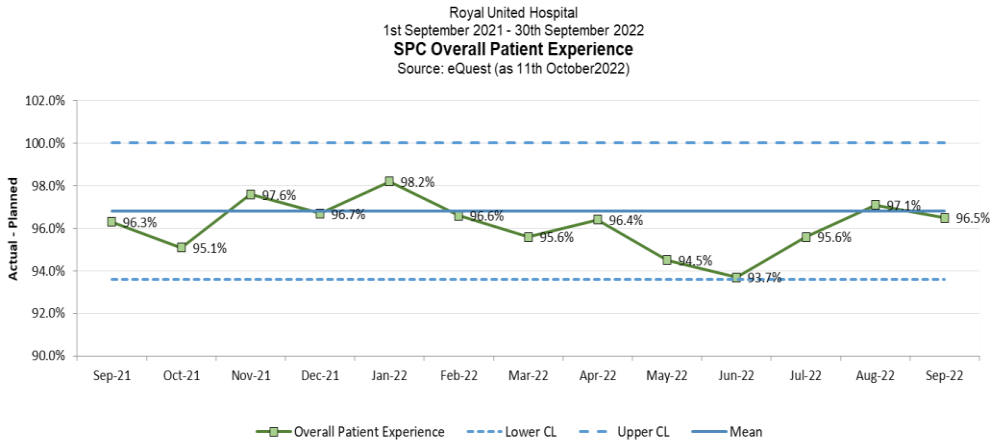
Clinical care and concerns (n=62). The highest number of contacts concerned inappropriate care or treatment 19% (n=12) a further 12% (n=8) were patients chasing test results. No trends were identified.

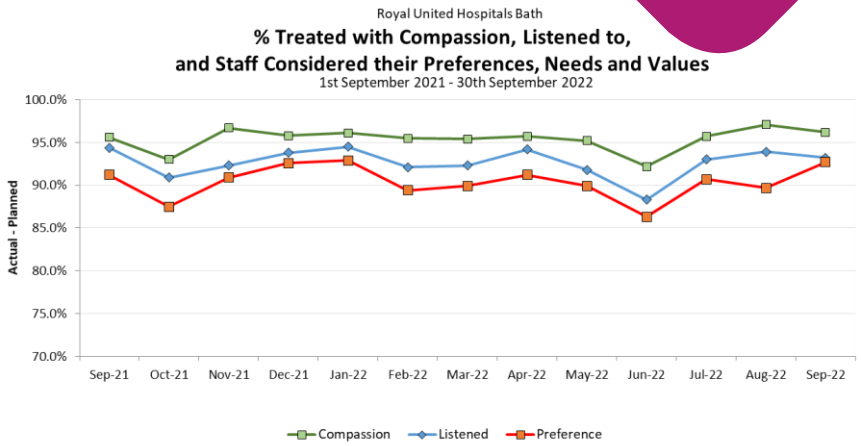
- 265 Required resolution (64%)
- 108 Requested advice or information (26%)
- 25 Compliments (6%)
- 15 Provided feedback (4%)
- 66 Appointments
- 62 Clinical Care and Concerns
- 45 Communication and information

Countermeasure/Actions	Owner
Outpatient departments are continuing to hold weekend clinics to support the backlog in appointments. Virtual and telephone appointments are being held where possible.	Specialty Managers
PALS met with Radiology and Gastroenterology Manager to understand the challenges the department is currently facing in order to support communication with patients around appointment and test result waiting times.	Specialty Managers/PALS and Reception Manager

Patient | Friends and Family Test

Historic Performance





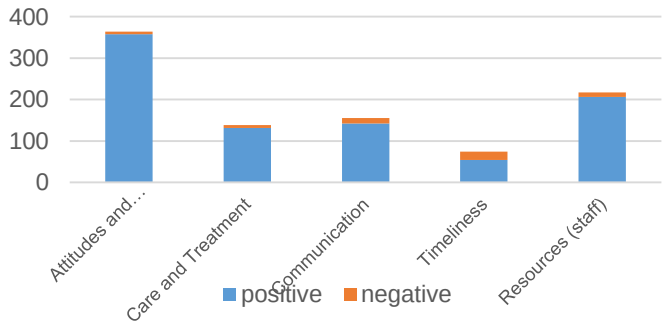
Is standard being delivered?

In September 2022 the proportion of patients across the Trust that responded positively (very good or good) about their overall experience was **96.5%. Above the 95% target on the scorecard.** Below shows this broken down for each clinical division.

What is the top contributor for under/over-achievement of the standard?
The numbers of responses in ED remain very low. 'Hello Lampost' is being used in ED to get patient feedback on their experience. The information from this will be included in future quarterly reports.

FFT responses September 2022	'Overall how was your experience of our service?'			
	Medicine Division	Surgery Division	F&SS	Corporate (ED)
Very good/ good	**96% (352)** ↑	**97% (226)** ↓	**98% (204)** ↓	**73% (11)** ↓
Poor/ very poor	2.4% (7)	1.5% (3)	0.5% (1)	20% (3)
Neither good nor poor	1.6% (6)	1.5% (3)	1.5% (3)	7% (1)

Themes - Patient experience feedback comments collected via FFT in September 2022:



As in September 2022 FFT Positive feedback – top three themes are:
Attitudes and behaviour of staff (n=358), Resources (Staff) (n=206) and Communication (n=142).

As in September 2022 FFT Negative feedback – top three themes are:
Timeliness (n=20), Communication (n=13) and Resources (staff) (n=11).

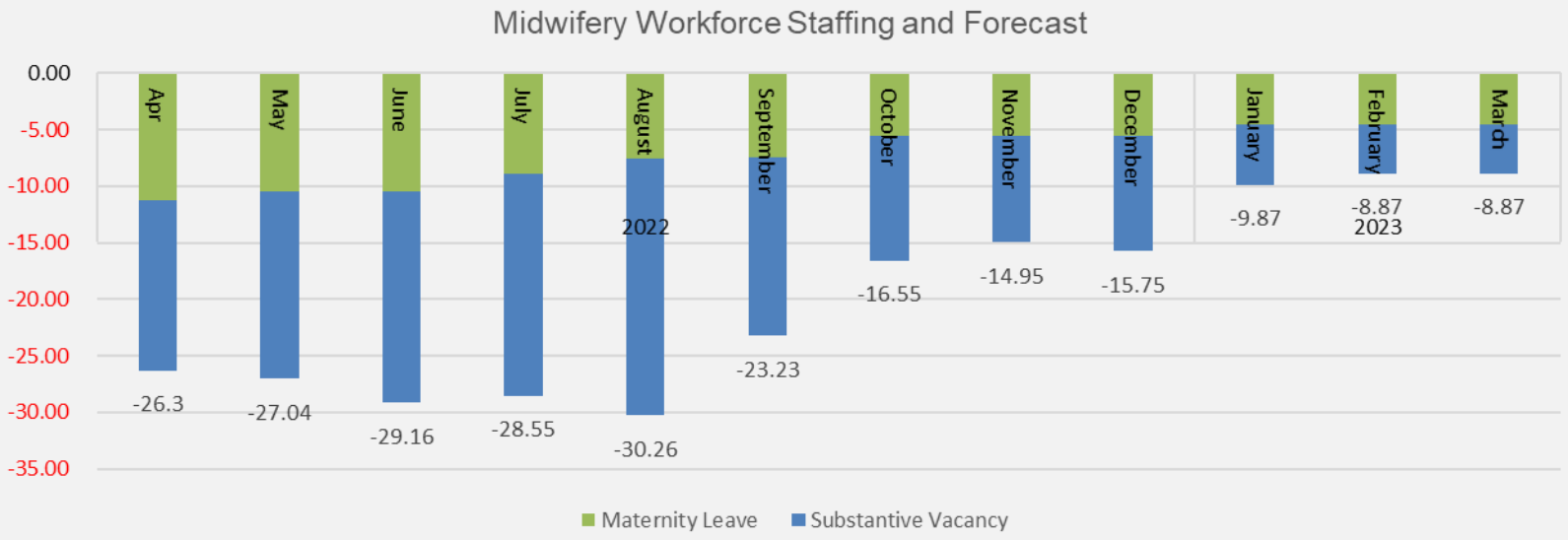
Patient Safety | Maternity Workforce

Measures	Summary
Minimum safe staffing in maternity to include Obstetric cover on Delivery Suite	Budget vs actual midwifery staffing. -23.23 whole time equivalent (WTE) (of which 7.44 WTE is maternity leave). **Substantive vacancy rate -15.79 WTE** Currently 60 hours/week consultant cover for obstetrics and gynaecology. Royal College of Obstetrics and Gynaecology (RCOG) recommendation that for a unit supporting 4-5000 births this should be 98 hours per week. Obstetric workforce review underway.

Measure	Aim/target	September 22
Midwife to birth ratio	≤1:27	1:35
Midwife to birth ration (including bank staff)	≤1:27	1:31
Supernumerary labour ward coordinator status	100%	99%
1:1 care not provided	0	1
Consultant presence on BBC (hours/week)	≥60 hours	60
Twice Daily MDT ward round	100%	X2 100%
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0

Actions:
Ongoing review of 1 episode when 1:1 care was reported as not provided to identify cause. No harm resulted.
Staffing challenges have continued throughout September, which is improving in October as new midwives complete their supernumerary period.

Recruitment – midwifery pipeline



Patient Safety | Maternity Workforce

Measures	Summary
Shift fill rates (in-patient services)	

	Day				Night				Care Hours Per Patient Day (CHPPD)				Day		Night	
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
Jul-22	7155.42	5555.67	5468.00	3336.50	5530.50	4484.50	1849.00	1149.00	688.00	14.6	6.5	21.1	77.6%	61.0%	81.1%	62.1%
Aug-22	7188.50	5463.92	5510.00	3413.25	5560.50	4701.00	1860.00	1314.00	625.00	16.3	7.6	23.8	76.0%	61.9%	84.5%	70.6%
Sep-22	6994.75	6160.50	5318.25	3344.50	5364.00	4762.23	1785.00	1067.00	743.00	14.7	5.9	20.6	88.1%	62.9%	88.8%	59.8%

Is standard being delivered?

- 1 to 1 care in labour was not achieved on one occasion
- 99% of shifts have a supernumerary Labour Ward coordinator
- The Midwife to birth ratio is not being met
- There is a 20.31 WTE midwifery workforce gap.

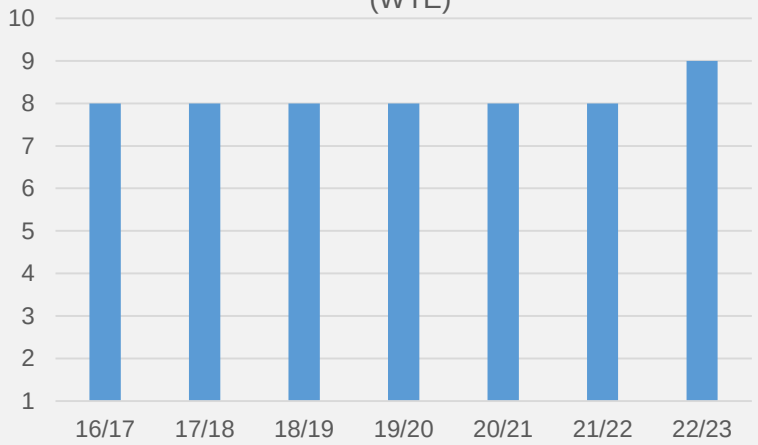
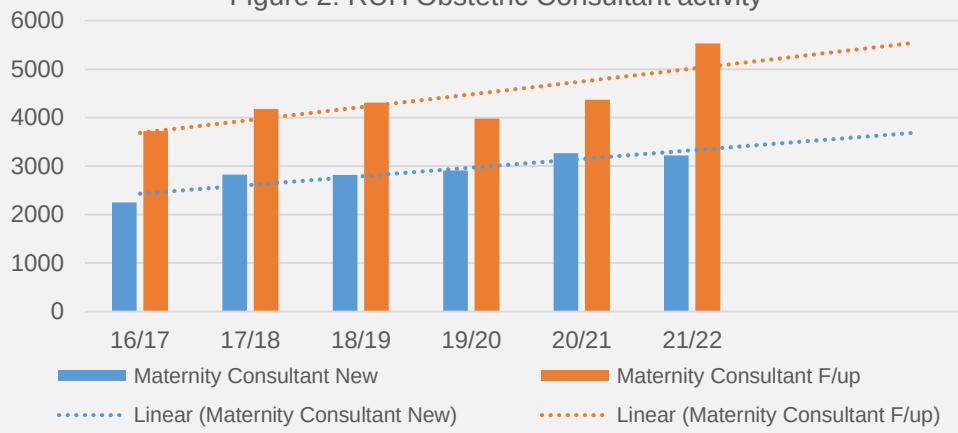
What is the top contributor for under/over-achievement?

- Vacancy rate
- Maternity leave
- Challenges in recruiting midwives
- Challenges with retaining midwives.

Countermeasure /Action (completed last month)	**Owner**
Recruited a Director of Midwifery – commences in post on 7 November.	CNO
Recruited Registered Nurses to work in maternity services Recruited newly qualified midwives Preceptorship programme established Recruit to maternity leave (n=8).	DOM Retention Midwife
Incentives introduced in June 2022.	DOM/DDO
Bid to recruit 8 International Midwives approved.	DOM

Countermeasure /Action (planned this month)	**Owner**
Working with NHSI to establish the longer term workforce plan for acute/community sites & Continuity of Carer.	DOM
Working with BSW Academy to widen routes into Midwifery.	DOM
Investigate red flag staffing episodes reported in September.	Matron

Patient Safety | Maternity Workforce

Measures	Summary
Obstetric Staffing	Figure 1: Total number of obstetric consultants (WTE)  Figure 2: RUH Obstetric Consultant activity 
Recruitment – Obstetric Consultant pipeline	2022-2023 / 2023-2024 Aug: 8; Sept: 8; Oct: 8; Nov: 8; Dec: 8; Jan: 9; Feb: 10; Mar: 11; April: 11; May: 11; Jun: 11; Jul: 11; Aug: 11; Sept: 11 The current funded establishment is 9 WTE Obstetric Consultants, 8 WTE are in post. An additional Consultant will commence in January 2023. • A workforce review is being undertaken to enable: • Moving from 60hrs to 98hrs Consultant presence as per Royal College of Obstetrics and Gynaecology (RCOG) recommendations • Splitting the on-call rota between Obstetrics and Gynaecology as per Ockenden recommendations • Further PAs are required to support the 43-48% increase in maternity consultant clinic appointments over the last 5 years.

Patient Safety | Perinatal Quality Surveillance Tool

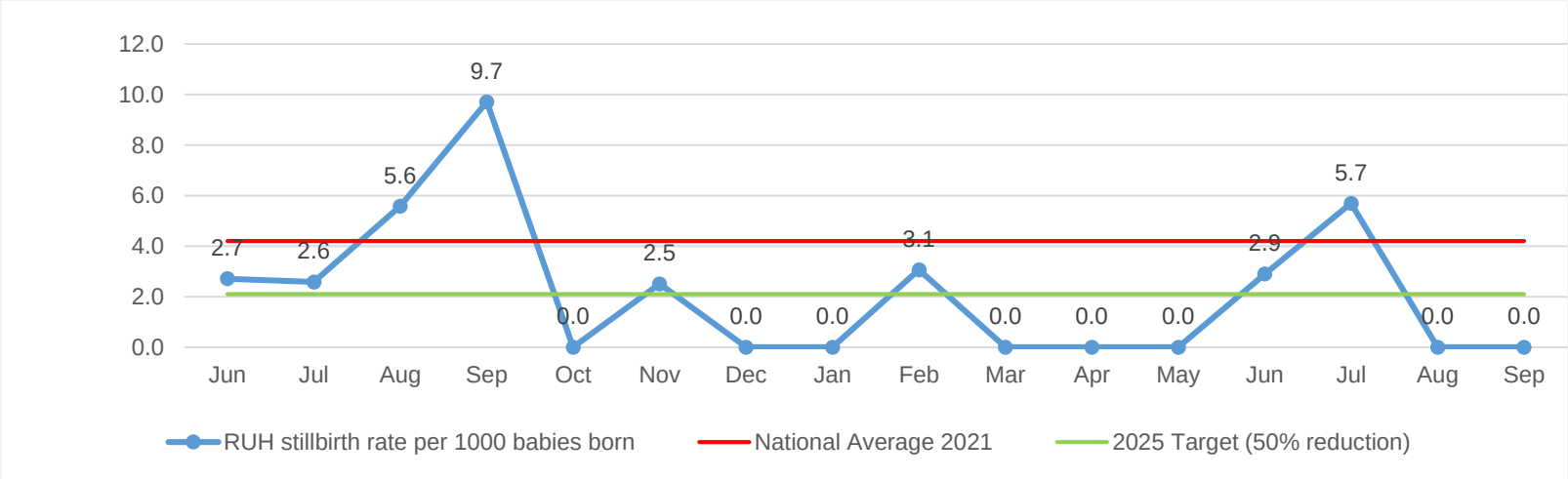
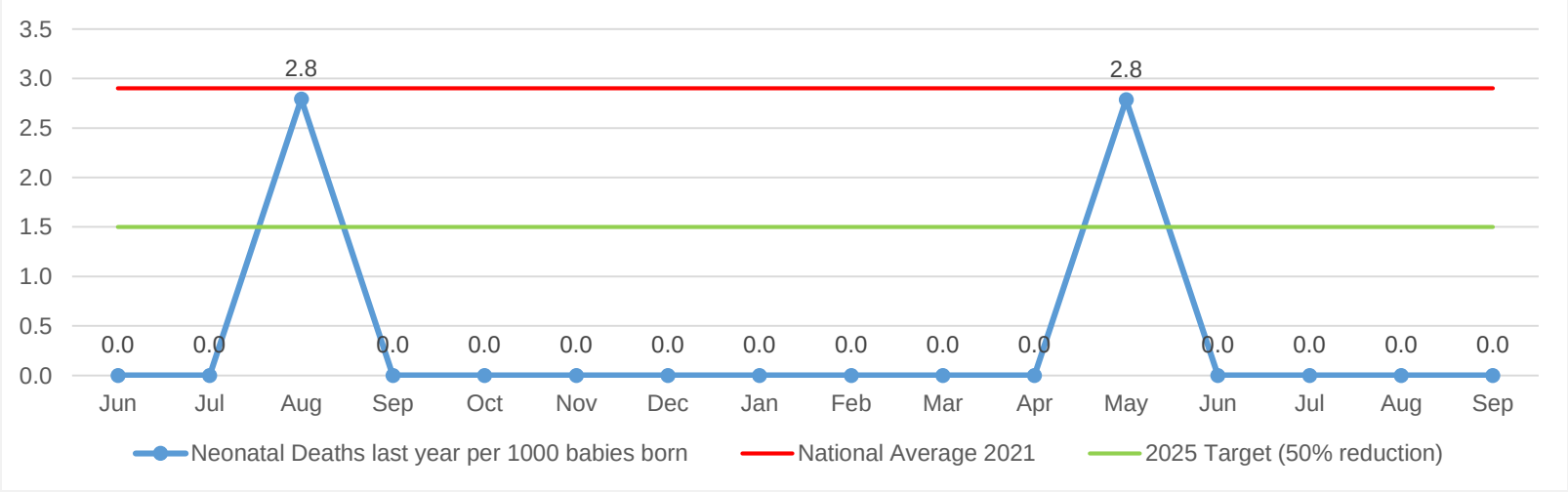
The information on the following slides form part of the new Quality Surveillance Model implemented nationally to ensure consistent oversight of Maternity and Neonatal Services at Board level on a monthly basis

Measures	Summary
Concerns or requests for actions from national bodies	Following National recommendations following Ockenden Report and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). Ockenden report including additional requirements published 30th March 22. Amended MIS year 4 standards published May 2022.
CNST 10 Maternity Standards (NHSR)	Amended MIS year 4 published May 2022. **Further amendment to submission date announced Sept 22 – Reporting period now 5/5/22 - 2/2/23** Some standards altered in line with Ockenden, which has affected Trust compliance. SA5 – Workforce planning must now demonstrate funding is in place to support full Birthrate Plus staffing recommendations, or action plan to achieve, including timescales, agreed at Board level. SA6 – CO monitoring level at 36 weeks average <80% via electronic reporting. Manual audit underway. SA8 – Risk to compliance due to late start of new fetal monitoring course and PROMPT compliance. Education Lead vacancy impacting delivery and reporting. Change within MIS: All trainees included within PROMPT training. See training update.
Review of all perinatal deaths using the real time data monitoring	All perinatal deaths within the Trust have been reported using the Perinatal Mortality Review Tool (PMRT) tool since 2018. PMRT reporting is Safety Standard 1 of the NHSR Maternity Incentive Scheme year 4. No postmortems will be routinely offered to 22 and 23 weeks late miscarriages effective from 1 September 2022. The Trust will continue to offer genetic testing and placental histology to all late miscarriages. There were 0 perinatal deaths reported in September. The PMRT action was to review the triage process for the Day Assessment Unit (DAU). This is underway.

RAG rating	
RED	Not expecting compliancy
AMBER	Expecting compliancy – plan in place to achieve
GREEN	Currently compliant

Safety Action Detail	RAG
SA1: Are you using the National PMRT to review perinatal deaths to the required standard?	Green
SA2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Green
SA3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Green
SA4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	Green
SA5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Amber
SA6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	Amber
SA7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Green
SA8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support, starting from the launch of MIS year 4?	Amber
SA9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Green
SA10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?	Green

Patient Safety | Perinatal Quality Surveillance Tool

Measures	Summary
Perinatal mortality rate	The following graphs demonstrate how Royal United Hospital NHS Trust is performing against the national ambition to reduce stillbirths by 50% by 2025. *RUH NHS Trust Stillbirth rate per 1000 births over last year:*  *RUH NHS Trust Neonatal Death rate per 1000 births over last year* 

Patient Safety | Perinatal Quality Surveillance Tool

Measures	Summary

Service User Feedback

Feedback	Sept 22
Number of compliments	2
Online compliments captured	
Number of PALs contacts/concerns	7
Complaints	1

Themes from September:

The theme for all PALS contacts expressing concerns related to issues around clinical care (failure to predict large baby, retained products post birth and waiting time for LSCS) and communication (difficulty with telephone contact).

CQC Ratings

CQC Maternity Ratings last assessed September 2018	Safe	Effective	Caring	Responsive	Well led	Overall
	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding

Maternity Safety Support Programme

N/A

Coroner's Regulation 28

N/A

Moderate Harm Incidents: The number of incidents graded moderate or above and the actions taken.

2

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI) which may account for an increase in the number of SIs reported in Maternity, although the outcome may not have been avoidable.

1. Term baby born rapidly following spontaneous labour with shoulder dystocia and cord tight around neck. Transferred for cooling. Referred to HSIB which is being triaged/
2. Postnatal Eclampsia

Serious Incidents (SI) reported in month

Serious Incidents (SI) reported in month			
Case ref		Date	Case Update
108058	HSIB – being Triaged	13/09/22	Referred and being Triaged by HSIB
108198	SI	22/02/22	Postnatal Eclampsia- RCA Investigation in progress

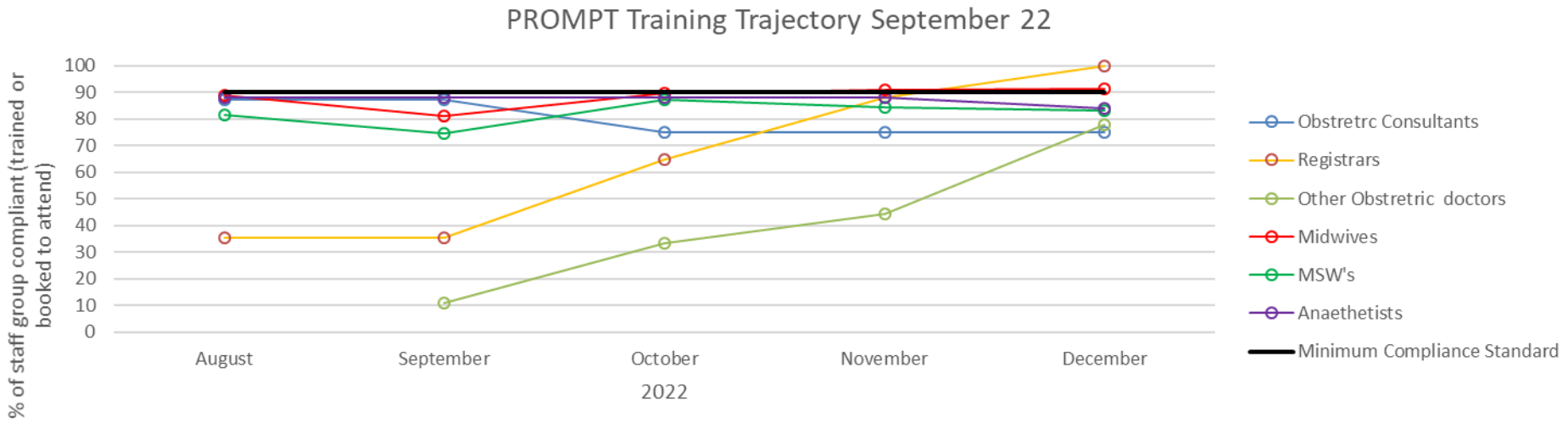
Ongoing SI Investigations update

Stage of Investigation	September 2022
HSIB logged	1
HSIB active cases	3
SI logged*	2
SI approved by Trust panel	1
Active Trust SI investigations to date**	2

*HSIB cases are automatically an SI but an RCA investigation is not completed by the Trust

**most SI investigations take approximately 3 months to complete so may feature in multiple months. This is not including HSIB cases, only Trust SI investigations

Patient Safety | Perinatal Quality Surveillance Tool



Background and underlying issues	Improvement actions planned, timescales, and when will improvements be seen	Risks to delivery and mitigations
90% compliance for all staff groups working in maternity have been mandated in the Clinical Negligence Scheme for Trusts (CNST) 2021-2022 guidance. Virtual training may be included if required, however face to face training will continue to be offered preferentially to focus on multi-disciplinary collaboration and effective team working. The revised CNST standards for year 4 mandate 90% compliance for all staff groups with fetal monitoring training. Including a competency-based assessment has been mandated by CNST 2021-22.	Clarity required from LMNS about doctors carrying over their PRoMPT and Fetal monitoring training from other Trusts. This is not done in other regions or Trusts. New B7 Quality and Education Midwife recruited full time to commence in November. PRoMPT and Fetal monitoring curriculum content rewritten ready to deliver for next 12 months. One training log document for trajectory and compliance ensures reporting is completely accurate and up to date. Overall **PRoMPT** compliance is currently below 90% and falls short of the standard; this is a result of new doctors, Midwives and MCAs starting in September. There are two PRoMPT sessions running in October to improve compliance and over 60 staff booked on. Not all new Doctors can be released at the same time to attend. **Fetal Monitoring** compliance is currently below 90%; but over 90% have attended the study day since the start of the training. K2 forms the competency based assessment part of training and staff are not marked as compliant until completed this. Places available at all sessions.	New requirement within MIS year 4 states that GP and sub-specialty trainees must be included in training if any obstetric commitment on rota. Addressing within specialty teams. Escalated within Division. All new doctors in training and GP and Specialist trainees within Obstetrics have been identified, and all are booked to attend PRoMPT and Fetal Monitoring training. Suggestion that training forms part of Doctors induction Sufficient places to service the demand and achieve over 90% compliance are available and booking staff on has been strengthened. Vacant Band 8 Patient Safety post recruited to. Deputy Director of Midwifery providing interim cover for the post.

MIS Year 4 Maternity Scorecard (Sep 170321- Sep 22)

(Mandated criteria taken from Maternity Dashboard)

		Nat. ave/ standard	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Comments
Workforce	Red flags: 1:1 care in labour not provided (BBC only)	0	0	1	1	0	0	0	0	0	0	0	0	0	1	
	Percentage of supernumerary labour ward co-ordinator status (%)	100%	90	95	98	100	100	100	98	100	97	97	98	100	99	
	Rostered consultant cover on BBC - hours per week	<60 hours	60	60	60	60	60	60	60	60	60	60	60	60	60	
	Consultant non-attendance when indicated in RCOG Roles and Responsibilities (as reported via Datix)	0												0	0	New metric
	Bath Birthing Centre twice daily round achieved (%)		77	77	67	84	81	79	94	93	90	93	97	94	X2 100 X3 83	TIMING OF ROUNDS – to be adjusted following obstetric staffing review (in progress)
	Midwife to birth ratio (establishment)	>1:27	1:35	1:35	1:33	1:31	1:35	1:30	1:32	1:34	1:34	1:34	1:34	1:38	1:35	Linked to vacancy rate. Including bank staff rate 1:31
	Number of women booked onto a Continuity of Carer pathway (%)	>=35%	52.3	43.3	50.0	42.3	43.2	40.0	40.9	40.5	43.8	41.3	36.2	37.0	41.7	No. of women booked onto a CoC pathway (AN & PN only). No national standard in place from Sept 22.
Safety	Risk assessment at every contact (Antenatal) (%)		50	54	54	61	56	55	78	56	71	51	51	47	48	Risk assessment at Booking 100%. Documentation focus. Digital solution not possible.
	Stillbirth number	Actual	3	0	1	1	0	1	0	0	0	1	2	1	0	N.B. 1x SB incorrectly reported here in Aug.
	Neonatal Deaths	Actual	0	0	0	0	0	0	0	0	1	0	0	0	0	
	Moderate Datix and above		2	2	3	3	2	0	2	5	2	3	0	1	0	
	HSIB		0	0	0	1	0	0	1	4	2	0	0	1	2	
Feedback	Number of compliments		1	1	2	0	4	1	1	1	1	4	3	0	2	
	Online compliments								291				*	*	*	Social media feedback temporarily paused
	Number of PALS contacts/concerns		6	8	9	4	15	8	6	8	18	9	6	6	7	
	Complaints		2	1	2	2	1	3	2	1	1	3	1	1	1	

MIS Year 4 Maternity Scorecard (Jun 21- Jul 22)

(Taken from Maternity Dashboard)

		Alert nat. ave/ standard	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Comments
Training	PROMPT/Emergency skills all staff groups (%)	>90%	71.9	74.3	71.98	71.34	76.6	84.0	91.2	91.8	95	91.4	91	78.7	79.5	See detail on training update page
	Percentage staff received fetal monitoring in labour training **(new from Sept 2021)** (%)	>90%	4.22	9.28	15.61	19.49	22.88	36.44	49.3	49.3	63.2	78*	82*	71.1	83.1	
	New-born life support (NBLS) (%)	>90%	78.25	79.65	79.15	80.20	77.8	89.0	91.2	92.2	96	91	91	77.5	79.5	
	Percentage of staff who have successfully completed mandatory CTG fetal monitoring annual competency assessment (%)	>90%	4.22	7.59	16.46	19.83	26.06	36.44	49.3	49.3	63.2	70.39	73	71.1	83.1	
	Coroner Regulation 28 made directly to Trust		Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	
	HSIB/CQC etc. with concern or request for action		Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	1	Nil	Nil	Nil	Working with HSIB in view of increased referrals March-May

The people in our community

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 6

The RUH, where you matter

Finance Director Focus

RUH Position
The Trust is £1.4m worse than plan at the end of September which is an improvement of £800,000 in the month.
There are some variances in the position which are being focussed on to reduce run rates and prevent a deviation from plan by the end of the year. A focussed recovery plan has been put in place for a number of areas where run rates increase and these include: ED medical staff back in line with budget; ensuring nursing expenditure is in line with allocated budget through a reduced use of agency hours, the deliver of QIPP and management of inflation costs. Progress is being made on these schemes and the run rate has reduced in some areas.

Elective Recovery
The elective recovery position improved significantly in September and was at 110% of 19/20 levels, which improved the year to date position to 106% (target 104%). Additional costs incurred to create further elective capacity have been covered by the additional elective recovery income.

Emerging risks and Forecast Outturn
The RUH is managing a number of risks within the financial plan that relate to the volume of Covid admissions; an increase demand on emergency services and a continued high number of patents in the hospital with no criteria to reside which reduces the available bed base for emergency admissions. Further costs will be spent to maintain the safety of the site over winter and the funding source is yet to be confirmed. The financial plan is expected to deliver with the implementation of the recovery plan £6m and further funding being available for winter.

BSW
The BSW system set a balanced plan for 2022/23 with a total of £51m of deficits across the three providers offset by a £51m of surplus with the ICB. We agreed that if the system was in balance each organisation is in balance and therefore a one off non-recurrent payment will be made to each provider to offset their deficit. The funding is non-recurrent and it is aimed to manage the cash implications of such deficits. Therefore the RUH will continue to monitor against the £19.3m deficit and will show the extra £19.3m as a bottom line adjustment to demonstrate the break-even position.

National Focus
The financial pressures impacting on the whole NHS are around increasing demand for emergency services with regular peaks being seen in Covid admissions which also create increased staff absenteeism, together with an increasing number of non criteria to reside patients on acute sites. This has a cost to the NHS and on top of the increasing inflation rates is leading to significant pressures being managed. There is no indication that further funding will be allocated to the NHS to manage these pressures and therefore we must continue to ensure we are focussing on achieving value for money. The commitment remains on reducing elective waiting times but this is becoming increasingly challenging due to the pressures highlighted. NHS England are looking at pension rules try and support the clinical workforce to stay within the NHS.

Executive Score Card

	Performance Indicator	Description	Target		Baseline	Actual 2022/23					
			Performing	Under Performing		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Sustainability Tracker Metrics	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	£0	£(148)k	£(188)k	£(464)k	£(1505)K	£(2214)K	£(1,398)k
	Forecast delivery of Group financial plan	Forecast variance from year to date plan	<=0	>0	£0	£0	£0	£0	£0	£0	£0
	Group delivery of breakeven	Total year to date financial performance	<=0	>0	£0	£(2.5)m	£(4.5)m	£(6.8)m	£(9.9)m	£(12.7)m	£(13.96)m
	Delivery of QIPP	Total QIPP delivery	N/A	N/A	N/A	£483k	£1.108M	£2.209M	£2.533 M	£3.110 M	£3.998m
	Delivery of QIPP against plan	Performance against plan	<=100%	>100%	48.0%	61.0%	115.0%	137.6%	116.0%	96.0%	96.0%
	Reduction in agency expenditure	Agency costs as a % of total pay costs	<= 3%	> 3%	3.0%	3.0%	6.0%	6.1%	5.0%	4.6%	4.4%
	Sickness against plan	Actual levels of sickness against average pre-pandemic levels	<= 4.1%	> 4.1%	7.7%	5.0%	2.8%	3.5%	4.9%	2.6%	2.4%
	Reducing no criteria to reside patients	No criteria to reside to reduce by 40% from December 2021	<= 90	> 90	149	155	129	128	138	136	129
	No COVID admissions	Average number of beds occupied by COVID patients	<=30	>30	64	35	19	28	72	26	24
	Reducing staff vacancies	Total vacancies reported each month	<=7.4%	>7.4%	7.40%	7.41%	6.00%	6.10%	6.47%	5.98%	5.70%
	Net impact of high cost drugs and devices	Total expenditure and income against plan for high cost drugs and devices (YTD)	<=0	>0	£0	£230k	£514k	£1.126m	£1.060m	£1.638m	£1.611m
	Increase productivity	Implied productivity based on financial and operational performance (Quarterly)	>=3%	3%	-20%	-15%	TBC	-22%	-22%	-22%	-22%
	Elective recovery	In Month Performance against 19/20 levels of activity (Value based)	>= 104%	< 104%	n/a	101%	108%	108%	95.0%	116%	110%
	Non elective activity	Performance against planned levels of activity (Value Based)	>= 100%	< 100%	n/a	92.0%	102%	103%	107%	108%	114%
	Delivery of capital programme	Variance from year to date planned capital expenditure	+ or - 1%	><1%	n/a	13.6%	15.0%	17.4%	7.5%	16.4%	14.1%
	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+ or - 1%	><1%	n/a	0	0	0	0	0	0
	Delivery of planned cash balance	Variance from year to date planned cash balance	+ or - 10%	><10%	n/a	(8.8%)	(6.4%)	(7.3%)	12.5%	30.2%	8.6%

Executive Summary

- The RUH delivered a deficit of £13.96 m against a plan of £12.56. The number of non-criteria to reside patients has reduced slightly but remains high with an average of 129, 39 above the planned level. High agency usage continues in the month with plans in place to target reductions in the use of mental health nurses. In the month an increase in elective activity resulted in activity being at 110% of 2019/20 levels which is above the 104% target. The year to date is also above target at 106% of 2019/20 levels. The focus remains on the financial recovery plan and management of risks to ensure the deficit plan can be achieved.

- The Trust is managing risks through the finance recovery plan totalling £6m. The key schemes are reducing agency mental health nurses; reducing agency usage for cleaning; ED medical staff rosters; QIPP plans; inflation management and Sulis reducing agency and increasing revenue. The run rates improved in the month for ED, cleaning and inflation costs, but due to the RMN usage not reducing as planned the run rate was not reduced in line with the recovery plan in September.

- £4.0m of savings have been delivered year to date against a plan of £4.1m of which £0.8m were non-recurrent. This is broken down into under-recovery of £0.4m against transformation programmes and £0.3m over-recovery against divisional programmes. Against the £14.8m QIPP plan for the year, £12.0m of plans have been identified to date. £10.8m of the QIPP savings are due to be delivered in the last half of the year. A number of new schemes, totalling £0.7m, have been identified during the month to help support the recovery plan.

- Pay for the RUH is over plan in month by £4.6m (£9.5m year to date). In part this had been driven by an additional £3.2m of pay awards being paid in September, with a corresponding increase in income. The main pay pressures for the month is for agency mental health nurses with an overspend of £0.3m (£1.8m year to date).

- Expenditure for the first six months of 2022/23 for drugs and devices was £2.9m below plan, £1.3m of this is offset by a corresponding reduction in income with the remaining £1.6m improving the Trusts position.

- Capital expenditure was £20.7m at Month 6 which was £3.4m less than planned.

- The closing cash balance for the Group was £40.4m which is £3.2m higher than planned.

True North I Breakeven Position

Statement of Comprehensive Income Period to 202206	Total					
	202206			YTD		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Commissioner Income (NHSE/CCG)	32,675	37,053	4,379	195,810	199,765	3,955
Other Patient Care Income	1,854	2,659	805	10,730	12,915	2,186
Other Operating Income	2,530	3,320	790	14,872	17,355	2,482
Income Total	37,059	43,032	5,973	221,412	230,035	8,623
Pay	(24,518)	(29,322)	(4,804)	(145,997)	(156,298)	(10,301)
Non Pay	(12,272)	(12,727)	(455)	(74,115)	(73,996)	119
Depreciation	(1,795)	(1,725)	70	(10,588)	(10,514)	74
Expenditure Total	(38,585)	(43,775)	(5,190)	(230,700)	(240,807)	(10,107)
Operating Surplus/(Deficit)	(1,526)	(742)	784	(9,288)	(10,773)	(1,485)
Other Finance Charges	(592)	(575)	17	(3,556)	(3,603)	(47)
Finance Charges	(592)	(575)	17	(3,556)	(3,603)	(47)
Surplus/(Deficit)	(2,118)	(1,317)	801	(12,844)	(14,376)	(1,532)

Adjusted Financial Performance						
Surplus/(deficit) before impairments and transfers	(2,118)	(1,317)	801	(12,844)	(14,376)	(1,532)
Remove capital donations/grants I&E impact	47	63	16	282	415	133
Adjusted financial performance surplus/(deficit) including PSF as per accounts	(2,071)	(1,254)	817	(12,562)	(13,960)	(1,398)
Adjusted financial performance surplus/(deficit)	**(2,071)**	**(1,254)**	**817**	**(12,562)**	**(13,960)**	**(1,398)**

Adjusted financial performance for the purposes of system achievement	**(2,071)**	**(1,254)**	**817**	**(12,562)**	**(13,960)**	**(1,398)**

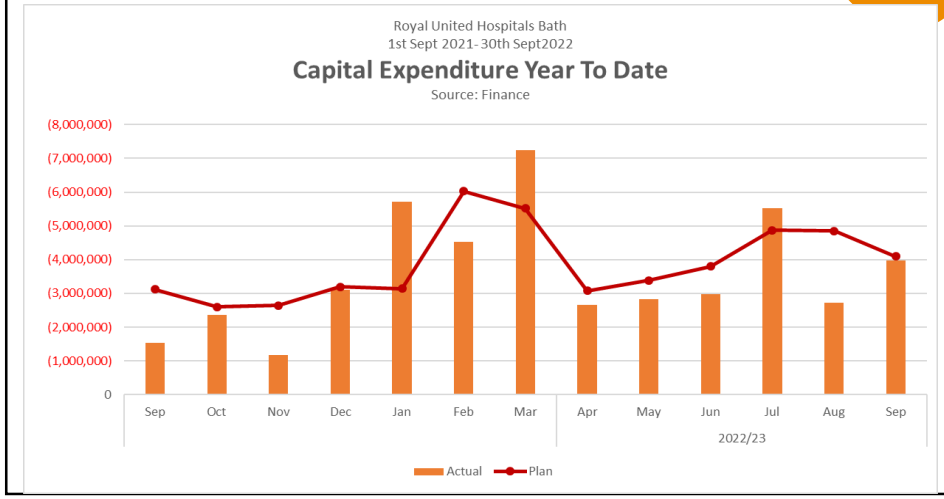
Key Points

The Group delivered a deficit of £13.96m year to date which is £1.4m adverse to plan.

Tracker Measure I Sustainability – Capital (RUH & SULIS)

Capital Programme

Capital Position as at 30th Sept 2022	Annual Plan	Forecast	Year to Date Plan	Year to Date Actuals	Year to Date Variance
	£000s	£000s	£000s	£000s	£000s
Trust Funded	(19,031)	(19,031)	(6,837)	(6,302)	535
External Funded (PDC & Donated):					
Cancer Centre PDC	(22,530)	(22,530)	(17,089)	(14,361)	2,728
Other PDC	(85)	(85)	0	0	0
Donated	(7,531)	(7,531)	(150)	(14)	136
Total	**(49,177)**	**(49,177)**	**(24,076)**	**(20,677)**	**3,399**



Is standard being delivered? No
What is the top contributor for under/over-achievement?
Trust funded programme is £0.5m under plan to date.

Currently still awaiting national confirmation for cover related to existing IFRS16 leases. A further national return is due in late October.

External PDC funded schemes The Cancer Centre works are £2.7m behind plan at the end of September. Delays in the dry lining have subsequently delayed M&E works, Kier have issued a revised programme and cash-flow which shows the works catching up over the year

Countermeasures completed last month

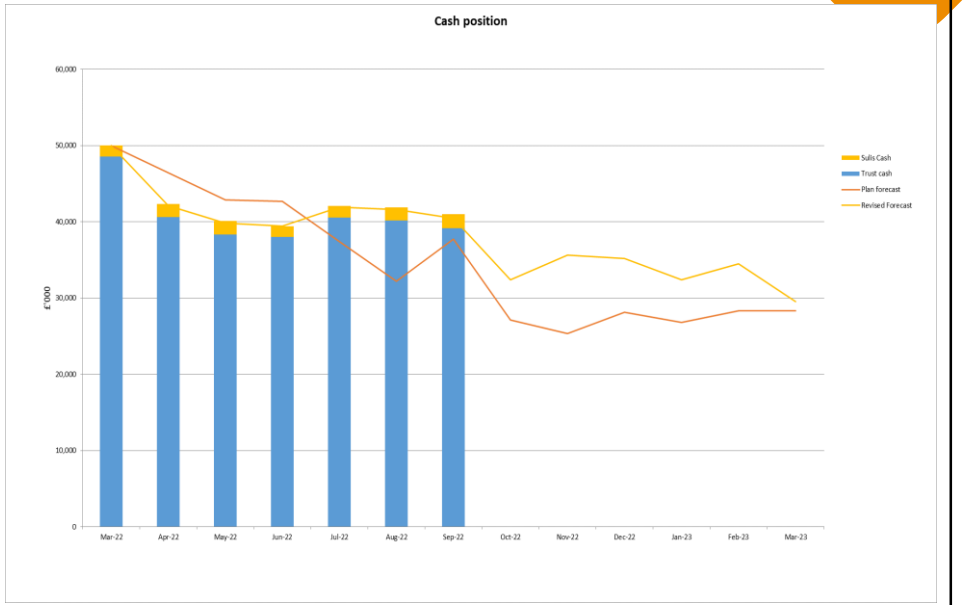
Countermeasure /Action	Owner
NA	NA

Countermeasures for the month ahead

Countermeasure /Action	Owner
CPMG to continue to monitor and mitigate for any risks arising	Director of Finance
Capital cover for IFRS16 leases to be determined with region	Deputy Director of Finance & Head of Financial Services

Tracker Measure I Sustainability – Cash (RUH & SULIS)

Cashflow statement	£'000
Operating Surplus/(deficit)	(10,773)
Depreciation & Amortisation	10,514
Income recognised in respect of capital donations (cash and	(6)
Impairments	0
Working Capital movement	2,297
Provisions	17
Cashflow from/(used in) operations	**2,049**
Capital Expenditure	(20,485)
Cash receipts from asset sales	0
Donated cash for capital assets	0
Interest received	255
Cashflow before financing	**(20,230)**
Public dividend capital received	14,196
Movement in loans from the DHSC	(156)
Capital element of finance lease rental payments	(1,128)
Interest paid	0
Interest element of finance lease	(124)
PDC dividend (paid)/refunded	(3,605)
Net cash generated from/(used in) financing activities	**9,183**
Increase/(decrease) in cash and cash equivalents	**(8,998)**
Opening Cash balance	**49,989**
Closing cash balance	**40,991**



Is standard being delivered for cash? Yes
The cash balance has decreased by £923,000 in month to £41m which is £3.2m higher than planned.

Countermeasures completed last month

Countermeasure /Action	Owner
Continual monitoring of cash flow	Head of Financial Services

Countermeasures for the month ahead

Countermeasure /Action	Owner
Continual monitoring of cash flow	Head of Financial Services
Develop a 24 month cashflow and update cash assumptions to reflect actuals	Financial Accountant

Tracker Measure I Sustainability – Balance Sheet (RUH & Sulis)

	31/08/2022 Actual £'000	30/09/2022 Actual £'000	Mv't in month £'000
Non current assets			
Intangible assets	7,586	7,382	204
Property, Plant & Equipment	257,745	260,628	(2,883)
Right of use assets - leased assets for lessee	30,303	29,872	432
Investments in associates and joint ventures			0
Trade and other receivables	2,852	2,866	(14)
Non current assets total	**298,486**	**300,748**	**(2,261)**
Current Assets			
Inventories	7,562	7,235	327
Trade and other receivables	16,586	20,009	(3,423)
Cash and cash equivalents	41,923	40,991	931
Current Assets total	**66,070**	**68,235**	**(2,165)**
Current Liabilities			
Trade and other payables	(62,976)	(65,556)	2,583
Other liabilities	(9,739)	(8,893)	(846)
Provisions	(131)	(187)	56
Borrowings	(4,997)	(5,023)	27
Current Liabilities total	**(77,843)**	**(79,659)**	**1,817**
Total assets less current liabilities	**286,715**	**289,324**	**(2,610)**
Non current liabilities			
Provisions	(1,857)	(1,857)	0
Borrowings	(33,761)	(33,270)	(491)
TOTAL ASSETS EMPLOYED	**251,097**	**254,196**	**(3,100)**
Financed by:			
Public Dividend Capital	217,122	221,539	(4,417)
Income and Expenditure Reserve	(5,932)	(7,249)	1,317
Revaluation reserve	39,906	39,906	0
Total Equity	**251,096**	**254,196**	**(3,100)**

The Group Balance Sheet (RUH and Sulis)

Month 6 against month 5 movement:

- Capital has increased in line with reported capital spend plan less depreciation.

- Cash has decreased between months.

Tracker Measure | Sustainability Savings

	Target Areas	Internal Annual Plan	Identified to date	Gap to identify	YTD Plan	YTD actual	YTD variance	Forecast Outturn	Forecast Variance to Plan	Recurrent	Non-Recurrent (NR) Mitigation
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Transformation Schemes											
Outpatient Productivity	315	158	158	0	0	0	0	158	0	0	0
Home First	0	0	0	0	0	0	0	0	0	0	0
Medicines Management	779	779	779	0	293	46	247	779	(0)	46	0
Agency and Recruitment - Nursing	1,461	1,461	1,461	(0)	235	246	(11)	1,460	1	246	0
Agency and Recruiment - RMNs	0	0	0	0	0	(216)	216	0	0	(216)	0
Agency and Recruitment - Medical	500	500	500	0	167	0	167	500	0	0	0
Theatre Efficiency	383	383	383	0	0	0	0	383	0	0	0
ICU Capacity	1,300	1,300	1,000	300	186	673	(487)	1,000	300	673	0
ICU Transformation Target	1,500	1,500	0	1,500	0	0	0	0	(1,500)	0	0
Investment Review - TIG	934	934	934	(0)	526	466	60	934	0	466	0
Elective Recovery (Orthopaedics)	200	200	200	0	0	0	0	200	0	0	0
Cleaning / Catering Income	275	275	275	0	140	138	3	275	0	138	0
Portering	75	75	75	0	0	0	0	75	0	0	0
Sulis Transformational Target	500	500	0	500	160	0	160	0	(500)	0	0
Workforce Processes	0	0	0	0	0	0	0	0	0	0	0
To be identified	281	149	0	149	81	0	81	870	(721)	0	0
Sub Total Transformation	**8,503**	**8,214**	**5,765**	**2,449**	**1,787**	**1,353**	**435**	**6,634**	**(2,420)**	**1,353**	**0**
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Divisional / Sulis QIPP											
Surgery	1,420	1,420	1,420	0	605	683	(78)	1,264	156	273	410
Medicine	1,678	1,678	836	842	385	527	(142)	1,615	63	184	344
Emergency Medicine	249	249	0	249	0	0	0	249	(0)	0	0
FaSS	775	775	821	(46)	304	317	(13)	775	0	317	0
ERM	325	325	278	47	141	83	58	325	0	83	0
Corporate	639	639	318	321	164	245	(82)	639	0	227	18
Sulis stretch target	500	500	500	0	160	0	160	500	0	0	0
Procurement stretch target	0	0	0	0	0	0	0	0	0	0	0
COVID	1,000	1,000	800	200	600	791	(190)	800	200	791	0
Sub Total Divisional	**6,586**	**6,586**	**4,973**	**1,613**	**2,359**	**2,645**	**(287)**	**6,166**	**420**	**1,874**	**772**
ERF Efficiency	1,500	0	0	0	0	0	0	0	0		
Non Recurrent slippage	2,000	0	2,000	(2,000)	0	0	0	2,000	2,000		
Total QIPP	**18,589**	**14,800**	**12,738**	**2,062**	**4,146**	**3,998**	**148**	**14,800**	**(0)**	**3,226**	**772**

Royal United Hospitals Bath NHS
NHS Foundation Trust

Report to:	**Board of Directors**	**Agenda item No:**	**12.0**
Date of Meeting:	**2 November 2022**		

Title of Report:	**Maternity and Neonatal Safety Report Quarter 2 Report**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author(s):	**Sarah Merritt, Deputy Chief Nurse & Director of Midwifery**
Appendices	**Appendix 1.0 Maternity Services Scorecard**

1. Executive Summary of the Report

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board of Directors of present and/or emerging safety concerns.

This report identifies that the Trust is currently non-compliant with training in maternity services. Multi-disciplinary training (MDT) emergency skills training PRactical Obstetric Multi Professional Training (PROMPT) is below the recommended 90% for some staff groups. An action plan has been developed to address this, inclusive of doctors in training. A new Maternity Training Lead has been recruited and commences in October 2022. Consequently the Trust is at risk of non-compliancy with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

Staffing levels have continued to be challenging and this report details the steps that have been taken to mitigate staffing levels. The temporary suspension of home and community births continued in Q2. Recruitment has continued at pace. The staffing trajectory demonstrates a significant improvement in staffing levels in Q3. Additional shifts for staff have been financially incentivised. Community births are scheduled to resume at one midwifery led unit (Frome) from 31/10/22. Continuity of Care teams are also suspended except for the most vulnerable families.

In Q1, the Healthcare Safety Investigation Branch (HSIB) identified that there was an increase in referrals from the RUH. From 22 March 2022 to 14 May 2022 (within a six week period) there were seven referrals to HSIB for investigation. Due to this increased number of cases, all referrals made by the RUH were investigated in line with the HSIB criteria prior to April 2020. This interim intervention was reviewed by HSIB in August and the additional oversight and monitoring was stood down.

In July 2022 the Trust sourced external independent support from NHS England (NHSIE) to review maternity services to support the Trust to identify challenges, risks and actions required to provide safe maternity care. The initial findings identified challenges within the workforce for maternity services from capacity and capability of the maternity leadership and governance structure, the establishment in place and the structure of working.

The initial findings also highlighted 6 immediate key areas of action required to improve safety within the service, which are now being addressed.

2.	Recommendations (Note, Approve, Discuss)
Discuss.	

3.	Legal / Regulatory Implications
It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)		
	1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
	1768	Maternity redesign staffing impact	4
	1948	Obstetric ultra sound scan capacity	8
	2013	Lack of adequate suturing lighting in birth rooms	4
	2225	Vacancies in senior nursing and midwifery leadership within the family and specialist services	9
	2175	Midwifery Staffing Vacancies	20
	2353	Replacement of ultrasound machine	4
	2359	Maternity Information System IT support/capacity	15
	2396	Obstetric theatre emergency call bells	6

5.	Resources Implications (Financial / staffing)
Non-compliance with the Maternity Incentive Scheme for Trusts, which has financial and safety implications for the Trust. There is a financial commitment required by the Trust to achieve compliancy.	

6.	Equality and Diversity
Equality and Diversity legislation is an integral component to registration.	

7.	References to previous reports
Previous monthly Perinatal Quality Surveillance reporting. MIS Combined paper Q3 February 2022. MIS Combined paper Q4 May 2022. Maternity and Neonatal Safety Report Quarter 1 Report August 2022. Safer Staffing Report - March 2022. Safer Staffing Report – August 2022. Nursing and Midwifery Establishment Review – Private Trust Board, January 2022. Nursing and Midwifery Establishment Business Case – Private Trust Board, March 2022.	

8.	Publication
Private.	

9.	Sustainability
This report has no impact on the Trust's approach to environmental sustainability, including its commitment to achieve net zero carbon status by 2030.	

10.	Digital
A number of the maternity workstreams have digital co-dependencies and a digital strategy for Maternity has been written.	

MATERNITY AND NEONATAL QUARTER 2 2022/23 SAFETY REPORT

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
Sept 2018 Inspection	Outstanding	Good	Good	Outstanding	Outstanding	Outstanding

Maternity Safety Support Programme in place	Select Y / N	No

	July	August	September
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓ see report	✓ see report	✓ see report
2. Findings of review of all cases eligible for referral to HSIB	✓ see report	✓ see report	✓ see report
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	✓ see report	✓ see report	✓ see report
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	✗ see report	✗ see report	✗ see report
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✗ see report	✗ see report	✗ see report
3.Service User Voice Feedback	✓ see report	✓ see report	✓ see report
4.Staff feedback from frontline champion and walk-abouts	✓ 21/7/22	✓ 26/8/22	✓ 22/9/22
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓ Nil	✓ Nil	✓ Nil
6.Coroner Reg. 28 made directly to Trust	✓ Nil	✓ Nil	✓ Nil
7.Progress in achievement of CNST 10	✗ 80%	✗ 80%	✗ 85%
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment:			Work - 67% Treatment - 79.6% (Staff Survey 2021)
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours:			100% (GMC 2022)

Table 1: Overview of safety metrics for maternity services

1. REPORT OVERVIEW

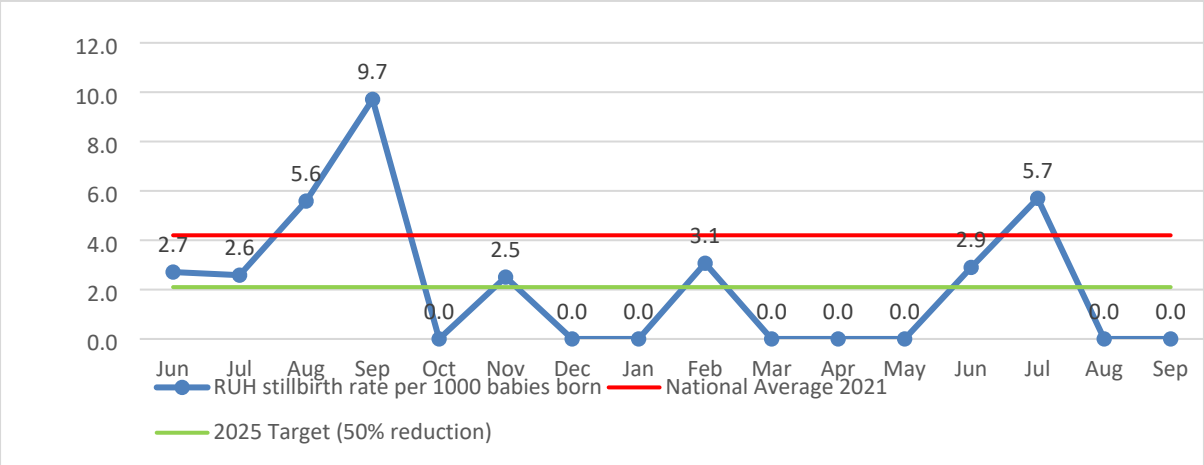
Progress update This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model*' (December 2020). The purpose of the report is to inform the LMNS Board and the Board of Directors of present or emerging safety. The information within the report reflects actions in line with Ockenden and the CNST Maternity Incentive Scheme, and progress made in response to any identified concerns.

2. PERINATAL MORTALITY RATE

The following graphs demonstrate how Royal United Hospital NHS Trust is performing against the national ambition.

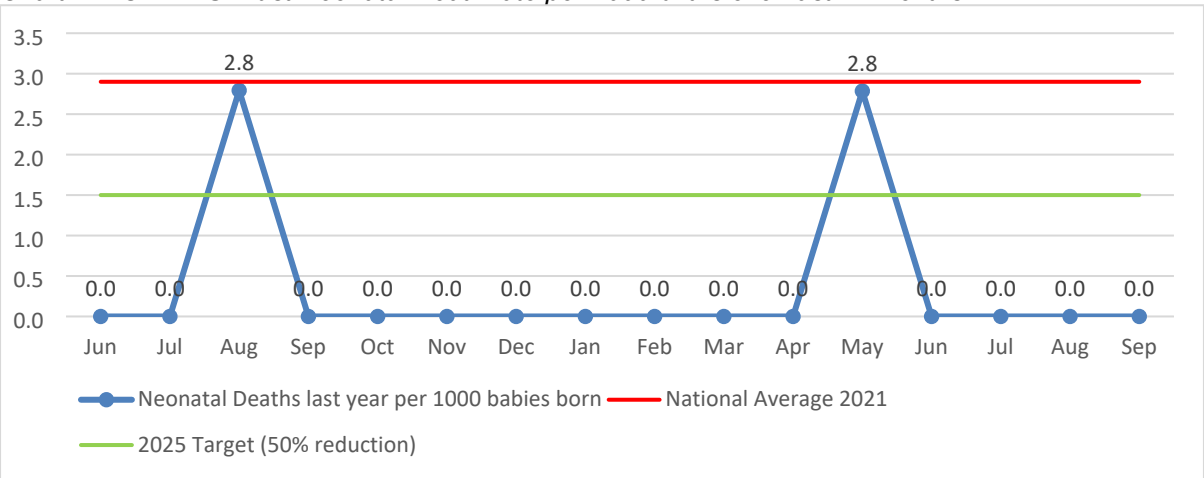
There were 2 still births in Q2, refer to section 2.1.

Chart 1. RUH NHS Trust Stillbirth rate per 1000 births over last 12 months



There were no reported neonatal deaths in Q2.

Chart 2. RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months



2.1 PERINATAL MORTALITY SUMMARY FOR QUARTER 2 2022/23

Table 2. Perinatal Mortality Summary Quarter 2 2022/23

2020/21 (excluding terminations for abnormalities)	Q2	Annual total
Stillbirths (>37 weeks)	0	0
Stillbirths(>24weeks-36+6weeks)	2	3
Late miscarriage (22+oweeks-23+6weeks)	0	2
Neonatal deaths	0	2
Total	**2**	**7**

2.2 Perinatal Mortality Review Tool (PMRT) real time data monitoring tool

All perinatal deaths within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is Safety Standard 1 of the NHS Resolution (NHSR) Maternity Incentive Scheme year 4.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy.

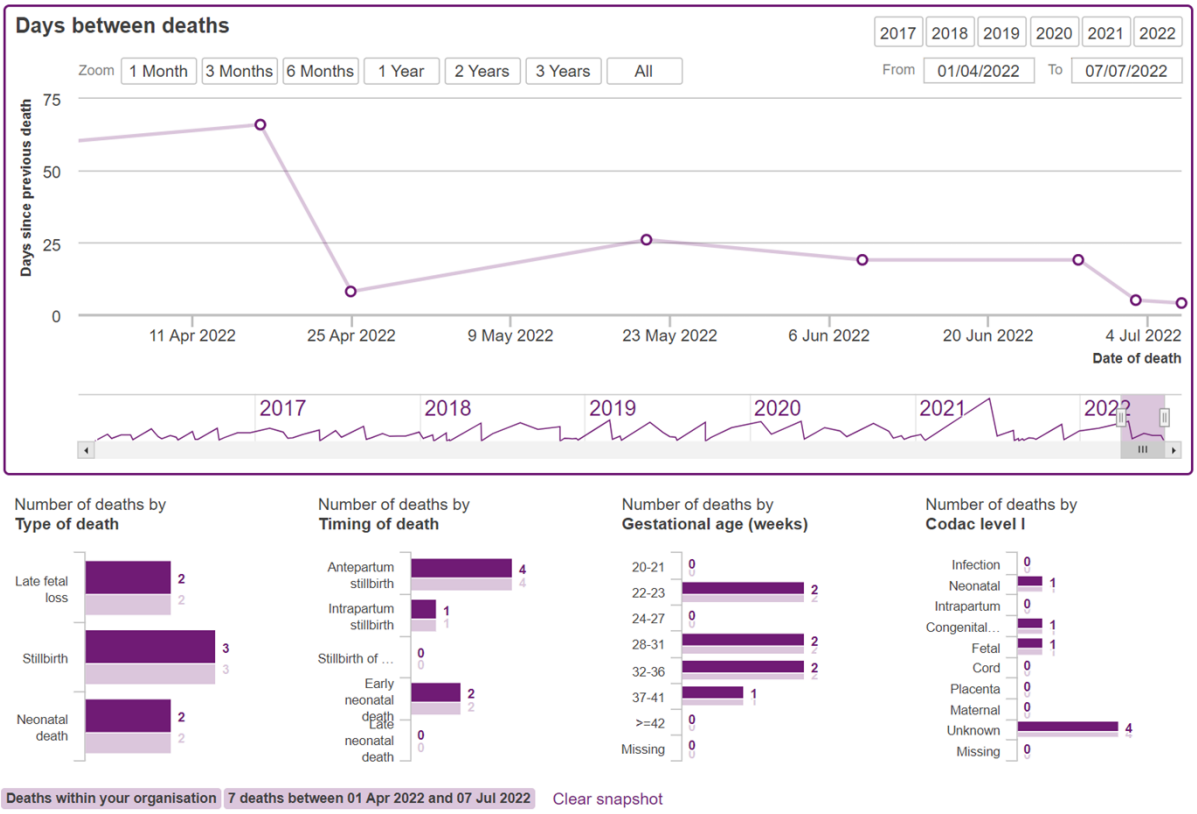
The RUH Electronic Patient Record records all stillbirths (24 weeks or greater gestation) and neonatal deaths.
There have been 3 perinatal deaths:

- 2 stillbirth (1 was an expected death of a co-multiple)
- 1 stillbirth where the pregnancy was terminated for fetal abnormalities (this is reported to MBRRACE but does not meet PMRT criteria)

The rate of stillbirth and perinatal death will be different.

All cases have been reviewed at the PMRT meeting, actions have been agreed and draft reports have been commenced. All parents have been informed and have contributed to the reviews. PMRT meetings include external panel members to ensure the process is robust and honest. Learning from the reviews is included in section 2.3.

*Chart 3. Reporting of RUH NHS Trust Deaths within Organisation 1/7/22 – 30/9/22**
**last perinatal death was in July. PMRT graph will only generate up to date of last death.*



2.3 LEARNING FROM PMRT REVIEWS

Table 3. Actions arising from PMRT reviews Quarter 2 2022/23

PMRT Issues and Action Plans Extract for Royal United Hospital Bath NHS Trust from reviews of deaths from 1/07/2022 to 30/09/2022						
Perinatal Case ID	Issue Text	Outcome Contribution	Action plan text	Implementation text	Person responsible	Target date
81978/1	Cabergoline was not given to suppress lactation.	Relevant to the outcome, and action is needed.	Pathway to be updated including Lactation and Loss SOP	Bereavement Care Pathway to be updated and disseminated	Bex Walsh, Bereavement Midwife	30/11/2022
82268/1	Reduced fetal movement leaflet not provided in mother's first language. Family members were used to interpret at times during her antenatal care.	Not relevant to the outcome, but action is needed.	Reminder sent on how to access Reduced Fetal Movement leaflet in different languages. Reiterate an interpreter must be used.	Reminder sent to all staff on how to access Reduced Fetal Movements leaflet in different languages.	Patient Safety team	30/09/2022

One case had no actions or issues as there is an on-going serious investigation and the post mortem results have not been published.

3. HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND MATERNITY SERIOUS INCIDENTS (SIs)

3.1 BACKGROUND

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Maternal Deaths
- Intrapartum stillbirth
- Early neonatal death
- Severe brain injury diagnosed in the first seven days of life

From 22 March 2022 to 14 May 2022 (within a six week period) there were seven referrals to HSIB for investigation. Due to this increased number of cases over a short period of time the Southwest Regional HSIB investigators held an internal round table meeting to discuss these cases to try to identify any common themes.

Due to the cluster of cases, we received a letter on 27 May 2022 from HSIB informing us that they would investigate all cases referred to them over a three month period until the end of August 2022. This would also include all babies that had a normal MRI scan after they had been cooled.

The Trust received an email from HSIB on 7 September 2022 advising they were stepping down the enhanced oversight as the Trust had only referred one case at the end of the three month period.

3.2 INVESTIGATION PROGRESS UPDATE

Table 4. HSIB referrals Quarter 2 2022/23

Ref	HSIB Reference	Confirmed level of investigation	Date confirmed Investigation	External Notifications and Other Investigations
108058	014673	Parents request despite normal MRI	12/10/22	
107283 *	013255	Normal MRI, however within HSIB cluster reporting timeframe	20/08/22	

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY SERIOUS INCIDENTS

During the month Quarter 2 there was 1 maternity Serious Incident. All cases referred to HSIB are investigated as serious incidents in the Trust.

Table 5. Maternity Serious Incidents Quarter 2 2022/23

Datix No	Category	Outcome	Immediate Learning
July			
None			
August			
107283*	Therapeutic cooling	MRI normal investigation however requires investigation by HSIB. Incident occurred during 3 month surveillance	
September			
104045	Post-natal care – Eclamptic fit	Incident occurred in Feb 22. RCA requested following complaint from family. SI not yet completed	Blood pressure monitoring and assessment of pre-eclampsia in the postnatal period

4. CONTINUITY OF CARE

4.1 BACKGROUND

Maternity transformation sets out to support implementation of The National Maternity Review (Better births (2016), the NHS Long-Term Plan (2019) and the national Maternity Transformation Plan.

4.2 PROGRESS TO DATE

On the 21 September 2022, NHSEI published a letter regarding Maternity Continuity of Carer (MCoC). All target dates for implementation of MCoC have been removed and local services will instead be supported to develop local plans that work for them. MCoC teams were suspended at the RUH in 2021 due to staffing sickness and vacancy and will be re-implemented in line with safe staffing levels.

Table 6. Continuity of Care pathway Quarter 2 2022/23

Continuity of Care	Quarter 2 2022/23
Total Bookings 29/40 on CoC pathway	38.5%
BAME on CoC pathway 29/40	28.5%

N.B. Although women continue to be booked on the continuity pathway, there is recognition that true continuity (including intrapartum care) is not being delivered. Antenatal and postnatal continuity continues to provided where possible, with vulnerable/at risk groups and those from a Black Asian and Minority Ethnic group are

being prioritised.

5 OCKENDEN UPDATE

5.1 OCKENDEN INITIAL REPORT UPDATE

In response to failures at Shrewsbury and Telford NHS Trust, the initial Ockenden report was produced by Donna Ockenden (Chair of the Independent Maternity Review) in December 2020. The report set out recommendations and highlighted seven Immediate and Essential Actions (IEAs) for all maternity services to enable them to improve safety for mothers and babies. The final Ockenden report was subsequently published in March 2022 and included 15 additional IEAs for all Trusts to act upon.

Table 7. Initial Ockenden Immediate and Essential Actions

	Green Amber Red	Actions/Mitigations:
IEA 1 Enhanced Safety		
IEA 2 Listening to women and families		
IEA 3 Staff Training and Working Together		1. Training needs analysis completed. 2. Non complaint with twice daily ward rounds >90% -including one at night. 3. Obstetric workforce review underway. 4. Face to face training– MDT Emergency Skills Training (PROMPT) identified as below 90% for some staff groups. Action plan developed and new education lead commenced in post.
IEA 4 Managing Complex Pregnancy		
IEA 5 Risk Assessment Throughout Pregnancy		Documentation of Risk Assessments taking place at every contact has dropped to 48%. 1. Digital option being explored regionally to improve the capture of this. 2. A Lead Midwife has been recruited to introduce a dedicated Birth Options clinic and pathways are in place for referral to consultant clinic. 3. The digital record aspect of the personalised care and support plan is now in place on the Maternity Information System
IEA 6 Monitoring Fetal Wellbeing		.
IEA 7 Informed Consent		

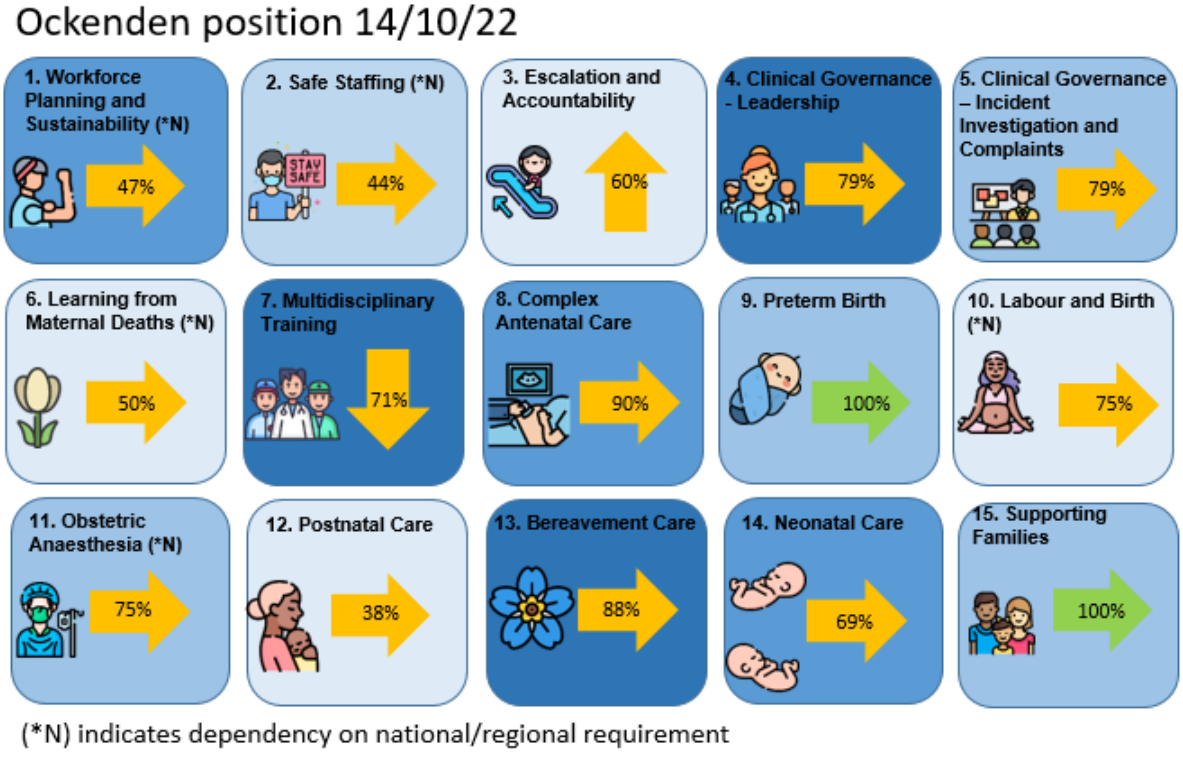
Workforce element		The Trust does not have a Consultant Midwifery although it is part of the Midwifery Oversight action plan.

Maternity Services have assessed themselves as fully compliant with 5 of 7 IEAs, partially compliant with 1 (IEA3) and non-compliant with 1 (IEA 5). The workforce element is an additional criteria which the Trust does not meet compliance. Whilst the Trust utilised the appropriate workforce planning methods, funding has not been identified to meet the shortfall in midwifery workforce. £331,795 was made available through Ockenden funding to the Trust to support the changes required from the initial report. This was utilised to fund an additional fetal monitoring lead consultant post, and mandatory training in fetal monitoring for all maternity staff. Any potential funding to support the final Ockenden report has not yet been announced.

5.2 OCKENDEN FINAL REPORT UPDATE – Q2 2022-2023

The Trust is not currently required to submit compliancy information or evidence to Ockenden on a regular basis. Initial assessment was completed in June 2021 and a resubmission of evidence was completed in November 2021. The next submission date for the final Ockenden report has not yet been confirmed.

Figure 1. Ockenden Final Report Position - Immediate and Essential Actions



Outstanding and completed locally identified actions are being tracked via a new Ockenden assurance tool.

6. TRAINING COMPLIANCE FOR ALL STAFF GROUPS IN MATERNITY RELATED TO THE CORE COMPETENCY FRAMEWORK AND WIDER JOB ESSENTIAL TRAINING

6.1 BACKGROUND

Maternity training is specified in detail in the Maternity Training Needs Analysis. Mandatory training compliance is less than the required 90%, underpinned by an action plan to increase training rates and compliance.

Sharing of local maternal and neonatal outcomes from serious incidents, near misses and never events are disseminated to staff in a variety of formats including maternity newsletter, staff e-mails, patient safety 'Safety Catch' newsletter including case studies, incorporated into training days and quality and safety whiteboards displayed in clinical areas.

A training trajectory has been written and an action plan is in place to ensure compliance is met for each staff group for all mandatory training.

6.2 TRAINING DATA

Chart 4. Prompt and fetal monitoring Training Compliance (%) by staff group Q2 2022/23

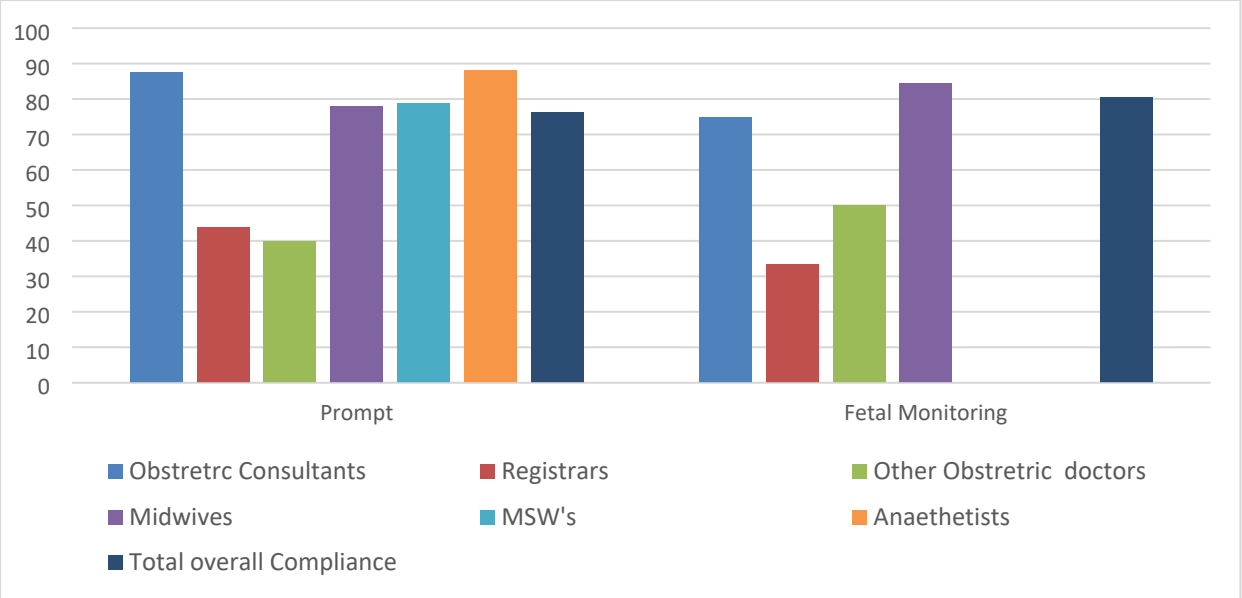
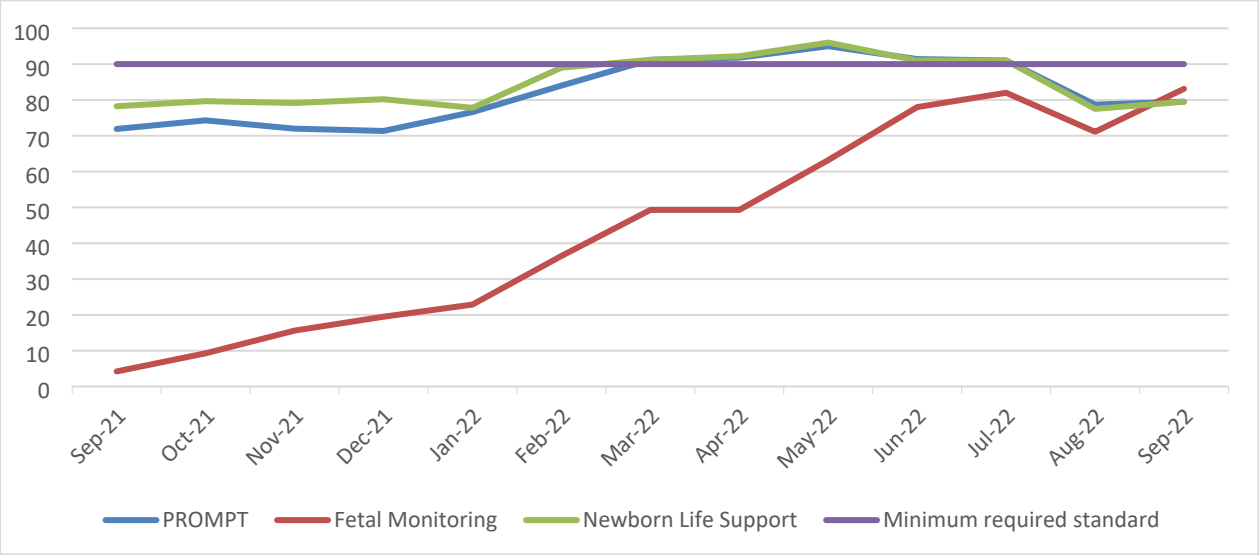


Chart 5. Training Compliance Year to Date



7. SAFETY CHAMPIONS PRODUCTION BOARD MEETINGS

All staff were invited to attend monthly meetings held with the Chief Nurse and the Non-Executive Director (Board Level Safety Champions on 21 July, 26 August and 22 September). The meetings in Q2 were attended by members of the maternity team from a range of areas, including community and specialist midwives.

Themes raised included:

- Reinstatement of community births and service readiness for this
- On call arrangements and planned staffing model
- Positive feedback received regarding the impact of the new Retention Support Midwife role
- Some concerns regarding community birth suspension being communicated to community midwives
- Incentives for additional bank shifts has been positively received and had a positive impact on staffing
- A noticeable shift in staffing levels and a more positive morale is evident
- Positive feedback regarding the inpatient service for smoking cessation
- Birth Reflections will be restarting in November 2022.

7.1 Board Safety Champions walkabouts

The Board Safety Champions undertook walkabouts across Maternity Services:

- 13 July – Chief Nurse visited the Bath Birth Centre
- 15 July – Chief Nurse visited Frome, Paulton, Chippenham and Trowbridge Maternity Units
- 24 August – Chief Nurse and Non-Executive Director visited: Day Assessment Unit and the Bath Birthing Centre
- 1 September – Chief Nurse and Chief Executive visited From, Paulton, Chippenham and Trowbridge Maternity Units
- 30 September – Chief Nurse and Non-Executive Director visited Mary Ward, Day Assessment Unit & Bath Birth Centre.

Actions from these visits are monitored via the Maternity and Neonatal Safety Champions meetings.

8. SAVING BABIES LIVES CARE BUNDLE V2

8.1 UPDATE

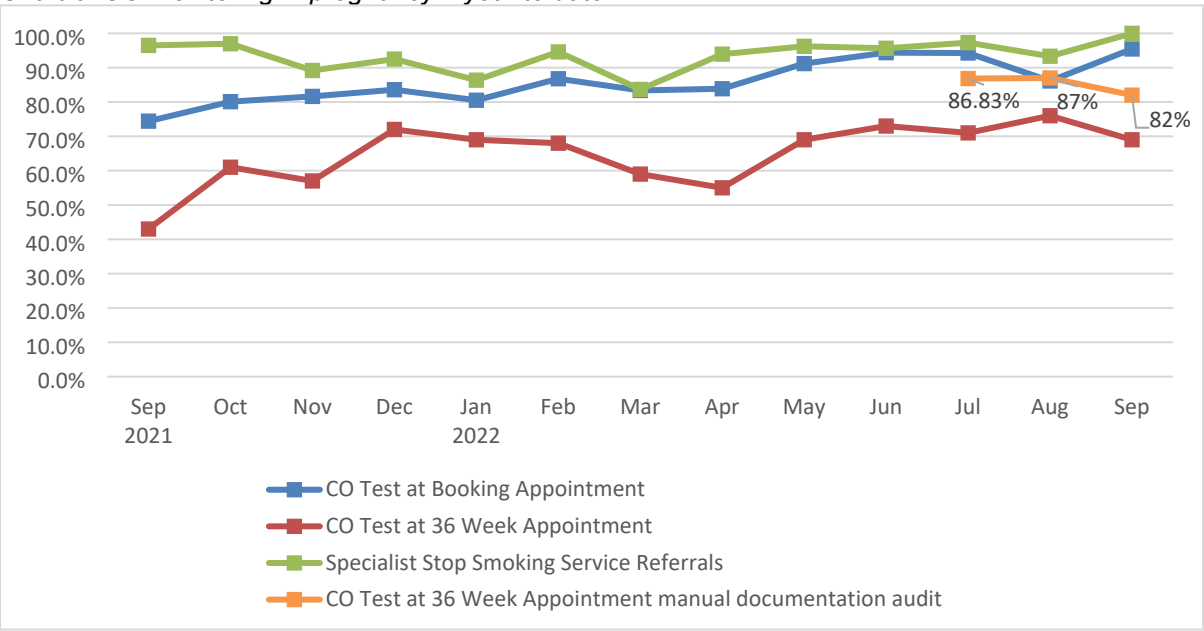
The Trust continues to work towards full compliance with all elements within Saving Babies Lives Care Bundle Version 2 (SBLCBv2). This is a requirement detailed in Safety Action 6 of the Clinical Negligence Scheme for Trusts. A full quarterly report shared with Quality Governance Committee which provide a detailed breakdown of all 5 elements.

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Risk assessment and surveillance for fetal growth restriction
- Element 3: Raising awareness for reduced fetal movements
- Element 4: Effective fetal monitoring during labour
- Element 5: Reducing pre-term birth

The Trust is compliant with 3 elements. The Trust is working towards full compliance with Element 1: Reducing Smoking in Pregnancy.

- CO monitoring at booking are consistently above 90%.
- Bookings at 36 weeks rates recorded electronically are below 80%. A manual audit of hand held notes has identified compliance of 86.3% and is ongoing. When completed this audit will demonstrate full compliance.

Chart 6. CO monitoring in pregnancy – year to date



In line with element 4, fetal monitoring training was commenced in September 2021, and is being rolled out to all staff. Over 80% of all staff have now completed this training, and non-compliant staff are booked to attend. Once above 90% this will demonstrate full compliance. See section 6.2.

9. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q2 2022/23

Following further amendments to the scheme in October 22, the reporting period has been confirmed as 5-5-22 to 2-2-23. The Trust is forecasting compliancy with the following MIS standards as of the end of that period:

Table 8. Maternity Incentive Scheme Update Q2 2022/23

No	Maternity safety action	RAG progress
1	National Perinatal Mortality Review Tool	Compliant.
2	Maternity Services Data Set (MSDS)	Compliant
3	Transitional Care and Avoiding Term Admissions to NICU	Compliant.
4	Clinical workforce planning	Compliant.
5	Midwifery workforce planning	Not fully compliant New required standard May 22: Funded establishment compliant with outcomes of BirthRate+ *or agreed plan, including timescale for achieving the appropriate uplift in funded establishment*. The plan must include mitigation to cover any shortfalls. Funding currently not agreed to meet increased establishment recommendations, but time specific plan in place to achieve. Repeat BirthRate + Review underway. Business case in development.
6	Compliance with all four elements of the Saving Babies' Lives V2	Not fully compliant See section 6. An average of > 80% required across a 4 month period, an action plan is also in place to improve performance
7	Service user feedback	Compliant.
8	Staff training	Not fully compliant Combined average for PROMPT is below 90%. See section 6.
9	Robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Compliant.
10	Reporting 100% of qualifying incidents under NHS Resolution's Early Notification scheme?	Compliant.

RAG rating	
RED	Not expecting to demonstrate compliance
AMBER	Expecting compliance – plan in place to achieve
GREEN	Currently compliant

10. THE NUMBER OF INCIDENTS LOGGED AND GRADED AS MODERATE OR ABOVE AND THE ACTIONS BEING TAKEN

Chart 7. Moderate or above incidents in Q2 2022/23

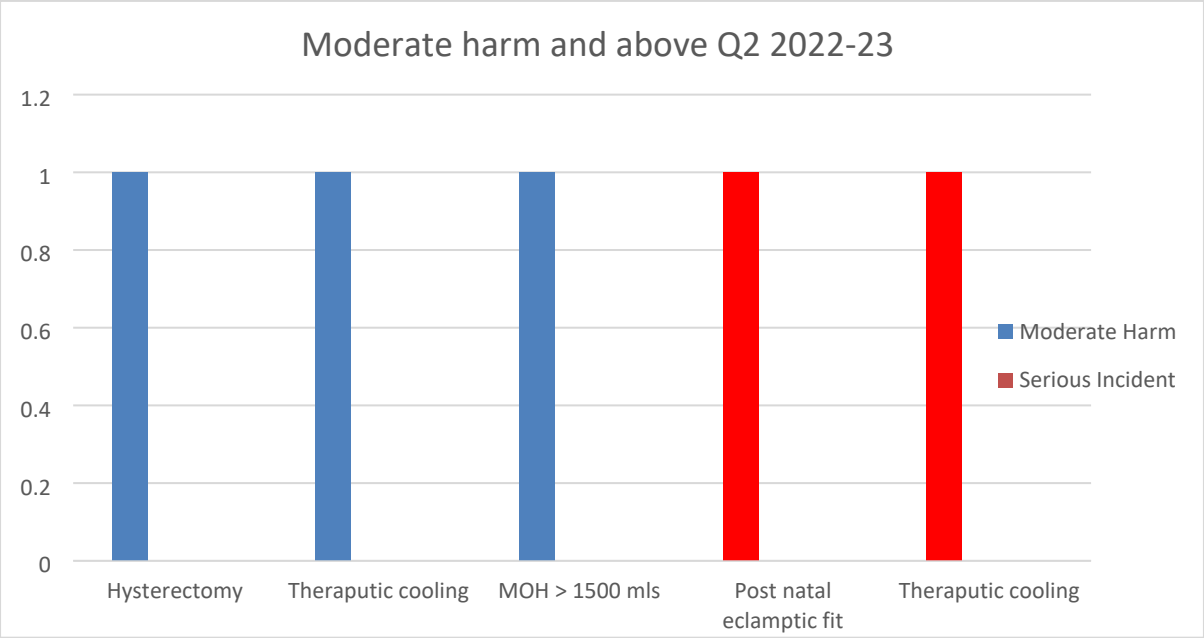


Table 9. Moderate or above incidents in Q2 2022/23

Month	Incident Category	Outcome/learning/Actions
July		
None		
August		
17/8/22	Post-partum Haemorrhage (PPH) > 1500	Post-operative observations, learning cascaded to obstetric theatre team
18/8/22	Therapeutic cooling	MRI normal investigation not required by HSIB
September		
13/9/22	Therapeutic cooling	MRI normal investigation not required by HSIB
14/9/22	Hysterectomy	Previous caesarean section x 5 and placenta praevia, expected complication of treatment
16/09/22	Post-natal eclampsia	Patient complained about care, investigation commenced

11. SAFE MATERNITY STAFFING

11.1 MIDWIFERY STAFFING

As of 18 October 2022, the budget vs actual midwifery staffing was -16.55 WTE (of which 5.56 WTE is maternity leave). This gives a substantive vacancy rate -10.99 WTE.

Chart 8. Midwifery Workforce staffing and forecast (not including long-term sickness) 18-10-22

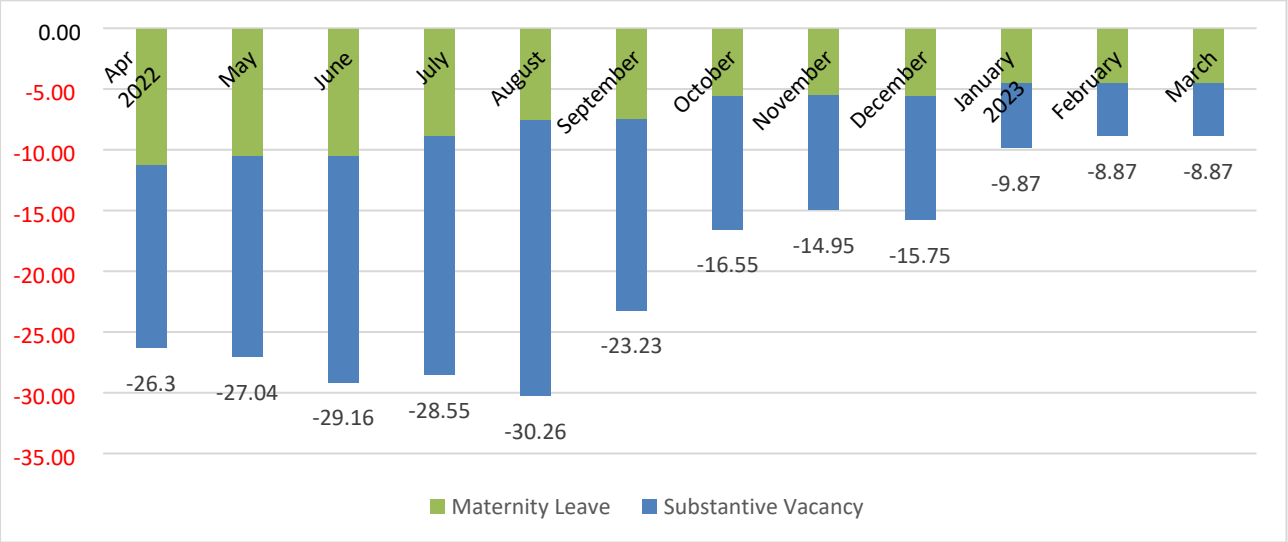


Table 10. Midwifery staffing safety measures

Measure	Aim	Jul 22	Aug 22	Sep 22
Midwife to birth ratio	≤1:27	1:34	1:38	1:35
Supernumerary labour ward coordinator status	100%	98%	100%	99%
1:1 care not provided	0	0	0	1

There was one occasion in September when it was reported that 1:1 care was not provided in Bath Birth Centre. No harm resulted, and an investigation has commenced to understand and address the contributing factors.

The Maternity services has continued to drive a robust recruitment campaign for qualified and support staff which is reducing the vacancy position.

The Director of Midwifery has a daily operational plan to safely deploy resources to manage the changes in demand and acuity. Initiatives to increase staffing levels include:

- Incentivising pay rates
- Registered nurses undertaking non-midwifery care
- Clinical support provided by members of the midwifery leadership team
- Repeat Birthrate+ assessment underway to reflect current acuity without Continuity of Carer, and utilising accurate headroom data.
- Recruiting to 100% maternity leave moving forward and over-recruiting by 8.9WTE
- Active recruitment campaign
- Agency Midwives employed
- Specialist rates for Registered Midwives, Maternity Care Assistants (MCAs) and Maternity Support Workers (MSWs) on bank.
- Career progression improvements for MCAs to MSWs.
- Local calculation of headroom reviewing three years of data for mandatory training, maternity leave, sickness and annual leave (32%).

Next Steps

- Stepped approach to reintroduce community births as safe staffing allows. Frome Birthing Centre re-opening to births on 31/10/22
- Resumption of all paused clinical services as safe staffing allows. Resumption of Birth Reflections services and Hello Baby antenatal classes
- Complete overhaul of e-rostering, including compassionate rostering
- Moving to weekly bank pay
- Review on-call arrangements for acute unit staff.

11.2 OBSTETRIC STAFFING

Table 11. Obstetric staffing safety measures

Measure	Aim	Jul 22	Aug 22	Sep 22
Consultant presence on BBC (hours/week)	≥60 hours	60	60	60
Consultant non-attendance in line with RCOG guidance	0	0	0	0
Twice daily MDT ward round	100%	97%	94%	100%

The ward rounds currently take place at 9am and 5pm in person, with a third virtual round by telephone at 10pm. The Obstetric team are working towards introducing a night shift ward round, and the need for this is incorporated in the ongoing Obstetric workforce review scheduled for completion in November 2022.

Consultant attendance at situations detailed in the RCOG Roles and Responsibilities of the Consultant Workforce guidance has remained 100% throughout Q2.

12. INSIGHTS FROM SERVICE USERS AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

Table 12. Complaints and compliments Q2

	Jul 22	Aug 22	Sep 22
Number of compliments	3	0	2
Number of PALs contacts/concerns	6	6	7
Complaints	1	1	1

Formal complaints within Q2 related to:

- Retained products following birth
- Dissatisfaction with outcome of SI review following pregnancy loss in 2021
- Communication and support – traumatised with unanswered questions following birth 6 months ago

There has been increased contact with the Patient Advice and Liaison Service (PALs) particularly driven by the suspension of community and home births.

A small number of PALS contacts related to concerns around failure to diagnose

issues such as small or large babies.

Co-production with Maternity Voices Partnership (MVP) has continued throughout Q2, the Trust internet has a suite of local services providing signposting. A new range of virtual tours and birth options films are also in development co-designed with MVP representatives.

My Care Hub app (pilot) co-designed with MVP launched as a pilot in July 2022 for families in the Chippenham area. This includes signposting to the LMNS website and NHS information and guidance as well as the RUH internet page.

12.1 SERVICE USER INSIGHTS TAKEN FROM A RECENT CQC STYLE PEER REVIEW

MVP collated feedback is not yet available for Q2.

A series of MVP '15 step walk-about' are being undertaken in all maternity areas. The feedback will be presented when available.

13. QUALITY IMPROVEMENT PROJECTS / PROGRESS

13.1 MATERNITY TRANSFORMATION INCLUDING BETTER BIRTHS

The Transformation Project Lead Midwife is leading on the implementation of a new Perinatal Pelvic Health Service across Bath and North East Somerset, Swindon and Wiltshire (BSW). BSW is a fast-follower site and is currently funded by NHSEI. The service is expected to commence in April 2023.

In Q2 2022/23, the Pregnancy Loss Support Nurse and the Psychological Wellbeing Midwife commenced in post. The roles will support implementation of a perinatal trauma service supporting women experiencing birth trauma and trauma related to baby loss.

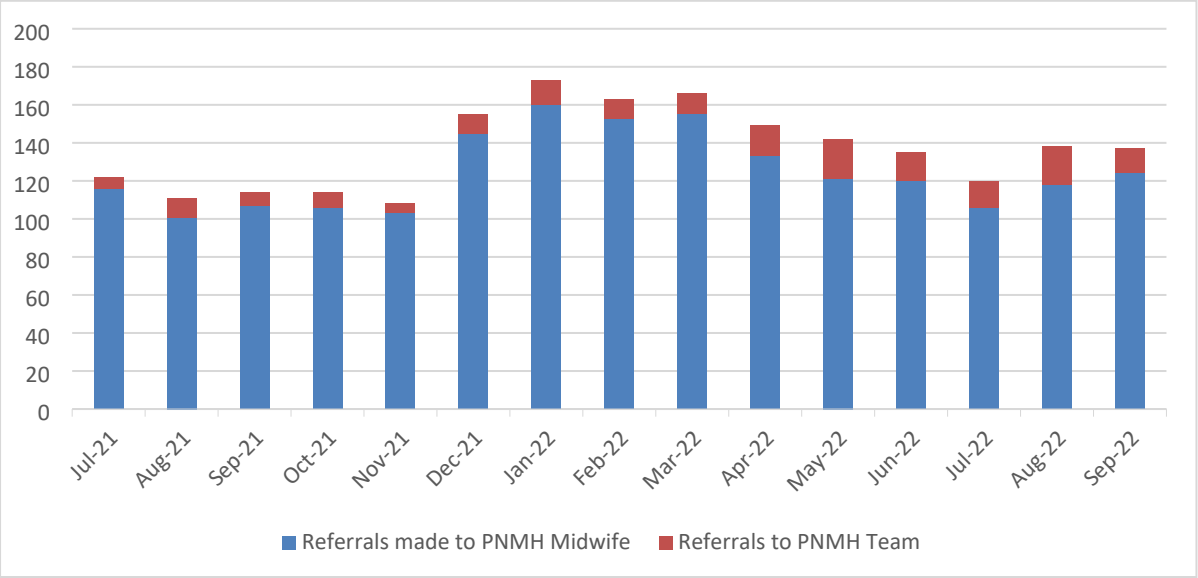
The Transformation Project Lead Midwife has been leading on a project to provide high-quality antenatal education videos across BSW. The professional videos will support women and families to make informed choices about their care, including place of birth. The scripts have been co-produced with the local Maternity Voices Partnership (MVP). Filming will take place in early Q2 2022/23.

Alternative plans for the building of an Alongside Midwifery Unit (AMU) and the re-design of a Day Assessment Unit (DAU) are being developed due to a lack of an identified funding route for the initial plans. In addition, floor plans for community hubs are being amended from feedback from staff and to ensure they are compliant with building regulations.

13.2 PERINATAL MENTAL HEALTH

The current Specialist Perinatal Mental Health Midwife (SPMHM) commenced in 2021 and provides specialist support to patients, ensuring pathways, policies and processes for at risk women are developed and implemented.

Chart 9. Women presenting with past or present mental health concern or referred on to the specialist perinatal mental health teams Q2 21/22 – Q2 22/23



As demonstrated in chart 9, there has been a sustained increase in the number of referrals to the SPMHM since December 2021 and the number of women with more severe mental health concerns requiring referral to the Perinatal Mental Health Team.

In Q2 22/23 there were no admissions to an inpatient psychiatric unit. There was no requirement for 1:1 observation on the ward. There were no known near-miss suicide attempts in pregnancy this quarter.

13.3 SAFEGUARDING

Maternity Safeguarding Key Performance Indicators (KPIs)
In Q2 there were 26 unborn babies on child protection (CP) plans across the service. This continues to be an increase on the data over the previous year (ranging from 17-23 per quarter).

The Safeguarding midwife undertook a case note audit of women with complex social factors to assess practice of women whose children were on the child protection register of had a Child in Need plan. 67% of women whose babies were on CP or had Child in Need plans had parenting observations documented during their postnatal stay on Mary ward. In 28% of the women audited, safeguarding concerns were documented on a pregnancy management note, however in 71% of the cases had a flag and safeguarding note had been created.

The Named Midwife for Safeguarding is working with the Midwifery Sister on Mary ward to produce a policy for the midwives to follow in the event of a suspected baby abduction. This will be presented to the Maternity Safeguarding Committee in Q3.

The Named Midwife for Safeguarding is producing a short guideline for the care of refugee women who are placed in the local bridging hotels. This will be presented to

the Maternity Safeguarding Committee in Q3.

The HOPE Boxes for women and their babies who are to be separated following the birth through the family court process have now been delivered and it is anticipated that we can start using these from Q3.

An action plan has been produced in response to the recommendations from the Wiltshire Child Safeguarding Practice Review of baby Eva. This will be presented to the Maternity Safeguarding Committee in Q3.

A rapid review has been conducted in Q2 in Wiltshire into the death of an 8 week old baby who was born at the RUH. The conclusion by the panel is that no Serious Practice Review is required.

13.4 INFANT FEEDING AND HEALTH IN PREGNANCY SPECIALIST SERVICES

The Trust are preparing for the UNICEF UK Baby Friendly Initiative (BFI) audit follow up visit in December. The Trust continues to work towards achieving UNICEF UK Baby Friendly Initiative (BFI) in anticipation of the audit in December 2022.

70 hours of breastfeeding peer support were delivered on Mary ward and the specialist infant feeding team provided 42 women with community based care. The tongue tie service delivered 75% of the funded provision (there is a plan to increase this to 100% when the vacancy factor reduces), providing an average of 14 appointments each week. Overall frenotomy rate remained within national recommendations at 4.7%. Feedback from the local Maternity Voices Partnership (MVP) indicated service users would like to see a reduction in the triage-to-treat time which can be up to 7 days.

A fixed term role has been introduced to provide specialist breastfeeding support for families living in areas of highest deprivation score. This services commences in October.

The specialist health in pregnancy teams provided a blended approach to service delivery utilising face-to-face, virtual and telephone contacts to eligible service users. Weight management support was offered to 216 women across Wiltshire and Bath and North East Somerset (BANES) and 98 women were identified to be eligible for Stop Smoking intervention. Of these, approximately 77% accepted support. The overall Smoking Status at Time of Delivery (SATOD) across Wiltshire/BANES was 6.2% (0.2% above the national target of 6% by the end of 2022, detailed in the Tobacco Control Plan for England, 2017).

14. ADVOCATING FOR EDUCATION AND QUALITY IMPROVEMENT (A-EQUIP) AND PROFESSIONAL MIDWIFERY ADVOCACY THEMES

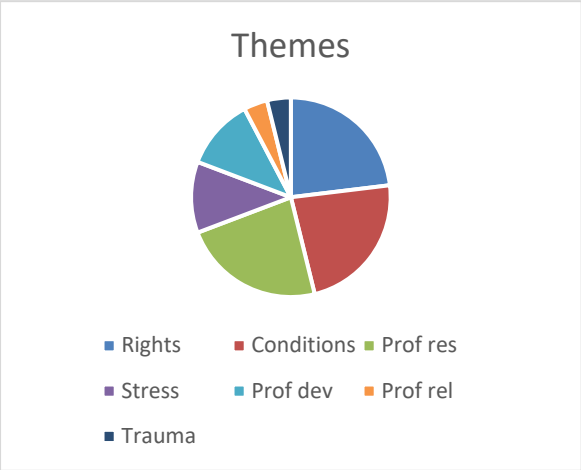
Professional Midwifery Advocates (PMAs) work within the A-EQUIP model to work with women in three ways:

- Supporting midwives to advocate for women

- Providing direct support for women within a restorative approach and
- Undertaking quality improvement in collaboration with women.

Requests for support in Q2 were received from across the maternity service, ranging from band 3-8.

Chart 10. PMA themes raised Q2



Themes Raised

1) Workplace rights
2) Working conditions
3) Professional responsibility
4) Work-related stress
5) Professional development
6) Professional relationships
7) Traumatic events

15. AVOIDABLE ADMISSION INTO THE NEONATAL UNIT (ATAIN)

Not yet available for Q2. Report to follow to Quality Governance Committee.

15.1 TRUST TRANSITIONAL CARE AND ATAIN RATES

Not yet available for Q2. Report to follow to Quality Governance Committee.

16.0 SAFETY IMPROVEMENT PLAN

Every Trust is required to develop a bespoke Maternity Safety Improvement Plan which brings together existing and new plans to progress these projects into one place.

In July 2022, the Trust sourced external independent support from NHSIE to review the services at the RUH and support the Trust to identify challenges, risks and actions required to provide safe maternity care. The review highlighted areas for improvement and areas of good practice focussed around 5 key themes

- Workforce
- Efficiency
- Safety
- Effectiveness
- Experience

The initial findings identified challenges within the workforce for maternity services

from capacity and capability of the maternity leadership and governance structure, the establishment in place and the structure of working.

The initial findings also highlighted 6 immediate key areas of action required to improve safety within the service. The Board Level Safety Champions are being briefed of progress in October 2022 prior to an update to the Board of Directors.

17.0 RED RISKS / RISK REGISTER HIGHLIGHTS

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1768	Maternity redesign staffing impact	4
1948	Obstetric ultrasound scan capacity	8
2013	Lack of adequate suturing lighting in birth rooms	4
2225	Vacancies in senior nursing and midwifery leadership within the family and specialist services	9
2175	Midwifery Staffing Vacancies	20
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	15
2396	Obstetric theatre emergency call bells	6

18.0 RECOMMENDATION

The Board of Directors is asked to receive and discuss the content of the report.

APPENDIX 1. MATERNITY PERINATAL QUALITY SURVEILLANCE SCORECARD

		Alert (nat. standard)	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Comments
Workforce	Red flags: 1:1 care in labour not provided (Bath Birthing Centre only)	0	1	1	0	0	0	0	0	0	0	0	0	1	
	Percentage of supernumerary labour ward co-ordinator status (%)	100%	95	98	100	100	100	98	100	97	97	98	100	99	
	Rostered consultant cover on BBC - hours per week	<60 hours	60	60	60	60	60	60	60	60	60	60	60	60	
	Consultant non-attendance when indicated in RCOG Roles and Responsibilities (as reported via Datix)	0											0	0	New metric
	Bath Birthing Centre twice daily round achieved (%)	100%	77	67	84	81	79	94	93	90	93	97	94	X2 100 X3 83	TIMING OF ROUNDS – to be adjusted following obstetric staffing review
	Midwife to birth ratio (establishment)	>1:27	1:35	1:33	1:31	1:35	1:30	1:32	1:34	1:34	1:34	1:34	1:38	1:35	Directly linked to vacancy rate. **Including bank staff rate 1:31**
	Number of women booked onto a Continuity of Carer pathway (%)	>=35%	43.3	50.0	46.0	43.5	44.0	40.9	40.5	43.8	41.3	36.2	37.0	41.7	No. of women booked onto a CoC pathway (AN & PN only). No national standard in place from Sept 22.
Safety	Risk assessment at every contact (Antenatal) (%)		54	54	61	56	55	78	56	71	51	51	47	48	Risk assessment at Booking 100%. Documentation focus. Digital solution not possible.
	Stillbirth number	Actual	0	1	1	0	1	0	0	0	1	2	0	0	N.B. 1x SB incorrectly reported here in Aug.
	Neonatal deaths	Actual	0	0	0	0	0	0	0	1	0	0	0	0	
	Moderate Datix and above		2	3	3	2	0	2	5	2	3	0	1	2	
	HSIB		0	0	1	0	0	1	4	2	0	0	1	1	
Feedback	Number of compliments		1	2	0	4	1	1	1	1	4	3	0	2	
	Online compliments							291				*	*	*	Manual count of positive feedback via social media

	Number of PALS contacts/concerns		8	9	4	15	8	6	8	18	9	6	6	7	
	Complaints		1	2	2	1	3	2	1	1	3	1	1	1	
Training	PROMPT/Emergency skills all staff groups (%)	>90%	74.3	71.98	71.34	76.6	84.0	91.2	91.8	95	91.4	91	78.7	79.5	See detail on training page
	Percentage staff received fetal monitoring in labour training **(new from Sept 2021)** (%)	>90%	9.28	15.61	19.49	22.88	36.44	49.3	49.3	63.2	78*	82*	71.1	83.1	
	New-born life support (NBLS) (%)	>90%	79.65	79.15	80.20	77.8	89.0	91.2	92.2	96	91	91	77.5	79.5	
	Percentage of staff who have successfully completed mandatory CTG fetal monitoring annual competency assessment (%)	>90%	7.59	16.46	19.83	26.06	36.44	49.3	49.3	63.2	70.4	73	71.1	83.1	
	Coroner Regulation 28 made directly to Trust		Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	
	HSIB/CQC etc. with concern or request for action		Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	1	Nil	Nil	Nil	Normal HSIB surveillance now resumed

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Board of Directors	Agenda item:	13.0
Date of Meeting:	2 November 2022		

Title of Report:	Infection Prevention and Control Annual Report
Status:	For Information
Board Sponsor:	Antonia Lynch, Chief Nurse
Author:	Lisa Hocking, Deputy Director of Infection, Prevention and Control
Appendices	

1. Executive Summary of the Report

The COVID-19 pandemic remained a key challenge for the Trust. National guidance has informed the Trust's local policies and protocols to support safe working and patient flow. Nosocomial transmission of COVID-19 has increased in correlation with an increase in community rates. It is worth noting that there has been a reduced prevalence of norovirus and influenza outbreaks compared to previous years.

The Infection, Prevention and Control (IPC) Board Assurance Framework was completed and presented to the Board of Directors in January 2021 and May 2022.

Reported infections

There were 55 cases of Trust apportioned Clostridioides difficile infections, against a threshold of 43 cases, 3 more than the previous year. This remains a risk to the Trust as numbers continue to steadily increase rather than decline, in the Trust and in other parts of the South West. This is being addressed via a Regional Collaborative. The Trust is benchmarking favourably with antibiotic prescribing and broad spectrum antibiotic use which is improving each quarter, therefore at this time, antibiotic prescribing outside of guidance is not a key contributor to the increase in rates.

There were no Trust apportioned MRSA bloodstream infections reported during 2021/22, this has been a year on year achievement for the organisation.

There were 23 hospital onset cases MSSA bloodstream infections; 7 cases less than reported last year. There is no expected trajectory for these infections. Best practice for cannulation and venepuncture is being championed to improve patient outcomes where infections could be preventable.

Gram negative bloodstream infections

The Trust reported 86 healthcare associated cases of E coli bloodstream infections against the threshold of 114 in 2021/22. This was an increase of one case compared to last year.

There were 16 hospital onset cases Klebsiella spp. bloodstream infections reported in 2021/22 against a threshold of 46, this was a decrease in 6 cases compared with last year's performance.

There were 19 cases of Pseudomonas aeruginosa bloodstream infections the threshold of 19 cases; 10 cases more than the previous year.

The largest contributor of these infections are associated to Hepatobiliary infection (which is generally unavoidable) and the next largest contributor is urinary tract infections which can be positively influenced by hydration levels. Actions are being taken to enhance patient hydration which requires focus for people in hospital and in the community.

This report provides data from April 2021 to April 2022. In the months following this there has been a deterioration in cleaning standards across the Trust. The Trust has financially invested in cleaning to meet the National Standards for Healthcare Cleanliness (2021), however there is a lag in the recruitment of staff. An accelerated recruitment plan is being implemented and the standards of cleaning are being monitored by the newly formed Cleaning Standards Group chaired by the Deputy Director of Estates and Facilities and the Deputy Director of Infection, Prevention and Control.

2.	**Recommendations (Note, Approve, Discuss)**
The IPC annual report is a mandatory requirement for publication. This report is for approval and onward presentation to Board of Directors.	

3.	**Legal / Regulatory Implications**
This report has a regulatory requirement to be written and published in the public domain	

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)**
There are no the risks arising or identified in the report	

5.	**Resources Implications (Financial / staffing)**
Nil	

6.	**Equality and Diversity**
The impact that the issues raised in the report could have on staff, patients and/or other members of the community from an equality, diversity and inclusion perspective should be reflected. Where the report relates to policy, strategy, procedure, function or service delivery/development, an equality analysis needs to be undertaken and included as an appendix to the report.	

7.	**References to previous reports/Next steps**
Has this report has been shared and discussed at the September 2022 Infection Prevention and Control Committee.	

8.	Freedom of Information
The Annual report is a Public report	

9.	Sustainability
This report has no impact on the Trust's approach to environmental sustainability, including its commitment to achieve net zero carbon status by 2030.	

10.	Digital
This report does not contribute to the Trust's Digital Strategy	

Royal United Hospitals Bath
NHS Foundation Trust

Infection, Prevention and Control

Annual Report | 2021/22

Contents

1 Executive Summary 4
2 Key progress 2020/21 5
3 Meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infections 7
4 Meticillin sensitive Staphylococcus aureus (MSSA) bloodstream infections 7
5 Gram negative bloodstream infections 9
5.1 *Escherichia coli* (E coli) bloodstream infections 9
5.2 *Klebsiella spp.* bloodstream infections 10
5.3 *Pseudomonas aeruginosa* bloodstream infections 10
6 *Clostridioides difficile* infection (CDI) 11
7 Norovirus 12
8 Influenza 13
9 Antimicrobial stewardship (AMS) 13
9.1 Staff update 13
9.2 Antimicrobial stewardship activities 13
9.3 Antimicrobial Consumption 15
10 Surgical Site Infection Surveillance 17
11 COVID-19 18
11.1 SARS CoV-2 18
12 Level 2 Infection Prevention and Control Training 19
13 Appendices 21
13.1 Infection Prevention and Control Team (IPCT) Structure and Arrangements 21
13.1.1 The Infection Prevention and Control Arrangements 21
13.1.2 The Infection Prevention and Control Team 21
13.1.3 Infection Prevention and Control Committee governance and reporting structure 22
13.2 MRSA bloodstream infections 22
13.3 MSSA bloodstream infections 22
13.3.1 MSSA bloodstream infection regional benchmarking 23
13.4 Gram negative bloodstream infections 23
13.4.*1 E coli* bloodstream infections 23
13.4.*2 Klebsiella* spp. bloodstream infections 25
13.4.*3 Pseudomonas aeruginosa* bloodstream infections 27
13.5 *Clostridioides difficile* infections 28
13.6 Cleaning 29
13.7 Decontamination of Medical Devices 30

Key:

Target met, Trust meeting standards, increase in performance from previous year

Target not met by narrow margins, Trust not meeting standards but evidence of improvement, slight reduction in performance from previous year

Target not met, Trust not meeting standards, significant reduction in performance from previous year

1 Executive Summary

1.1 This is the annual report of the Director of Infection Prevention and Control (DIPC) and summarises the work undertaken at the Royal United Hospitals Bath NHS Foundation Trust to manage infections during the period 1 April 2021 to 31 March 2022.

1.2 The Trust is compliant with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance which was revised in July 2015.

1.3 During 2021/22 Two MRSA bloodstream infections were reported by the Trust however there were no Trust apportioned MRSA bloodstream infections.

1.4 There were 95 cases of MSSA bloodstream infections reported. There were 23 hospital onset cases; 7 cases less than reported last year.

1.5 The Trust reported a total of 269 cases of *E coli* bloodstream infection in 2021/22, this includes both hospital, community onset and community provider cases. There were 49 hospital onset cases: an increase of one case against last year's figures. There were 37 community onset healthcare associated cases. In total 86 healthcare associated cases were reported against the threshold of 114.

1.6 There were 75 *Klebsiella spp*. bloodstream infections reported in 2021/22; this includes a case reported on behalf of a community provider. 16 hospital onset cases were recorded; a decrease in 6 cases compared with last year's performance. 7 community onset healthcare associated cases were reported making a total of 23 Trust apportioned infections 50% lower than the threshold of 46.

1.7 There were 38 cases of *Pseudomonas aeruginosa* bloodstream infections reported: 10 cases more than the previous year. 14 hospital onset and 5 community onset healthcare associated cases were reported making a total of 19 against the threshold of 19 cases.

1.8 There were 114 cases of *Clostridioides difficile* infection reported of which 55 cases were Trust apportioned; 3 more than were reported in the previous year. The Trust apportioned cases comprised of 36 hospital onset and 19 community onset healthcare associated cases. The threshold was 43 cases.

1.9 There were 3 outbreaks of norovirus between April 2021 and March 2022.

1.10 There were no outbreaks of influenza between April 2021 and March 2022.

1.11 The COVID-19 pandemic remained a key challenge for the Trust. National guidance has informed Trust policies and protocols to support safe working and patient flow. Nosocomial transmission of COVID-19 increased in correspondence to peak in community rates.

1.12 The Infection, Prevention and Control Board Assurance Framework was completed and presented to Board of Directors in January 2021 and was updated and taken to Infection, Prevention and Control Committee (IPC) in March 2022 and Board of Directors in May 2022.

1.13 The antimicrobial stewardship programme has continued throughout the year. The antimicrobial consumption reduction targets have been met and work is ongoing to reduce this further.

1.14 Surgical site infection mandatory surveillance continued throughout 2021/22. There has been a significant reduction in surgical site infections post elective colorectal surgery.

1.15 The target for compliance with infection prevention and control Level 2 training did not meet the 90% target; there were 79.8% of staff trained by the end of March 2022.

2 Key progress 2020/21

2.1 The Infection Prevention and Control Team have been instrumental in ensuring that any change in National guidance in relation to COVID-19 has been reflected in Trust guidance and policies. The team have continued to support staff to work safely and to ensure that patient pathways are maintained to prevent the spread of infection. There has also been collaborative working with colleagues in the Bath Swindon and Wiltshire Clinical Commissioning Group to enable sharing of policies and standardise the approach to preventing and managing infection across the three acute trusts: RUH, Great Western Hospitals NHS Foundation Trust and Salisbury District Hospital.

2.2 During 2021/22 the Infection Prevention and Control Team further increased their on-call commitment to include weekends and public holidays outside of the winter months in order to support the Trust to sustain patient flow and with the management of COVID-19 related incidents. This included the team being on-site and increasing working hours.

2.3 The Infection Prevention and Control Team continued to lead on outbreak prevention and management during the pandemic and were responsible for external reporting of incidents and submission of other reports as required internally and externally.

2.4 The Infection Prevention and Control Team supported the adoption of the national IPC e-learning package for all staff and have offered face to face training sessions when required. The national IPC e-learning package will replace the Trust online training during autumn 2022.

2.5 Mandatory surveillance of health care associated infections has continued alongside the Infection Prevention and Control Team's key involvement with the COVID-19 pandemic. All cases have been reviewed and reported through the Public Health England data capture system. This includes reporting of infections for GPs and other provider organisations who use the RUH laboratory for processing specimens. A major challenge to this has been the delay in acquiring the new generation version of Infection Control Net (a digital system that enables the Trust to track patients and associated care data) which is used by the team to view results and undertake surveillance. At present the system does not import certain results including those reported by the RUH laboratory which has meant that the team are using multiple systems to analyse data. It is anticipated that the new system will be in place by December 2022.

2.6 The Infection Prevention and Control Reference Group has continued to meet on a weekly basis. The group has been instrumental in delivering guidance and policy changes and has expanded its membership for all staff to attend who require advice on managing infections that is specific to their specialty.

2.7 The Infection Prevention and Control Team have revised the following policies during the last year:

- Aseptic Non-Touch Technique
- Chicken Pox and Shingles
- Standard Infection Control Precautions and Hand Hygiene
- Infection Prevention and Control Surveillance
- Linen
- Tuberculosis
- Transmissible Spongiform Encephalopathy Agents including CJD

2.8 The Infection Prevention and Control Team have contributed to the paperless inpatient documentation project and have advised on revision of key documents that support patient care. These documents will replace some of the care plans that are currently paper based. The team have also revised the Trust standard stool chart and led on replacing this and training staff to use it in all adult inpatient settings

3 Methicillin resistant *Staphylococcus aureus* (MRSA) bloodstream infections

The reporting of MRSA bloodstream infections is mandatory for all NHS trusts. There is a national target of zero preventable MRSA bloodstream infections.

There were 2 cases reported by the Trust during 2021/22. Both cases were community onset and were attributable to the designated Clinical Commissioning Group (CCG). There have been no hospital onset cases since February 2021.

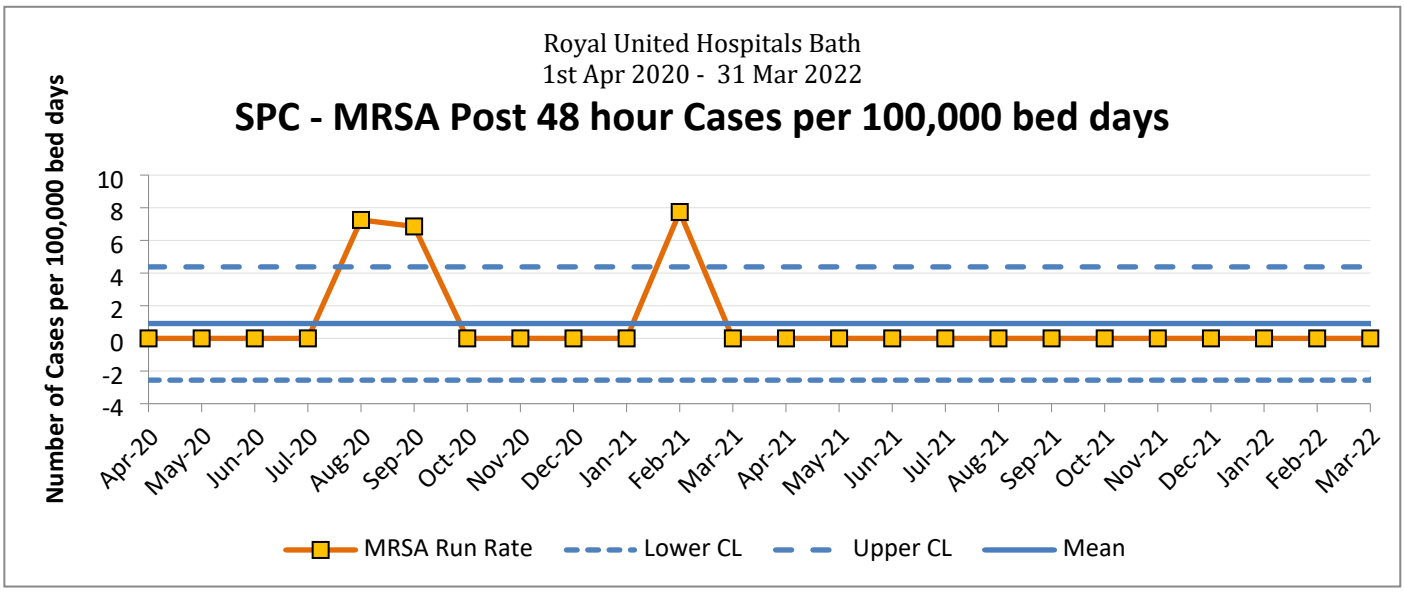


Figure 1: Trust apportioned MRSA bloodstream infections since April 2020

See Appendix 13.2 for further information on these investigations and regional MRSA rates.

4 Methicillin sensitive Staphylococcus aureus (MSSA) bloodstream infections

MSSA bloodstream infections have been part of mandatory surveillance since 2011. There are currently no national reduction targets or thresholds set for this infection.

In 2021/22 there were 95 cases of MSSA bloodstream infection reported; 72 taken within 2 days of admission and 23 hospital onset cases where the blood cultures were taken after 2 days. The number of hospital onset cases has reduced by 7 in comparison with the previous year.

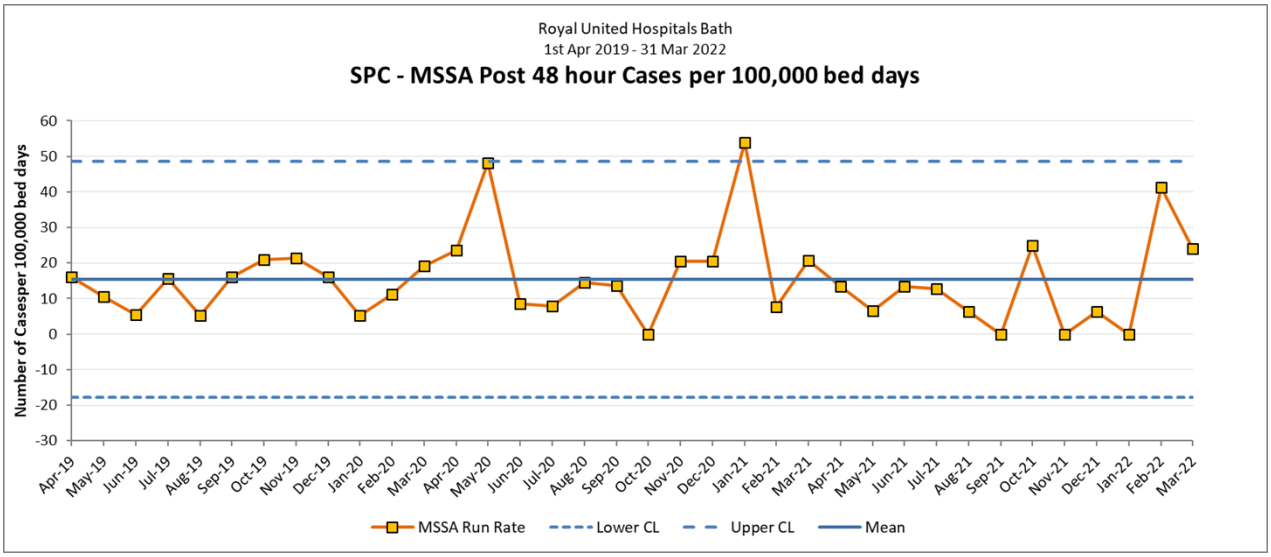


Figure 2: Trust apportioned MSSA bloodstream infections per 100,000 bed days since April 2019

Actions taken

All cases of MSSA bloodstream infection are assessed by the microbiologists and on discussion with the relevant clinical team they identify the potential source of infection. This includes a physical examination of the patient where possible and a review of any radiological reports alongside other microbiological samples if appropriate. In some cases affected patients have complex illness and histories, where it is not possible to identify a single source of infection and these are reported as cause unknown. The microbiologists advise the clinical teams on treatment of all patients with MSSA bloodstream infections and continue to provide follow up for the duration of their inpatient stay.

During 2021/22 vascular access devices remained the most likely source in a large proportion of Trust attributed MSSA infections. Focused work has been undertaken to prevent the infections however learning from root cause analysis investigations has shown that peripheral venous cannula are being left in situ for longer than required and documentation of insertion, removal and observation of cannula sites is inconsistent. Improvement strategies are being worked through with the Senior Sisters/Charge Nurses and Matrons to improve documentation and reduce harm.

See Appendix 13.3 for further information on these investigations and regional MSSA rates.

5 Gram negative bloodstream infections

In July 2021 NHS England and NHS Improvement published Minimising *Clostridioides difficile* and Gram-negative Bloodstream Infections alongside the NHS Standard Contract for 2021/22. This document set infection thresholds for each NHS Trust, NHS Foundation Trusts and Clinical Commissioning Groups. Hospital trust thresholds include all healthcare associated cases: both hospital onset and community onset where the patient has been discharged from hospital within a certain timeframe. The timeframe for community onset healthcare associated Gram-negative bloodstream infections is within 28 days of discharge from the reporting trust.

5.1 *Escherichia coli* (E coli) bloodstream infections

During 2021/22 the Trust reported a total of 269 *E coli* bloodstream infections. This includes 1 case reported on behalf of a community provider. There were 49 hospital onset and 37 community onset healthcare associated cases reported: a total of 86 Trust attributed infections. The threshold was set at 114 cases for the year therefore the Trust achieved the reduction trajectory.

See Appendix 13.4.1 for more information

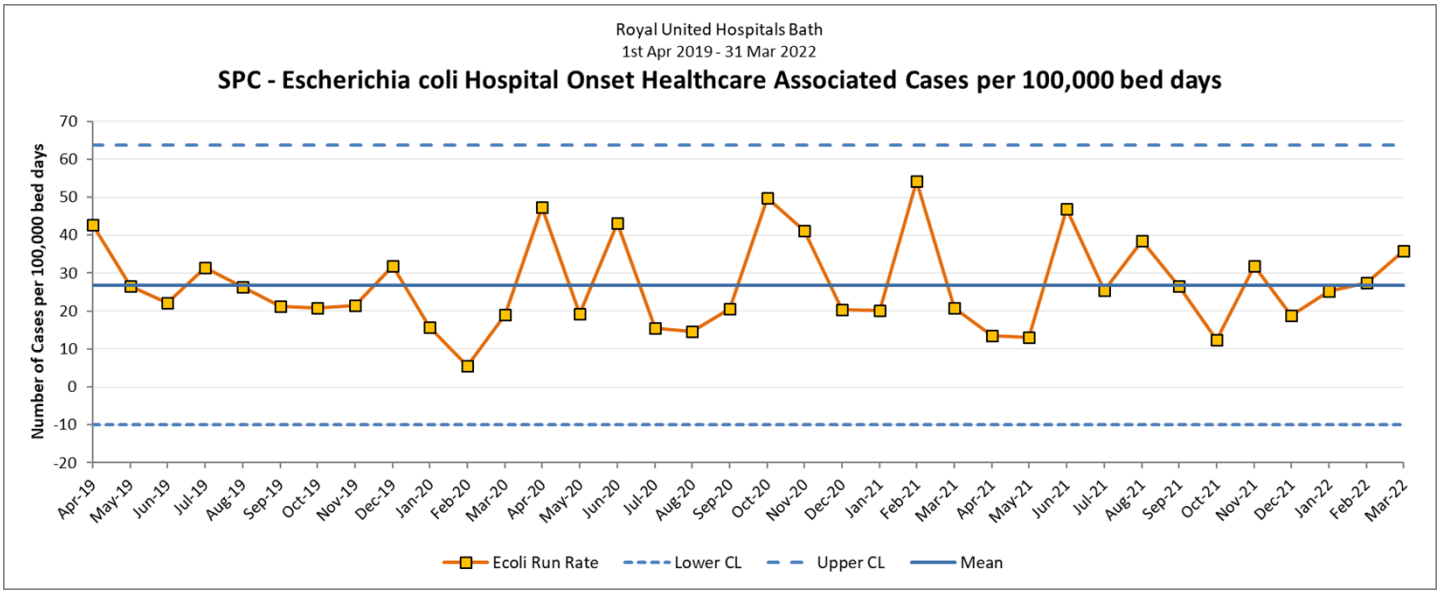


Figure 3: Hospital onset healthcare associated E coli bloodstream infections since April 2019

Actions taken

Hepatobiliary is the most common source of the infections overall (76 cases). For hospital onset cases the most common source of infection was the lower urinary tract (13 cases). The infections can be linked to dehydration; work to improve patient hydration has been ongoing during the last year however other factors can also be linked to this such as extreme heat on wards in the summer months.

Actions taken to reduce E coli bloodstream infections will also had a positive impact on reducing infections from *Klebsiella spp.* and *Pseudomonas aeruginosa*.

5.2 *Klebsiella spp.* bloodstream infections

There were a total of 75 cases of *Klebsiella spp.* bloodstream infections reported during 2021/22, this includes a case reported for another provider: blood cultures taken at Frome Community Hospital.

There were 16 hospital onset healthcare associated cases, 6 cases less than reported in 2020/21. There were 7 community onset healthcare associated cases reported making a total of 23 Trust apportioned cases against the NHS Standard Contract threshold of 46 cases.

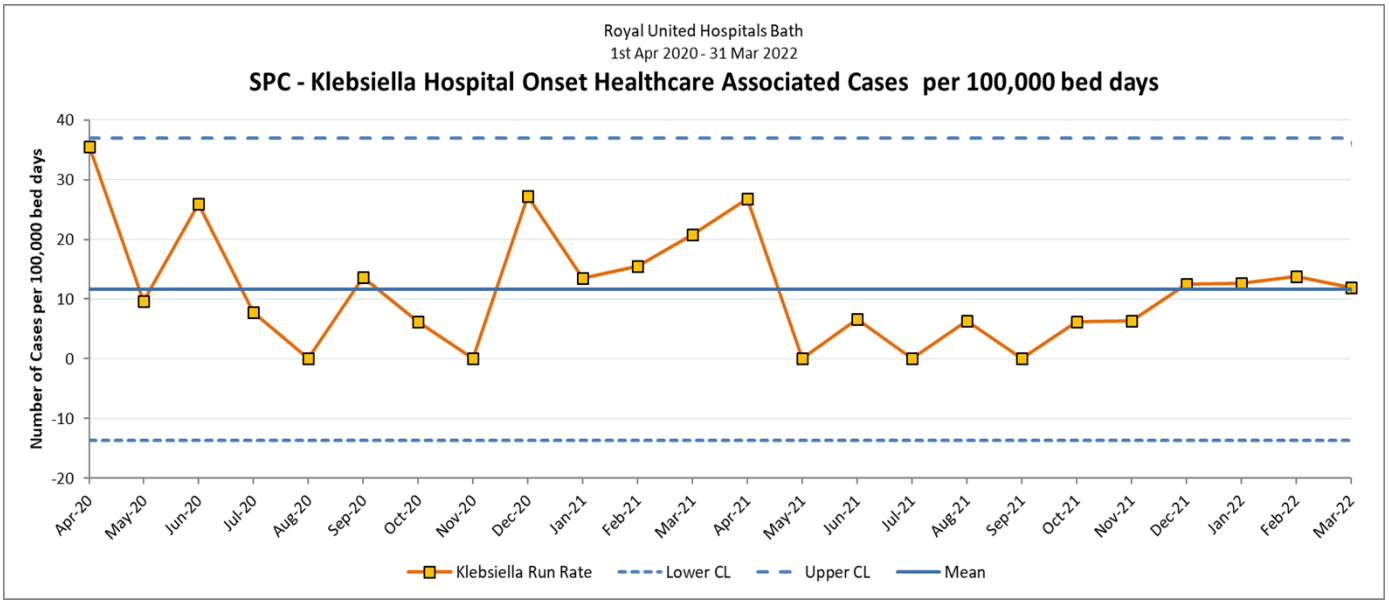


Figure 4: Hospital onset healthcare associated Klebsiella spp. bloodstream infections since April 2020

Actions taken

All cases were reviewed by the microbiologists or the infection prevention and control nurses and the potential source identified. The most common source of infection was identified as hepatobiliary however for hospital onset cases there were two sources that were identified as the most common, although in relatively low numbers. These were lower respiratory tract infections and lower urinary tract.

See Appendix 13.4.2 for more information.

5.3 *Pseudomonas aeruginosa* bloodstream infections

There were a total of 38 cases reported during 2021/22. There were 14 hospital onset and 5 community onset healthcare associated cases. The total number of Trust apportioned cases was 19 against the NHS Standard Contract threshold of 19.

Actions taken

As with the other Gram negative infections all cases were reviewed by the microbiologists and the source of infection identified where possible. The most common source of infection was the lower urinary tract overall and this was also found to be the most common source of hospital onset cases.

See Appendix 13.4.3 for more information.

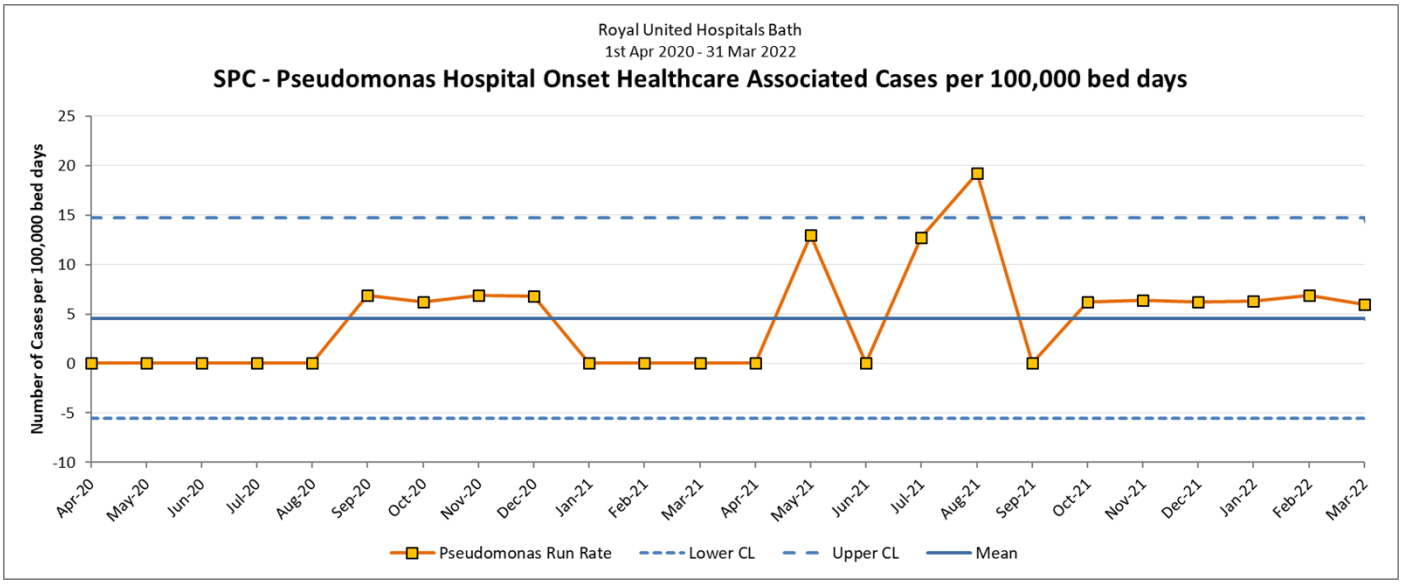


Figure 5: Hospital onset healthcare associated Pseudomonas aeruginosa bloodstream infections since April 2020

6 *Clostridioides difficile* infection (CDI)

National *Clostridioides difficile* thresholds were published within the 2021/22 NHS Standard Contract. The threshold for the Trust was set at 43 cases.

The Infection Prevention and Control team reported a total of 114 cases for the year which included 3 cases for other healthcare providers. There were 36 hospital onset and 19 community onset healthcare associated cases reported therefore the total number of Trust apportioned cases was 55, 12 cases above the threshold.

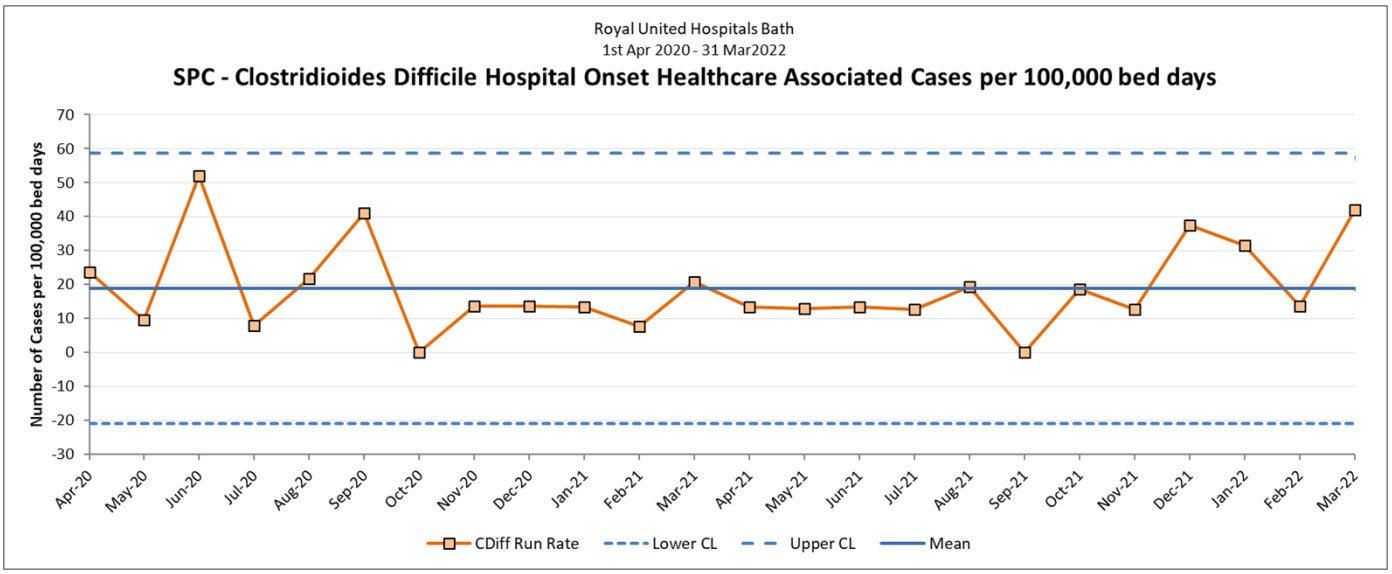


Figure 6: Hospital onset CDI infections since April 2020

Actions taken

Root cause analysis (RCA) is undertaken for all hospital onset *Clostridioides difficile* infections. An action plan is produced in each case and the RCAs are presented by the Senior Sister/Charge Nurse at an RCA 72 hour meeting which is arranged by the appropriate clinical Division. Themes are drawn at the review meetings and recommendations made to the Divisions for improvement actions. The RCAs and action plans are also presented to the Divisions who are responsible for monitoring against the action plans.

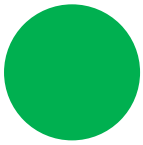
Completion of stool charts and recognition of diarrhoea has been a consistent theme therefore the Infection Prevention and Control Team developed a revised stool chart which is simpler to use and aids identification of when a stool sample needs to be taken. The new charts were distributed across the Trust in early 2022 and feedback from staff has been positive.

Antimicrobial stewardship is also key to reducing *Clostridioides difficile* infection. More information on the work of the Antimicrobial Stewardship Team is provided in Section 9 of this report.

A *Clostridioides difficile* infection reduction work plan has been reinstated for 2022/23. The Infection Prevention and Control Team will support the clinical Divisions to complete the actions.

See Appendix 13.5 for further information and regional CDI rates.

7 Norovirus



During 2021/22 there were 3 bay or ward closures due to outbreaks of diarrhoea and vomiting caused by norovirus. There were a further 16 incidents where beds were closed for up to 48 hours following the isolation of a patient with confirmed norovirus however no other patients acquired the infection during the bay closure.

There were a total of 127 bed days lost in total: 92 of which were lost during the 3 outbreaks.

Month	Location	Number of patients with norovirus	Bed days lost
June 2021	OPAU Bay 1	7	29
June 2021	OPAU whole ward	8	56
November 2021	Haygarth Bay 2	2	7

Table 1: Norovirus outbreaks in 2021/22

All areas were cleaned thoroughly prior to admitting new patients after the end of each outbreak was declared.

8 Influenza

There were no influenza outbreaks during 2021/22 however there were 6 incidents where bays were closed to new admissions due to single cases of Influenza A. All of these incidents occurred after National lockdown restrictions were lifted within the community.

The Trust policy is to close areas to new admissions for 4 days following patient contact however in all of the incidents the bays were opened earlier as either all of the patient contacts had been discharged or isolated. A total of 9 bed days were lost.

9 Antimicrobial stewardship (AMS)

9.1 Staff update

The Antimicrobial Stewardship (AMS) Pharmacist post-holder returned from maternity leave in August 2020. The Senior Pharmcy Technician for antimicrobials was recruited in May 2021.

There are 2 Consultant Microbiologists in post who share the AMS duties.

9.2 Antimicrobial stewardship activities

AMS Activities	Description	Issues
Committee	Quarterly meetings, report to Infection, Prevention and Control Committee (IPCC) and will report to the deteriorating patient working group. Membership has been expanded to include representation from areas of high consumption including: • Respiratory • Haematology • Acute medicine • General Surgery • Trauma and Orthopaedics The Trust Antimicrobial Stewardship policy is due to be ratified in July 2022 to provide a clear reporting and governance structure.	Meeting now running as of November 2021, next scheduled July 2022. One meeting was missed in Spring 2022 due to not being quorate. The Chief Medical Officer is the interim chair however a more permanent chair is being sought.
AMS Rounds	Face-to-face Microbiology rounds are undertaken, these include: • Critical Care - daily • Haematology/Oncology MDT- weekly • Cardiology/Infective Endocarditis MDT- weekly • Staphylococcus aureus bacteraemia weekly reviews • Complex patient review - weekly • Outpatient Parenteral Antibiotic therapy (OPAT) virtual round - weekly • Carbapenem reviews - twice weekly • Prosthetic joint infection meetings - monthly • Medical Assessment Unit - weekly	

	• AMS rounds on Parry and Pulteney ward based on Antimicrobial compliance audit data and complexity of patients on these wards.	
C. difficile	Weekly rounds by Consultant Microbiologist Contribution to RCAs, data on potential causitive antibiotic trends, primary care feedback of none-guideline use of antibiotics.	
CQUIN/ MOP/Standard contract	Urinary Tract Infection CQUIN: in progress since April 2022 AMS team have updated adult guidelines. Community Acquired Pneumonia (CAP) CQUIN: in progress led by respiratory, AMS team are in process of reviewing adult CAP guidelines	
Regional	Bath Swindon and Wiltshire (BSW) AMS network South West antimicrobial pharmacist network	
Training	Level 2 AMS update complete and live on Electronic Staff Record (ESR). Full programme of face to face/blended teaching by AMS team underway since Summer 2021 including updates to: • Acute Medical team • Pharmacy team • Emergency Medicine medical team • Surgical doctors in training • Stroke team • Respiratory team.	
Audit	Trustwide compliance audit performed quarterly by AMS pharmacist and fed to Divisional and Governance leads in addition to the Antimicrobial Stewardship Group Members. Areas that are underperforming are selected for AMS rounds and AMS education. Areas of good performance are now ranked in top 3 and celebrated Vancomycin/gentamicin therapeutic levels/avoiding toxicity. Results led to Adjustment of Gentamicin care plan re-audit due 2022 Carbapenem review – 2 x per week Audit of Staphylococcus aureus bacteraemia led to adjustment of community acquired sepsis guidelines March 2022.	
Guidelines	Updated as required – with additional safety information and new recommendations. Paediatric guidelines have been separated and are on MicroGuide. All paediatric guidelines have been reviewed by the paediatric team in Spring 2022. Adult antimicrobial guidelines will be reviewed in Summer 2022.	
Safety	Gentamicin prescribing process update – care plan now mandatory on ePMA Review of OPAT prescribing processes, clinical governance and structure ongoing.	
Comms	World Antibiotic Awareness Week Nov 2021, Antimicrobial Stewardship Newsletter quarterly Updated guidelines highlighted on Workplace (internal staff communication platform) and All Staff Brief.	

Table 2: Antimicrobial Stewardship activity in 2021/22

9.3 Antimicrobial Consumption

(a) Total Consumption

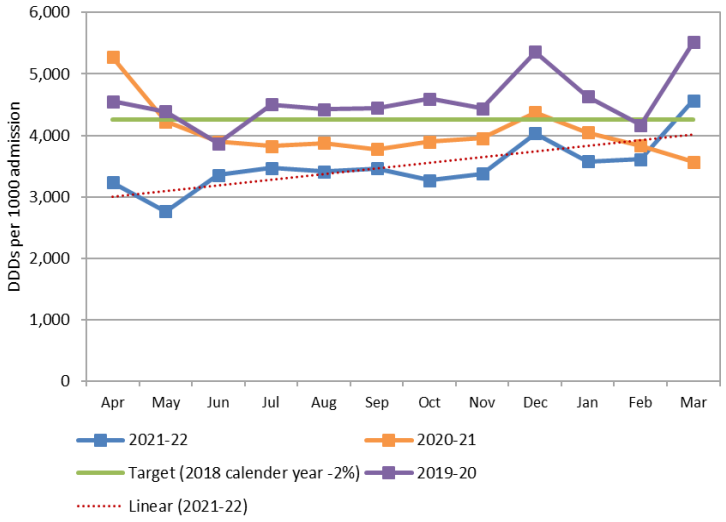


Figure 7: Total antibiotic consumption 2021/22

Antibiotic Consumption
Public Health England (PHE) have set a target to reduce Defined Daily Doses (DDD) by 2% this year against 2018 calendar year (4350).

Target 2018 -2% = **4,263**.

Total number of DDDs/1000 admissions for 2021/22 = **3,524** achieving the target.

The aim for 2022/23 is to maintain DDDs below the PHE recommended threshold.

(b) Carbapenem Consumption

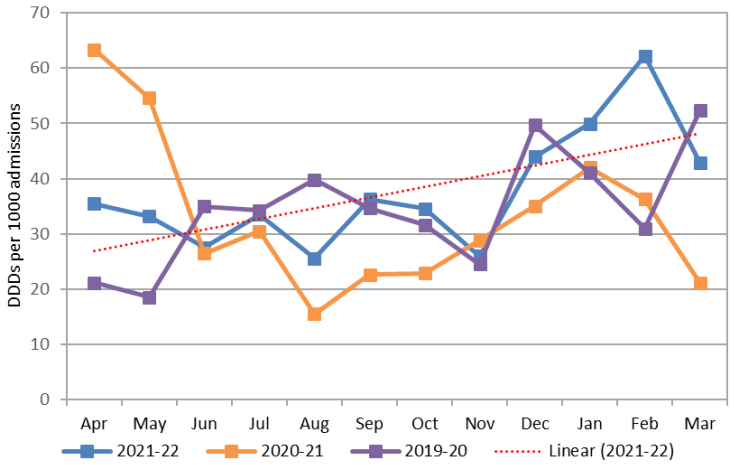


Figure 8: Carbapenem consumption 2021/22

Carbapenem Usage
Consumption is higher than the previous year but usage remains low compared to Regional and National figures.

Although not a CQUIN target, the aim is to reduce Carbapenem consumption and reserve its use for patients who require it as per microbiology advice to avoid antibiotic resistance.

Total no. of DDDs/1000 admissions for 2020/21 = **31**

Total no. of DDDs/1000 admissions for 2021/22 = **37**

Twice weekly reviews of Carbapenem as flagged by pharmacy have been re-established to ensure all prescriptions are appropriate.

In comparison to the Region, the Trust is the **second** lowest user of Carbapenem per 1000 admissions.

(c) Access Group

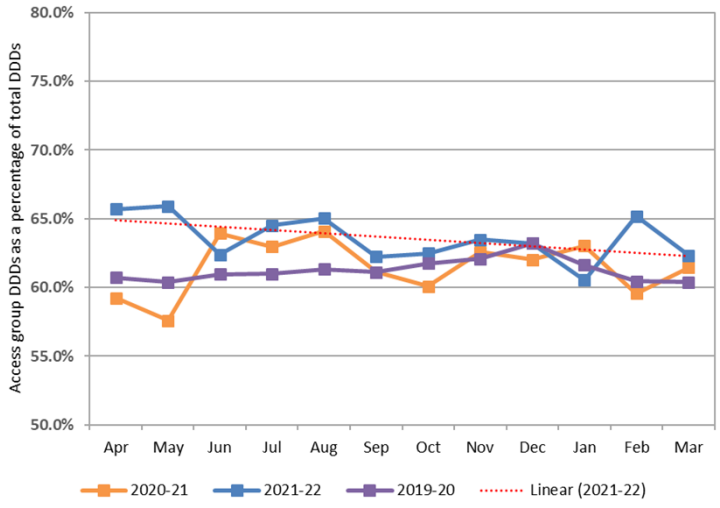


Figure 9: Access group antibiotic consumption 2021/22

ACCESS Group Antibiotics
The use of World Health Organisation (WHO) classified 'ACCESS' antibiotics remains above 60% which is higher than the National and Regional figure.

Although not a CQUIN target, it is important the Trust continues to monitor the proportion of antibiotics prescribed within the ACCESS group to help reduce antibiotic resistance and preserve the effectiveness of 'last resort" antibiotics that are needed when all others fail.

Total for 2020/21 = **62%**

Total for 2021/22 = **62%**

The aim for 2022/23 is to increase this figure and utilise more ACCESS group antibiotics.

(d) Watch and Reserve Group

The use of WHO classified 'Watch' antibiotics is 38% and 'Reserve' group antibiotics remain low at around 1 - 2% and the Trust remains the lowest user of these classes of antibiotics in comparison to the Region and Nationally.

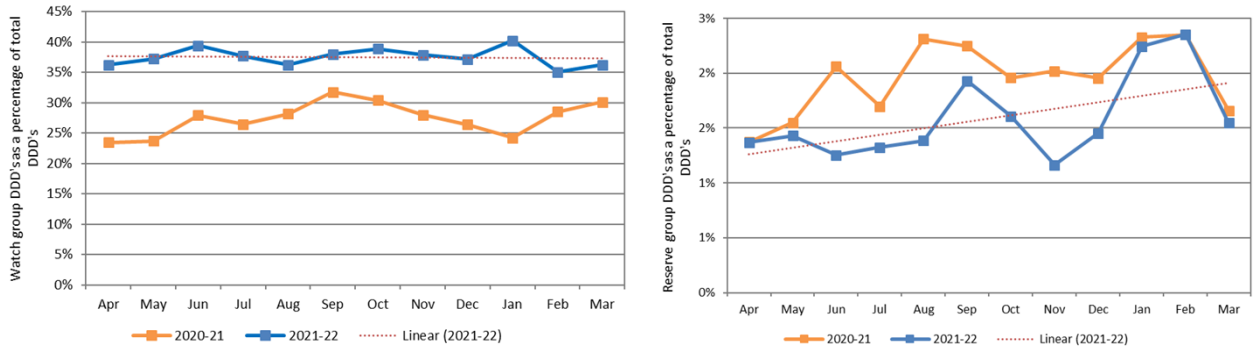


Figure 10: Watch and Reserve group antibiotic consumption 2021/22

9.4 Training Compliance

- AMS Level 1 = 88% (target 90%)
- AMS Level 2 = 64.1%, lowest compliance amongst bank staff
- ARK = 63.2% - increasing according to projections.

Antimicrobial Stewardship is important to improve antibiotic prescribing, protect individual patients and the local population from unintended harm from antibiotic overuse including Health Care Associated Infections (HCAI), and contribute to slowing antibiotic resistance.

The Trust is committed to following the principles outlined in the Department of Health (DH) guidance "Antimicrobial Stewardship: Start Smart then Focus" and follow the guidance and processes set out in National Institute of Clinical Excellence (NICE) NG15 and the Public Health England 5 and 20

year action plans on AMR https://www.gov.uk/government/collections/antimicrobial-resistance-amr-information-and-resources#strategic-publications

10 Surgical Site Infection Surveillance

10.1 Mandatory Surveillance

The Trust takes part in the mandatory surveillance of surgical site infections which involves the reporting of infections post-operatively in patients undergoing certain types of orthopaedic surgery. This includes surveillance of patients prior to and post discharge and also patients who are readmitted with post-operative infections. If the infection has occurred within 30 days of the surgery, or in the case of implant surgery within one year, the incident will be reported as a surgical site infection.

The surgical site surveillance nurses are employed by the Surgical Division. They routinely report on surgical site infections in patients who had undergone a total hip replacement (THR), total knee replacement (TKR) and repair of a fracture to the hip. The surveillance nurses also collect and report data for certain types of breast surgery however this is not mandatory.

Reporting has continued for all periods for surgical site infections within the fractured neck of femur and breast surgery cohort.

The Trust has continued to report on total knee and total hip replacement surgery. The numbers involved are greatly reduced compared to pre-pandemic levels due to the impact of non-elective care on the ring fenced orthopaedic elective ward causing the cessation of TKR and THR surgery for periods over the past 12 months.

The Trust received a letter in April 2022 relating to the surveillance period July – September 2021 identifying it as a high outlier for TKR surgical site infections with an infection rate of 1.0%.

The Trust had zero TKR surgical site infections April 2021-March 2022 but due to the reporting period for comparison of the past 5 years for all Trusts the Trust was identified as an outlier. During the past 5 years, extensive work has been undertaken to reduce all surgical site infections.

Table 3 identifies the surgical site infection percentage per reported pathway over the past 4 reported quarters for the RUH compared to all Trusts. The reporting period for comparison to all Trusts is 5 years.

Procedure	RUH	All Trusts
Total Hip Replacement (THR)	0%	0.3%
Total Knee Replacement (TKR)	1.0%	0.3%
Repair of Femur	0.4%	0.8%

Table 3: Surgical Site Infection percentage per reported pathway

10.2 'PreciSSion' project

It is recognised that surgical site infection is more common after colorectal surgery where wounds are frequently contaminated by bowel content and rates are reported between 8-30%.

Within the reporting period, the surgical site infection team have been working closely with the colorectal teams to support the 'PreciSSion' Project.

Measuring Surgical Site Infection from 30 day patient reported outcomes has now been successfully implemented and has been in place since May 2020.

Following implementation of the 'PreciSSion' bundle in May 2020, there has been a 70% reduction in surgical site infection for elective colorectal surgery, which has decreased from a baseline average of 24% to 7% and this has been sustained for 12 months.

Due to the early success of the project, the Trust has elected to continue to be part of the project in the South West and as such the surgical site infection nurse will continue to collect data and support the work of the 'PreciSSion' Project. This is not reportable to the UK Health Security Agency at this time.

11 COVID-19

11.1 SARS CoV-2

During 2021/22 there where peaks of COVID-19 infections nationally, regionally and locally which increased hospital admissions significantly. The Trust has maintained an escalation plan for the periods of time when COVID-19 infections increase so that cohort areas can be utilised to accommodate patients to be cared for together. This also liberates side rooms to admit patients with COVID-19 into specialty beds if required or to allow for the isolation of clinically extremely vulnerable patients or those with other communicable diseases.

There were many changes in national policy last year which have been reflected in the Trust guidance. These include changes in personal protective equipment (PPE) use, isolation and screening of patients and the removal of the high, medium and low risk pathways (red, blue and green pathways). The Infection Prevention and Control Team has been instrumental in supporting staff to adjust to changing guidance and developing standard operating procedures and action cards for staff to utilise.

Daily outbreak or ward review meetings have continued during the peaks of infection with a membership that includes clinicians, workforce planning and cleaning.

Nosocomial transmission has also increased during peaks of infection however the most recent COVID-19 variants have not resulted in patients becoming very unwell and admissions to Intensive Care have fallen. In many cases nosocomial infection is detected when patients have asymptomatic COVID-19 screening as part of the admission or discharge process.

Nosocomial COVID-19 infections are categorised as follows:

- COVID-19 detected between days 0-2 of admission – these are community acquired cases not nosocomial infections
- COVID-19 detected between days 3-7 of admission – indeterminate nosocomial infection that could have been acquired in the community
- COVID-19 detected between days 8-14 of admission – probable nosocomial infection
- COVID-19 detected on day 15+ of admission – definite nosocomial infection

The number of infections detected by month is summarised in the table below with the breakdown of the infections into nosocomial and community acquired categories. Those marked as 'requires checking' include cases where patients may have been tested within 90 days of a previous infection.

COVID infections	2021																							
	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		2022 Jan		2022 Feb		2022 Mar	
Definite	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	2.1%	6	2.7%	0	0.0%	16	9.4%	13	7.0%	8	5.5%	17	6.1%	
Probable	0.0%	0	0.0%	0	0.0%	1	1.3%	6	5.5%	4	2.8%	5	2.3%	3	1.9%	5	2.9%	7	3.8%	16	11.0%	26	9.4%	
Indeterminate	20.0%	0	0.0%	2	11.8%	3	3.8%	9	8.2%	13	9.0%	8	3.6%	6	3.9%	26	15.3%	16	8.6%	14	9.7%	45	16.2%	
Community Acquired	80.0%	2	50.0%	13	76.5%	70	87.5%	90	81.8%	119	82.1%	197	89.1%	136	87.7%	117	68.8%	135	72.6%	102	70.3%	180	65.0%	
Requires Checking	0.0%	2	50.0%	2	11.8%	6	7.5%	5	4.5%	6	4.1%	5	2.3%	10	6.5%	6	3.5%	15	8.1%	5	3.4%	9	3.2%	
Total	5		4		17		80		110		145		221		155		170		186		145		277	

Table 4: Nosocomial infections by month

The Trust has worked collaboratively with the other acute NHS organisations within Bath Swindon and Wiltshire (BSW) CCG to align practices regarding management of patients who are COVID-19 contacts and the length of time they require isolation.

The Divisional Patient Safety Teams lead on reporting and investigating nosocomial COVID-19 patient deaths.

12 Level 2 Infection Prevention and Control Training

Level 2 infection prevention and control training is mandatory for all patient-facing staff. This training has been delivered by e-learning since December 2019. The e-learning package is being revised and will be relaunched before the end of 2022.

The Trust has a target of 90% compliance with Level 2 infection prevention and control training; in April 2022 the overall compliance was 79.8%, a drop from 84.4% last year. None of the Divisions/Departments achieved the 90% target.

Division/Department	Training compliance 2021-22	Training compliance 2020-21
Bank	64.7% (↓3.6%)	68.3%
Corporate	76.3% (↓11%)	87.3%
Emergency Medicine	66.5%	N/A*
Estates and Facilities	76.5% (↓4.5%)	81%

Family and Specialist Services	82.4% (↓7.5%)	89.9%
Medicine	86.6% (↓1.3%)	87.9%
Non-Paid and Recharge°	54.5% (↓45.5%)	100%
Research and Development	88.4% (↓6.3%)	94.7%
Surgery	83.1% (↓1.7%)	84.8%
Trust	**79.8% (**↓4.6%)	**84.4%**

Table 5: Mandatory Training compliance

*Emergency Medicine were included in the Medical Division figures last year

°N.B there are only 11 staff who are eligible for training in this department which affects the compliance significantly; they can only achieve 90% if at least 10 staff have completed their training.

13 Appendices

13.1 Infection Prevention and Control Team (IPCT) Structure and Arrangements

13.1.1 The Infection Prevention and Control Arrangements

The Chief Executive holds the ultimate responsibility for all aspects of infection prevention and control within the Trust.

The Chief Nurse is the designated Executive lead; Director of Infection Prevention and Control (DIPC). The Chief Nurse reports directly to the Chief Executive and the Board and is the chair of the Infection Prevention and Control Committee (IPCC) and was the Senior Infection Prevention and Control Nurse's line manager until the Deputy Director of Infection Control/Associate Chief Nurse was appointed in February 2022. The Deputy DIPC/Associate Chief Nurse reports directly to the Chief Nurse/DIPC.

The Infection Control Doctor (ICD) is a consultant microbiologist who provides expert microbiological advice and supports the DIPC. There are now two consultant microbiologists who share this role; one is the lead ICD and the other is the Deputy ICD.

The Senior Infection Prevention and Control Nurse is responsible for the operational management of the Infection Prevention and Control Team (IPCT) and for ensuring that the Infection Prevention and Control Strategy is embedded.

The Infection Prevention and Control Nurses (IPCNs) provide expert clinical advice and support to Trust staff in the delivery of the Strategy. The team covers all sites within the Trust including the community birthing centres, the Sexual Health Clinic and Sulis Hospital.

The team also provided cover via a service level agreements for the Independent Health Group.

13.1.2 The Infection Prevention and Control Team

The team is made up of the following staff:

- 1 whole time equivalent (WTE) Deputy Director of Infection, Prevention and Control
- 1 WTE Senior Infection Prevention and Control Nurse Band 8a
- 0.91 WTE Infection Prevention and Control Nurse Band 7
- 2.65 WTE Infection Prevention and Control Nurses Band 6
- 0.8 WTE Surveillance and Administration Assistant Band 3

13.1.3 Infection Prevention and Control Committee governance and reporting structure

The Trust Infection Prevention and Control Committee reports to Quality Board and Quality Governance Committee, which in turn reports to the Board of Directors.

13.2 MRSA bloodstream infections

There were no hospital onset MRSA bloodstream infections during 2021/22. The Trust reported 2 community onset cases; these were investigated by the appropriate CCG leads and feedback on any issues identified were provided to the patients' General Practitioner (GP) and other healthcare services accessed by the patients.

The wards and departments that in previous years had been high risk for MRSA infections have worked on ensuring that the screening and decolonisation guidance is followed. This will have impacted on reducing the number of serious infections.

13.2.1 MRSA bloodstream infection regional benchmarking

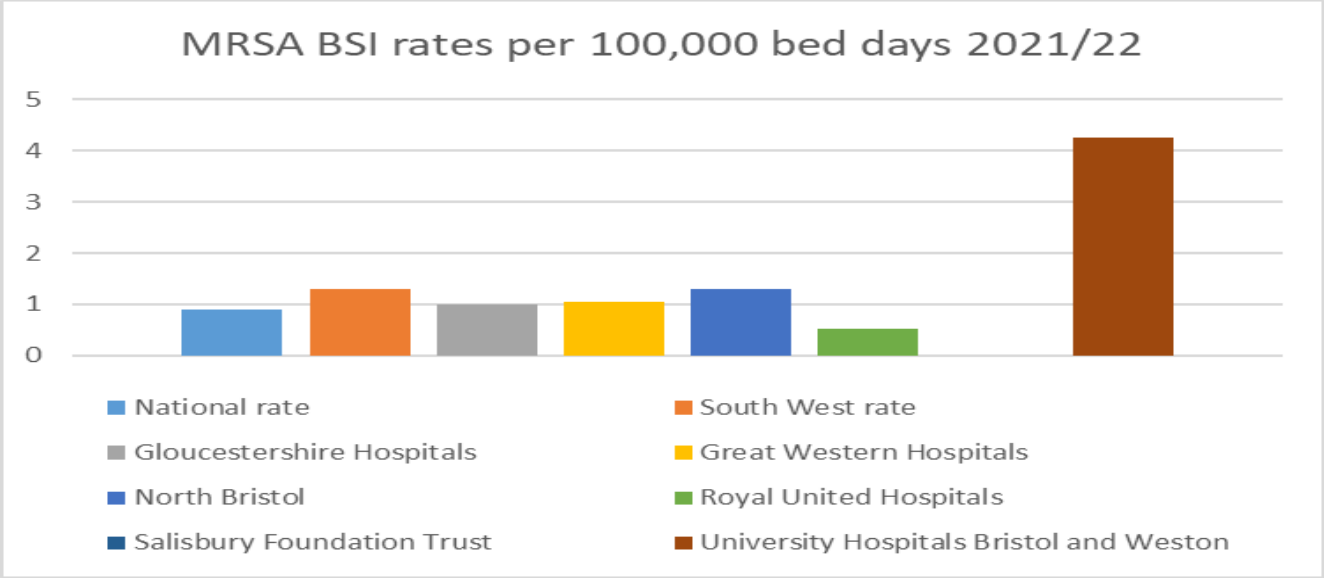


Figure 11: MRSA BSI (bloodstream infection) rates 2021/22

The Trust now has one of the lowest rates of hospital onset MRSA bloodstream infection within the region. The Trust has a rate of 0.52 against the South West average of 1.31.

At the time of writing this report it had been more than 500 days since the last Trust apportioned case.

13.3 MSSA bloodstream infections

Peripheral venous cannula associated infections accounted for 39% of the hospital onset MSSA bloodstream infections. These infections are avoidable and remain a concern.

The Senior Sister/Charge Nurses have focused attention on documentation of insertion, maintenance and removal of intravascular devices to ensure that these are not left in situ for longer than required and that any possible signs of infection are identified early however this has not reduced the number of reported infections.

The Trust Peripheral Cannulation Policy is awaiting revision and forms part of the improvement work that is taking place across the Trust. This will include further training requirements.

13.3.1 MSSA bloodstream infection regional benchmarking

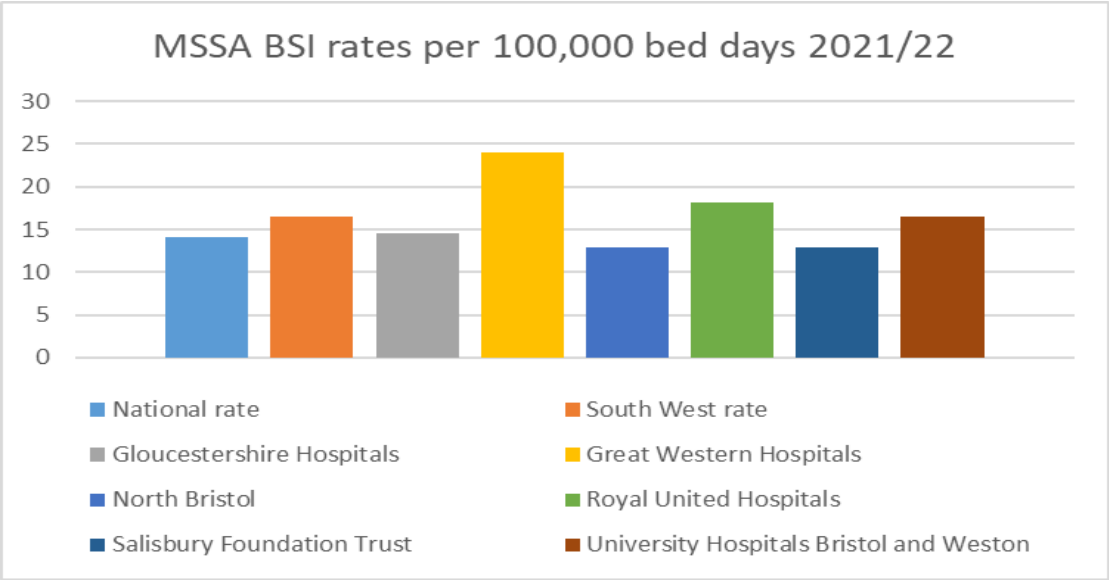


Figure 12: MSSA BSI (bloodstream infection) rates 2021/22

At the end of 2021/22 the Trust had a rate of 18.2 against the South West average of 16.47. The Trust sits in the middle of the benchmarking for the three trusts within BSW.

13.4 Gram negative bloodstream infections

In July 2021 quality requirements for minimising rates of Gram negative bloodstream infections to threshold levels were introduced for the first time as part of the NHS Standard Contract. Thresholds were set for each trust and Clinical Commissioning Group in England.

13.4.*1 E coli* bloodstream infections

The mandatory surveillance *of E coli* bloodstream infections commenced on 1 June 2011. From 2011-2017 these infections were split into community apportioned (blood cultures taken within 3 days of admission) and trust apportioned (blood cultures taken 3 days or more after admission).

From July 2017 the definition changed to hospital onset and community onset cases. All hospital onset cases are defined as those where the positive blood culture is taken 2 or more days after admission and are recorded as healthcare associated.

Community onset cases are where the blood culture has been taken either in the community or within the first 2 days of admission to hospital. Community onset cases are further broken down into healthcare associated and non-healthcare associated infections. Community onset healthcare associated infections are defined as those where the patient has either been in the reporting hospital in the preceding 28 days. Non-healthcare associated infections are where the patient has not been in the reporting trust in the preceding 28 days.

Mandatory surveillance includes positive blood cultures taken at GP practices or community hospitals in the Trust figure as the Infection, Prevention and Control Team reports these on the United Kingdom Health Security Agency (UKHSA) Healthcare Associated Infections Data Capture System on behalf of primary care and provider organisations. There were 2 cases reported for community providers during 2021/22.

	Hospital onset healthcare associated	Community onset healthcare associated	Community onset non-healthcare associated
Apr 2021	2	2	18
May 2021	2	3	24
Jun 2021	7	5	14
Jul 2021	4	6	16
Aug 2021	6	1	22
Sept 2021	4	1	16
Oct 2021	2	3	11
Nov 2021	5	3	15
Dec 2021	3	1	18
Jan 2022	4	3	8
Feb 2022	4	5	13
Mar 2022	6	4	8
TOTAL	**49***	**37**	**183**

*There were 48 hospital onset cases reported in 2020/21.

Table 6: E coli bloodstream infections 2021/22

All patients who have a confirmed *E coli* bloodstream infection, including community onset cases, are reviewed by the Microbiologists or Infection Prevention and Control Team who identify the most likely source of infection based on their review of the patient and their underlying pathologies. The source or cause of infection and any risk factors are reported via the UKHSA HCAI data capture system.

The most common cause *of E coli* bloodstream infection was hepatobiliary which accounted for 76 (28%) cases. Hepatobiliary infections are most likely to be associated with a patient's lifestyle or with underlying cancers.

The second most common source of infection was lower urinary tract in non-catheterised patients which accounted for 67 (25%) cases. The lower urinary tract was also the top contributor to hospital onset infections; 13 cases of which 5 were urinary catheter associated. The Catheter Passport has been revised and relaunched this year. All patients who are discharged with urinary catheters should have a passport that they carry with them when they have contact with healthcare professionals.

The Trust is also working collaboratively with our colleagues in BSW on a Gram negative infection reduction plan.

There were 27 cases (10%) where the source of infection was unknown or there was no underlying source of infection identified.

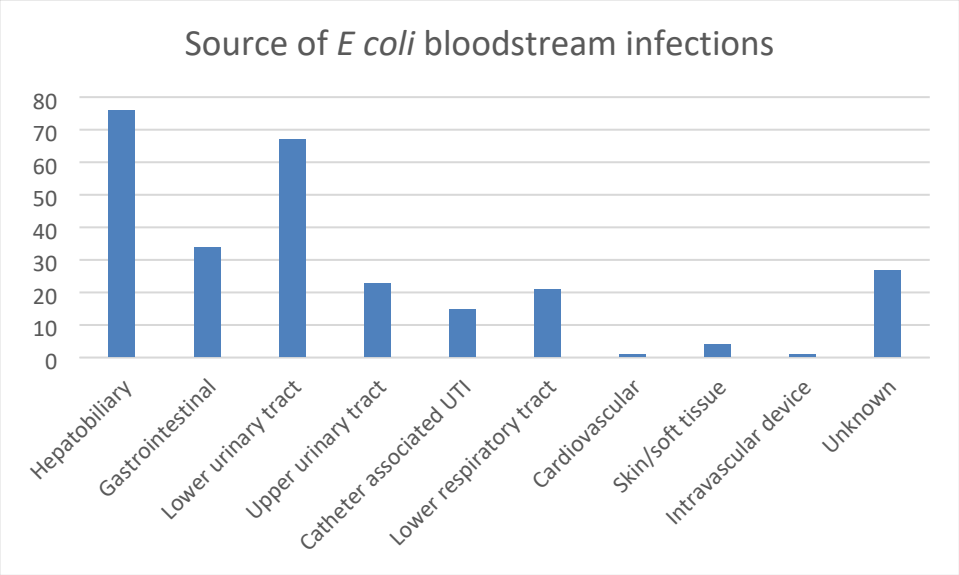


Figure 13: Source of E coli bloodstream infections 2021/22

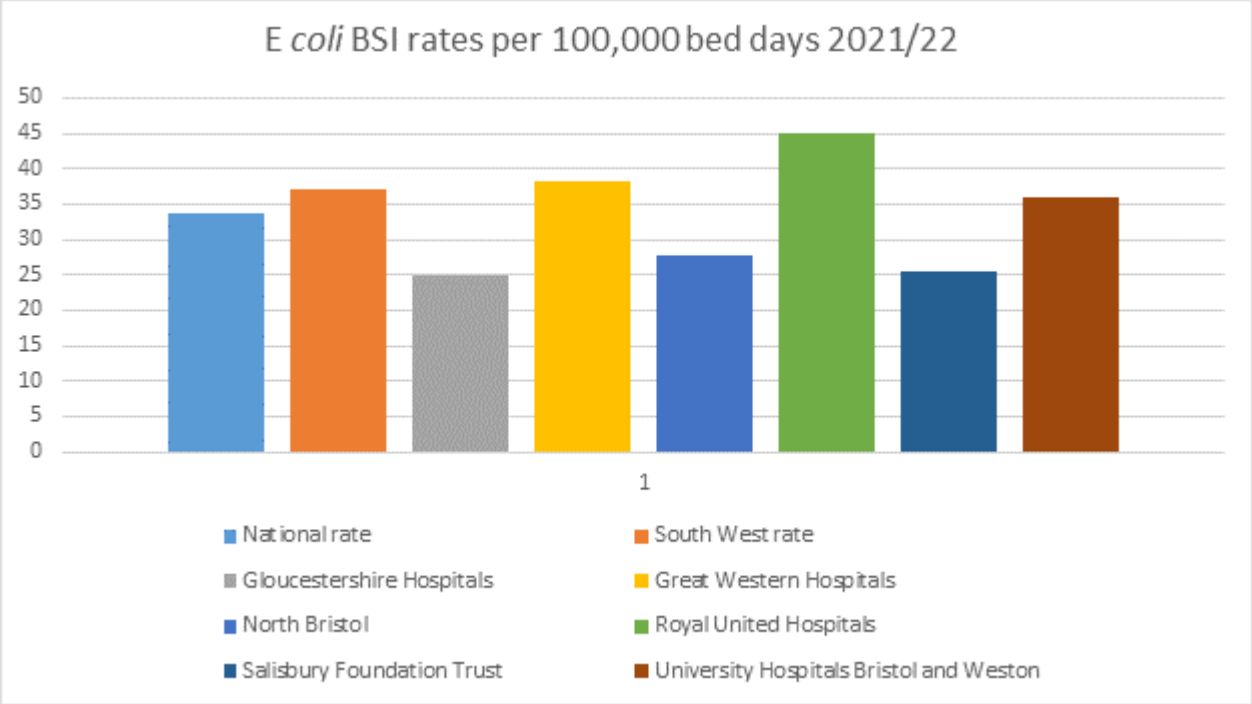


Figure 14: E coli BSI (bloodstream infection) rates 2021/22

The Trust has a rate of 45.16 for *E coli* blood stream infections; this is higher than the national and South West average of 37.11 and we are an outlier in comparison with the other trusts within BSW.

13.4.2 *Klebsiella* spp. bloodstream infections

Klebsiella are Gram-negative bacteria that are found in the environment and also in the human intestinal tract. They commonly cause healthcare associated infections and are the second most frequently identified source of Gram-negative bloodstream infection after *E coli*.

The Trust has continued to report all *Klebsiella spp*. bloodstream infections the UKHSA data capture system as part of the mandatory surveillance programme during 2021/22. They are also identified

as hospital onset healthcare associated, community onset healthcare associated and community onset non-healthcare associated cases.

A total of 75 cases were reported by the Trust in 2021/22 of which 16 were hospital onset and 7 cases were community onset healthcare associated: a total of 23 Trust apportioned cases against the NHS Standard Contract threshold of 46 cases.

Klebsiella pneumoniae was the most prevalent species isolated during 2021/22, making up 84% of cases reported.

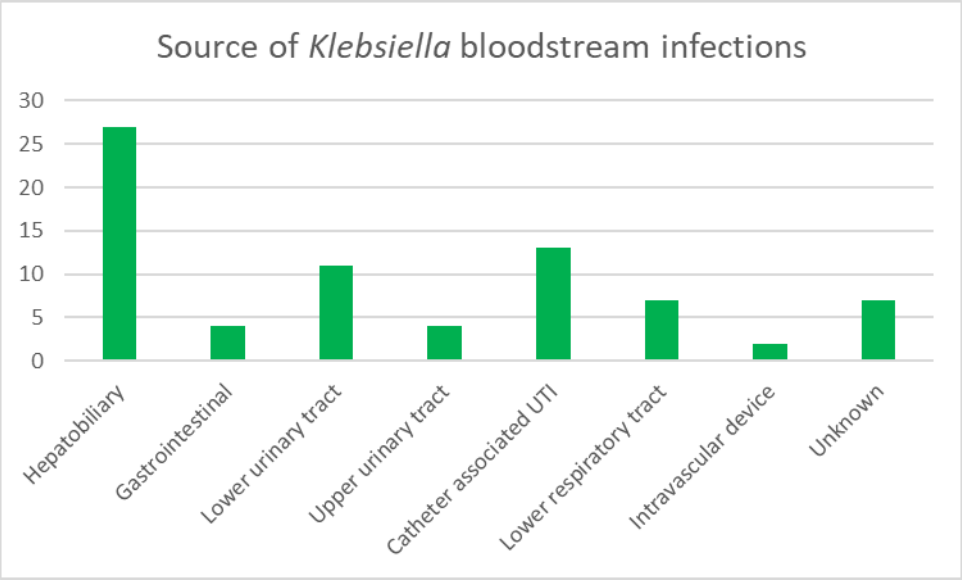


Figure 15: Source of Klebsiella spp. bloodstream infections 2021/22

The most common source of infection was identified as hepatobiliary and this accounted for 27 (36%) cases, the second most common source was the lower urinary tract in patients with indwelling urinary catheters at 13 cases (17%).

The most common sources of infection in hospital onset cases were the lower urinary tract (4 cases) and the lower respiratory tract (4 cases). Three of the lower respiratory tract infections were diagnosed in ventilated patients on the Intensive Care Units. Actions taken to reduce and prevent *E coli* bloodstream infections will also have an impact on *Klebsiella sp*. The Intensive Care Units have care bundles for prevention of ventilator associated respiratory tract infections and these have continued to be used.

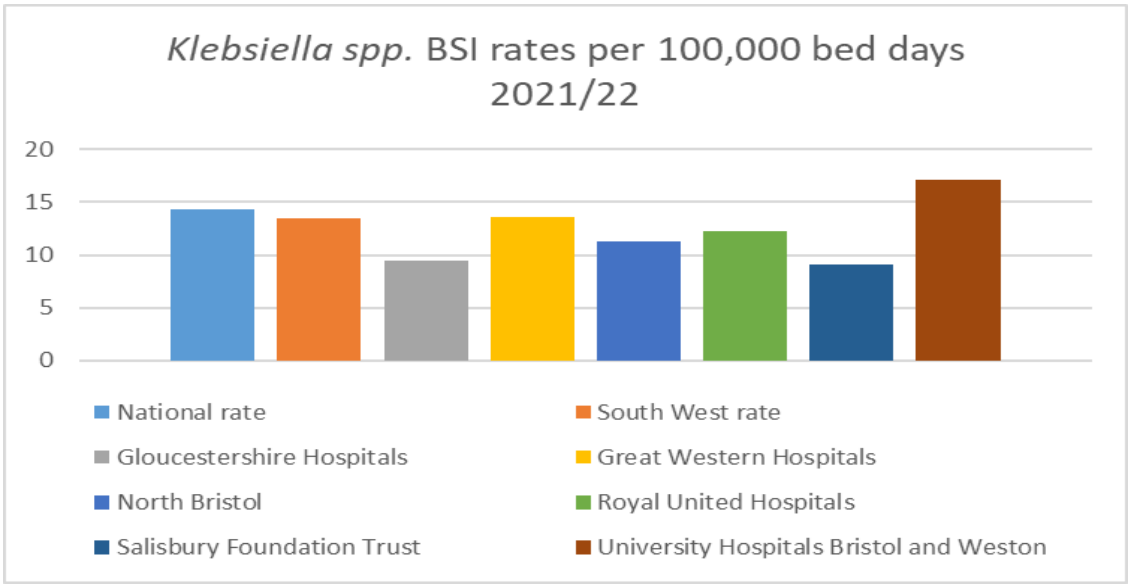


Figure 16: Klebsiella spp. BSI (bloodstream infection) rates 2021/22

The Trust has a *Klebsiella spp* blood stream infection rate of 12.29 which is below the national and South West average of 13.49. The Trust sits in the middle of the pack for the three trusts within BSW.

13.4.*3 Pseudomonas aeruginosa* bloodstream infections

Pseudomonas aeruginosa are Gram-negative bacteria found in soil and water. It is an opportunistic pathogen which can cause a wide range of infections, particularly in patients who are immunocompromised. The organism is known to cause infections by contaminating invasive devices such as urinary catheters.

The Trust has continued to report all *Pseudomonas aeruginosa* bloodstream infections via the UKHSA data capture system during 2021/22.

The same process is used as with the other Gram-negative bloodstream infections; each case is reviewed by a microbiologist; the most likely source and risk factors are identified and antimicrobial treatment is adjusted accordingly.

A total of 38 cases were reported by the Trust in 2020/21 of which 14 were hospital onset and 5 community onset healthcare associated. The total number of Trust apportioned cases was 19 which matched the NHS Standard Contract threshold.

The most common source of infection was the lower urinary tract 11 (29%) cases however 7 of which were urinary catheter associated and include patients with catheters inserted in the community and within hospital. This was also the case for patients with hospital onset infections: the lower urinary tract was the most common source (4 cases), 3 of which were catheter associated.

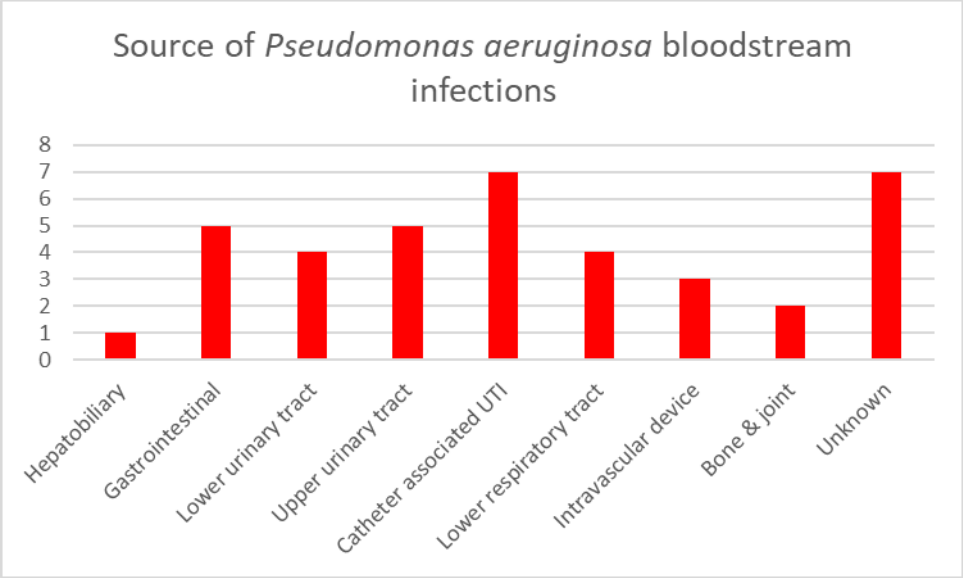


Figure 17: Source of Pseudomonas aeruginosa bloodstream infections 2021/22

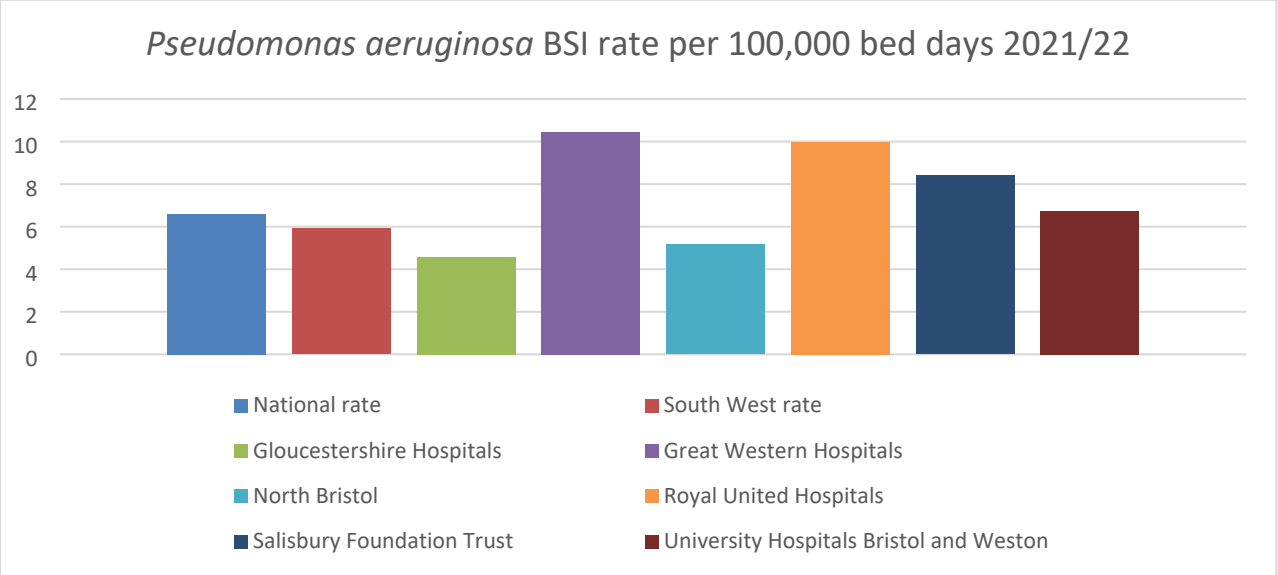


Figure 18: Pseudomonas aeruginosa BSI (bloodstream infection) rate 2021/22

The Trust has a *Pseudomonas aeruginosa* blood stream infection rate of 9.99 against the South West average of 5.91. The Trust sits in the middle of the benchmarking for the three trusts within BSW.

13.5 *Clostridioides difficile* infections

The reporting of the number of cases of *Clostridioides difficile* (CDI) infections is mandatory for all NHS Trusts. All cases over 2 years of age must be reported. Both hospital onset and community onset healthcare associated cases, where the sample has been taken within 28 days of discharge, are attributed to the Trust.

In 2021/22 the NHS Standard Contract threshold for Trust apportioned Clostridioides difficile infections was set at 43 cases. A total of 114 cases were reported during this period of which 36 were hospital onset and 19 were community onset healthcare associated cases therefore there were 55 Trust apportioned cases; 12 over the threshold.

The Trust are working collaboratively with primary care the other organisations within BSW to reduce the *Clostridioides difficile* infection rate.

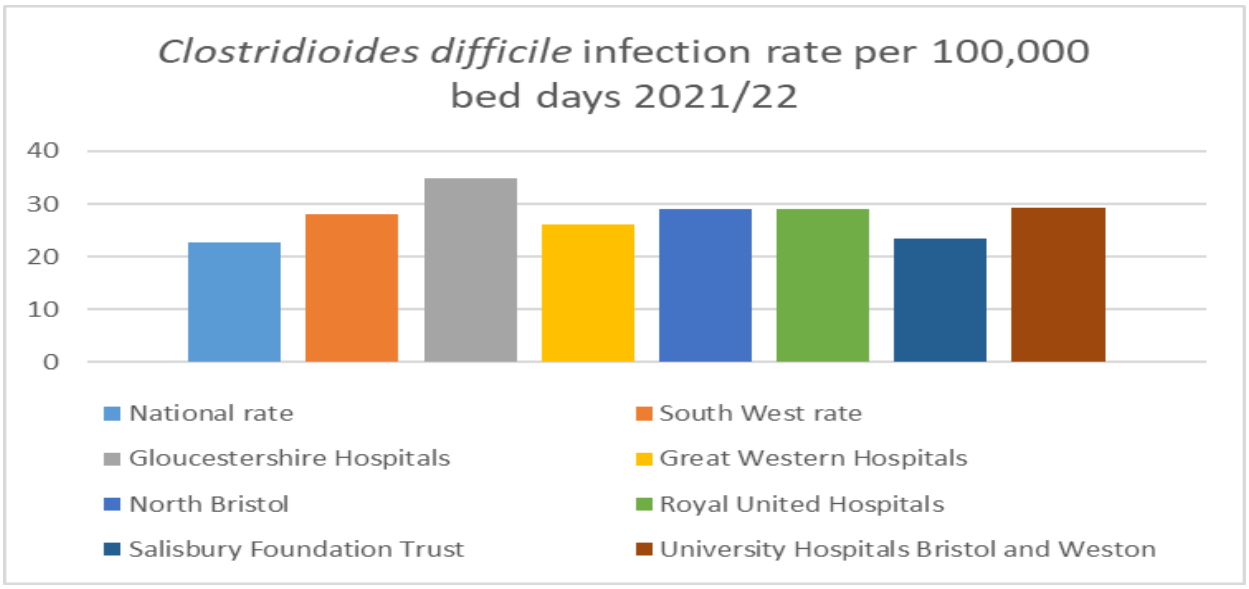


Figure 19: Clostridioides difficile infection rate 2021/22

It has been identified that some inpatient areas have had missed opportunities for obtaining stool samples, this has been addressed and improvements are being seen, which needs to be sustained. There have repeated samples being sent on patients with a history of Clostridioides difficile infection (CDI), without considering a medical review and conversation with the microbiology team. Reducing unnecessary sampling may have reduced the number of reported CDI toxins by two or three patients. This is being addressed with improved communication and monitoring as part of the CDI clinical rounds.

The UK *C difficile* prevention advice 'How to deal with the problem' has not been updated since the 2008. Hand hygiene, isolation, prescribing (including antibiotic reviews), cleaning and use of technologies such as ultraviolet light (UV-C) decontamination remain the fundamentals to best practice. The Trust is following the current tool kit and the Trust is anticipating new management and treatment guidance at the end 2022.

The Southwest as a whole has a higher than average rate for the Country, and the Trust is not alone in seeing high numbers of *C difficile* cases. However the Trust have reported more cases than the two neighbouring Trusts. This data has led to a Bath and North East Somerset, Swindon and Wiltshire (BSW) wide collaborative, the aim is to understand the wider issues that are driving acute and community CDI rates.

The IPC team will continue to collaborate with integrated care board colleagues and healthcare colleagues in the attempt to discover the true causes of a patient acquiring and developing *C difficile*. This in turn will develop an action plan to be able to start to reduce the *C difficile* numbers

13.6 Cleaning

The increased cleaning frequencies of frequently touched surfaces and shared toilet facilities due to COVID-19 continued during the year, utilising additional temporary staffing. This was in line with Public Health England//UKHSA guidelines for healthcare facilities. All cleaning in clinical areas was completed using a sodium hypochlorite and detergent solution.

The cleaning audit scores reported are summarised in the table 7:

Risk Level	2020/21	2021/22
Very High Risk – 98%	97.93%	96.79%
High Risk – 95%	96.63%	95.06%
Significant Risk – 85%	96.90%	94.61%
Low risk – 75%	93.56%	91.12%

Table7: Cleaning standards scores

The Patient Led Assessment of the Care Environment (PLACE) assessment did not take place nationally due to the pandemic and therefore no results are available for this year.

Following publication of the National Standards of Healthcare Cleanliness in April 2021, work has been underway to redesign the cleaning service to meet the minimum mandated frequencies. The resulting business case was been approved, and a Human Resources consultation with cleaning staff was undertaken. Implementation of the new cleaning patterns and cleaning frequencies due to commence in August 2022. A derogation has been obtained from NHS England & Improvement to delay implementation until this date.

Recruitment of additional cleaning staff commenced in May 2022 and temporary staffing has been used to fill vacancies and for cleaning of increased frequencies, however, this has resulted in increased occurrences of lower than optimum staffing availability. This is reflected in the cleaning scores.

Functional risk areas, cleaning responsibilities and cleaning specification have all been approved through the Infection Prevention Control Committee. Cleaning frequencies of shared patient toilets in FR1 and FR2 functional risk areas have been increased to four full cleans daily.

13.7 Decontamination of Medical Devices

Central Decontamination

Sterile Services (SSD) is accredited to BS EN ISO 13485:2016 and registered with the Medicines and Healthcare products Regulatory Agency (MHRA) for the assembly, supply and distribution of sterile packs and instrument sets for hospitals and other health care related establishments. SSD re-manufactures procedure packs, single instruments and theatre sets using the items which are mutually compatible and used in accordance with manufacturer's instructions and users requirements – to conform to Annex V Section 3.2 and Article 12 of MDD 93/42/EEC Revision 2007/47/EC. The items are thermally disinfected and will be sterilised in accordance with Health Technical Memorandum (HTM) 01-01 guidelines.

Currently SSD supplies 121 locations – internal & external to the Trust. During 2021-22 SSD processed 189,962 items which included 1,703,981 instruments.

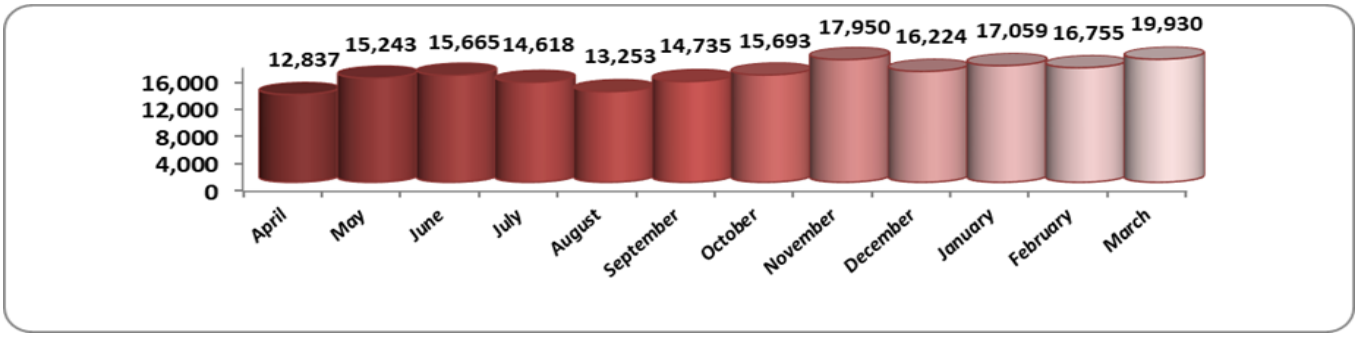


Figure 20: Items processed by SSD by month for 2021/2022

SSD provides a comprehensive decontamination services to various service users for re-useable heat sensitive flexible endoscopes. High level disinfection service for flexible endoscopes is managed by SSD in accordance with the British Society of Gastroenterology Guidelines for Gastrointestinal Endoscopy and HTM 01-06.

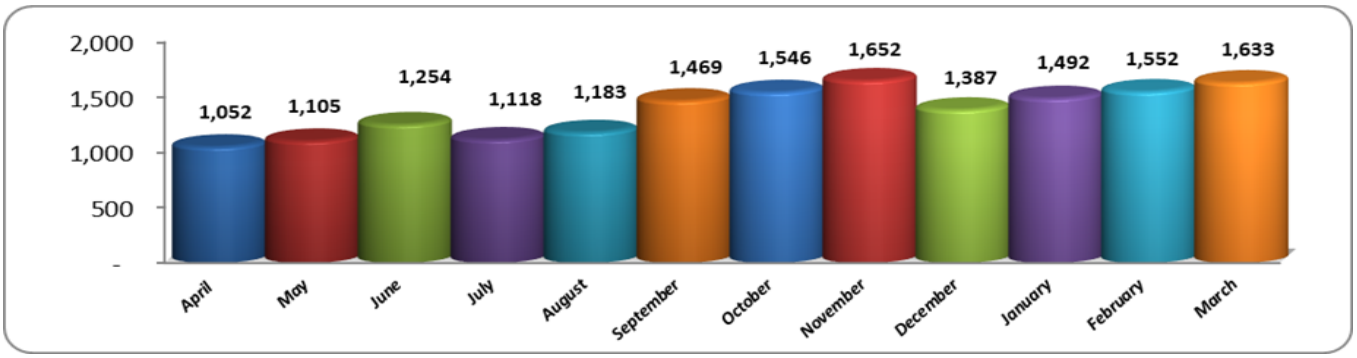


Figure 21: Endoscope Dispatched per Month 2021-22

SSD is working to address increased work load due to post-COVID-19 recovery plans and replacing aging infrastructure.

Local Decontamination

SSD & IPC team are working with rest of the clinical colleagues to improve the local decontamination standards. Addressing variance in documentation (policies, standard operating procedures, risk assessments & training records) is very important to give assurance on patience safety. Fourteen locations are using Trophon devices for trans-vaginal probes. Inadequate decontamination of reusable Lenses in Ophthalmology is in Trust risk register.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board	Agenda item:	14.0
Date of Meeting:	2nd November 2022		

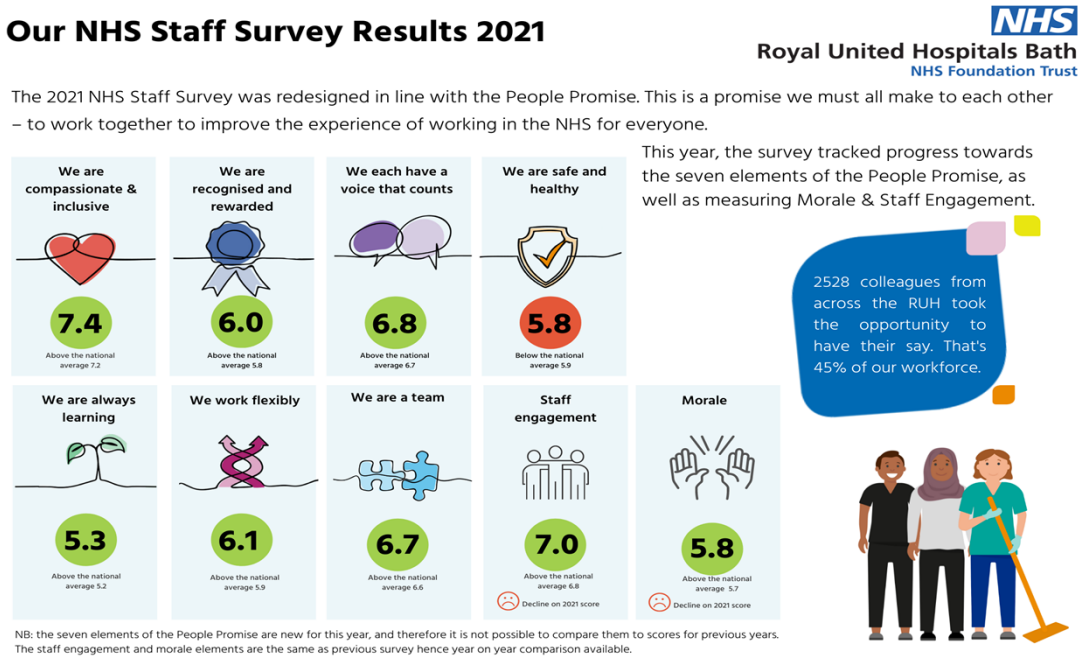
Title of Report:	Staff Survey up-date – 2021 Survey
Status:	
Board Sponsor:	Alfredo Thompson, Director of People and Culture
Author:	Helen Back, Associate Director of Learning and Culture
Appendices	Appendix 1: Deeper Dive reports.

1. Executive Summary of the Report

The NHS Staff Survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. The survey offers us a 'snapshot in time' of how people experience their working lives at the RUH, gathered at the same time each year; the strength of this approach is that it captures a national picture alongside our local detail, so that we can benchmark and share good practice to make improvements.

At present we are working on issues highlighted by the 2021 survey, in parallel with encouraging responses to the 2022 survey, and preparing to refresh our work plans informed by the 2022 Staff Survey results, which we will receive in early 2023.

The 2021 data showed us that the RUH is above average into all areas of the People Promise, with one exception: "**we are safe and healthy**". Whilst these results were not echoed by our results regarding "positive action on health and well-being" (for which we scored above average), the concerns about being safe and healthy did link to our results about adequacy of staffing and resources. These themes have continued to be a concern through results from our 'Making a Difference' quarterly survey.



Our 2021 survey data highlighted:

- **Staffing levels** – by the end of this year, we will have recruited around 232 new nurses to the organisation, many of whom will be from overseas. However, the Making a Difference (quarterly) survey and anecdotal feedback show this isn't how it feels. We are now looking at the impact of annual leave/sickness/turnover and skill mix, using 'A3 thinking' (A3 thinking is a logical and structured approach for problem solving and continuous improvement).

- **Experience of black and ethnic minority colleagues** – our Workforce Race Equality Standard (WRES) Action Plan, is clear about the positive action needed and zero tolerance required to ensure all our staff have equitable opportunity and experience. A full time Head of Equality, Diversity and Inclusion has been appointed to lead this agenda. Our first Equality, Diversity and Inclusion conference was held in October 2022.

- **Quality annual appraisal** – the appraisal process, to include talent management and Health and Well-being conversations is currently being redesigned for launch on our new Learning Management System in 2023/24. The new process in being designed in consultation with colleagues at the RUH, whilst being aware of our current best practice approaches.

We concluded that further work and detail was needed to understand the reasons/root causes, from our colleagues, around the other two themes, please see the included slide set (Appendix 1) for detail around these response and proposed actions.

- Reporting of violence and abuse (200 responses)
- Exhaustion and burnout (750 responses)

Metrics to monitor progression against these key themes are detailed in reporting of the RUH People Plan to the People Committee. As these metrics are annual, this year's data will provide an assessment of progress.

The 2021 Staff Survey data for the RUH was received late this year (because of issues with the supplier), which caused some delays and prompting a move to different supplier. Local actions are taken at a Divisional level to support teams. This coming year we will obtain data at a more detailed level, allowing us to further understand how people feel with wards and smaller teams.

We are taking many actions this year to promote and increase response rates to the survey launched on 3rd October, Team, including outreach support, increased communications, manager tool kits, sharing weekly data and individual and team prizes for completion rates.

To date this approach is seeing benefits with a response rate of 28% to-date, which sits above the national average. This response rate was accurate at time of writing, a more accurate position will be shared verbally at the Board meeting.

2.	Recommendations (Note, Approve, Discuss)

The Board is asked to NOTE actions taken, as detailed within the attached slide set and to encourage support from colleagues across the RUH to make actions happen.

The Board is asked to NOTE that huge effort is being put into promoting the 2022 Staff Survey.

The Board is asked to DISCUSS the concerns about 'reporting of violence and abuse' and 'exhaustion and burnout' as these issues will require cross-organisational action.

3.	Legal / Regulatory Implications

Health and Safety at Work Act
This Act places a legal duty on employers to ensure, so far as reasonably practicable, the health, safety, and welfare of employees, and to ensure that employees and others are kept safe; our detailed work around violence and aggression will address this legal requirement.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

The issues identified in the NHS Staff Survey 2021 are represented in the Board Assurance Framework (BAF), "Strategic Priority 2: Be an outstanding place to work where staff can flourish".

Risks regarding whether there are enough people at the RUH to deliver our services may lead to increased experiences of incivility, discrimination, burnout, higher agency spend and poor patient outcomes.

5.	Resources Implications (Financial / staffing)

Additional funding has already been aligned to nursing staffing and to recruit to a Head of ED&I.

A new Learning Management System, which will support the new appraisal processes has been funded from within budget.

There will be implications around rest rooms and other suggested actions; these are currently being quantified.

6.	Equality and Diversity

One of the key themes identified was around the metrics for our black and minority ethnic colleagues; the actions detailed in this report support positive action to reduce inequality. There is a focused effort this year, to increase response rate and diversity of response rate to the NHS Staff Survey, to ensure that responses are representative.

7.	References to previous reports/Next steps

Report and slides, previous versions shared at People Committee – October 2022

8.	Freedom of Information
Public	

9.	Sustainability
No impact identified on carbon sustainability.	

10.	Digital
This report references the use of IT systems including Datix and the Learning Management System. Further work is required to understand the digital implications.	

Royal United Hospitals Bath
NHS Foundation Trust

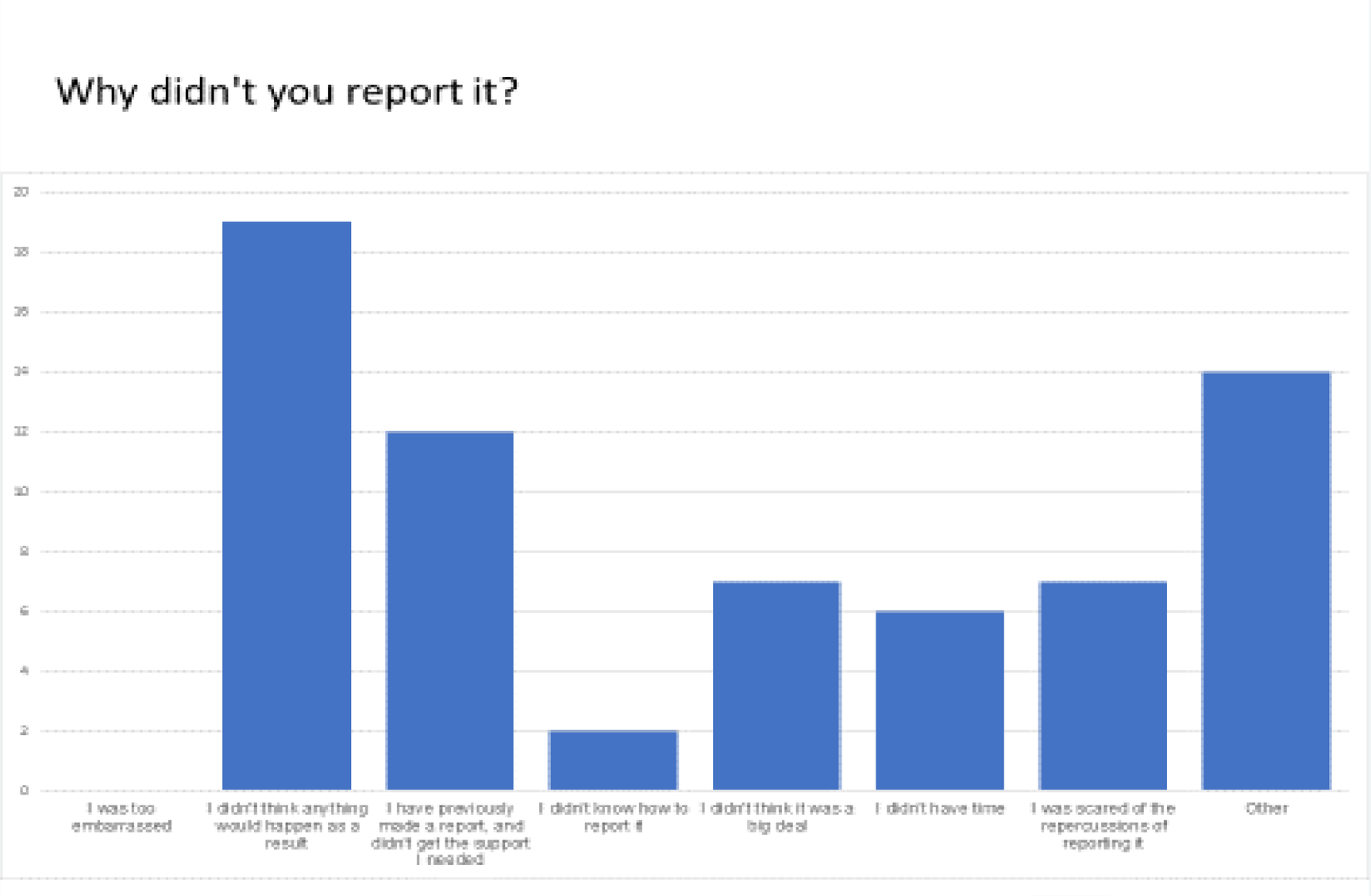
Staff Survey 2021

Deeper dives:

- Under-reporting of violence and aggression
- Burnout and exhaustion

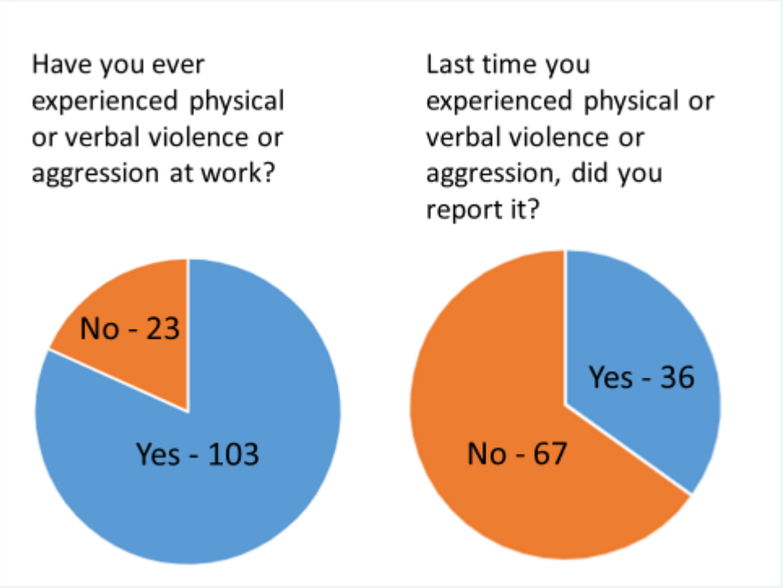
The RUH, where you matter

Violence and abuse – survey about reporting



"Patient had dementia and or delirium there was an organic reason for it."

"it is quite common to experience verbal abuse in the role I work in so don't always think to report it unless it is extreme"

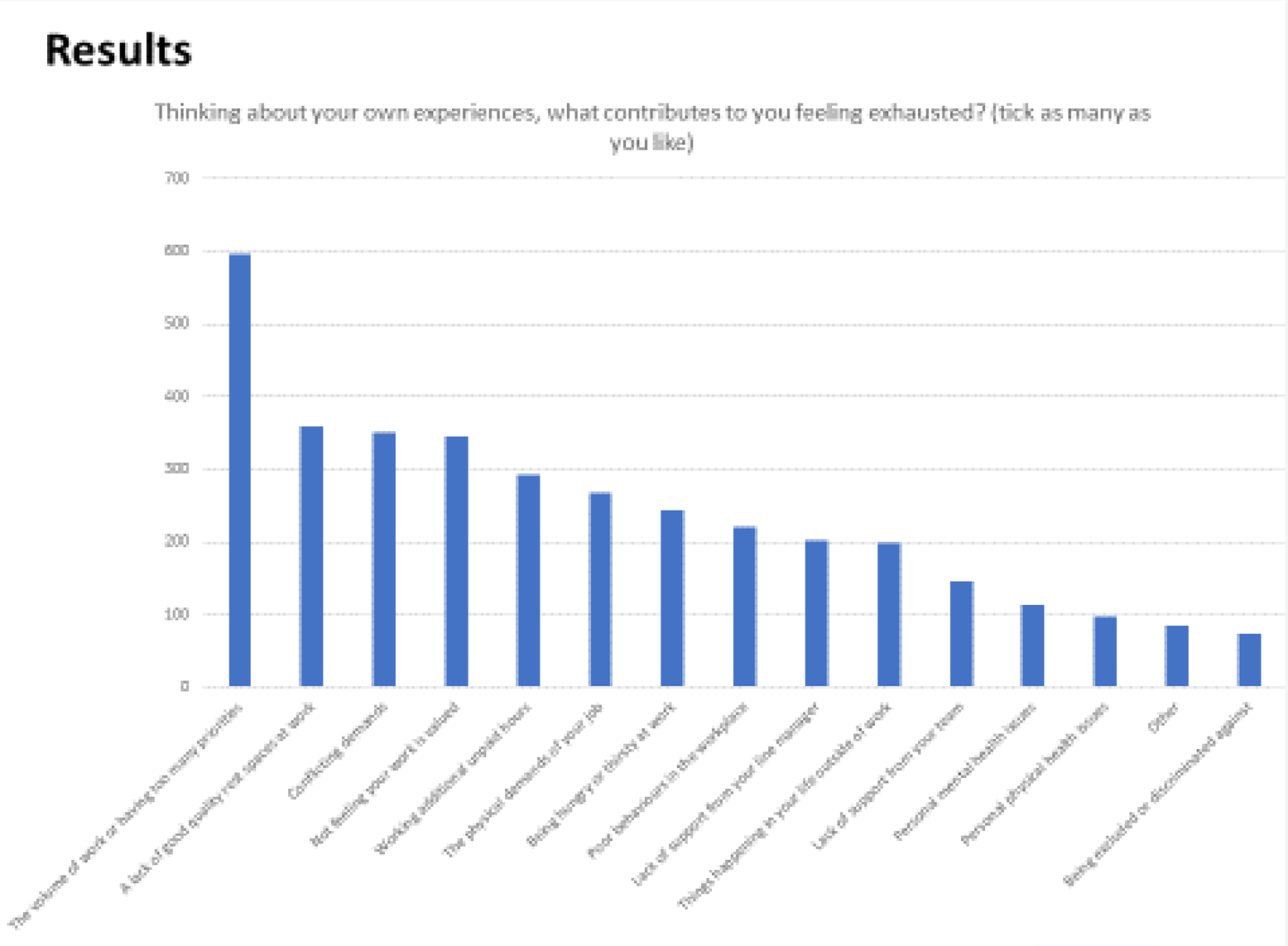


We are **safe** and **healthy**

Our responses:

- Working group to tackle incidents of violence, including security team (for example, ‘zero tolerance’. Body-cams).
- Risk and Assurance team reviewing the current Datix to support all levels of staff with managing incidents in a more effective way.
- Dashboard under development to enable access to consistent real-time data for thematic review of incidents.
- Discussions with dementia leads - how to support staff.

Burnout and exhaustion – survey about root causes



Top five causes of burnout cited by people at the RUH:

1. *Volume of work, too many priorities.*
2. *A lack of rest spaces.*
3. *Conflicting demands.*
4. *I am not valued.*
5. *Additional unpaid hours.*

We are **safe** and **healthy**

Our responses

- Support from ‘Health and Well-being Facilitators:
  - Education around signs of pressure/stress/burnout
  - Mental Health First aid training
  - Health and well-being conversations
- Food / drink options
  - Including overnight food
  - Meal deal options
  - Water stations in all areas
- Rest spaces
  - We have assessed and are improving rest environments.
  - Education Centre have offered cleaning team option to create rest spaces.
- Listening events, centred around our vision ‘You matter’
  - Practical steps to ensure we can support staff.
  - Ensuring we take steps to ensure colleagues know they are valued.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	15.0
Date of Meeting:	2 November 2022		

Title of Report:	Health & Safety Annual Report
Status:	For discussion
Board Sponsor:	Brian Johnson, Director of Estates and Facilities
Author:	Corrina Sheridan, Health and Safety Manager
Appendices	App 1. Annual Health and Safety Report 2021/2022 (attached)

1. Executive Summary of the Report

This is the Annual Health and Safety management report that covers the reporting period from 1st April 2021 to 31st March 2022.

The intention of the report is to outline the Trust's approach to Health and Safety Management, provide information and data to assess the RUH performance with regard to Health and Safety matters and provide a summary of additional key activities carried out during the year.

The report states that the Trust continue to actively manage and address risks however the Covid Pandemic continues to have a significant impact resulting in decreased health and Safety auditing and mandatory training compliance

However, it is believed that compliance levels will increase in the future as restrictions are lifted enabling increased access to clinical areas and larger class sizes for training.

The Health & Safety committee and associated subgroups are performing well, with good levels of governance and risk management practices being applied. The Health and Safety committee have oversight of a number of risks these risks are managed using datix and where possible and appropriate responsibility is devolved to the most appropriate subgroup where the detailed actions and plan can be discussed in greater levels of detail.

2. Recommendations (Note, Approve, Discuss)

The report does not make any recommendations - It is requested that BoD note the contents of the report and the verbal update provided.

3. Legal / Regulatory Implications

Health and Safety at Work Act 1974
Health and Social Care Act 2008
Workplace (Health, Safety and Welfare Regulations) 1992
CQC regulations 2009
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)
The Health and Safety Committee has oversight of various risks. These risks are captured on the RUH risk register (datix) and are managed by the most appropriate subgroups. Each risk has a named lead and an associated action plan with timeframes.	

5.	Resources Implications (Financial/staffing)
As outlined in risk 2159, the budget made available due to the Covid Pandemic is being used to support the delivery of the FFT testing service. There will potentially be a shortfall in resources when this budget is withdrawn. This is being managed through the Datix risk management process and subsequent action plan.	

6.	Equality and Diversity
No issue identified	

7.	References to previous reports/Next steps
This report has been to the Non-Clinical Governance Committee.	

8.	Freedom of Information
Public	

9.	Sustainability
N/A	

10.	Digital
N/A	

Royal United Hospitals Bath
NHS Foundation Trust

Annual Health and Safety Report 2021-22

Reference Number:	
Author & Title:	Corrina Sheridan, Health and Safety Manager Matt Taylor, Interim Head of Estates
Sponsor:	Brian Johnson, Director of Estates & Facilities
Action required:	For Information

Index:

Annual Health and Safety Report 2021-22 ____ *3*

1. Executive Summary ____ **3**

2. Introduction and Background ____ **4**

2.1. Introduction ____ 4
2.2. Management Responsibilities ____ 4
2.3. Governance Structure ____ 5

3. Performance during 2021-22 ____ **6**

3.1. Health and Safety Incident Reporting ____ 6
3.2. RIDDOR Reporting ____ 7
3.3. Health and Safety Training ____ 9
3.4. Moving and Handling Training ____ 10
3.5. Health & Wellbeing ____ 10
3.6. Water Safety ____ 10
3.7. Asbestos ____ 11
3.8. Fire Safety ____ 12
3.9. Safe Use of Bed Rails and Profiling Beds ____ 13
3.10. Site Development Program ____ 13
3.11. Medical Gas Committee ____ 14
3.12. Decontamination Committee ____ 15
3.13. Radiation Committee ____ 16

4. Summary of Additional Activities Undertaken During 2021-22 ____ **19**

4.1. Risk Assessment Dashboard ____ 19
4.2. HSE Improvement Notice ____ 21
4.3. First Aid Arrangements ____ 21
4.4. Delivery of IOSH Managing Safely ____ 22
4.5. Face Fit testing ____ 22
4.6. Mass vaccination Centre (Bath race course) ____ 22
4.7. Health & Safety Service Delivery ____ 23
4.8. IOSH Peer Reviews ____ 24

5. Conclusion ____ **24**

Annual Health and Safety Report 2021-22

1. Executive Summary

This annual report has been prepared to inform the Board of Directors (BoD) of the health and safety management activities that occurred from 1st April 2021 to 31st March 2022. These activities are based upon the Trust management responsibilities and governance defined herein and aligned with the Health and Safety Executive (HSE) key health and safety issues relating to healthcare provision. The Trust approach and framework are intended to give visibility and assurance that the Trust has measures in place to limit the impact of health and safety issues on patients, employees and members of the public.

The Health and Safety Committee and its subcommittees are generally well-attended. They review the risk areas and actions, develop mitigation plans and monitor progress.

Throughout the year, we have seen a decrease in the total number of incidents reported, 531 this year compared to 706 in the previous year. Reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR) reportable incidents have decreased from 232 to 26 compared with last year.
Both of these decreases are related to reducing ill health-related incidents of staff affected by work acquired Covid 19.

All subject areas illustrate a decline in all areas of compliance in the year for Trust staff completing training.
Moving and handling (level 2), a face-to-face training session has increased to 10 per session per pre-Covid. This is the maximum number that can be trained safely by one trainer. Unfortunately, there are regular non-attendances to the training sessions, possibly due to sickness or staff not being released from clinical duties.

The Trust risk assessment matrix contains approx. One hundred forty departments with a core of 11 risk assessments. The number of risk assessments that each department must have depends on what was identified as being needed in the health & safety risk identification checklist, which all departments have completed. Some departments required all 11 and even some additional assessments for the unique hazards present in the department, whilst some only needed one or two.

The planned approach of starting a three-year rolling programme of health and safety audits from 01/04/20 is continuing with a focus on clinical areas in the first instance as Covid restrictions reduce.

All actions within the HSE Improvement Notice have been completed to comply with the requirements of the Improvement notice. All Covid related issues are now being led by Public Health as the HSE is no longer involved with matters relating to Covid 19.

The Health and Safety team continue to run the Fit testing service with no extra resource, which has impacted health and safety service provision when public health requirements to test additional staff have to be met at short notice. Currently, extra hours provided by our volunteers are paid for using the Covid cost code. When this funding stops, there is no money available in the health and safety budget to cover this extra cost.

Estates & Facilities have been using Datix for the central management of risks for over a year. The process is embedded into each sub-groups and safety committee and is reviewed at least quarterly. Most E&F risks are typically building/engineering, which relates to the high backlog maintenance figure of ~£57m. A summary of each safety committee that reports to the H&S committee are contained within the report.

2. Introduction and Background

2.1. Introduction

This annual health and safety report has been compiled to follow the format and style of previous annual reports. The data and content have been prepared with input from the Director of Estates & Facilities, the Interim Head of Estates, the Health and Safety Manager and the Health and Safety team.

2.2. Management Responsibilities

This annual report covers the period from 1st April 2021 to 31st March 2022. The report's purpose is to provide key information regarding the Trust's health and safety arrangements to protect its employees, patients, contractors and public members.

The Trust's health and safety framework is based on the 1997 Health and Safety Executive publication titled 'Successful health and safety management (HSG 65) which follows the plan, do, check, act approach.

The Health and Safety Executive (HSE) set out key health and safety issues relating to healthcare provision, and the Trust has measures in place to limit the impact of these on patients, employees and members of the public.

From the HSE guidance, *health* topics include:-

- Ergonomics and working environment (including DSE)
- Health and wellbeing
- Water safety
- Asbestos
- Stress management

From the HSE guidance, *safety* topics include:-

- Slips and trips and falls
- Violence and aggression
- Lone Working
- Moving and handling
- Safe use of Bed rails and profiling beds
- Fire Safety
- H&S audit Program
- Site development program

The Trust adopts the HSE guidance and uses the topics as a framework to structure the regular and annual reporting, providing transparency and assurance of the Trust's health and safety activities.

Responsibility for health & safety in the Trust rests with the Board of Directors, specifically with the Director of Estates and Facilities. Trust responsibilities are managed through the Health & Safety Committee (HSC) and the Trust Health and Safety Policy.

Staff at all levels throughout the Trust have devolved responsibilities for health & safety, and the Trust has a risk management framework to measure and manage health and safety responsibilities.

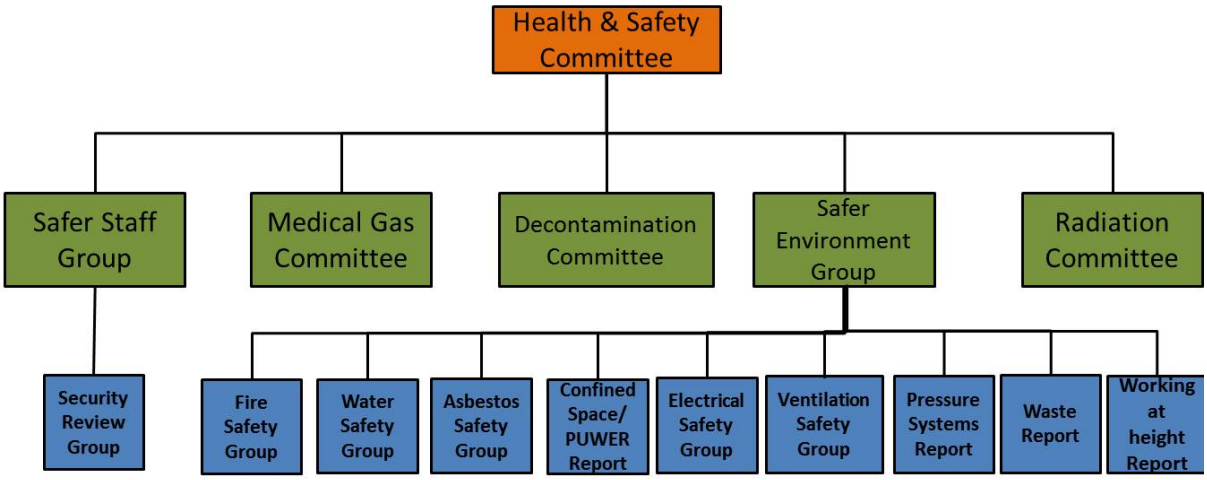
2.3. Governance Structure

The Director of Estates & Facilities chairs the organisation's Health and Safety Committee (HSC), with representation from both the staff side and management across a wide range of departments; the committee meets quarterly.

The HSC upwardly reports to the Non-Clinical Governance Committee (NCGC), which reviews the minutes of the quarterly meetings.

Two key subgroups (Safer Staff Group and Safer Environment Group) collect and review quarterly reports from all specialist meetings. The sub-groups to the HSC are assigned with the operational assurance of specific areas or aspects, as demonstrated by the structure diagram below. Each sub-group is chaired by a relevant expert, has representation from the staff side and management and meets quarterly.

Health & Safety Committee Structure



3. Performance during 2021-22

3.1. Health and Safety Incident Reporting

The table below shows the breakdown of reported incidents from 2016-17 to 2021-22; these are the risk categories and data drawn from Datix.

Category	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Trend
Environment/H&S non-clinical	135	148	158	113	57	85	↑
Fire	62	69	65	86	72	70	↓
Ill Health	13	28	27	11	260	118	↓
Personal Accident/accidental injury	420	389	385	364	315	258	↓
Vehicle	23	13	28	18	2	0	↓
Total	653	647	663	590	**706**	**531**	↓

The table documents the total number of Health & Safety incidents reported with positive improvements in fire, personal accidents, ill health and vehicle-related

incidents. The significant decrease in ill health incidents is related to the reduction of staff Covid related illness that was prevalent in 2020. The increase in the environment and H & S non-clinical incidents could be related to more on-site staff as more services return to 'business as usual.

Fire:

The below table summarises the Trust's compliance with mandatory fire training.

Since April 2021, mandatory training compliance has reduced from 82% to 75.5%. The most significant contributor to this is the bank, with 444 staff requiring training. The Trust would need 961 staff to be trained to reach their target compliance of 90%.

Compliance levels are monitored and discussed at the quarterly Fire Safety Committee, where representatives from clinical divisions attend.

With the support of the Authorising Engineer, the Trust Fire Safety Advisor is reviewing the training needs analysis for fire and will share their proposal with the fire safety committee for sign-off. Fully aligning with best practices will likely reduce training for non-clinical staff (three yearly), although training for clinical staff will remain the same (annual).

		Compliance	Eligible Staff	Training Requirement Met	Training Required
	⊞	90%			
Trust Compliance Level	▲	**75.5%**	6635	5011	1624
427 Bank	▲	53.2%	949	505	444
427 Capital Summary	◆	83.3%	18	15	3
427 Charity Summary	◆	88.2%	17	15	2
427 Corporate Division	▲	76.1%	539	410	129
427 Facilities Division	◆	85.1%	469	399	70
427 Family and Specialist	▲	76.6%	1007	771	236
427 Medical Division	◆	81.1%	2062	1673	389
427 Non-Paid & Recharge	▲	31.8%	22	7	15
427 Research &	◆	81.2%	69	56	13
427 Royal United Hospitals	▲	0.0%	1		1
427 Surgical Division	▲	78.0%	1427	1113	314
427 West of England	◆	85.5%	55	47	8

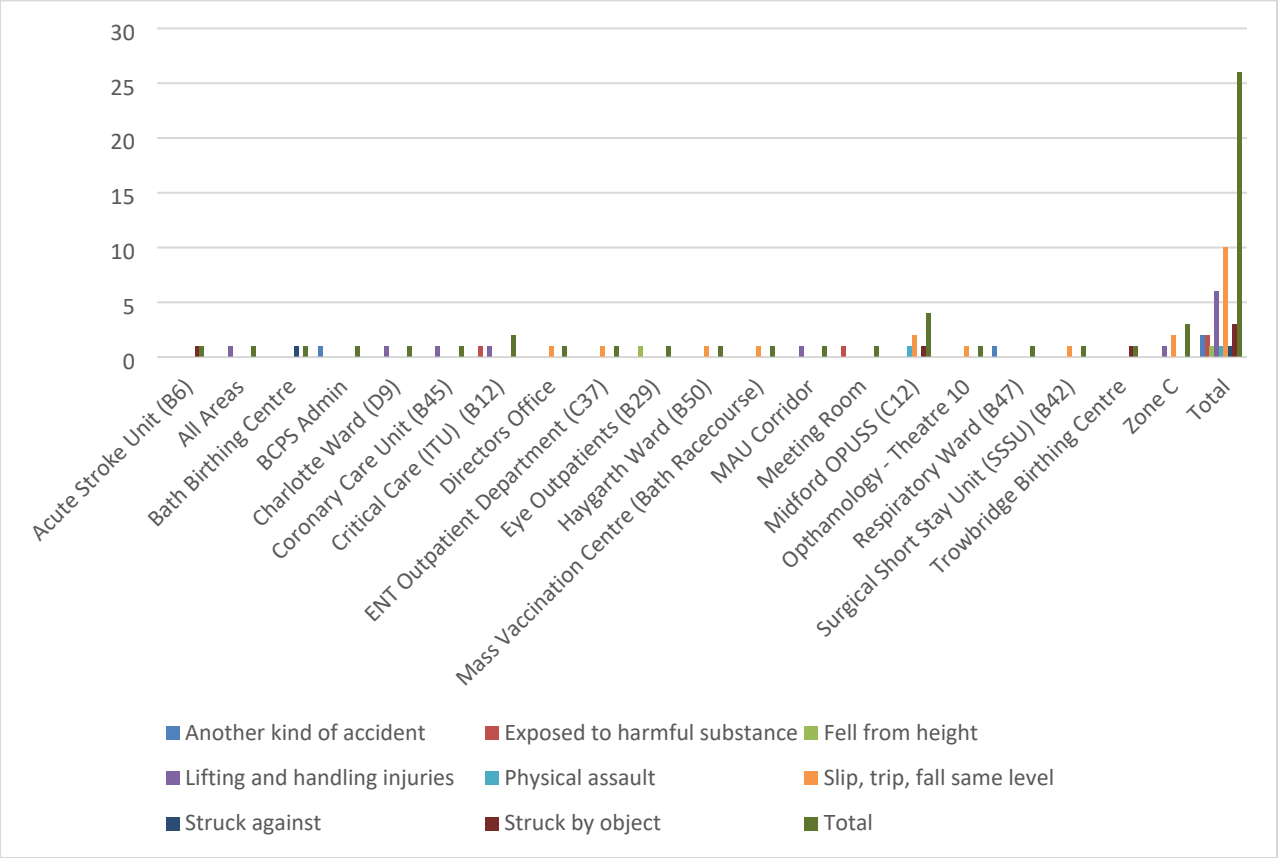
Report as at: 05/04/2022 06:30:03 run by MIS\Matt.Taylor

3.2. RIDDOR Reporting

There were 26 RIDDOR reported from 1st April 2021 to 31st March 2022, as shown in the table below. This decreases by 206 from the 232 incidents reported in 2021-22.

This is due to the reduced exposure to substances hazardous to health biological hazards category previously reported from the Covid outbreaks within clinical areas.

2021-22 RIDDOR Category	Estates & Facilities	Medical Division	Surgical Division	FASS (formerly Women & Children)	Corporate	Total
Exposure to a substance hazardous to health- Biological	1			1		2
Lifting & Handling injuries		3	1	2		6
Physical Assault		1				1
Slip, trip, fall (same level)	2	2	4	1	1	10
Struck against				1		1
Struck by object	1	1		1		3
Fell from height	1					1
Another kind of accident		1	1			2
Total	**5**	**8**	**6**	**6**		**26**



3.3. Health and Safety Training

Health and safety training relates to the areas shown in the table below. The training compliance figures and annual trajectory for the reporting year are shown.

Subject	2017-18	2018-19	2019-20	2020-21	2021-22	Trend	Target
Conflict Resolution Training	79.5%	81.5%	86.7%	**89.1%**	87.4%	↓	90%
H & S	90.1%	89.4%	90.0%	**87.8%**	84.7%	↓	90%
Moving and Handling (Level 1)-Loads	89.4%	90.7%	91.3%	**88.8%**	85.6%	↓	90%
Moving and Handling (Level 2)-Patients	78.5%	78.6%	93.9%	**76.4**	71.1%	↓	90%

All subject areas illustrate a decline in all areas of compliance in the year for Trust staff completing training.
Moving and handling (level 2), which is a face-to-face training session, has increased numbers to 10 per session as per pre-Covid. This is the maximum number that can be trained safely by one trainer. Unfortunately, there are regular non-attendances to the training sessions, which could be due to sickness or staff not being released from clinical duties.

Target compliance figures above are determined by the Education team, with input from the Health and Safety team.

The divisional speciality managers have been sent the health and safety training information separately so that they can see at a glance which areas need to be encouraged to carry out training urgently.

Ergonomics and Working Environment, Including DSE

The Trust is required to undertake risk assessments for ergonomics and the working environment, and this is achieved via the Trust template assessment for display screen equipment (DSE). The responsibility for preparing a DSE assessment sits with individual employees, and line managers are responsible for ensuring these are produced, and mitigations implemented that may arise from the assessments. DSE assessments need to be undertaken by staff and reviewed/updated where any

changes to ergonomics or working environment change (i.e. staff member moves, new desk or equipment etc.).

In order to assist with the process of undertaking DSE assessments across the Trust, the Health and Safety Advisor, who is the subject matter expert, has worked with the IT department to streamline the ordering process for specialist DSE equipment to reduce waiting time and keep staff in work.

42 DSE assessments have been supported by the Health and Safety team this year which in some cases has had to be completed via teams meeting or staff members sending photographs of the home workstation.

3.4. Moving and Handling Training

The Health and Safety team has a resource of a Health & Safety Advisor who is competent to provide moving and handling training across the Trust.
Within this year, 38 new Department trainers have completed and passed the train the trainer course provided by the Health and Safety Advisor, and 17 Department trainers have had their refresher training. This allows those 55 Department trainers to give clinical staff within their area a moving and handling update as required. This gives the Trust a total of 115 date department trainers, with only five areas currently without an allocated staff member. The Health and Safety Advisor continues to update these areas when required, along with giving specific advice or support to patients and staff on wards when required. All of the above is totally dependent on the Health & Safety Advisor being on-site; any sickness or annual leave leaves the Trust without a competent person.

3.5. Health & Wellbeing

The Health and Safety Manager is an active member of the Trust Health and Wellbeing group. As part of this work stream, areas of risk or concern relating to sickness levels and RIDDOR reports are being supported with guidance to prepare suitable risk assessments, implementation (by divisions) of suitable documentation and – where necessary – bespoke training from the Health and Safety team, to reduce and manage risks appropriately.

The Health and Safety Manager is continuing to support individuals and teams with stress risk assessments.

The Health and Safety team work in partnership with Occupational Health to carry out more complex workstation assessments, which have enabled staff to stay at work.

The Health and Safety team are working with the Employee Assistance Programme Manager to support required actions to comply with the NHS England health and wellbeing framework.

3.6. Water Safety

All controlled documents associated with water safety remain in date, with a review of the water safety policy being due for renewal in November 2022. The water safety plan is currently under review to reflect minor changes in British Standards.

The Water Safety Group (WSG) continue to meet quarterly with good representation. This includes attendance from external subject matter experts such as the Authorising Engineer (Water) and Consultant Microbiologist.

All appointments for Designated Person, Authorised Person(s), and Authoring Engineer remain in date.

All active risks on Datix associated with water safety are reviewed at least quarterly and contain an up-to-date action plan for them to achieve their target score. Since the previous annual report, several high-scoring risks have been closed as they have been sufficiently mitigated. These are:

- High counts of legionella within Radiology – resolved through pipework replacement.
- The resilience of the heat source from the CHP (combined heat and power) plant – automatic changeover valves were installed.

There have been recent challenges with the recording of flushing evidence for little-used outlets. The agreed change of process is to tailor cleaning records so that they, more specifically, evidence flushing took place, which mitigates the need to record flooding evidence separately.

There are no concerns to raise regarding water safety.

3.7. Asbestos

The Control of Asbestos Policy remains in date and is subject to periodic review. The Asbestos Management Plan, which translates the policy into workable standard operating procedures (SOPs), is currently under review following advice from the recently appointed Authorising Engineer.

The Asbestos Safety Committee (ASC) continues to meet quarterly, with key representation from Estates and Capital Projects.

Since the previous annual report, the Trust has appointed an independent Authorising Engineer for asbestos, and they have conducted their initial audit. Their recommended areas of improvement are:

1) **Improve access to the asbestos register.** The asbestos register now resides on the cloud and is accessible to all members of the Estates Department. All Trade staff have a mobile app installed that provides access based on their location. All work orders scheduled within areas known to contain asbestos have a safety notice attached requiring trade staff to confirm they have read and understood the risk register prior to carrying out work.

2) **Inconsistent approach to the identification of asbestos prior to building work.** Asbestos Management Plan has been reviewed to consolidate Trust best practice, and training has been provided to each member of the Capital Projects Team. A member of the Capital Projects Team has also been nominated as an Authorised Person.

3) **Asbestos Management Plan requires review**. Currently under review with support from Authorising Engineer. Will include changes to the process for risk assessment of asbestos-containing materials and recording of asbestos surveys. Target completion of July 2022.

4) **Training records**. A training needs analysis has been carried out to identify additional training needs beyond basic asbestos awareness. This additional training has been provided to Capital Projects, Estates Officers and Senior Estates Officers.

The greatest asbestos risk on site remains the heavily contaminated South Duct beneath the hospital. The duct contains loose asbestos fibres and is considered a ‘controlled space’, requiring a permit to work and dedicated breathing apparatus for entry. This risk is well documented on Datix, although the project to address this during 21/22 was deferred until 22/23 due to the challenging capital position. Existing control measures remain in place.

3.8. Fire Safety

The Fire Safety Policy is in date and subject to annual review through the Fire Safety Committee.

The Fire Safety Committee continue to meet quarterly to discuss all matters of fire safety. Attendance has occasionally been below quorum due to operational pressures on clinical teams, although the progress of actions has been requested outside of committees.

Since the previous annual report, the Trust has appointed a new Authorising Engineer (Fire) to provide external, professional advice for fire safety at the RUH. Their initial audit took place in August 2021 and highlighted the following recommendations:

1) **Recording of Maintenance**. Maintenance of fire safety devices is currently recorded on paper records due to the inadequacies of the Trust's bespoke computer-aided facilities management (CAFM) System. The CAFM system is currently being replaced, and planned maintenance is being set up during 2022. To mitigate this, the Trust is using its specialist contractor to carry out 'one-off' maintenance of all devices to bring the system into compliance.

2) **Fire Risk Assessments**. The Trust Fire Risk Assessments were significantly out of date, and their replacements did not follow the requirements of best practice. The Trust has employed Oakleaf Ltd. to conduct fire risk assessments of all clinical areas. This action will be closed by the summer of 2022.

3) **Fire Training**. The Authoring Engineer suggested in some cases, staff were over-trained, and in other areas, they were under-trained depending on the responsibilities placed on them in the fire safety policy. A training needs analysis for fire is currently being developed. Training has already begun for areas of under-training, leading to enhanced training for trade staff on compartmentation, fire doors and fire dampers.

The Trust has continued to invest capital into fire safety risks. This has led to the replacement of fire doors, obsolete fire devices and repairs to fire compartmentation. Fire compartmentation remedials remain on the Trust capital program, with an intended £300k dedicated to addressing remaining high and medium risks.

3.9. Safe Use of Bed Rails and Profiling Beds

All beds have been replaced Trust wide and comply with Gov.UK guidance. Bed rails: management and safe use, which specifies the requirements for safe use.

There have been no reported incidents in 2020-21.

3.10. Site Development Program

During FY21/22, the Capital Projects Team delivered £22.1 of investment across 53 projects. Some of the most significant projects are listed below:

- Cancer Centre (ongoing)
- ED - Paediatric Upgrade
- Haygarth Ward Upgrade
- Helena Kitchen
- Breast Unit Expansion (Trust & charity funded)
- Apley House Reconfiguration
- HIP2 E9 Mezzanine Fit-out
- HIP2 John Apley Demo & Car Park
- ED Same Day Facility Upgrade 20/21
- Modular CT
- Nasal Endoscopy Room
- B36 Ward Expansion & AHU
- Lift Upgrade
- HV Cable Installation
- South Duct Asbestos enabling
- Pathology MES Enabling
- Sulis MRI (& CT enabling)
- Rolling Replacement of plant and assets
- Contribution to Backlog Maintenance
- Manor House Remedial Works
- Emergency lighting
- Fire Compartmentation
- Diabetes & Endocrinology Roof
- Theatre UPS
- Endoscopy Compartmentation
- Theatre Vacuum plant
- West Duct Lighting
- Nurse Call Upgrade Phase 2
- Atrium Smoke extract system

The Capital Project team continues to undertake individual risk identification for each capital project via a risk matrix; these are compiled at the outset of projects and reviewed on a regular basis.

Capital projects and their risks are reviewed at project boards and upwardly reported to the redevelopment board. Risks generally sit separately from the Trust Datix recording system unless a specific risk or issue requires escalation.

The Health and Safety team supports capital projects with ad hoc visits to areas of construction on the Trust site to ensure safe working practices are being employed by all involved.

3.11. Medical Gas Committee

The Medical Gas policy is in date and subject to annual review through the Medical Gas Committee.

The Medical Gas Committee (MGC) continues to meet quarterly, with key representation from Estates, Capital Projects, MEMS, Portering, Pharmacy and Clinical Divisions.

The management and provision of piped oxygen continue to be a focus of NHSE, although there are no local concerns for oxygen resilience at RUH. Maintenance continues to take place as required, and the business continuity plan is regularly exercised during periods of peak demand.

Unfortunately, minimal progress has been made in addressing the provision of designated nursing officer (DNO) training for the senior nursing team due to the impact of covid. A valid risk assessment remains in place with mitigation, although progress is no longer in line with the prescribed action plan.

Progress is now being led by the Trust Head of Estates and recently appointed Associate Chief Nurse.

There are no other concerns to raise.

3.12. Decontamination Committee

The Trust Decontamination Policy is in date and subject to annual review through the Decontamination Committee.

The Decontamination Committee continues to meet quarterly, with key representation from Estates, Sterile Services Department, Microbiology, Capital Projects, and the Surgery Division.

Both the production and quality reports received from the SSD team are well presented, with no issues and within the past 12 months. The SSD team have retained their ISO 13485:2016 accreditation for quality management. The engineering reports have been updated to include sections on plant availability and downtime to ensure the risks of over-utilisation to support clinical demand are well managed and understood.

All appointments of the Designated Person, Authorised Person and Authorising Engineer remain in date. The Trust is currently re-tendering the provision of Authorising Engineer as the contract is approaching expiry, although this is unlikely to present any challenges.

Two key risks have been closed since the previous annual report. These are the decontamination of the TOE probe and issues with service lifts.

The greatest risk continues to be the decontamination of instruments used in community settings. The Decontamination Committee is sufficiently assured instruments are being decontaminated correctly and that the risk to patients is low; however, the traceability and evidence of decontamination require improvement. There is an action plan and audit schedule in place led by the Trust Decontamination Lead. This risk is being monitored quarterly, with regular updates being provided at the decontamination committee and monthly at the trust infection prevention and control committee.

There are no other concerns to raise.

3.13. Radiation Committee

The Radiation Protection Committee (RPC) last met on 6th April 2022.

External Inspections/Reports

- The RUH was inspected by the 'Office for Nuclear Regulation (ONR) on 16th March 2022. The ONR inspection was concerned with the transport of radioactive material. The hospital was found to be in keeping with the legislation. A copy of the ONR report has been sent to the Trust Secretary.
- The annual report to the Environment Agency regarding the inventory of radioactive waste was submitted in February as required by the hospital's EPR permit – the hospital remains within its permit limits.

Internal Reports

Audits:

- Audits of IRR17 compliance are due shortly.
- The Radiopharmacy is currently underway.

Doses

Staff Doses:

- A programme for measuring staff radiation doses is in place. Since the last report, Radiopharmacy staff that prepare the radiopharmaceuticals have been designated as classified workers.
- Higher doses were noted for some Radiopharmacy staff shortly after the service opened, but with further experience, these are now coming down.

Patient Doses:

- Patient dose audit and Optimisation have been undertaken for the period, and recommendations have been made.
- New 'Local Diagnostic Reference Levels' for a number of procedures were ratified by the Medical Exposures Committee (part of the RPC).

Environmental monitoring:

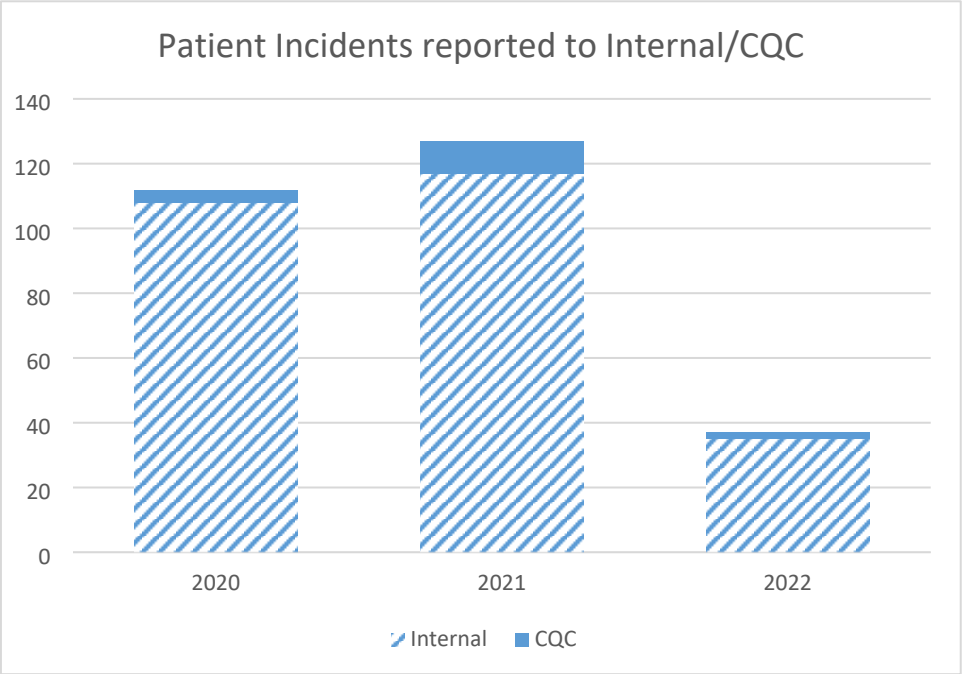
- Environmental dose monitoring has been carried out; most results were satisfactory, but some areas are having the measurement repeated to check the results.
- Radon measurements have been made in all areas that were due for assessment. The Radon detectors have been returned, and the results are now awaited from Public Health England.

Equipment & Developments

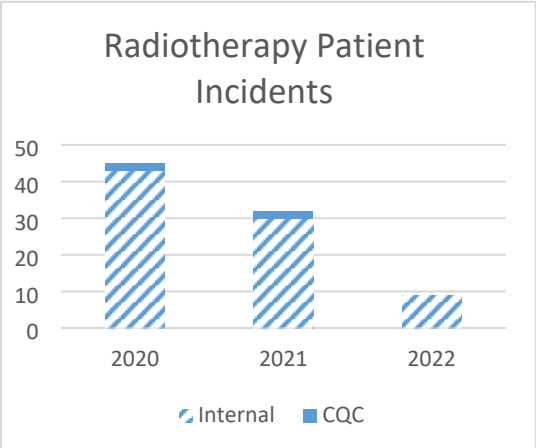
- The on-site Radiopharmacy opened in January 2022. Appropriate legal consent was applied for and received from the HSE in December 2021. The HSE will make an inspection of the site later in the year.
- Work on drains which carry radioactive material was briefly mentioned. How best to identify these drains is ongoing and being discussed with Estates. One suggestion was for a 'Permit to Work' notice on the drain cover itself and a trefoil on the inside wall of the drain.
- Ageing X-ray equipment now has its own risk assessments, e.g. Paulton Hospital (installed 1997) and Emergency Department (installed 1998). A formal assessment of the image quality will be undertaken, and the number of rejected images will be checked to confirm that patients are not receiving repeat exposures. The RUH RPA (Laura Martin) has attended planning meetings to assess equipment and building specifications.
- Building works are underway in Radiotherapy to prepare the LA1 bunker for the new linear accelerator. Expected install date August 2022- clinical January 2023. external RPA has been appointed (Helen Coomber)
- CT scanning service for Radiotherapy is now being undertaken in RUH PET (I scan per day) and at Genesis Care, Aztec West Bristol, by RUH staff. There are plans to transfer the work done at Genesis Care to Sulis this summer (until the Dyson Cancer Centre is complete in autumn 2023). It was noted that the Shared Employer radiation protection documentation for these other employers is all in hand.
- 'Insourcing' has been set up for the Breast Unit and the Oral and Maxillofacial Surgery Department. Despite the significant challenges and misunderstanding of what was involved at the beginning to set up the services, they have run well due to RUH staff commitment.
- Dyson Cancer Centre – The RUH RPA has provided advice for the radiotherapy CT scanner, DEXA scanner, and the nuclear medicine department.
- Sulis - CT scanner replacement – the current external RPA is appointed until the end of June, at which point the RUH RPA is expected to take on the role (conditional on an SLA being in place).

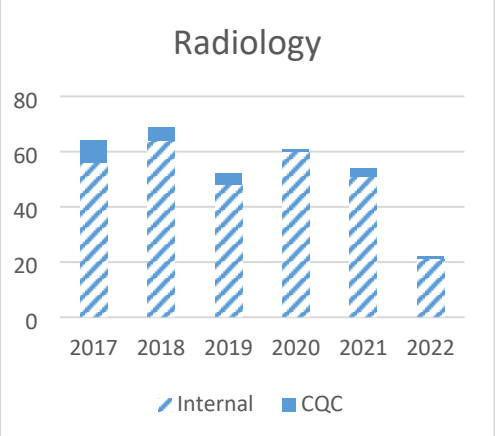
Incidents

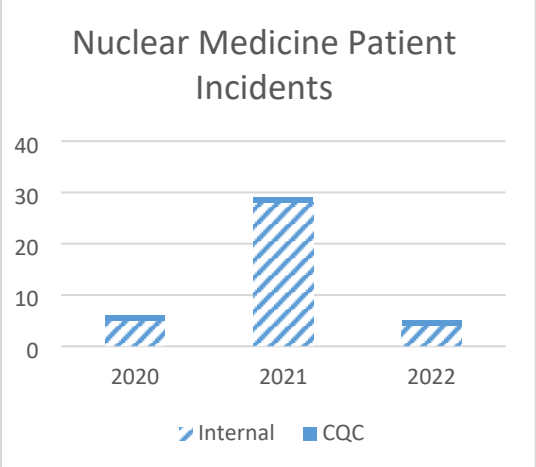
- IR (ME) R incidents – In 2021, there were a total of 119 radiation incidents involving patients; 9 were reported to the CQC and 110 were reported internally. In the first three months of 2022, there have been 19 radiation incidents involving patients; 2 have been reported to the CQC and 17 were reported internally.
- With regards to the 2 CQC reportable incidents, one was a result of the need to repeat a scaphoid x-ray on two patients due to the same cassette being used. The other was caused by the need to repeat 2 GFRs due to an incorrect standard sample.
- Total CQC and Internal IRMER incidents for the whole of 2020 vs Jan-Apr 2021



IRMER incidents (internal and CQC) by department







- IRR incidents (Oct 2021 – March 2022) - there have been 14 incidents in total (12 in PETCT and 2 in CT).
    - There were seven occasions in PETCT where manual draws of activity were necessary and five incidents of recorded contamination. Discussions about contamination incidents in PET have resulted in guidance being provided to staff to prevent further spills.
    - There were two instances where CT doors were opened during a CT warm-up, one in CT3 and the other in CT4. Staff will be reminded to lock doors at the top as well as to use the thumbwheel, whilst new installations will be recommended to have a spring-loaded top bolt.

- The IRMER and IRR data were reviewed, but no trends of concern were found.

Documentation/Legislation

- The Radiation Safety Policy and Radioactive Waste Policy which were previously approved by the H&S Committee, have been published on the intranet.

- Staff making up the kits in Radiopharmacy have been designated as classified workers.
- A review of the risk assessment for the Dental Mobile in theatres has identified the requirement for an outside worker and/or Cooperation of Employers' agreement document to cover GWH employees operating the x-ray unit in the presence of RUH employees.
- A number of Risk Assessments have been written and reviewed:
  - RA is in draft for the LA1 Bunker with the pending installation of Varian TrueBeam.
  - The Radiopharmacy RAs were written in March and September 2021, and the second-person verifications are being finalised.
  - RAs for NM & PETCT have been reviewed.
  - Radiology RAs have all been reviewed apart from four (two of which are works in progress)

4. Summary of Additional Activities Undertaken During 2021-22

4.1. Risk Assessment Dashboard

The Trust risk assessment matrix contains approx. One hundred forty departments with a core of 11 risk assessments. The number of risk assessments that each department is required to have is dependent on what was identified as being needed in the health & safety risk identification checklist, which all departments have completed. Some departments required all 11 and even some additional assessments for the unique hazards present in the department, whilst some only needed one or two.

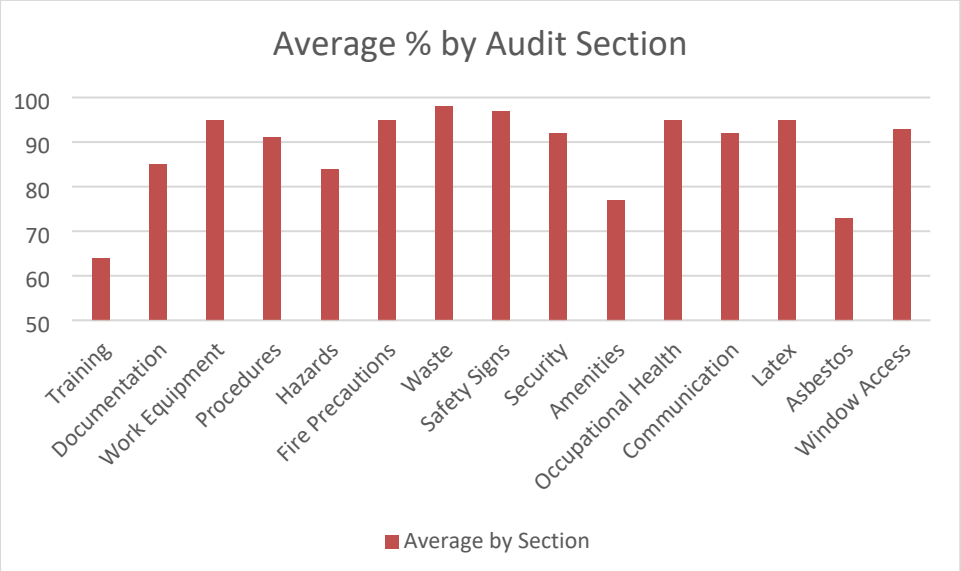
Name of Risk Assessment	Number outstanding	% of completed RA's	Status
H&S Risk Identification checklist completed	0	100%	↔
Slips ,Trips & Falls (STF)	12	92%	↑
Control of substances hazardous to health (COSHH)	7	94%	↔
First aid	17	89%	↑
Manual Handling (non-patient)	20	87%	↑
Bariatric patient management	5	92%	↔
Hoist and sling	3	94%	↔
Interdepartmental transfers	0	100%	↔
Lateral transfer	3	95%	↔
Lead Aprons, the wearing of	3	80%	↔
Standing transfer (Sit to stand transfer)	8	89%	↔
Sharps	6	88%	↔
Total number of Risk Assessments across the trust		**90.73%**	↑

This information is being verified via the health and safety audit process. However, with the audit ongoing, it is now known that many departments across the Trust have not kept up to date with their health and safety documentation, and this has caused the information above to no longer be accurate but is attached for continuity.

All departments have received an Audit self-assessment which is the first step in the audit process. Once completed and returned to the Health and Safety team, the information is then verified along with verifying the department's risk assessments, COSHH controls and general H&S procedures and documentation.

The number of Audit self-assessments currently sent out:	127 out of 132 (or 96%)
The number of Self Assessments returned:	92 (or 72% of those sent out)
The number of audits in progress and undertaking actions under guidance from the H&S team:	51 (or 55% of those returned)
The number of audits where progress has stalled due to lack of response, clinical pressure or management structure changes:	31 (or 24% of departments contacted)
Number of Audits completed:	36 (or 39% of those returned/28% of those audits sent out)

From this information, it is clear that a great many departments across the Trust (69%) are either undertaking actions that arose from the audit, such as generating risk assessments, completing COSHH documentation or similar, or have stalled in the movement for various reasons.



The graph above shows that across the Trust, training levels, staff amenities, documentation knowledge and knowledge of asbestos are lower than desired.

The health and safety team are working with those departments that require assistance to improve these numbers.

4.2. HSE Improvement Notice

All actions within the Improvement Notice have been completed to comply with the requirements of the notice. The Health and Safety team are working closely with the Infection and Prevention Control team to ensure that all relevant control measures are in place in a timely manner, as the HSE are no longer dealing with Covid related issues. These are now being led by Public Health.

4.3. First Aid Arrangements

The Health and Safety (First Aid) Regulations 1981 require employers to provide adequate and appropriate equipment, facilities and personnel to ensure their employees receive immediate attention if they are injured or taken ill at work.

The Health and Safety team has prepared a first aid resource pack, which is available for all departments to use via the intranet. A risk assessment will inform each department what is required to ensure compliance with the above regulations, and this risk assessment forms part of the suite of assessments that are included in the compliance dashboard.

The health and safety checklists highlight the need for divisions or departments to complete the risk assessments. Currently, 89% of the Trust has returned risk assessments to the Health and Safety team for First Aid.

4.4. Delivery of IOSH Managing Safely

All line managers are required to manage health and safety as part of their responsibilities, and all staff have responsibility for working safely and following health and safety arrangements. The Director of Estates and Facilities and the Head of Estates are currently undertaking their IOSH Managing Safely course online due to Covid 19 restrictions.

4.5. Face Fit testing

The Health and Safety team continues to provide the Face Fit testing service with no additional resources. This service will continue to be provided as per health and safety regulations to ensure that all staff that require an FFP3 mask fit test will have access to the service in a timely manner. Ongoing testing will continue to ensure compliance with Trust infection control guidelines and the HSE Guidance on respiratory protective equipment fit testing.

* FFP3 face masks are used to provide protection from viruses, bacteria, and solid or liquid, toxic aerosols. These masks are commonly used by those working in the healthcare industry as personal protective equipment (PPE)

4.6. Mass vaccination Centre (Bath race course)

The Health and Safety team continue to assist with the safe rollout of the vaccination service provided at Bath Racecourse. This involves ad hoc visits to the site, providing the slips, trips and falls risk assessment for the whole site and working with staff and partners to give health and safety advice as required.

There have been 20 reported Datix in relation to the mass vaccination centre. Five of these are slips, trips and falls generally relating to wet weather conditions and external ramps/access egress.

The 1 RIDDOR report from the Mass Vaccination Centre is related to a staff member who slipped on the ramp whilst leaving the marquee.

Four reported incidents are related to sharps which are to be expected when taking into consideration the number of vaccinations carried out over the financial year.

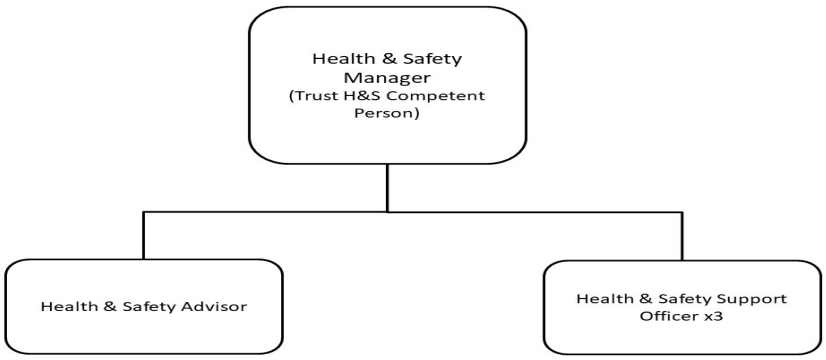
No other trends were identified; the other nine reported incidents are spread across nine different categories.

All Datix incidents are investigated as appropriate

4.7. Health & Safety Service Delivery

The Health and Safety team comprises a Health and Safety Manager, a Health and Safety Advisor and currently, two Health and Safety Support officers. As one

member of the team left the organisation in March 2022, interviews to find a replacement take place in June 2022.



The Health and Safety team continue to run the Fit testing service with no extra resource, which has had an impact on health and safety service provision when public health requirements to test further staff have to be met at short notice. Currently, extra hours provided by our volunteers are paid for using the Covid cost code. When this funding stops, there is no money available in the health and safety budget to cover this extra cost.

The health and safety annual plan sets out key actions which focus the Trust's attention on encouraging strong leadership through active management and collective ownership, and creating healthier, safer workplaces by targeting risk priorities and implementing effective measuring and monitoring systems.

The Health and Safety team is supporting Departments as requested with completing risk assessments. Generic risk assessment templates are available on the health and safety page on the intranet for Departments to amend and use.

Key themes from the annual health and safety action plan:

- Providing strong leadership;
- Actively managing health and safety;
- Promoting and developing a strong health and safety culture across the Trust;
- Monitoring reports of accidents, ill health and near misses;

Risk priorities:

- Moving and handling
- Slips, trips and falls,
- Safer Sharps
- Stress management

4.8. IOSH Peer Reviews

There has been no formal peer review; however, the Health and Safety Manager has a network of health and safety professionals to engage with to enable shared learning to be disseminated. The Health and Safety Manager has been working closely with other Trusts and informally supporting the Health and Safety Advisor at Salisbury Hospital until a permanent Health, and Safety Manager has been appointed there.

5. Conclusion

Note the content of this report as a record of Health and Safety performance for the Trust through 2021-22. The Trust continues to actively manage and address risks, and during the year, the prioritisation due to Covid 19 continued to have a significant impact; continued work is planned through the coming year.

There has been a decrease in health and safety training compliance, possibly due to clinical work pressures for clinical staff and sickness.

The health and safety audit is now underway in areas where access has not been restricted and will continue to gather pace as local restrictions reduce. The outcomes of the health and safety audit action plans will identify any areas of concern and inform the health and safety priorities going forward.

Taking into consideration the extra pressure and time constraints caused by managing the needs of the Fit testing service and the resignation of one member of the team, the Health and Safety work streams Trust-wide are on track as per the annual health and safety plan.

Learning outcomes from the HSE inspection and subsequent improvement action plan will be applied and reviewed on a regular basis to ensure that standards are maintained to comply with Public Health requirements.

The Health & Safety committee and associated subgroups are performing well, with good levels of governance, evidence and compliance across all areas.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	16
Date of Meeting	2 November 2022		

Title of Report:	People Committee Chair's Update Report
Status:	For information
Sponsor:	Sumita Hutchison, Non-Executive Director/Chair of the People Committee
Author:	Catherine Soan, Executive Assistant and Anna Mealings, Non-Executive Director
Appendices	None

Purpose

To update the Board of Directors on the activity of the People Committee held on 10th October 2022.

Background

The People Committee's purpose is to monitor the Trust's activity to achieve its True North goal 'to be an outstanding place to work where staff can flourish', and to provide assurance to the Board that the Trust is discharging its strategic priorities and statutory responsibilities relating to its people and their development. The Committee will also deal with any matters within the people and organisational development agenda as delegated to it by the Board.

Business Undertaken

2021 Staff Survey Update

Last year we heard themes around staffing levels, the experience of black and ethnic minority colleagues, reporting of violence and abuse, exhaustion and burnout and the quality of annual appraisals. In the last 6 months staffing levels have increased, a zero tolerance approach has been taken to racism, appraisals have been redesigned to include talent and health and wellbeing. In addition a Head of Equality, Diversity and Inclusion at band 8 has been appointed. We have observed that physical violence towards our staff from patients and other employees is significantly under reported. A survey was conducted to understand root causes of the unwillingness to report violence and abuse and a perceived inactivity when it is reported, was the highest scoring reason for not reporting it. A working group to look at tackling incidents of violence has been established and the risk and assurance team are supporting staff with managing incidents in a more effective way.

A dashboard is in development to enable Divisional, Specialty and Department teams access consistent real-time data for thematic review of incidents. Discussions with dementia leads on how to support staff was underway. We have also conducted a survey to understand the root cause of burnout and exhaustion. Our people have described the volume of work, lack of rest spaces, conflicting demands, not being valued and additional unpaid hours as contributing factors. In response, we had introduced the provision of overnight food and meal deal options, we have assessed and are improving the environment and the Education Centre have offered the cleaning team space to rest.

The 2022 Staff Survey was launched on 3rd October. Colleagues are given 15 minutes protected time to complete the survey and the OD team will visit areas to assist with this. We are sharing weekly progress updates and offering prizes.

Fusion Network Update

The co-Chair of the Fusion Network, Uzo Ibechukwu presented an update, he highlighted that attendance was an issue and this was consistent across the networks because the time was not protected. The Chair/s were undertaking their roles in their own time and there was a risk of losing them because of this. The Chair and members of this Committee want to highlight to the Board the incongruency of what we say is important (inclusion and diversity) and our actions (relatively small level of investment in this space). We (the Board) are asking people to take on meaningful roles to help us become a place where all our staff can flourish at the same time we expect individuals, such as the Chairs of Fusion Network groups, to do their fulltime roles, which is often more than 40 hours a week – as an example. Are we clear on what role we want the Fusion Networks to play? What does good look like for the RUH? If so, we willing to acknowledge the time this requires?

International Recruitment Update

The Trust had been recruiting international nurses since 2018 and on the date of the meeting, 399 international colleagues had started at the Trust. Covid had presented some challenges with our international recruitment, however, numbers had increased and by the end of the year we will be back on trajectory.
CPD money had been idenfied to pay for Clinical Practice Educators to support our overseas nurses.

The Trust has been recognised nationally with a pastoral care award.

Given that international nurses are a significant and important part of Trust the Committee asked for a further session to get a better understanding of what the experience is like from an international perspective – across the entire employee lifecycle (recruitment, onboarding, development, experience in the broader Bath community).

Digital Talent Programme Update

The Committee noted that the initial phase was complete. Strong foundations had been built with new ways of working to deliver more value with less work, reinvesting into value adding activities. Some of the improvements outlined included:

- Offer letter templates being reduced from 16 to 1
- Digitalisation of offline paper offers
- New digital onboarding
- Inclusive manager recruitment training
- New candidate communications
- Streamlining of the vacancy approval process and improved data collection. Previously, time to hire was an average of 12.5 weeks, it was now 8.4 weeks.

Phase 2 of the programme will run until the end of December and workstreams were progressing. It was acknowledged that this had been a culture change for the organisation and that it was possible we had not invested enough resource into the programme.

Improving Together Update

The Committee received an update on the plan for the next 12 months whereby any staff member, with line management responsibility will be invited to participate in training to develop and strengthen their leadership skills. In parallel, we will be implementing the tools and routines of Improving Together one step at a time across the whole organisation, this means that every ward/department will be part of this programme over the next 12 months.

The Committee receieved a presentation on how Improving Together had been implemented in Urgent Care and the positive impact it had made on a disparate team coming together.

Key Risks and their impact on the Organisation

At the time of the meeting, the Trust had been under significant operational pressure and it was recognised that we are asking staff to do more and that it is hard for people to feel they matter under those circumstances. This had an impact on the health and wellbeing of our colleagues. There was concern that the cultural changes we were putting in place were not being felt across the organisation due to the current pressures.

There was a risk, as described above, that unless Staff Network Chairs are given protected time, they will be unable to continue with the role.

Key Decisions

The Committee approved the new description of People BAF Risk 3 and requested that resilience is incorporated into the new BAF.

Exceptions and Challenges

None identified.

Governance and Other Business

The meeting was convened under its Terms of Reference.

Future Business

The Committee conducted business in accordance with the work plan. The Committee agreed they would like a future report on how we tackle physical harm to staff via a digital solution.

Recommendations

It is recommended that the Board of Directors note this report and discuss the Fusion Network Update.

Report to:	Public Board of Directors	Agenda item:	
Date of Meeting:	2nd November 2022		

Title of Report:	Research and Development Annual Report
Status:	For Information
Board Sponsor:	Richard Graham, Acting Chief Medical Officer
Author:	Kelly Spencer, Head of Research Operations
Appendices	Appendix 1 – RUH staff research publications Appendix 2 – Research Charitable Funds Appendix 3 – Research Staff Survey Results Appendix 4 – Details of research income 21/22

1. Executive Summary of the Report

This report details RUH research activity for the 2021/2022 financial year.

It is well established that patients cared for in a research active environments have better outcomes and our aim year on year is to increase our research portfolio to be able to offer our patients the very best treatments, medicines and services. In line with the CQC well-led inspection domain we are conducting a number of work-streams to improve use of research and research evidence across all Trust services.

This has been a challenging year for research at RUH, reflected nationally and attributed to the capacity and backlog issues facing the whole of the NHS. In spite of this, research led by RUH has continued to grow and partnerships with Universities are stronger than ever, demonstrated the large amount of collaborative work ongoing and planned.

Patient feedback is exceptional with 99% agreeing they were treated with courtesy and respect and 96% feeling valued. Staff have continued to flourish with better than average staff survey results across all seven elements.

The success in delivery of large scale COVID-19 vaccine clinical trials, leading to new booster vaccines and changes in national immunisation policy, is also notable.

2. Recommendations (Note, Approve, Discuss)

The report does not make any recommendations. The Public Board of Directors is asked to note the contents of the report.

3. Legal / Regulatory Implications

Operating according to the UK Policy Framework for Health and Social Care Research. This includes maintaining compliance with relevant UK legislation when conducting research and ensuring all Trust Research Governance processes are aligned to Health Research Authority (HRA) Approval processes.

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

No impact on risk register or BAF.

5.	Resources Implications (Financial / staffing)
All research activity is funded from externally generated research funding. The reduction in overall activity has resulted in a reduction of some of these income streams. Work is ongoing to bring these back to pre-pandemic levels to ensure a break even position and stability of the research workforce.	

6.	Equality and Diversity
The Research and Development (R&D) Department is committed to delivering the objectives of the National Institute for Health Research (NIHR) to continue to increase patient equality in terms of access to clinical trials. The R&D department's long-term vision is to offer research participant opportunities to all Trust patients and to broaden our "offer" to hard to reach and minority groups.	

7.	References to previous reports/Next steps
Not applicable	

8.	Freedom of Information
Public	

9.	Sustainability
Not applicable. No impact on ability to deliver BAF	

10.	Digital
Not applicable.	

Research and Development Annual Report 2021/22

1. Introduction

Clinical research is vital for providing the evidence needed to deliver high quality and cost effective healthcare services, and to improve outcomes for patients both locally and nationally. It is through research that we are able to develop and test new treatments and approaches to healthcare, and better understand existing conditions. Research studies are taking place all the time across our Trust.

The NHS Constitution[1] sets as a principle that 'the NHS aspires to the highest standards of excellence through its commitment to innovation and the promotion, conduct and use of research'. The handbook to the Constitution[2] highlights the importance of innovation and medical research as 'integral to driving improvements in healthcare services for patients'.
NHS England has a duty, through its mandate from the Department of Health, to promote research and the use of research evidence in the NHS. It views innovation and research activity as a core duty for NHS organisations.

The Research and Development Team at RUH are fully committed to developing and supporting research which improves the quality and experience of care for local people, as well as making our contribution to wider health improvements. The national and local response to COVID-19 has showcased the clear link between research and better outcomes for individuals and the NHS.

It is now well established that patients cared for in a research active environment have better outcomes[3] and our aim year on year is to increase our research portfolio to be able to offer our patients the very best treatments, medicines and services. We continue to work with many different organisations national and internationally, to enables our patients to have access to new medicines, devices or treatments as part of a clinical trial.

RUH has a strong track record of undertaking both locally and nationally led research, with around 250 individual research projects open at any given time. RUH staff are named on close to 400 peer reviewed research publications during 21/22 a significant output for a hospital of our size (appendix 1). We have collaborative links with local Universities and work closely with the National Institute for Health Research (NIHR) Clinical Research Network to put in pace the staffing and infrastructure required to give RUH patients the opportunity to participate in research.

2. Overview of research activity for the year

This period saw a steady recovery from the impacts of the COVD pandemic on non-COVID research activity. All studies that had been suspended to allow vital COVID research to be prioritised were either re-opened or abandoned, if deemed to be unfeasible within current patient pathways or staffing structures.

The ability of many studies to re-open or to recruit participants at pre-pandemic levels has been adversely affected by broader capacity issues within the hospital. Departments such as pharmacy, radiology and chemotherapy are unable to give required levels of support to research, due to facing their own backlogs and recovery from COVID impact. Similarly, clinical staff have reduced capacity to undertake the activities associated with research such as supporting identification of eligible participants and conducting follow-up assessments.

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
[2] The handbook to the NHS Constitution, January 2019, NHS England
[3] Recognising research: how research improves patient care | RCP London

Overall recruitment of participants into research was **2737,** with 1760 or **65%** coming from non-COVID related research. This represents a 15% increase on the previous years' figures (see Figure 1), an important achievement in light of the challenges described. This total, however, is boosted by one or two high recruiting observational studies, which between them contributed well over 1000 recruits, therefore masking the difficulties faced with opening and delivery of intervention research.

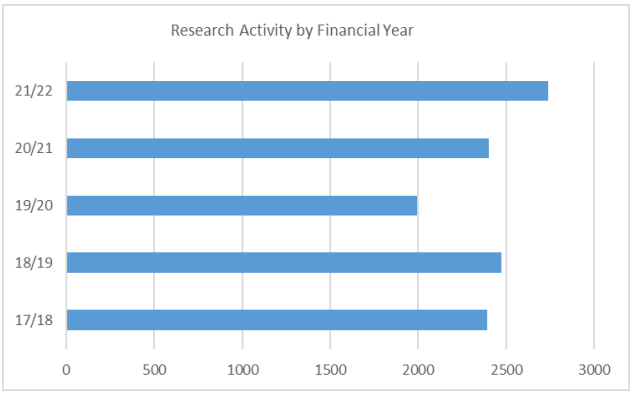


Figure 1. RUH recruitment of participants into research by financial year

As can be seen from regional reports (figure 2), RUH has fallen behind similarly sized acute hospitals in the region for overall recruitment performance.

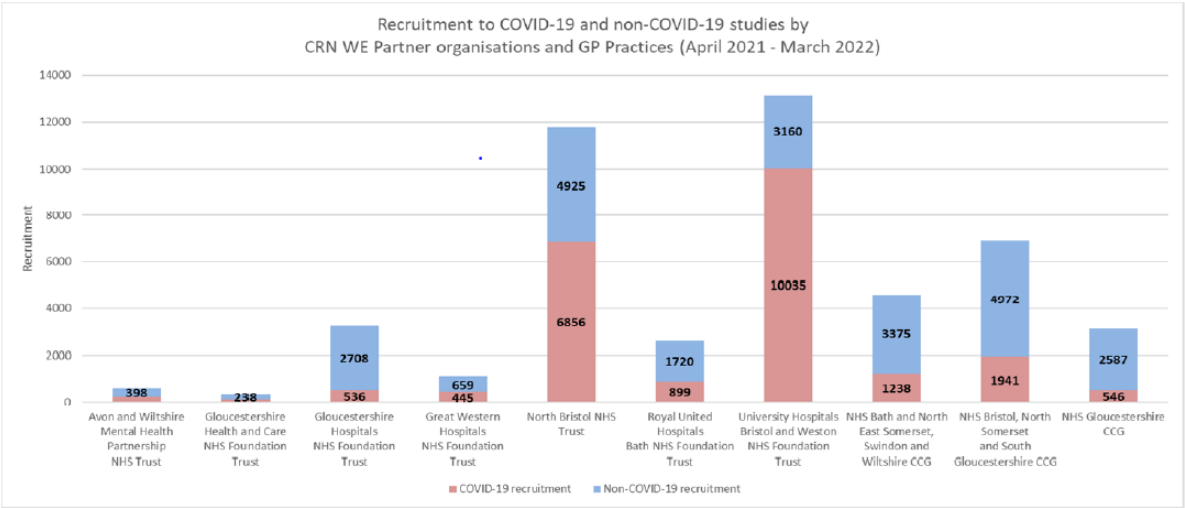


Figure 2. Regional recruitment of participants into research 21/22. *Data taken before end of year "data cut"

To address these difficulties in delivery of interventional studies the R&D department has worked closely with pharmacy and radiology to better support capacity planning. All studies in set-up are discussed at monthly meetings, priority lists agreed and, if required, a maximum number of scans/patients agreed. This work has seen a backlog of over 30 studies requiring Clinical Trials Pharmacy support reduce by half and a reduction in the time taken for radiology to make capacity decisions. This work is ongoing, with capacity remaining challenging, particularly for oncology and haematology clinical trials.

The breadth of clinical areas undertaking research across the Trust remains broad (figure 3), with emerging activity in areas such as Radiology/Artificial Intelligence (AI) and dermatology.

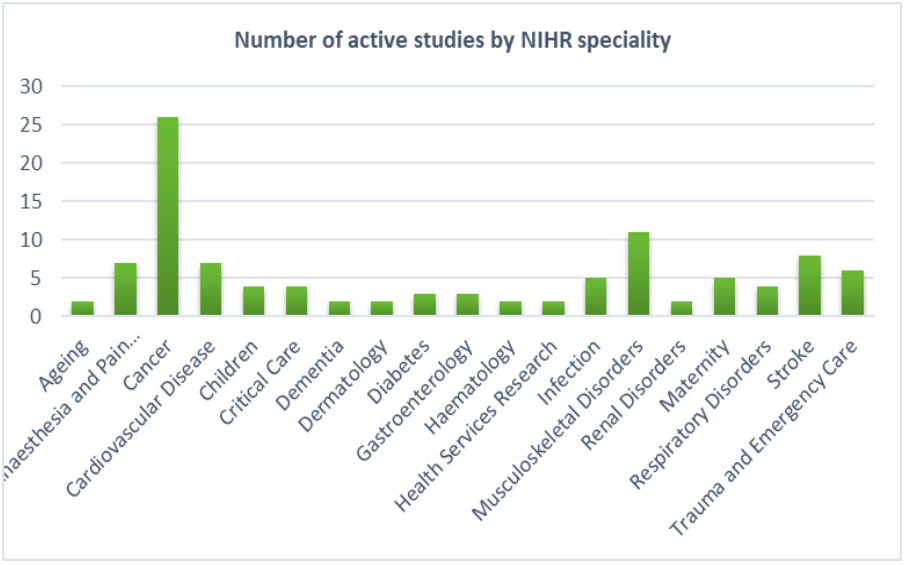


Figure 3. The number of studies with recruitment in 21/22 by NIHR speciality group

Focus on vaccine research

As previously reported, since the start of the COVID pandemic RUH research staff have played a significant role in the development of COVID-19 vaccines.

This began in July 2020 with RUH staff working with colleagues in both UHBW and NBT to directly support the trials that led to approval of the very first Oxford/AstraZeneca vaccine. This gave RUH research staff the skills and knowledge required to undertake these essential trials at RUH. Since this time we have created a dedicated vaccine research team who have established themselves with an excellent reputation for delivering commercially and non-commercially sponsored research studies to time and on target. The ability to undertake these, often time sensitive and high intensity, research studies has been a department wide effort with staff co-opted from all speciality research teams to work on these trials. This has had some impact on our ability to bring non-COVID research back to pre-pandemic levels (see section 2 above) justified due to the vital nature of this work.

We have worked with numerous pharmaceutical companies on clinical trials that have led to the approval of four new COVID-19 vaccines, including an Omicron specific booster and the first UK approved bivalent vaccine[4] (offering protection against multiple variants of COVID in one vaccination). This team also played a pivotal role in conducting the "ComFluCov" trial, which informed national policy on the ability to give both COVID-19 and Flu vaccinations at the same time, saving the NHS a significant amount of time and resources.

A recent paper in the Lancet journal[5] suggested that COVID-19 vaccines have prevented up to 20 million deaths in the first year of use. The role that the RUH has played in this should be celebrated as a great achievement. Moreover, this work has generated over £400,000 income in this financial year alone, with a projection of over £800,000 based on trials that are currently open or in set-up.

Looking forward we envisage that this work will continue to thrive and develop, as the pipeline of COVID-19 vaccine reduces we will expand into vaccinations for other infectious diseases with significant public health burden.

[4] https://www.gov.uk/government/news/first-bivalent-covid-19-booster-vaccine-approved-by-uk-medicines-regulator

[5] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00320-6/fulltext

3. RUH led research

The RUH has a successful portfolio of research led by clinicians at the hospital often in conjunction with academics at three local Universities (University of Bath, University of Bristol and the University of West of England). There are also multiple collaborations with leading national experts in the NHS as well as international collaborators. External funding applications are regularly submitted to the National Institute for Health Research, local and national charities and pharma companies to support projects designed to answer questions that are directly related to patients and services here at the RUH.

The Trust was successful in being awarded £1.8m of new external grants to support its research during 2021/22. We are proud to support a wide range of staff to lead research and this includes doctors, midwives, nurses, therapists and health scientists. Our successful projects can be focused here at the RUH but also partnership with other local and national NHS hospitals to deliver multi-centre research. Industry supports our research by providing additional expertise, equipment, software and resources.

The following table provides some details of the successful awards and shows some of the breadth of research interests and strengths across the Trust. This is only a snapshot of the RUH led research portfolio and there are significant ongoing projects, funded in previous years, in several other areas including Pain, Orthopaedics, Parkinson's Diseases and Ageing, Respiratory and Critical Care.

Lead Applicant	Specialty	Title of Project	Amount awarded	Funder
Dr Jonathan Rodrigues/Dr Ali Khavandi	Radiology/ Cardiology	Super Rehab- Can we reverse coronary heart disease in metabolic patients?	£ 297,477.00	NIHR - RfPB
Dr Ali Khavandi/Dr Jonathan Rodrigues	Radiology/ Cardiology	Reversing the burden of atrial fibrillation with a novel lifestyle and risk factor modification intervention (Super Rehab)	£ 244,804.00	RUH X
Dr Daniel Augustine	Cardiology	IMPULSE – Improving pulmonary hypertension Screening by Echocardiography	£ 592,997.00	Jansenn Pharmaceuticals
Prof Esther Crawley	Paediatrics	GEM - How common is late onset Pompe disease in young people and adults treated for Chronic Fatigue Syndrome or Myalgic Encephalomyelitis (CFS/ME): cross-sectional study.	£ 577,255.00	Sanofi with University of Bristol
Dr Raj Sengupta, Dr Inma Mauri-Sole, Dr Tom Welsh	Rheumatology Dermatology Aging	Qualitative evaluation of virtual appointments at RUH	£ 3,769.00	UKRI via University of Bath
Jennifer Haworth	Orthodontics	The use of digital water technology in orthognathic surgery	£ 14,950.00	British Orthodontic Society
Anna Pease (UWE) Karen Patrick (RUH)	Maternity	Preventing Sudden Unexpected Deaths in Infancy: an assessment and planning tool for families at increased risk	£ 4,647.00	NIHR RfPB with UWE
Dr John Pauling	Rheumatology	The Warmer (Wearable Ambulatory Raynaud's Measurement Recorder) Project	£ 45,944.00	Scleroderma and Raynaud's UK (SRUK)
Dr Darren Hart	Clinical Imaging	Healthcare Science Innovation Fellowship	£ 15,000.00	NHS England & NHS Improvement
		Total	**£ 1,796,843.00**	

*Further details of these awards are available on request from the R&D department, Jane Carter, Head of Research Development jane.carter14@nhs.net

To give a flavour of a few of our major RUH led studies there follows a focus on three National Institute for Health Research Funded Projects to demonstrate what has been achieved, what is ongoing and what is just beginning. These include:-

- The PROMPT Programme Grant for Applied Research (2015-2022) **£2,019,356**. Prof Neil McHugh Hon Consultant Rheumatologist RNHRD and Professor, Department of Life Sciences, University of Bath
- Chief-PD Health Technology Award (2019-2023) **£2,429,153**. Dr Emily Henderson, RUH and Honorary Consultant Senior Lecturer, University of Bristol
- Super-Rehab: Coronary Artery Disease Research for Patient Benefit (2022-2024) **£297,477**. Dr Jonathan Rodrigues, Consultant Radiologist RUH and Dr Ali Khavandi, Consultant Cardiologist RUH.

The Prompt programme: Early detection to imPRove OutcoMe in people with undiagnosed Psoriatic arthriTis (the PROMPT programme), including the TUDOR Randomised Clinical Trial

This programme started in 2015 and has involved over 3000 patients in 7 discrete projects. The study focused on the screening and diagnosis of patients with psoriasis who then went on to develop Psoriatic Arthritis. The background to this is that longitudinal observational studies suggest that patients who are referred to secondary care early with psoriatic arthritis (PsA) have a better outcome. This programme not only looked at if this were true but how we could accurately measure outcomes and what we need to include to ensure these are important to patients. Using data from patient focus groups, a multi-centre cohort study, primary care health records (Clinical Practice Research Datalink, CPRD), and a prospective randomised clinical trial (RCT) the study addressed the following objectives.

Objectives:

1. To identify disease activity and impact outcomes important to patients with PsA in comparison to existing ones (PROMS).
2. To assess the validity of new measures of disease activity derived from patient engagement (ASSESS).
3. To explore barriers to diagnosis and the experience of screening from a recipient perspective (GAPS).
4. To identify modifiable risk factors for the development of PsA using the CPRD (EPIC).
5. To compare the performance of screening tools for detecting undiagnosed PsA (COMPARE).
6. To investigate the clinical effectiveness (TUDOR) and cost-effectiveness (COSPA) of detecting undiagnosed PsA.

The study has been a major undertaking and has recently submitted its final report to the NIHR and will be continuing to publish the results in the coming months. The overall conclusion was that screening for psoriatic arthritis is likely to be cost-effective in a psoriasis population, although evidence of clinical effectiveness will require longer term follow-up. Findings will inform the design of future studies that may benefit from targeting screening to a population of patients with psoriasis with enhanced risk(s) of developing PsA.

Chief-PD - A phase 3 trial of Rivastigmine to prevent falls in Parkinson's Disease.

Parkinson's disease is a common condition particularly affecting older people. Falls are a very frequent complication of the disease affecting 60% of people with Parkinson's every year. Having a fall can be devastating, resulting in broken bones, injuries and hospital admission. In addition, people lose confidence in their walking and ability to get out and about so can become more isolated and anxious. As the population ages, the number of people living with Parkinson's disease and the occurrence of complications will increase.

This research is led by Chief Investigator Dr Emily Henderson and a team at the University of Bristol with the RUH being the lead NHS site for recruitment of patients and delivery of the trial. Participants are randomly assigned to receive the medication Rivastigmine or placebo and provide information on their health and occurrence of falls over the following 12 months. A total of 35 sites around the UK are also taking part and recruiting a target of 600 patients to take this approved medication and collect outcome data to establish whether it can reduce the number of falls experienced by people affected by this disease. The trial was interrupted and had delays due to the pandemic but aims to complete recruitment towards the end of 2022. The RUH has been a major recruiter to the study and supported the new sites with set up as required.

Super Rehab: Can we reverse coronary artery disease? (a feasibility study)

This project is led by Dr Jonathan Rodrigues who was awarded the Outstanding Clinical Radiologist Researcher of 2021 by the combined Royal College of Radiologists and National Institute for Health Research. He has been a driving force in expanding the research portfolio at the RUH in the area of radiology to support better diagnosis in conditions in Cardiology, Pulmonary Hypertension and other related diseases.

SuperRehab is a concept developed previously at the RUH led by Dr Ali Khavandi and involves providing lifestyle support in the form of exercise and dietary advice on an ongoing but tapering basis to patients. To prove that **Super Rehab** not only works, but should be offered to patients with early forms of coronary heart disease on the NHS up and down the country, a feasibility trial has commenced in Bath and Bristol with the aim of moving to a future multiple centre trial with larger numbers across the UK in 2-3 years.

As a first step to achieving this, we have recently won the support of the National Institute for Health Research to run a study testing the feasibility of delivering Super Rehab to this important patient group, and testing trial procedures. This will allow us to not only improve the way that Super Rehab is delivered to our patients and how it fits into the working patterns of our colleagues delivering it, but will help check that study procedures and tests are manageable and give us some initial pilot data into the sorts of impact Super Rehab may have on coronary heart disease.

The study will include 50 participants randomised to either Super Rehab or to continue with normal care only. Participants in the study will all have imaging tests of their heart and blood vessels, blood tests, blood pressure checks and fitness checks at the start, middle and end of their involvement in the study.

We'll also take the opportunity at the end to interview patients who went through the Super Rehab programme to find out more about their experience and highlight any areas for improvement. As well as the potential benefits we believe patients involved in the study will gain, the valuable information gained from this study will support the design and delivery of a future multi-centre study testing Super Rehab in patients across the country.

We are also delighted to report that another of our active researchers Prof Grey Giddins was awarded the Royal College of Surgeons of England Hunterian Professor for 2022, in recognition of his contribution to research in biomechanics of injuries in the wrist and hand. He is currently leading an ongoing NIHR Invention for Innovation Grant at the RUH developing a new Drill Guidance System for surgeons in collaboration with the University Of Bath Department Of Mechanical Engineering.

3.1 Research Capability Funding (RCF)

NIHR Research Capability Funding (RCF) is allocated to research-active NHS organisations in receipt of NIHR grant income to enable them to maintain research capacity and capability. At RUH this income stream is predominantly used to support the work required to prepare further grant applications through an award scheme overseen by the R&D Executive Committee. In 21/22 the RUH was awarded just over £200,000 of RCF, which was invested across 14 different projects and also used to support central roles with the R&D team. Details of some of the major funded projects are in the table below.

Applicant Name	Speciality	Summary of Project
J Graby, J Rodrigues, A Khavandi	Cardiology	This feasibility study will assess whether it is possible to integrate a novel intensive lifestyle intervention ("Super Rehab") into the care of high-priority patients with coronary artery disease.
W Loughborough, R Bowen	Oncology/Radiology	A prospective proof of concept study assessing whether whole body MRI is more accurate than CT (current standard of care) in assessing the effectiveness of systemic cancer treatment in breast cancer patients with bone only metastases.
A.Cookson, J.Rodrigues & J. Clark	Radiology/AI	To create an automated and sophisticated screening tool for use in patients with suspected pulmonary hypertension
B.Ainsworth & J.Suntharalingam	Respiratory	To use patient-centred methods to inform the development of a high quality digital mindfulness intervention that can be evaluated in subsequent feasibility and confirmatory trials
M.Western, T.Welsh & O.Perkin	Dementia	The aim of this project is to optimise an exercise snacking intervention designed to support older people maintain functional independence, robust health and wellbeing, and reduce risk of falls through improved physical function
S.Moore, J.Campbell & A.Emery	Haematology	The primary aim of this research project is to determine the feasibility and safety of individually-prescribed exercise training in multiple myeloma patients undergoing anti-cancer therapy
John Pauling	Rheumatology	The funding shall be used to assemble an investigative team to develop a proposal that will underpin a future clinical trial investigating the potential preventative role of vasoactive therapy in averting PAH in systemic sclerosis

As in previous years a large proportion of this RCF funding has been utilised to support local clinicians and academic staff to prepare and submit external funding applications, both those based at RUH and also in collaboration with local universities. Of note this year has been investment in longer term positions, namely a Cardiology and a Respiratory Research Registrar, to undertake pilot and feasibility work in support of external applications. This has led directly led to the success of the "SuperRehab" research programme.

This programme of investment of RCF into grant development will continue in future years and be used to further strengthen RUH led research and collaboration with our University partners.

3.2 Charitable funds for Research

We are fortunate to be able to support research projects through generous donations and legacies given to the hospital for research. The RUH hold a number of charitable funds, including restricted funds, to support research at the RUH and RNHRD. The Heads of Department are fund-holders on four funds and there are further research funds held by other specialty leads within clinical areas. The aim is to utilise these funds to encourage

researchers and provide support for new research projects in the Trust and to support staff in the dissemination of research results. Funding is also allocated for education purposes including support of joint PhDs and research prizes.

See Appendix 2 for the latest report on Research Charitable funds

4. Patient Experience

Our teams, researchers, clinicians and all the support departments who help us deliver our research portfolio work diligently to improve outcomes for patients both locally and nationally. However, we would not be able to conduct research if it was not for patients and members of the public volunteering to participate. The voluntary aspect of research participation means it is essential that research patients have a high quality experience and that their involvement and time is valued.

To this end RUH research patients are being offered the opportunity to feedback via a national Participant Research Experience Survey (PRES). During 21/22 5% of eligible RUH research participants feedback using this questionnaire.

Feedback from participants gained in 21/22 was overwhelmingly positive with **96%** of respondents strongly agreeing or agreeing that researchers valued them taking part in research. Of note, **99%** of respondents stated that they were treated with courtesy and respect, an exceptional response and testament to the dedication of research staff to give patients an outstanding experience of care. The least positive feedback related to participants feeling they have been kept updated about the research they are taking part in. This can in part be attributed to the long duration of many research studies and time taken to be able to ascertain any significant results. We are working with local and national research sponsors to identify ways in which communication with participants, especially in relation to results of the study, can be improved.

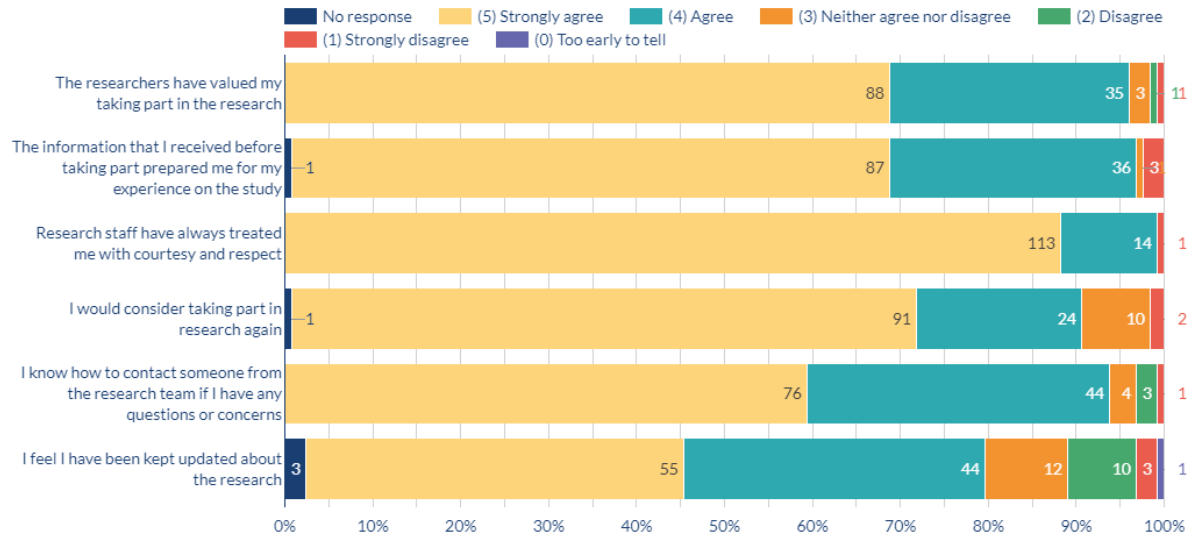


Figure 4. Graphical representation of PRES responses for RUH participants

The use of this tool is relatively new and as such is taking some time to become an established part our work. Research studies often have huge amounts of information that patients are required to understand in order to give fully informed consent to participate, and as such timing this questionnaire to avoid participants feeling overwhelmed is key. It is our ambition to increase the number of research participants and range of studies from which

this feedback is received. This will give more meaningful feedback upon which we can act to further improve the participant experience.

5. Staff Development and Wellbeing

The R&D Directorate directly employs over 80 research staff (63.5wte), this is a diverse group of Nurses and Midwives, Allied Health Professionals, Clinical Trials Assistants (similar role to a Health Care Assistant), Administrators and Database staff. The department is structured into broad speciality teams (Cancer, Acute Care, Rheumatology, Maternity and Planned Care), each led by a Senior Research Practitioner/Nurse/Midwife.

As in previous years teams have engaged well with the Staff Survey and 21/22 saw a 73% response rate. The R&D Directorate achieved above both Trust and National averages across all seven elements of the People Promise (appendix 3). Both staff morale, and recognition and reward, were celebrated as key achievements with scores significantly higher than average, a great accomplishment given the pressures of recovery from the pandemic. Action plans are in place to improve feedback relating to specific questions '*There are opportunities for me to develop my career in this organisation'* and *'If I spoke up about something that concerned me I am confident my organisation would address my concern'*.

5.1 Career Development

As a key part of our response to staff survey feedback we are increasing the support available for research staff to develop in their role. We have included 'Research Career Opportunities' as an induction session for all new starters to the department which aims to arm staff with the knowledge of opportunities within clinical research so that they can immediately start shaping their career pathway.

A larger piece of work is ongoing around supporting those employed as Clinical Research Practitioners, for whom opportunities are more limited than for professionally qualified staff. Nationally, as especially apparent during the COVID-19 pandemic, the clinical research delivery infrastructure is reliant on not just research nurses and midwives, but also the support of researchers with non-clinical backgrounds. A directive is in place from the NIHR to ensure there is recognition of the clinical research practitioner (CRP) as a profession, and as such a national directory and subsequent register has been created. At present RUH have some staff on the directory but none have yet completed their registration. We have set up a monthly protected time for CRP's to work on their registration application, supported by one of our senior members of staff. In time, we plan to organise career talks from colleagues in industry and those who have run their own projects, in the short-term this has been a great opportunity for CRP's to connect with colleagues working in different areas of research and to provide set time for personal development.

During 21/22 we have set aside a small amount of 'research capacity funding' to support R&D staff to undertake external training and attend conferences. At a department level we are also working with research study sponsors to allow for CRP's and Research Nurses to take on roles with more responsibilities within research studies. We are promoting research delivery staff as Principal Investigators of studies through our own monthly departmental meetings. We are also ensuring that researchers with non-clinical backgrounds can take on roles which may have previously only been available to research nurses or midwives, ensuring they are fully supported. One example of this is that we are working with colleagues in the education centre and pharmacy to understand whether CRP's could give sub-cut medications for research studies. As an additional benefit to this work we envisage it will take some pressure away from our clinical colleagues who as outlined previously find supporting research increasingly difficult.

6. Research Engagement

Creating a culture across the organisation that values research, and use of evidence, is one of our key drivers. Research is beneficial to people and patients, with breakthroughs enabling earlier diagnosis, more effective treatments, prevention of ill health and better outcomes. Research is also beneficial to healthcare professionals who are able to develop imaginative solutions for real NHS problems, improving care and increasing job satisfaction.

In September 2018 the CQC signed off the incorporation of clinical research in its Well Led Framework (NHS Trusts). The focus is on how well an NHS Trust as a whole supports research activity at three levels.

Research equity – how does the organisation support the research programme across the breadth of its services?

Research facilitation – how does the organisation proactively support the delivery of research from board level to the clinical setting(s)?

Research awareness – how does the organisation make research opportunity known to patients, the public and healthcare professionals?

To support the organisation wide preparedness for this CQC element a Research Engagement Lead has been appointed to undertake a number of key projects outlined below.

6.1 RUH Research Network

To improve access to research and research skills for those staff not employed directly in research role a "Research Network" has been established, which is now in its second year. The Research Network is open to all RUH staff and those from partner organisations. A meeting is convened alternate months via Teams, as a community to increase awareness of research and increase research activity amongst health professionals. It is open to all, whether just dipping a toe into research or further on in research career. It is an opportunity to unite health professionals with an interest in research, promote networking, get peer support, share knowledge and expertise and raise awareness of research opportunities. This initiative has gained national recognition through conference presentation[6].

In 2021, five online Network meetings included; how to navigate ethical and research governance processes, developing a career in research, an introduction to research funding pathways for health professionals and how to get your research noticed. Attendance numbers increased over the year as the initiative gained momentum. A full programme of meetings is planned for 22/23. Key aims for the next year include an evaluation of the Research Network and to extend the reach of the initiative to partner organisations.

6.2 Silver and Gold Ward Accreditation programme

A survey undertaken in 2020 indicated that awareness of research amongst RUH NMAHPs in particular was limited, with those having undertaken higher level (MSc) study being better informed. To facilitate the spread of research awareness more broadly though the organisation research questions have been incorporated into the Silver Ward Accreditation Programme. These relate to signposting a patient to research studies and asking staff to describe the benefits of the RUH being a research active Trust. In March 2022, questions were submitted for inclusion in the Gold accreditation process. These include asking for; examples of how research evidence has informed the delivery of patient care, staff describing how the Trust supports research opportunities for patients and staff, and describing research evidence relevant to their area of practice.

[6] Grieve S & Hirst L (2021) Establishing a virtual Research Network for Nurses and Midwives. RCN international nursing research conference. Sept 2021

Now that these questions have had time to embed 22/23 will see us collating data on the outcome of these questions in each clinical area where accreditation is undertaken. These data will inform targeted approaches to highlight successful engagement with research and to flag areas which needed further support.

6.3 Raising the profile of research at the RUH

The profile of research has further been raised via a number of approaches including: participation in the Nursing and Midwifery Grand Round as a presenter, articles in Trust newsletters, utilising Workplace as a forum to disseminate information, and being an invited speaker at events held by external organisations. The Research Engagement Lead is collaborating on a number of projects which will result in submission of articles for publication, including a scoping review and reporting a national survey.

It is our ambition to further support and grow this work in 22/23 with a number of projects including the introduction of a small scheme to support NMAHPs to have the opportunity to produce abstracts for presentation at relevant national conferences, and to pilot a 'Clinical Research Link' initiative to support integration of the research team and clinical team and to embed research into the ward culture.

A significant amount of work has been undertaken to improve and update the R&D inter and intranet pages, with final versions to be launched within the next year. Research outcomes and achievements are also regularly featured in Trust communications, staff brief, exec videos and Workplace, alongside press releases around stories of local interest.

7. Next Steps and Future of RUH Research

This has been a challenging year for research at RUH, reflected nationally and attributed to the capacity and backlog issues facing the whole of the NHS. In spite of this, research led by RUH has continued to grow and partnerships with Universities are stronger than ever, demonstrated the large amount of collaborative work ongoing and planned. Staff have continued to flourish and patient feedback is exceptional. The success in delivery of large scale vaccine clinical trials is also notable.

Our vision moving forward is to build a culture where development and delivery of research, and use of evidence, is truly embedded in the provision of outstanding healthcare across the community in collaboration with, and for the benefit of, patients and the public. To do this we will

- Continue our engagement work to create a culture that values research and use of evidence across the Trust.
- Further spread research across the Trust to better enable patients to participate in research.
- Build our external relationships to be an active research partner in our local community.
- Continue to support our staff to develop and enable them to provide excellent care to all research participants.

Appendix 1. RUH peer reviewed journal publications 2021/22

RUH Staff Publications Bibliogra

Appendix 2 – Research Charitable Funds

Charitable Research Funding Report May 2022
Prepared by Jane Carter, Head of Research Development

Background
The RUH hold a number of Charitable funds, including restricted funds, to support Research at the RUH and RNHRD. The Heads of Department are fund-holders on four funds and there are further research funds held by other specialty leads within clinical areas. The aim is to utilise these funds to encourage researchers and provide support for new research projects in the Trust and to support staff in the dissemination of research results. Funding is also allocated for education purposes including support of joint PhDs and research prizes.

PhD funding
Funding for PhD students in conjunction with local Universities (currently University of Bath) which will provide benefits to the patients of the RUH and potentially further afield. There is potential to set up similarly joint PhDs with the University of the West of England and early discussions are in progress. These would focus on more Nursing and Allied Health Professional candidates.

Dr Dan Augustine, Prof Dylan Thompson and Dr Oliver Peacock
£31,573 contribution – 3 year project "Harnessing Technological Innovation to improve cardiac rehabilitation" .
The aim of this project is to work with patients and healthcare professionals to co-develop a digital solution to enable cardiac rehabilitation to be delivered in the community.

Dr Chris Dyer and Dr Christof Lutteroth of the Centre for Digital Entertainment
£12,000 contribution – 3 year project Jan 2020 -Sept 2023 "In Someone Else's Shoes: Empathy through VR" A Doctor of Engineering (EngD) project
The aim of the project is to develop a VR simulator that helps clinical staff to develop empathy and understanding for people affected by cognitive or mental disorders.

RNHRD General Research Fund

In 20/21 the RNHRD General Fund which had received a significant donation (c£146k)
A small project/infrastructure programme grant scheme which had existed at the RNHRD for many years was re-vamped and four deadlines were held during the year. This proved popular and had an average of two applications per deadline. A peer review committee with membership from across the RNHRD services and both Heads of Research review the applications. Teams meetings allowed applicants to give a presentation and answer questions and a consensus decision made. Feedback is provided to applicants to enhance the project proposals from the peer review. The following received awards, many of which have recently commenced or are in the process of commencing and will see expenditure in this financial year.

Small Projects - Applicant and Title	Award
Dr Ellie Korendowych, Incorporating patient reported outcome measures into the Bath Lupus Cohort Study	4,153.00
Dr Ben Mulhearn - Research project studying the rise in GCA incidence during Covid-19	10,000.00
Olivia Taylor - Qualitative research project to enhance LoCATE - Long Covid Services for Adolescents	1,340.00
Dr Jessica Ellis - Support for SLE patient advisory group for research	2,686.00
Marc Batalla - Research project investigating the feasibility of Cognitive Multisensory Rehabilitation in CPRS	9,175.00
TOTAL	**£67,756**

Charitable funds are also valuable to provide otherwise un-achievable advances in infrastructure to facilitate future research. This, in the past and currently, focusses on the move to paperless collection of Patient Reported Outcome Measures (PROMs) for different specialties. Electronic capture not only improves the patient experience in clinic and allows their treating clinician to have the most up to date scored PROMs to make diagnostic and treatment decisions, but provides a repository for the data for research analysis as well.

Infrastructure Programme – Applicant and title	
Dr Jenny Lewis and Dr Jeremy Gauntlett-Gilbert. Development of online clinical outcomes for pain services	£40,402.31
Infrastructure award recommended for resubmission	
Dr Sarah Skeoch (on behalf of Rheumatology consultants) Expanding rheumatology clinical research capabilities though increasing data management capacity	£58,914

Other areas supported from the RUH General Research Fund, RNHRD Arthritis and RNHRD Rheumatology Funds

There are a number of costs which are supported on an ad-hoc basis which are not covered by other sources of funding (NIHR Clinical Research Network, Grant income, Commercial income etc) which promote the RUH as a research active hospital. These include support for journal publication costs where the Trust has acted as Sponsor and the research work was led from the RUH. Support is awarded to staff to present research at national and international conferences, again where this is accredited to the RUH, and where no other sources of funding are available. This has been minimal over the last couple of years due to the impact of the pandemic. Historically patent costs for projects where the patent arises from a research project are supported from Charitable funds (currently one ongoing).

Spending Plans and future fundraising

The spending plans for 2022/23 are attached and if predictions are correct will leave most of the funds at a low level at the end of the year. Research is important and the R&D Exec recognise that a fundraising campaign to be able to continue to support the activities described above is essential. We are compiling some information on outcomes and impacts of previous small projects and short synopses of the type of funding awarded for promotion purposes.

Appendix 3

Research & Development - NHS Staff Survey Results 2021

NHS
Royal United Hospitals Bath
NHS Foundation Trust

The 2021 NHS Staff Survey was redesigned in line with the People Promise.
This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone. This year, the survey tracked progress towards the seven elements of the People Promise, as well as measuring Morale & Staff Engagement.

We are compassionate & inclusive

7.9

Above the national average 7.2, above the RUH score 7.4

We are recognised and rewarded

6.9

Above the national average 5.8, above the RUH score 6.0

We each have a voice that counts

7.3

Above the national average 6.7, above the RUH score 6.8

We are safe and healthy

6.9

Above the national average 5.9, above the RUH score 5.8

Key

- Above or equal to RUH score & above or equal to national average
- Above or equal to national average but below RUH score
- Below RUH score & below national average

53 colleagues from across Research & Development took the opportunity to have their say. That's 73% of the workforce.

We are always learning

5.7

Above the national average 5.2, above the RUH score 5.3

We work flexibly

7.3

Above the national average 5.9, above the RUH score 6.1

We are a team

7.4

Above the national average 6.6, above the RUH score 6.7

Staff engagement

7.5

Above the national average 6.8, above the RUH score 7.0

Morale

6.7

Above the national average 5.7, above the RUH score of 5.8

Appendix 4 – Details of R&D Income 21/22

All research activity undertaken at RUH and research staff salaries are externally funded. It is therefore essential that income levels are sustained to ensure stability of the workforce and continuation of research activity at current levels.

Below is a summary of research income by broad category over the past 3 years.

Income Detail	2018-19	2019-20*	2021-22
Delivery Income (NIHR/CRN)	£ 1,292,174.33	£ 1,332,347.00	£ 1,468,580.00
Research Capability Fund	£ 157,915.46	£ 427,901.34	£ 246,581.00
Other - Central Codes	£ 99,990.36	£ 435,815.36	£ 191,995.73
Commercial Income (Not Grant)	£ 15,209.74	£ 385,928.84	£ 183,647.09
Non Commercial Income (Not Grant)	£ 9,533.76	£ 219,124.70	£ 491,369.21
Grant (Commercial and Non Commercial)	£ 1,343,189.76	£ 1,474,477.19	£ 1,287,979.73
Total Income	**£ 2,918,013.41**	**£ 4,275,594.43**	**£ 3,870,152.76**
*significant additonal non-recurring awards to support COVID-19 research response			

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	18.0
Date of Meeting:	2 November 2022		

Title of Report:	Finance and Performance Committee Update Report
Status:	For Discussion
Sponsor:	Jeremy Boss, Chair of the Finance and Performance Committee
Author:	Jeremy Boss, Chair of the Finance and Performance Committee
Appendices	None

Purpose

This report summarises the discussions, recommendations and approvals made by the Finance and Performance Committee on 26 September 2022, to provide the Board with an update of the Committee's activities.

Background

The Finance and Performance Committee holds delegated responsibility from the Board of Directors; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

The Committee reviewed the updates to the BAF and agreed to further review the financial recovery risk score at the October meeting.

The Committee received an update on the Trusts performance. The elective recovery data would be re-forecasted for the October meeting, to incorporate assumptions around winter planning. Performance remains challenging with many of the NHS targets not being achieved. However, there are signs of improvement and some real achievements despite the difficult headwinds.

The Director of Finance provided an update on the financial position for the RUH Group. The RUH is behind the budgeted position as is Sulis. Recovery plans are being developed for the RUH and for Sulis. For Sulis it will be difficult to develop a recovery plan that will bring Sulis back in line with the plan given the one off nature of some of the cause. The Committee would be provided with further information on how the Trust could get back on budget at the next meeting and ongoing.

It was noted by the committee that the Transformation / QIPP targets for the second half of the year are much more demanding than the first half of the year. Given Transformation savings achieved to date are behind plan, there is a significant risk for t this step up in delivery which will be monitored going forward.

The Divisional Director of Operations for Surgery provided the committee with an overview of Ophthalmology Elective Recovery.

The Committee received an update on the Surgery Division Budget. The Board would receive a report in regard to GIRFT reports, and the model hospital data, which would highlight the Trusts position and opportunities for improvement, with a proposed deliverable plan for next year.

The Director of Finance presented the finance vision update and highlighted that the Trust was managing a number of risks across the BSW, and there was currently a deficit plan for each provider, and a surplus plan for the ICB, to ensure the system achieved break even. The risk share proposal meant that if other organisations do better than planned by the end of the year, the risks were managed as a system. The Committee agreed to the proposal and noted the update.

The Chair welcomed Andy Whiting, Rubicon to the meeting. The Director of Finance presented the Financial Strategy Update slides.

New Governance arrangements were proposed to encompass the annual business planning cycle and the longer-term financial recovery plans. The committee accepted the proposals. Andy Whiting observed that the Trust currently had an emerging clinical strategy, with a completed activity model and financial model, which would give a clearer idea of the size of the issue to be solved. He suggested merging the strategies and use the information and evidence to set a level of ambition for efficiency.

The Committee were provided with an update on Nursing Budgets for agency staff which highlighted a significantly increased number of requests for mental health nurses. Initial actions have been put in place to manage this issue including consideration of substantive staffing levels. However, to date this had not resulted in a fall in demand. This will continue to be monitored by the committee.

The Committee reviewed the HFMA Financial Sustainability check list and agreed that it was a good starting point for the internal auditors to review, with the proviso that it was revisited once complete.

The Committee self-assessment process was approved by the Committee.

Key Risks and their impact on the Organisation

- Financial plan for recovery for this year's budget outturn is challenging for the RUH and Sulis.
- Operational performance continues to be challenging although there are some positive signs of improvement despite considerable head winds.

Key Decisions

- Approved work plan
- New Governance arrangements recommended for approval for the Business planning cycle and longer financial recovery plan.

Exceptions and Challenges

Nothing impacted on the Committee's ability to undertake its business.

Governance and Other Business

Finance and Performance Committee meets monthly and the Committee's Terms of Reference are reviewed annually.
The Committee's membership consists of the Non-Executives, the Chair, and the Chairs of the Non-Clinical Governance Committee, and the Clinical Governance Committee.

Future Business
In addition to standing items, the Committee will consider: • One of the worst examples of NHS procurement – lessons learnt • Managing the budget - Family and Specialist Services • Developing the long term finance plan • Work plan • Finance strategy update Phase 2- the solutions • Performance deep dive
Recommendations
The Board is asked to note this report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	19.0
Date of Meeting:	2 November 2022		

Title of Report:	Charities Committee Update Report
Status:	For Information
Sponsor:	Jeremy Boss, Chair of Charities Committee
Author:	Jeremy Boss, Chair of Charities Committee
Appendices	n/a

Purpose

This report summarises the discussions, recommendations and approvals made by the Charities Committee on the 15th September 2022 to provide the Board with an update of the Committee's activities.

Background

The Charities Committee holds delegated responsibility from the Board of Directors (the Corporate Trustee of the RUH Charitable Funds), this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

The Head of Fundraising provided the Committee with an update on the work of RUHX since the last meeting and would provide a deep dive on legacy income at the next meeting. The Committee approved the request for a new Charity Project Manager for a 12 month period to drive ward funds forwards.

The Committee received an update on the work of Art in the Heart.

The Committee reviewed the risk register and the suggested changes were approved.

The Committee noted the update from the Friends of the RUH and looked forward to continuing working with the friends and helping them wherever possible.

The Committee reviewed the summary of income and expenditure funds by directorate. There were a number of funds that continued to hold large balances that were not being spent and were being monitored by Finance.

The Financial Accountant highlighted that the general fund was going to be in a tight position, and if there were any further deficits in fundraising or investment losses it would not be possible to cover them through the general fund.

The Committee agreed that the cash flow forecast did not suggest any further drawdowns of investments for this financial year.

The Committee approved the spending plans.

Following market feedback by our Investment Manager the Committee approved the remaining Cancer Centre money to be drawn down from investments to cash at an interest rate of 3% as it will be needed in the short rather than medium term.

The Committee approved the terms of reference.

The Committee reviewed the Charities Committee effectiveness questionnaire and agreed it should be circulated for completion.

The Committee approved the Annual report and accounts for sign off along with the letter of representation.

The Committee approved the work plan.

Key Risks and their impact on the Organisation

- Inflationary risk on building projects
- Risk to the general fund if there are any further deficits

Key Decisions

- Approved the Annual report and accounts
- Following market feedback by our Investment Manager the Committee approved the remaining Cancer Centre money to be drawn down from investments to cash at an interest rate of 3% as it will be needed in the short rather than medium term.
- Approved the terms of reference

Exceptions and Challenges

Nothing impacted on the Committee's ability to undertake its business.

Governance and Other Business

The Charities Committee meets at least four times a year, its members consist of 2 Non-Executive Directors, the Director of Finance and Director of Nursing.

Future Business

- Charitable funds SFIs (2 yearly review)
- Staff/patient story
- Charitable Funds Policies and Procedures

Recommendations

The Board is asked to note this report.

Report to:	Public Board of Directors	Agenda item:	20.0
Date of Meeting:	2 November 2022		

Title of Report:	Non-Clinical Governance Committee (NCGC) Update Report
Status:	For Noting / Discussion
Board Sponsor:	Sumita Hutchison, Chair of NCGC
Author:	Stephanie Spottiswood (Executive Assistant)
Appendices	None

Purpose

This report sums up discussions, recommendations and approvals made at the Non-Clinical Governance Committee meeting on 18 August 2022 and 31 October 2022, to provide the Board with an update of the Committee's activities.

Background

The Non-Clinical Governance Committee holds delegated responsibility from the Board of Directors; this report provides evidence to satisfy the Board that the tasks required to meet those responsibilities are being carried out.

Business Undertaken

18 August 2022

- **Board Assurance Framework (BAF) Risks - Cyber Security**
  - The Trust was in a better position in terms of staffing capacity to manage the risk.
  - A dashboard was being developed to reflect visible risk, prioritization, and an overall view of investment vs risk.
  - There was an overarching risk in terms of out of date software.
  - Phishing remained the number one threat, and therefore important to step up awareness within the Trust.
  - Important to recognize within the BAF the importance of resources and training, recovery procedures after a major incident such as a cyber-attack, and a clear working plan with the Emergency Preparedness, Resilience and Response (EPRR) team (and within the Business Continuity Plan (BCP)).
  - The Chief Digital Officer assured the Committee that there were ongoing discussions with the Trust EPRR team. A table-top simulation exercise had recently taken place, and debrief being prepare
- **Environmental sustainability.**
  - A detailed conversation about further embedding environmental sustainability into the organization, to be reflected in the BAF by broadening its scope.
  - Opportunities of working within the ICS and Trust level.
  - Staff and clinician engagement - an important area for development given the lack of funding available to deliver the net zero ambitions.
  - A revised work plan and BAF to be brought to the next NCGC and then to Board.
- **Digital Strategy**

- The digital strategy was being updated to align with the Strategic Narrative.
- It was important to maximize and enable staff to use the IT systems, and to ensure that they were user friendly in the first instance.
- It was important that the delivery of the Trust goals was driven by patient and staff insights, which also linked to the visitor experience.
- A BSW work stream had been set up to discuss virtual wards.

Prioritization of Trust Capital

- With the numerous competing demands for capital year on year, and the prioritization and de-prioritization of Trust schemes, it was imperative to be able to adapt Trust goals.

31 October 2022 – verbal update.

Key Risks and their impact on the Organization

- A fuller conversation was needed on the risks of non-implementation of strategies - Digital, Sustainability and backlog maintenance, so that a Board decision could be made on either changing the strategy or allocating more resources.

Key Decisions

None.

Exceptions and Challenges

Nothing impacted on the Committee's ability to undertake its business.

Governance and Other Business

The Non-Clinical Governance Committee meet on a monthly basis, and the Committee's Terms of Reference reviewed annually.

The Committee's membership consists of the Non-Executives, the Chairs of the Non-Clinical Governance Committee and the Clinical Governance Committee.

Future Business

N/A

Recommendations

The Board is asked to note this report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Board of Directors	Agenda item:	22a
Date of Meeting:	2 November 2022		

Title of Report:	Finance and Performance Committee Terms of Reference Review
Status:	For Approval
Board Sponsor:	Jeremy Boss, Non-Executive Director
Author:	Adewale Kadiri, Head of Corporate Governance
Appendices	Appendix 1: Terms of Reference

1. Summary of the Report

The Terms of Reference of the Finance and Performance Committee indicate that they will be reviewed at least every year to ensure that they remain relevant and that they capture the entirety of the Committee's remit.

Overall, the Terms of Reference continue to capture all the elements of the Committee's work, but a couple of changes are recommended to emphasise its current role in relation to overseeing the Trust's efforts to recover both its financial and operational performance, and to confirm its role in approving business cases as delegated by the Board.

These changes have already been considered and approved by the Committee.

2. Recommendations (Note, Approve, Discuss)

The Board is asked to approve the updated Terms of Reference.

3. Legal / Regulatory Implications

None identified

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

None identified

5. Resources Implications (Financial / staffing)

None identified

6. Equality and Diversity

None identified

7. References to previous reports

The Committee's Terms of Reference were last reviewed in January 2021

8. Freedom of Information

Public

Royal United Hospitals Bath
NHS Foundation Trust

Finance and Performance Committee
Terms of Reference

1. Constitution of the Committee

The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Finance and Performance Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Terms of Reference

2.1 Purpose and objectives

The Finance and Performance Committee's purpose is to provide assurance to the Board on the Trust's financial and operational performance, and in particular:

- the effectiveness of the Trust's business planning process and principles for internal budget setting
- the effectiveness of the Trust's financial management systems
- the effectiveness and robustness of financial planning
- the effectiveness and robustness of capital investment management
- the robustness of the Trust's cash investment strategy
- the extent to which the Trust is operating in line with its annual business plan objectives in terms of financial and operational performance
- the extent to which forecast performance matches operational targets and improvement trajectories, ensuring that issues of non-delivery are escalated to the Board
- the identification, forecast and delivery against Quality, Innovation, Productivity and Prevention (QIPP) and other cost improvement schemes
- the Trust's relationship with its partners within the BaNES, Swindon and Wiltshire Integrated Care System (BSW), and the changing approaches to commissioning, contracting, joint working and the allocation of resources.
- assessment of the impact of the COVID-19 pandemic, and the extent to which the Trust's elective care delivery is in line with agreed targets.

The Committee will incorporate the principles of Improving Together into their work, and those presenting to it will be expected to make use of relevant tools from the Bath Improvement System in doing so.

3. Roles and Responsibilities

3.1 Reporting

- To oversee the ongoing development of the Integrated Performance Report.
- Monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is fully sighted on areas of compliance and non-compliance.
- To review the Trust's annual financial plan, monitoring and challenging any changes to forecast outcomes.
- To review in detail any major performance variations in order to obtain assurance on behalf of the Board as to the effectiveness of corrective actions and associated governance arrangements.
- To consider changes to Trust reporting requirements in response to any new regulatory arrangements.

3.2 Financial performance management

- To monitor the Trust's performance against its financial control total.
- To undertake high level, exception based monitoring of the delivery of financial performance to ensure that the Trust is operating in accordance with its annual business plan objectives and where it is not, assure itself that appropriate action is being taken by the Executive Team.
- To assess the factors, across BSW, that contribute to the risk of financial deficits and monitor the effectiveness of action plans to address these.
- To oversee the creation and achievement of divisional and corporate financial recovery plans.

3.3 Operational performance management

- Assessment of the Trust's delivery against NHS constitutional standards.
- Review forecast performance against operational targets and improvement trajectories, escalating issues of non-delivery to the Board, and monitoring against achievement of any incentive funding arrangements.
- To particularly oversee improvement in key areas of operational performance, including in elective, diagnostic and cancer care, emergency care, and working with community and local authority partners to reduce the number of length of stay for patients who are medically fit to be discharged.
- To assess Trust performance against established benchmarking indices and that of neighbouring and similar organisations.

- To maintain scrutiny of operational performance and the extent to which this continues to be affected by the COVID-19 pandemic, and to review the impact that this has on other aspects of care across the Trust.

3.4 Income management

- Review the Trust's evolving relationship with its key commissioners and BSW partner organisations, taking account of new and emerging funding models.
- Review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk.

3.5 Annual Trust planning cycle

- To consider the Trust's medium and long term financial strategy, in relation to both revenue and capital.
- To oversee the Trust's business planning process and agree the principles and approach to internal budget setting and the development of divisional business plans linked to the Trust's True North and Breakthrough Objectives.
- Review the annual QIPP and Cost Improvement Programmes to provide assurance that delivery risk is minimised and productivity and efficiency opportunities maximised, in particular that savings programmes and forecasts are realistic and deliverable.

3.6 BSW

- To contribute to the development of a system-wide approach to resource allocation and management across BSW, and to support efforts aimed at ensuring that the ICS achieves and maintains break even.

3.7 Other matters

- Approval of business cases on delegation from the Board of Directors
- Review the Trust's procurement strategy, systems and arrangements with a view to ensuring that best value is derived. To m~~M~~onitor progress against NHS standards for procurement using, for example, the Model Hospital.
- To receive updates on any changes to relevant areas of national policy or guidance, and how these will be implemented within the Trust.

4. Membership

The Finance and Performance Committee is comprised of at least three Non-Executive Directors appointed by the Board. One of these Non-Executive Directors will be appointed as Chair of the Committee.

The following officers will be required to attend meetings of the Finance and Performance Committee on a standing invitation by the Chair:

- Chief Executive
- Deputy Chief Executive and Director of Finance
- Deputy Director of Finance
- Chief Operating Officer
- Deputy Chief Operating Officer
- Head of Corporate Governance.

Where executive directors are in attendance at a Committee meeting, attendance of their deputies is optional, other than where such deputies are presenting an agenda item. Other members of staff, including members of the divisional leadership and the finance teams will attend by invitation.

5. Quorum and attendance

Business will only be conducted if the meeting is quorate. The Committee will be quorate with four voting members present, two of whom must be Non-Executive Directors.

Members will be required to attend a minimum of 80% of meetings.

6. Reporting

The Chair of the Finance and Performance Committee will, at the next available meeting of the Board, report on the activities of the Committee at its last meeting.

The Chair of the Finance and Performance Committee shall make whatever recommendations to the Board deemed by the Committee to be appropriate (on any area within the Committee's remit where disclosure, action or improvement are needed).

The Chair of the Finance and Performance Committee shall liaise with the Chairs of other Board Committees where necessary to ensure that cross-committee issues

receive adequate oversight (by, for example, arranging to attend other Committee meetings).

7. Frequency

The Committee will meet at least ten ~~six~~ times a year. Additional meetings may be arranged as required.

8. Other Matters

The Head of Corporate Governance will be responsible for providing administrative and governance support to the Committee, including:

- Agreement of the agenda with the Chair, the Director of Finance and the Chief Operating Officer
- Collation of the papers
- Taking the minutes and keeping a record of the matters arising and issues to be carried forward, and
- Advising the Committee on its role and operation.

The Committee will undertake an annual review of its performance against its Terms of Reference and work plan in order to evaluate the achievement of its objectives. The outcome of this review will be reported to the Board.

These Terms of Reference will be reviewed at least every year as part of the process of monitoring the Committee's effectiveness.

Terms of Reference approved by the Finance and Performance Committee on 20 October 2022 ~~20 January 2021~~

Ratified by the Board of Directors on ~~27 January 2021~~

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Board of Directors**	**Agenda item:**	**22b**
Date of Meeting:	**2 November 2022**		

Title of Report:	**Quality Governance Committee Terms of Reference Review**
Status:	**For Approval**
Board Sponsor:	**Ian Orpen, Non-Executive Director**
Author:	**Adewale Kadiri, Head of Corporate Governance**
Appendices	**Appendix 1: Draft updated Terms of Reference**

1. Executive Summary of the Report

The Terms of Reference of the Quality Governance Committee indicate that they will be reviewed at least every year to ensure that they remain relevant and that they capture the entirety of the Committee's remit.

Overall, the Terms of Reference at Appendix 1 continue to capture all the elements of the Committee's work, but a small number of amendments are suggested (highlighted in track changes), including strengthening the focus on the patient experience, adding the COO or one of their deputies as mandatory attendees, and providing the option for Sulis related quality matters to be discussed at this Committee at their request.

These changes have already been considered and approved by the Committee.

2. Recommendations (Note, Approve, Discuss)

The Board is asked to consider and approve the updated Terms of Reference.

3. Legal / Regulatory Implications

It is recognised good practice for all Board Committees to assess their effectiveness and the extent to which they have met their Terms of Reference.

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

None identified

5. Resources Implications (Financial / staffing)

None identified

6. Equality and Diversity

None identified

7. References to previous reports

This is an annual exercise.

8. Freedom of Information

Public

Quality Governance Committee
Terms of Reference

1. Constitution

The Board of Directors ("Board") has established a Committee to the Board to be known as the Quality Governance Committee. The Committee ("Committee") has no executive powers other than those specifically delegated in these Terms of Reference.

2. Terms of Reference

2.1 Purpose

To provide assurance to the Board that the Trust has a robust framework for the management of key critical clinical systems and processes focussing on the quality of these systems and processes.

2.2 Objectives

- The primary objective of the Committee is to provide assurance to the Board that the key critical clinical systems and processes are effective and robust, and prioritised against the relevant risks on the Board Assurance Framework. These systems will include, but are not limited to:

- Incident Management and Reporting;
- Quality Improvement;
- Quality Care which is safe, effective and focuses on providing a ~~with~~ positive patient experience
- Compliance with the CQC Essential standards of quality and safety;
- NHS Resolution Compliance;
- Quality Account priorities, and production and publication of the Quality Account;
- Research and Development, as it relates to clinical quality in the Trust
- Maintaining clinical competence.

In addition the Committee will:

- Consider external and internal assurance reports and monitor action plans, in relation to clinical governance, resulting from improvement reviews/notices from the Care Quality Commission, Health and Safety Executive and other external assessors.
- Consider, at their request, quality and clinical governance related matters at Sulis Hospital.
- Horizon scan for matters for consideration.

3. Membership

The Committee shall be appointed by the Board to ensure representation by Non-Executive and Executive Directors as well as representation of the views of users, carers and Trust services.
The membership of the Committee shall consist of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors
- Chief Nurse (Lead Executive)
- Medical Director

Each member will have one vote with the Chair having the casting vote, if required. Should a vote be required a decision will be determined by a simple majority.

The following participants are required to attend meetings of the Quality Governance Committee (mandatory participants):

- Chief Operating Officer (or one of the Deputy Chief Operating Officers)
- Head of Corporate Governance
- Divisional attendance by either the Head of Division or Divisional Governance Lead (or nominated Deputy)
- ~~Other individuals as agreed necessary by the Chair, including the Chief Operating Officer~~.

4. Quorum

Business will only be conducted if the meeting is quorate. The Committee will be quorate with three members, including at least two Non-Executive Directors (of which one may be the Chair) and either the Chief Nurse or the Medical Director (or their formally nominated deputy), being present. All efforts will be made to ensure that both the Chief Nurse and the Medical Director (or their respective deputies) are in attendance at each meeting.

5. Attendance by Members

The effectiveness of the Committee meetings is driven by the quality of the attendance. It is therefore expected that all of those identified in paragraph 3 will attend or be represented by a deputy at every meeting.

6. Attendance by Others

The Chief Executive and Chair of the Board may attend.

The Committee shall co-opt as it deems necessary.

7. Accountability and Reporting Arrangements

The Committee will be accountable to the Board. The Chair of the Committee will as soon as practicable, present a report to the Board of Directors on the activity of the Committee at its last meeting. The report shall draw to the attention of the Board issues that require disclosure to the full Board, or that require executive action.

The Committee shall refer to the other Board Committees (Audit, ~~–~~ Non-Clinical Governance, People and Finance and Performance Committees) matters considered by the Committee deemed relevant for their attention. The Committee will consider matters referred to it by those other Committees.

The Committee will develop and maintain a work plan which will describe the key reports it will consider during the year.

8. Frequency

The Committee will meet on a bi-monthly basis ~~at least four times a year~~.

Additional meetings may be arranged when required to support the effective functioning of the Trust.

9. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

10. Monitoring Effectiveness

The Committee will undertake an annual review of its performance against its Terms of Reference and work plan in order to evaluate the achievement of its duties. This review will be presented to the Board in the form of the Committee's annual report.

11. Other Matters

The servicing, administrative and appropriate support to the Chair and Committee will be undertaken by a nominated Executive Assistance who will record minutes of the meeting. The planning of the meetings is the responsibility of the Chair.

12. Review

These terms of reference will be reviewed annually as part of the monitoring effectiveness process.

Terms of Reference reviewed by the Quality Governance Committee on 16 August 2022~~9 March 2021.~~

Ratified by the Board of Directors on 2 November 2022.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Board of Directors**	**Agenda item:**	**22c**
Date of Meeting:	**2 November 2022**		

Title of Report:	**Review of Audit Committee Terms of Reference**
Status:	**Approval**
Author:	**Adewale Kadiri, Head of Corporate Governance**
Board Sponsor:	**Antony Durbacz, Non-Executive Director**
Appendices	**Appendix 1: Terms of Reference**

1. Executive Summary of the Report

The Audit and Risk Committee's Terms of Reference define the committee's structure and purpose, and how it carries out its functions.

At the Committee's meeting in December 2021, it approved a range of changes to the Terms of Reference, including clarification of its role in relation to the Board Assurance Framework, as well as its responsibilities in relation to counter fraud and security management. These changes were ratified by the Board at its meeting in January 2022.

The Committee conducted a further review of the Terms of Reference in September 2022, but in view of the comprehensiveness of the previous work, it is not proposed that any additional changes be made, with the exception that senior clinical representation be provided at each meeting of the Committee.

2. Recommendations (Note, Approve, Discuss)

The Board is asked to consider the changes and approve the updated Terms of Reference of the Audit and Risk Committee

3. Legal / Regulatory Implications

The role of the Audit and Risk Committee is key to the maintenance of effective corporate and financial management systems in the Trust. The Board relies on the Committee to gain assurance in respect of a number of key regulatory and governance requirements, including those imposed by the CQC and NHSE/I. It also ensures that the Trust's approaches in areas such as counter-fraud, the management of interests and gifts and cyber-security are in line with accepted best practice.

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

None

5. Resources Implications (Financial / staffing)

Not applicable

6. Equality and Diversity

Not applicable

7.	References to previous reports
This is an annual review. The previous year's review was completed in December 2021.	

8.	Freedom of Information
Public	

Appendix 1

AUDIT AND RISK COMMITTEE
TERMS OF REFERENCE

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit and Risk Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Purpose and Objectives

(a) Governance, internal control and risk management

The Committee shall oversee and scrutinise the establishment and maintenance of an effective system of internal control and probity across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

In particular, the Committee will:

- Review the adequacy and accuracy of all risk and control related disclosure statements (in particular, the Annual Governance Statement and Value for Money assessment), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- Review, and where necessary approve the Annual Report and Accounts and assess the extent to which these comply with relevant legislation and guidance;
- Oversee the Trust's risk management arrangements, including the risk management strategy, the Board's risk appetite and the effectiveness and coordination of the various risk registers;
- Assess the effectiveness and responsiveness of the Board Assurance Framework process, including the consistency of risk scoring, the completion of actions to fill gaps in control and assurance, and the extent to which the BAF is aligned with the Trust's objectives and the wider risk management system as above;
- Review the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- Assess the effectiveness of policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements including in relation to Fit and Proper Persons; and
- Review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud Authority.

In carrying out this work the Committee will place significant reliance on the work of Internal Audit, External Audit and other assurance functions, but will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, probity and internal control, together with indicators of their effectiveness.

(b) Internal Audit

The Committee shall ensure that there is an effective internal audit function in place, which complies with the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Accounting Officer and the Board. This will be achieved by:

- provision of a value for money Internal Audit service;
- review and approval by the Committee of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework and from engagement with the other Board Committees; and
- consideration of the findings emerging from internal audit work (and management's response), ensuring that all accepted recommendations are actioned within agreed timescales, and facilitating co-ordination between the Internal and External Auditors to optimise resources and ensure shared learning;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- periodic review of the efficiency and effectiveness of internal audit.

(c) External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor;
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust, and associated impact on the audit fee;
- review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses, and
- consideration of any lessons or learning emerging post-audit to ensure greater efficiency and effectiveness in future years (to also include learning from the External Auditor's work with other clients and the wider sector).

(d) Local Counter Fraud Specialist

The Committee shall ensure compliance with the requirements of Section 24 of the NHS Standard Contract that the Trust has put in place appropriate arrangements to address counter fraud and security management issues, including that there is an effective counter fraud function established by management that meets the NHS Requirements of the Government Functional Standard 013: Counter Fraud and provides independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration on the appointment of a Counter Fraud Service, the fee and Terms and Conditions of engagement;
- Oversee the effective operation of Counter Fraud and to ensure that the Counter Fraud Service is appropriately resourced and has appropriate standing within the Trust; and
- Review the Counter Fraud Policies, Strategies/Plans and to consider major findings of Counter Fraud Reports, management's response and subsequent action.

(e) Other Assurance Functions

The Audit and Risk Committee shall review the findings, or ensure that they are reviewed by a relevant body, of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include externally commissioned reviews by relevant Department of Health and Social Care Arm's Length Bodies or Regulators/Inspectors relating to the governance and operations of the Trust. In such cases, the Committee will seek assurance from those directly involved in the review that the relevant learning has been taken on board and shared, and that plans to address any recommendations are on track.

The Committee will seek and receive assurance around the Trust's approach to ensuring data quality, in relation, in particular to the internal and external reporting of financial and operational performance.

The Committee will also seek and receive assurance that the Trust has adequate information governance arrangements, such that it effectively safeguards patient and other sensitive information in its possession in line with relevant legislation and guidance from the Information Commissioner's Office.

The Committee will also have oversight of the adequacy of the Trust's approach to cyber-security. It will provide assurance to the Board that the systems and processes in place are sufficiently robust to ensure, as much as is possible, protection of the Trust from attacks and threats.

The Committee may rely upon the work of other committees within the organisation, which can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Non Clinical Governance Committee, the Clinical Governance Committee and the Finance and Performance Committee. These

committees may also ask the Audit and Risk Committee to consider, as part of its work plan, issues that are brought to their attention that fall more appropriately within this Committee's remit.

The Committee shall also ensure that the requirements set out in the Trust's Standing Financial Instructions and Standing Orders are addressed, which also include:

- Monitoring compliance with Standing Orders and Standing Financial Instructions;
- Reviewing schedules of losses, compensations and settlements with staff, and making recommendations to the Board; and
- Reviewing schedules of debtors/creditors balances over 6 months old and over a de-minimis limit as defined by the Audit and Risk Committee and related explanations/action plans.
- Reviewing the register of interests, gifts and hospitality to ensure that personal interests do not conflict with those of the Trust and that positions are not abused for personal gain or to benefit family and friends.

(f) Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, probity and internal control.

They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

(g) Financial Reporting

The Audit and Risk Committee shall review the Annual Financial statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Un-adjusted mis-statements in the financial statements
- Major judgemental areas
- Significant adjustments resulting from the audit

3. Membership and Attendance

The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of no less than three members. The Chair of the organisation shall not be a member of the Committee.

Members will include:

Chair	Non-Executive Director
Other Members	Non-Executive Director

Non-Executive Director

In the absence of the Chair, another Non-Executive Committee member will perform this role.

Others in attendance	Director of Finance Deputy Director of Finance Head of Corporate Governance Chief Nurse Medical Director External Audit Internal Audit Local Counter Fraud Specialists Head of Financial Services

In addition, one of either the Chief Nurse or the Chief Medical Officer or one of their deputy or associate directors will attend each meeting of the Committee to provide a clinical perspective to the discussions.

Each member will have one vote with the Chair having the casting vote, if required. Should a vote be required a decision will be determined by a simple majority.

a. Quorum

A quorum shall be two members.

b. Attendance by Members

The Chair of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 75% of all meetings and be allowed to send a Deputy to one meeting per annum.

c. Attendance by Officers

The Director of Finance and appropriate Internal and External Audit, and Local Counter Fraud representatives shall normally attend meetings.

The Chief Executive and other Executive Directors may be required to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. The Chief Nurse and the Medical Director will be required to attend on an alternate basis.

4. Accountability and Reporting Arrangements

The Committee will be accountable to the Trust Board. A report of the meeting will be submitted and presented at the next available Board meeting by the Chair who will draw to the attention of the Board issues that require disclosure to the full Board, or require executive action.

The Committee shall refer to the other Board Assurance Committees (the Non Clinical Governance Committee, the Clinical Governance Committee, the People Committee and the Finance and Performance Committee) matters considered by the Committee to be relevant to their work. The Committee will consider matters referred to it by those three Assurance Committees.

The annual work plan of the Committee may be reviewed by the Committee at any given time.

The Committee will draft and present to the Board an annual report of their work drawing out successes and areas for development and focus.

5. Frequency

The Committee will meet no less than four times a year.

Additional meetings may be arranged when required to support the effective functioning of the Trust. Internal and External Audit may request a meeting if required.

6. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

7. Monitoring Effectiveness

The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties. This review will inform the Committee's annual report to the Board.

8. Other Matters

The Committee shall be supported administratively by the members of the Corporate Governance and Finance teams whose duties in this respect will include:

- Head of Corporate Governance to agree the agenda with Chair
- PA to Director of Finance to collate the papers and minute meetings
- Director of Finance, Head of Financial Services and Head of Corporate Governance to advise the Committee on pertinent areas.

9. Review

These terms of reference will be reviewed at least annually as part of the monitoring effectiveness process.

Current version: September 2022~~1~~
Next review date: September 2023~~2~~

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Board of Directors**	**Agenda item:**	**22d**
Date of Meeting:	**2 November 2022**		

Title of Report:	**Non-Clinical Governance Committee Terms of Reference Review**
Status:	**For Approval**
Board Sponsor:	**Sumita Hutchison, Non-Executive Director**
Author:	**Adewale Kadiri, Head of Corporate Governance**
Appendices	**Appendix 1: Updated Terms of Reference**

1. Executive Summary of the Report

The Terms of Reference of the Non-Clinical Governance Committee indicate that they will be reviewed at least every year to ensure that they remain relevant and that they capture the entirety of the Committee's remit.

Overall, the Terms of Reference continue to capture all the elements of the Committee's work, but the Board is asked to consider some relatively minor changes to address particular issues that had been raised by members. The Terms of Reference were last updated earlier this year, but the aim is to align the timing of all Committee terms of reference reviews so that they are dealt with at the November Board meeting.

2. Recommendations (Note and Discuss)

The Board is also asked to consider and approve the proposed amendments to the Committee's Terms of Reference.

3. Legal / Regulatory Implications

None

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

None

5. Resources Implications (Financial / staffing)

None

6. Equality and Diversity

Not applicable

7. References to previous reports

This is an annual review.

8. Freedom of Information

Public

Royal United Hospitals Bath
NHS Foundation Trust

Non-Clinical Governance Committee
Terms of Reference

1. Constitution

The Board of Directors ("Board") hereby resolves to establish a Committee to the Board to be known as the Non Clinical Governance Committee ("the Committee"). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Terms of Reference

2.1 Purpose

To provide assurance to the Board that the Trust has a robust framework for the management of risks arising from or associated with estates and facilities, environment and equipment, sustainability (environmental) health and safety, digital development and cyber-security, reputation management, information governance, business continuity and other non-clinical areas as may be identified.

2.2 Objectives

The primary objectives of the Committee are to provide assurance to the Board that the key critical non-clinical systems and processes are effective and robust, and to provide effective scrutiny in these areas under delegated responsibility from the Board. These systems will include, but are not limited to:

- IM&T including Information Governance;
- Environmental sustainability and carbon reduction
- Health & Safety;
- Relationship Management / Communications;
- Policy Management;
- Facilities Management;
- Estates Development.

In addition the Committee will:

- Review the controls and assurances against relevant risks on the Board Assurance Framework, in order to assure the Board that priority risks to the organisation are being managed and to facilitate the completion of the Annual Governance Statement at year end.

- Consider external and internal assurance reports and monitor action plans, in relation to non-clinical risk, resulting from improvement reviews/notices from the Health and Safety Executive and other external assessors.

- On occasion seek assurance from a Lead Director from another Committee.

- Seek assurance from the Coach House, Executive members of the Committee and other attendees as to the extent and pace at which the Improving Together methodology is being embedded across the Trust.

3. Membership

The Committee shall be appointed by the Board to ensure representation by Non-Executive and Executive Directors as well as representation of the views of users, carers and Trust services

Membership of the Committee will comprise of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors
- Director of Estates & Facilities (Lead Executive)
- Director of Strategy
- Chief Digital Officer

The Head or Deputy Head of Corporate Governance shall attend each meeting.

Each member will have one vote with the Chair having the casting vote, if required. Should a vote be required a decision will be determined by a simple majority.

4. Quorum

Business will only be conducted if the meeting is quorate. The Committee will be quorate with three voting members present, including at least one Non-Executive Director and one Executive Director.

4.1 Attendance by Members

The members will be required to attend a minimum of 80% of all meetings. Executive members may be represented by their deputies ~~and be allowed to send a Deputy to one meeting per annum.~~.

4.2 Attendance by Officers

The Chief Executive and Trust Chair may attend any meeting of the Committee.

The Committee may invite Heads of Department or any other member of staff to attend their meetings when the Committee is discussing areas of the operation that are the responsibility of that Head.

5. Accountability and Reporting Arrangements

The Committee will be accountable to the Board. The Chair of the Committee will, as soon as practicable, present a report to the Board of Directors on the activity of the Committee at its last meeting. The report shall draw to the attention of the Board issues that require disclosure to the full Board, or require executive action.

The Committee shall refer to the other Board Assurance Committees (the Audit, People, Finance and Performance and the Quality Governance Committees) matters considered by the Committee to be relevant to their work. The Committee will consider matters referred to it by those other Assurance Committees.

The Committee will develop a work plan which will describe the key reports it will consider during the year. This work plan will be agreed by the Board of Directors.

In view of the particular range of systems and processes on which this Committee has oversight, Executive and Non-Executive members are encouraged to use their Go and See visits to triangulate the information that is presented to them at meetings.

6. Frequency

The Committee will meet at least four times a year.

Additional meetings may be arranged when required to support the effective functioning of the Trust.

7. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Board will retain responsibility for all aspects of internal control, supported by the work of the Committee, satisfying itself that appropriate processes are in place are in place to provide the required assurance.

The Committee has decision making powers with regard to the ratification of non-clinical policies and approval of non-clinical procedural documents. It is established to provide recommendations to the Board on risk management, governance and patient, staff and public safety issues.

The Committee is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

8. Monitoring Effectiveness

The Committee will undertake an annual review of its performance against its Terms of Reference and work plan in order to evaluate the achievement of its duties.

9. Other Matters

The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:

- Agreement of the agenda with the Chair and attendees;
- Collation of the papers;
- Taking the minutes and keeping a record of the matters arising and issues to be carried forward; and
- Advising the Committee on pertinent areas.

10. Review

These terms of reference will be reviewed annually as part of the monitoring effectiveness process.

Terms of Reference approved by the Non-Clinical Governance Committee on 18 August ~~31 January~~ 2022.

Ratified by the Board of Directors