Bundle Public Board of Directors 1 March 2023

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, 1 March 2023, 13:00 – 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		Enc.
3.	Declarations of Interest		Verbal
4.	Minutes of the Board of Directors meeting held in public: 11 January 2023		Enc.
5.	Action List		Enc.
6.	Governor Log of Assurance Questions and Responses (For Information)		Enc.
7.	Items Discussed at Private Board		Verbal
8.	Patient / Carer / Staff Story	Toni Lynch, Chief Nurse Sharon Manhi, Lead for Patient and Carer Experience	Pres.
9.	CEO and Chair's Report	Libby Walters, Deputy Chief Executive	Enc.
10.	Agenda Item Withdrawn		
The People We Care For			
11.	Maternity Quarterly Update – Q3	Toni Lynch, Chief Nurse Zita Martinez, Director of Midwifery	Enc.
12.	Integrated Performance Report	Brian Johnson, Director of Estates and Facilities	Enc.
13.	Quality Governance Committee Update Report	Ian Orpen, Non-Executive Director	Enc.
The People in Our Community			
14.	Finance and Performance Committee Update Report	Jeremy Boss, Non-Executive Director	Enc.
15.	Non-Clinical Governance Committee Update Report	Sumita Hutchison, Non-Executive Director	Enc.
The People We Work With			
16.	Freedom to Speak Up Guardian Annual Report	Alfredo Thompson, Director for People and Culture	Enc.
17.	Medical Revalidation Annual Statement	Andrew Hollowood, Chief Medical Officer	Enc.
Governance			

CLOSING BUSINESS			
18.	Any Other Business	Alison Ryan, Chair	Verbal
Date of Next Meeting: 3 May 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, 11 JANUARY 2023,
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
Nigel Stevens, Non-Executive Director
Paul Fairhurst, 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
Jocelyn Foster, Director of Strategy
Libby Walters, Director of Finance

Non-Voting

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

In attendance

Sharon Manhi, Lead for Patient and Carer Experience
Jessica Baldrian, Director's Office Administrator *(minute taker)*
Peter McCowan, Public Governor
Horace Prickett, Public Governor
Suzanne Harris, Public Governor
Nicola James, Public Governor
Vivienne Harpwood, Public Governor
Zita Martinez, Director of Midwifery
Dr Claire Park, Lead Obstetrician
Kate Atkins, Patient Story
Elswyth Atkins, Patient Story

BD/23/01/01 Chairs Welcome and Apologies

The Chair welcomed everyone to the meeting and confirmed that no apologies were received.

BD/23/01/02 Written Questions from the Public

There were no written questions received from the public.

BD/23/01/03 Declarations of Interest

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

BD/23/01/04 Patient Story

The Chair welcomed the Lead for Patient & Carer Experience who introduced the patient Kate Atkins and her baby Elswyth. She also introduced Zita Martinez, Director of Midwifery and Claire Park, Consultant Obstetrician.

Ms Kate Atkins explained that she had given birth to Elswyth (her 3rd child) in August 2022. The Board of Directors watched a short film in which Kate shared her experience of giving birth at the RUH. Kate said that she had an all-round good experience and was looked after well. She was undecided as to who she wanted to deliver her baby however she was helped to make the decision by the Clinical and nursing staff who gave has a choice and didn't make assumptions. Kate felt that she was given a choice as to how she wanted to deliver her baby and how to wanted to feed her baby even though this was her third child she felt that she had that choice. She added that the staff who looked after her after the caesarean section in recovery and on the wards were fantastic – they introduced themselves, they were reassuring and helpful. She explained that the midwives at the RUH made sure that she and her baby were safe and looked after, and were extremely receptive to questions.

The Chief Nurse thanked the patient for coming in and telling her story, and commented that it was timely due to the amount of media coverage that maternity services across the country was currently getting, as well as the focus on maternity across the Trust.

Ian Orpen thanked the patient for her story. He asked a question regarding the patient's comment that she had not felt able to change her mind regarding her method of delivery, which was chosen for her as she was unable to choose. He wanted to know what would have made that different, and what would have helped. The patient replied that an 'undecided' option would have been useful, as this would have meant that the nurses did not have to choose for her, and enabled her to make a decision later on without feeling constrained. She also commented that it could be difficult for a patient to say that they had changed their mind, and that it would be useful for the hospital to ensure that the patient was happy with their decision.

The Director of Midwifery thanked the patient for her story and highlighted the importance of informed consent and open questioning, as well as the power of language. The Lead Obstetrician agreed with this, and commented that an undecided sticker should definitely be implemented. The Chair highlighted the importance of understanding that patients might not have been through this journey before, and therefore not be able to predict how they will feel. She suggested that this feedback should be brought to all aspects of the Trust, not just maternity.

The Chief Medical Officer commented that it was important to use feedback to focus on what went well as well as what did not, and that this also reinforces positivity within the workforce. He commented that this patient story not only reinforced good practice, but also demonstrated what the Trust could do to improve. He highlighted the importance of perfecting the consent process.

The Lead Obstetrician commented that there was a plan in place to allow patients more autonomy with their choices around their pregnancy, which was going to be within the new digital structure. She commented that it should be easier for patients to write their preferences into an app rather than confronting a member of staff.

The Board of Directors thanked the patient for her story.

BD/23/01/05 Minutes of the Board of Directors Meeting held in Public on 2nd November 2022

Jeremy Boss commented that there was a slight inaccuracy in item 19: Charities Chair's Update Report regarding funding, and agreed to send a few words over to the Head of Corporate Governance regarding this.

Action: Jeremy Boss / Head of Corporate Governance

The Chief Nurse commented that on page 95 of the Maternity Quarterly Report Zita Martinez should be down as the Director of Midwifery, and Dr Claire Park as Lead Obstetrician. For the annual report there should be stringent national guidelines, but local decision making. In AOB, it should read 'divisional directors of nursing'. The Chair asked the Head of Corporate Governance to update the minutes.

Action: Head of Corporate Governance

BD/23/01/06 Action List and Matters Arising

The actions presented as closed were approved. The following actions had further updates: PB581: An update would be presented at the Board in March 2023.

BD/23/01/07 Governors' Log of Assurance Questions and Responses

The Chair noted that the Governors' Log was a document presented for information. The Board noted the update.

BD/23/01/08 CEO and Chair's Report

The Chief Executive provided an overview of the report, and the following points were highlighted:

- Kerry Perkins, Maternity Matron, was named Midwife of the Year by the MAMA Academy.
- Hannah Hyett, Trauma Audit and Research Network Administrator, was presented with the Woodford Award. This was due to a great deal of work, as the Trust was behind in reporting, and Hannah was able to get on top of this and ensure that data reporting was up to date and up to standard.
- Several teams from the Trust were shortlisted for national awards.
- The Connecting Cultures project was also shortlisted, which focused on overseas nurses. The Chief Executive reported that overseas nurses joining the organisation very quickly felt a part of the RUH, and also tended to stay in the organisation they landed in.
- The Freedom to Speak Up team was also shortlisted at the HSJ Awards. A great deal of work had been carried out over the last two years by the team in order to cultivate a culture that allowed staff to speak up and to expand the service.
- Dr Dan Augustine had been chosen as President-Elect of the British Society of Echocardiography, which also helped to raise the profile of the team.
- The 'Changing Places' facility was opened in December.

The Chief Executive formally welcomed the Chief Medical Officer to his first official Board meeting. The Board of Directors noted the update.

BD/23/01/09 Items Discussed at Private Board

The Chair gave an overview of the key items discussed at Private Board highlighting:

- General operational pressures were discussed, both nationally and within the Trust.
- People and cultures within the Trust were discussed, as well as the staff survey, where significant progress had been made.

- Sulis Hospital and its future was discussed. The Chair noted that the Governors would receive a briefing regarding Sulis in June.
- The integrated care system and its finances were discussed.

The Board of Directors noted the update.

BD/23/01/10 Board Assurance Framework Summary Report (BAF)

The Head of Corporate Governance provided the Board with an overview of the changes made to the BAF since the last meeting. He reported that no new risks had been added to the BAF since the last report in November 2023. However, the mitigations for those risks had been changed. He highlighted the following:

- The Executive Team had met the previous day to discuss their priorities regarding the upcoming BAF and upcoming risks for the next few years. The new BAF of 2023/2024 would be created in the next few months.
- Some risks for 2023/24 would remain the same as the current BAF, such as winter pressures, finances, and quality. New risks could include elements regarding the Trust's estate.
- The Trust needed to think of itself as a corporate citizen of BaNES and Wiltshire, and should look at what the system was doing to contribute towards environmental improvement and the life of citizens within the area.

The Board of Directors noted the update.

BD/23/01/11 Audit & Risk Committee Update Report

Antony Durbacz provided the Board with an update on the work of the Audit & Risk Committee. He highlighted the following:

- The BAF was a central piece of work to the Audit & Risk Committee, and was a highly practical document in terms of reviewing risk.
- A lot of time was spent discussing cyber, as one of the risks that stood out on the risk register. A lot had been done regarding cyber, but the question remained as to where the Trust wanted to be in regards to cyber, and where investments should go.
- KPMG provided an update on progress made since the last meeting and confirmed all reviews were due for delivery by 31st March. There were currently 16 overdue actions, two of which were high priority. The Committee raised concerns at the increasing number of overdue actions, the responsibility of the Executive Team needed to be reinforced.
- Counter fraud carried out a review of how the Trust maintained financial control during the pandemic, and concluded that the Trust was successful.
- Further work was going to be carried out regarding medicine management, which was an audit that was carried out under the previous auditors. Some of the actions that arose from it had not necessarily been concluded.

The Board of Directors noted the update.

BD/23/01/12 Quality Governance Committee Update Report

Ian Orpen provided the Board with a report on the work of the Quality Governance Committee. He highlighted the following:

- There had been an exceptionally powerful patient story which was detailed within the report. There was a plan in place to ensure the Trust used the feedback given.

- There were previously issues with the aseptic unit, but the Chief Pharmacist and his team carried out some great work to turn this around, and there had been a marked improvement.
- From February, the Quality Governance Committee was moving to monthly meetings (probably ten meetings per year).

The Chair commented that the recruitment process was underway for two Non-Executive Directors (NED), one to replace Jeremy Boss when his term of office ended on the 31st March 2023, and the other was a new appointment for an additional NED with a clinical background.

The Board of Directors noted the update.

BD/23/01/13 Integrated Performance Report

The Chief Medical Officer presented the Integrated Performance Report, which presented the data from November 2022. He also gave a verbal update regarding the more recent data, and highlighted the following:

Performance – In November the performance was very good, especially in terms of ambulance handover and performance within the Emergency Department. Neither of these were up to the ideal standard, but had improved considerably from the previous data. Cancer 62-day performance had dipped slightly, but currently the Trust was one of the best hospitals in the region in terms of maintaining that performance. Elective recovery had improved, with a consequential improvement in patients waiting a long period of time for procedures.

Finance – The financial situation was looking negative due to operational pressures, as well as the elective recovery position. Much of this was being driven by non-criteria to reside patients, as staff were struggling to manage flow throughout the Trust. Agency spend was an issue that had begun to improve.

Workforce – The Trust had a positive record in recruitment, but needed to focus on maintaining staff, and combatting issues with staff sickness, work was ongoing in this area. Staff sickness had had a knock on effect with the ability to manage wards, which was an issue as the number of beds within the organisation had had to increase, in areas that did not necessarily fit into wards. Appraisal and management training were both affected at times of pressure for the Trust. Appraisal figures were at a reasonable position compared to other Trusts, but the Trust was not meeting national or internal targets. This was a reflection of operational pressures over winter.

Quality – The knock on effect of operational pressures was that there were issues relating to quality of patient care, and patient safety. There was a significant increase in the number of hospital-acquired infections. Some of the most significant instances were 8 cases of Clostridioides Difficile and 10 hospital associated E-coli infections reported over November. There had been in-depth investigations as to how to deal with the rise in hospital-acquired infections, but no specific cause had been pinpointed so far, apart from possible issues with cleaning services. Covid-19 infections had also affected the operational pressures within the Trust, and had increased from November to December, though had peaked on 27th December and had started to decline. At the peak, there were 68-70 patients in hospital beds with Covid-19, and 50-60 patients with flu. There had since been a drop off in numbers. Prior to Christmas, the Trust was also affected by cases of Strep A and RSV, which unusually occurred at the same time, increasing pressure on the system. Some of the issues described in the report regarding pressure ulcers in November were projected to increase going

forward, because of pressure on staff having to take patients to different areas of the hospital. The report described a bleak position in November, though with many positive improvements. The projection going forward into winter was that there would be some deteriorations due to operational pressures, though improvements were being observed in terms of infection control.

Ian Orpen asked whether more patients were entering the hospital with Covid-19, or whether more of them were acquiring it within the Trust. The Chief Medical Officer replied that more patients were entering the hospital with Covid-19 and presenting with respiratory problems associated with the virus.

Sumita Hutchison noted that the report had mentioned a significant reduction in the number of mental health nurses, and asked why this was the case, as there had been a national increase in mental health cases. The Chief Nurse replied that not everybody with a mental health condition needed a mental health nurse, and that those that did were those who were a risk to themselves and others. She reported that the biggest challenge currently was the population with dementia and delirium, and those patients that were confused, disoriented and aggressive. Mental health nurses were not trained to handle patients living with dementia, so the number of bookings for RMNs had been reduced, and Band 2 and 3 one-to-one bookings had been increased. A business case was being put together to analyse the needs of those patients, and a training package was actively being developed with an external provider to ensure that there was a cohort of nurses that were trained in the de-escalation of patients living with dementia or delirium. The reduction of mental health nurses was therefore due to purposeful attention, deliberation and discussion.

Jeremy Boss commented on the oversubscription issue of bed utilisation and bed bases, and linked it to the issue of infection control. He asked what the plan was regarding short term improvements to adding toilets and facilities to wards and individual rooms. The Director of Estates and Facilities replied that there were plans in place to convert existing side rooms to en-suites to ensure self-contained units. He reported that this piece of work was about half way through, and that it had begun in September 2022, though there were initial delays at the beginning of the project. A decision had been made to pause the work during January due to winter pressures, but this work would re-start again in February, with the expectation that this would be completed by the end of the year. This would create an increase of 23 new side rooms beyond this time last year, which was positive, though there was a lot of work still left to do. The Chief Operating Officer commented that the Trust had been roughly 100 beds short over the winter, with about 60 escalation beds open and 40 people waiting for beds in the Emergency Department. He highlighted that it was important not to be overly optimistic when considering mitigations for the future, and that robust schemes were required going into next winter, including considering increasing the bed base of the RUH.

The Chair asked whether the whole hospital was mobilised during New Year (where there were extra pressures), or whether some departments were unaffected. The Chief Medical Officer replied that the Trust had come together to deal with the extra pressures, and that extra medical staff were being spread to handle current pressures, as well as additional registrars. Once a critical incident had been declared, additional powers were available in order to release the Trust from the situation. He commented that the wider community as well as the RUH had come together to mitigate this. He noted that the extra work and mobilisation that had taken place was not sustainable going forward, and that this should be seen as a catalyst for the following winter. The Chair commented that in the plans for the next winter, the costs should not be spent on the hospital that would be better spend outside in the community, enabling the Trust not to have an oversubscription of beds for those patients who

could be being cared for elsewhere. She noted that managing that acute spend was a challenge, but an important one going forward into next winter.

The Board of Directors noted the update.

BD/23/01/14 Winter Planning

The Chief Operating Officer explained that during the current winter, the Board had made a decision in August or September to mobilise winter schemes, which allowed the actions to begin earlier than they might otherwise have done, and mitigated risk.

He explained that Ward 4 (which was run by HCRG in St Martin's Hospital) had been a big success over winter, opening in November and adding 20 beds that made a huge difference to the RUH pressures. There was much more involvement in flow work compared to last year, particularly from sisters and ward teams. United Care BaNES was not where it needed to be, but was a big positive step in collaborating with BaNES Council, and outlining the boundaries between social and hospital care.

On the more negative side, several winter schemes had slipped and not provided as many beds as expected. United Care BaNES provided under half of what was hoped for in terms of capacity. There were also not enough nursing home beds in the community, which was being worked on to obtain funding. Infection was beyond what was predicted, with 78 Covid-19 patients and 58 flu patients. Emergency Department demand was also high, with 26% more patients on average than before the Covid-19 pandemic.

The Chief Operating Officer noted learning to be taken into next year, highlighting the need to void overly positive thinking. The Trust appeared to be in a long-term trend of operational pressures, and these needed to be looked at realistically and practically. Areas for focus were SDEC (Same Day Emergency Care) and the front door, avoiding admissions and managing the Emergency Department. Another area was wards, and achieving flow through the wards. A third area for focus was getting patients home when ready, and working more closely with social care.

Paul Fairhurst asked how long Ward 4 was planned to be open for, and what flexibility there was to have it open longer than planned if required. He also asked whether any circumstances could be in place to consider keeping it open indefinitely, and if so, how this would work financially. The Chief Operating Officer replied that the Trust attempted to keep Ward 4 open last year, and that the funding to keep it open this year was kept in baseline as part of the funding agreement over the following year. He highlighted that Ward 4 had to be kept open, or the bed utilisation issue would be ongoing. He reported that funding had come through to support this.

The Chair commented that there had been many positive changes within the Trust, with data going in the right direction and improving. There was incremental improvement in many areas, particularly within workforce.

The Board of Directors noted the update.

BD/23/01/15 Learning from Deaths (Quarter 2)

The Chief Medical Officer provided an overview of the Learning from Deaths Q2 report. He highlighted the following:

- There was currently a backlog of Structured Judgement Reviews (SJRs), which was due to the fact that the legal team that were passing them on had some staffing gaps. This had now been resolved, so the backlog should begin to clear.
- The quality of the SJRs showed a number of patients who entered the organisation and experienced inadequate care.
- There had been triangulation between serious incidents, inquest reports, and SJRs, to look into common themes, both in terms of mortality, but also wider patient safety.
- Emerging themes were: medication control (patients being prescribed the wrong medication, or not prescribed any medication), anti-coagulation (the administration and governance around this was being looked at), and documentation (particularly the mix of digital and paper reporting).
- In terms of clearing the backlog, Professor Richard Graham had written to the medical examiners regarding this, which had helped to create a priority.

Ian Orpen thanked the Chief Medical Officer for his report, and asked to what extent the scores were being audited. The Chief Medical Officer replied that in terms of quality assurance there was a subjectivity issue due to the medical examiner filling in each report. There had been some success with one individual in each area filling in reports, which created some consistency.

Jeremy Boss reflected how far the Trust had come within this area since he started working at the RUH six years ago. He acknowledged that there was certainly further work to do, but that it was so much more structured, organised and robust than it had been before. He commented that the change in terms of medical examiners was a positive step, and reassured the Board that learning from deaths was taken very seriously within the RUH. He asked whether there were any national benchmarks that the Trust could measure itself against, and how the organisation was performing nationally. He also commented that he would expect more deaths to come through in the coming months, and that the Trust should prepare for this. He asked whether a sample had been taken of SJRs, to ensure that no learning was being missed.

The Chief Medical Officer replied that there was a clear identification process regarding the patients, and that the process regarding medical examiners was to review the notes themselves. The lead medical examiner reviewed every death to ensure that it could be processed correctly, and discussed with the coroner if necessary.

Sumita Hutchison commented that there had been a previous conversation regarding reading signals, and asked how this report fed into the broader triangulating conversation, as well as the complaints report. The Chief Medical Officer replied that this would be fed through the governance process, and be reported into the committees, but that it also sat with individuals such as himself and the Chief Nurse in terms of triangulating information.

The Chair commented that this was one of the most important developments she had seen in terms of hospital assurance, as learning was obtained with regards to general care, as well as mortality. She asked whether the development had been made nationally, the Chief Medical Officer confirmed that it had been implemented nationally, but that take-up had been different across different organisations and was taking time to embed. He reported that the RUH was performing particularly well in this instance, and that it was not yet a national rule that medical examiners had to fill out mortality reports, but that this was something that the RUH had implemented anyway.

The Board of Directors noted the report.

BD/23/01/16 Maternity Incentive Scheme Sign Off

The Director of Midwifery presented the Maternity Incentive Scheme for the Board to sign off.

Ian Orpen commented that there had been a great deal of work going on in the last 12 months, with a great deal of change happening in that time. He commented that he felt reassured by the Director of Midwifery's involvement, giving a different perspective and fresh eyes along with vast experience. He noted that the patient story reflected what was being seen on the ground, and highlighted the importance of robustness of processes in place.

The Board of Directors approved the Maternity Incentive Scheme.

BD/23/01/17 Review of East Kent Maternity Report

The Chair welcomed Claire Parks, Lead Obstetrician to present the report. The Chair commented that previously East Kent Maternity had been outstanding, but its performance had recently dropped.

The Lead Obstetrician gave an overview of the Review of East Kent Maternity Report, highlighting the importance of not becoming complacent in what the Trust had achieved. She reported that four themes had been identified as aspects needing change:

1. Monitoring safe performance
   - In relation to the RUH, there was a lot of digital work going on behind the scenes to capture a robust network to monitor the work and care provided. This would also identify learning themes and triangulate data to learn from. Work was going ahead to move forward with the digital strategy.
2. Standards of clinical behaviour – not resting on roles
   - This related to having a kind and compassionate culture to work in. The Lead Obstetrician commented that there was an excellent inherent and grounded culture in Midwifery in the RUH.
3. Flawed team working
   - The Trust ran many disciplinary trainings, and was the first in the country to run undergraduate multiple disciplinary trainings.
   - The Trust was affiliated with the Royal College of Obstetricians and the Royal College of Midwives, where both medical students and midwifery students learn together using simulation training that was set to be rolled out nationally.
   - There was more work to do from a national level in relation to building kindness and cultural changes in medical and midwifery students. This was already happening in the RUH, which was third in the country this year with the GMC standards of supporting trainees.
   - The importance of driving forwards and working better with the maternity voices partnership and friends and family tests to get better feedback.
4. Organisational culture
   - Moving forwards, the plan was to become more inclusive from the shop floor all the way up through the Board. An issue with East Kent was that things were being hidden from Board, and here in the Trust there was a very open culture, with a patient safety champions representative to sit on the Board.

The Chair highlighted the importance of bringing all information to the Board, saying that the Board needed to hear when things were going wrong, as they had the power to make changes. The Lead Obstetrician replied that it was highly positive that the Trust had the

culture in place to be open, and that what was needed from the Board was support with the appropriate infrastructure and tools to carry out a gold standard level of service for patients.

The Lead Obstetrician reported that there had been an Ockenden visit recently, and that last time she presented to the Board, they were awaiting the results. She informed the Board that there had been four main comments in the report: improving morale, linked with improvement trajectory, a strong safety on focus through communication processes with good escalation processes in place, but with visible compassionate leaders.

Ian Orpen thanked the Lead Obstetrician for her report, and asked a question regarding the learning that could be taken on. He commented that culture and morale had shifted, and that learning could help to improve this. The Chief Nurse commented that the most useful thing that she had learned was to listen to what the staff were telling her. She noted that this behaviour and attitude was shared among executive colleagues in all areas of the Trust. She commented that it was positive to see the Director of Midwifery and the Lead Obstetrician demonstrating the kind and passionate leadership behaviours that connect patients and staff, and that they had made a significant positive difference since they started working at the Trust. She reported that she felt confident about the future moving forward.

The Chief Operating Officer commented that there were some useful comparisons that could be made between Maternity and the Emergency Department due to their recent reviews. He suggested that he look at triangulating the data on this with the Chief Nurse, as there could be some useful learning to take away from it.

Action: Chief Operating Officer / Chief Nurse

The Chief Medical Officer commented that there had been rapid change in organisational culture over the past year, and that it would be useful to be able to pinpoint what exactly changed this. The Director of Midwifery commented that coming from another organisation she could reflect that the Trust was having similar issues to every unit, as all Trusts were dealing with the Covid-19 pandemic. She pointed out that staff shortages had an impact on safety, wellbeing and resilience. She commented that there needed to be a solid midwifery leadership team, and that during the pandemic a leadership presence was not there every day. The Director of Midwifery commented that while there was a core cohort of obstetricians and gynaecologists, there was still a staff shortage compared to national standards. The culture still existed in a clinical sense, but it did not exist outside of that space because the focus was on getting through the day-to-day issues.

Sumita Hutchison asked how effective the Trust was at reading signals, and while it was positive that Ian Orpen's committee was looking at this, the overall issue was broader, and the Board's effectiveness should also be examined. The Chair replied that a seminar was coming up on governance and data triangulation. She reported that the Private Board meeting had looked at directors bringing in verbal reports from members of staff on the ground regarding what was going on in individual departments, and that this needed to be formalised in the way that it was reported. She commented that before any judgement was made regarding infrastructure, evidence was needed from what staff were saying as well as from the internal audit.

The Board of Directors noted the report.

BD/23/01/18 Quality Account 2021-22 (Final)

The Head of Corporate Governance presented the Quality Account for 2021-2022. He highlighted the following:

- The draft version of this report came to the Board in July 2022, and unfortunately it was prepared late. Systems were put in place to prevent this from happening again. The comments from partners outside the organisation were also received late, which was why the report was only just being brought to the Board and was ready for publication.
- The quality priorities for the coming year were due to be agreed, and members of the Council of Governors Quality Working Group would be involved in this.
- The Quality Accounts for 2022/23 would be drafted at the same time as the annual report so that both documents go through similar timescales in terms of production, which the anticipation that the deadline for quality account would again be the end of June.
- This report would be for publication on the website, subject to Board approval.

Paul Fairhurst commented on page 13 of the report (which summarised quality governance), and asked why the Quality Governance Committee was not referenced. The Head of Corporate Governance replied that the current strict governance processes used went via the Trust Patient Safety Group (what used to be Quality Board), and that this group had overseen the preparation of the report from a governance perspective. He reported that this would be changed going forward to ensure that the Quality Governance Committee were also involved. He commented that previously QGC had been informed of the process, but had not been directly involved in agreeing or overseeing priorities. The Chair commented that this paragraph looked as though it had been copied in from previous reports, as it mentioned governance as opposed to just quality accounts, and was using the old matrix. The Head of Corporate Governance noted that this was the current process when the draft was made. The Chief Executive commented that timings mentioned in the report should also be looked at, because of the last report being late.

Jeremy Boss commented that prior to the pandemic, the audit committee would view the final quality report alongside the accounts, though they were no longer required to. The Head of Corporate Governance confirmed this, and added that there used to be both a quality report and a quality account, but that the quality report was no longer required. The current piece of work was just the quality account, which was the only statutory requirement. Jeremy Boss commented that in the report, ‘2022 to 2022’ needed to be changed to ‘2021 to 2022’.

The Board of Directors approved the Quality Account for 2021/22, including feedback from BSW ICS.

BD/23/01/19 Complaints Annual Report

The Chief Nurse provided an overview of the Complaints Annual Report. She highlighted the following:

- The last year had not been easy in terms of complaints where patient attendances increased by 17%.
- There had been an 80% increase in formal complaints and a 47% increase in PALs contacts. This year was looking at similar numbers.
- Whilst during that year, there was a societal move towards normality, within the NHS there were continued significant challenges as they continued to learn about Covid-19. The option of visiting patients was intermittently offered on a limited basis, which caused frustration both for patients and visitors. The number of patients waiting for operations increased, and the organisation’s ability to be agile in communications with patients decreased. There were also increased waiting times in urgent and emergency care pathways, and during this community and home births had to be ceased due to a

shortage of midwives. Due to all of these issues, the Trust had not met the expectations of patients and families, as well as its own expectations.
- An increasing number of complaints were observed regarding clinical care, which overall accounted for 60% of formal complaints. This was a key focus going into the new year.
- An area that required radical improvement was the way in which patients and family members were listened to and communicated with, as complaints regarding this rose to 18%.
- Some changes had been made regarding the handling of complaints, specifically a movement towards improving the quality of responses to patients, as the language used was quite formal. There was work being carried out with teams to ensure that they viewed complaints as a point of learning.
- 10% of complaints were re-opened last year, which was an improvement on the previous year, and reflected the work that had been done to attempt to respond to all complaints honestly and transparently.
- The PALS service had exponentially increased contacts, which reflected the complexity of the scenario that the Trust was working in.
- Over the next few weeks, there was a plan in place to move to a single point of access for people who want to contact the RUH, so that patients would not have to choose between PALS and complaints. This would allow for easier stratification of data, and to decide how best to manage complaints and concerns in a more straightforward way.

The Chair commented that complaints were always a really useful point of learning, and that the way in which they were dealt with was highly important for the Trust.

Sumita Hutchison commented on part six of the paper (equality and diversity), and linked it to the patient story from the Quality Governance Committee meeting. She asked whether any recurring issues relating to equality and diversity were being observed in the complaints data. The Chief Nurse replied that they did not currently log the ethnicity of the complainants (or age/gender), and this could be something to consider for the future. She commented that within the content of the complaints, themes were identified, and that over the last 18 months a small number of complaints related to equality, diversity and inclusion. The Chief Executive agreed that it would be a useful aspect of the data to be able to view when looking at complaints.

The Director of Estates and Facilities commented that in the recent months since introducing the new parking system, there had been no complaints received.

Ian Orpen commented that the Chief Nurse's report regarding the new approach to complaints was encouraging to hear, and thanked her for her report.

The Board of Directors approved the report.

BD/23/01/20 Finance and Performance Committee Chair's Update Report

Jeremy Boss provided an update following FPC and highlighted the following points:
- There were financial and operational consequences to the pressures that the Trust had been under over the past year.
- Several contracts had been recommended to the Board for approval.
- The budget for the upcoming year would be reviewed at upcoming meetings, looking for key focuses from the data from the past year.

The Board of Directors noted the update.

BD/23/01/21 Charities Chair's Update Report

Jeremy Boss provided an update following the last Charities Committee meeting. He highlighted the following points:

- He reminded the Board that the purpose of the Charities Committee was to discharge the corporate trustee responsibility of the RUH to a separate registered charity.
- There were some significant issues regarding charitable giving due to the cost of living crisis.
- Legacies had slowed down over the pandemic, and whilst this was improving, it was doing so slowly. Legacies were an important part of money received, but were extremely unpredictable.
- A number of new projects had been approved, with new funding initiatives.

The Board of Directors noted the report.

BD/23/01/22 Non-Clinical Governance Committee Annual Report

Sumita Hutchison provided an overview on the work of the Non-Clinical Governance Committee's Annual Report and highlighted the following points:

- The self-assessment responses identified some key areas for focus.
    - The Committee spent a lot of time focusing on sustainability and digital, as well as health and safety.
    - The Committee could spend more time on learning improvement and innovation.
- There was discussion regarding cross-communication of Committee chairs, and some exchanges that could take place.

The Chair commented that there were many ways of conducting cross-communication between committee chairs, and that this was being explored.

The Board of Directors noted the report.

BD/22/09/23 Any Other Business

There was no other business discussed.

The meeting was closed by the Chair at 16:27 hours.

Agenda Item: 6

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY 11 January 2023

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
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	April 23	The new draft Code has now been approved and will come into effect on 1 April 2023. The Head of Corporate Governance has agreed with the Chief Executive that its provisions are incorporated within the Trust's Integrated Governance Framework (IGF). The IGF will also be updated to incorporate an Accountability Framework (divisional accountability) and will be presented for approval at the April Board meeting.	Head of Corporate Governance
PB585	**Minutes of the Board of Directors Meeting held in Public of 2nd November 2022** Jeremy Boss and the Head of Corporate Governance to correct a slight inaccuracy in item 19: Charities Chair's Update Report regarding a comment on funding.	BD/23/01/05	Jan 2023	Mar 2023	The relevant section of the November 2022 minutes has been amended. **To close**	Jeremy Boss / Head of Corporate Governance
PB586	**Minutes of the Board of Directors Meeting held in Public of 2nd November 2022**	BD/23/01/05	Jan 2023	Mar 2023	Minutes updated. **To close**	Head of Corporate Governance

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
	The Chief Nurse commented that on page 95 of the Maternity Quarterly Report Zita Martinez should be down as the Director of Midwifery, and Dr Claire Park as Lead Obstetrician. For the annual report there should be stringent national guidelines, but local decision making. In AOB, it should read 'divisional directors of nursing'. The Chair asked the Head of Corporate Governance to update the minutes.					
PB587	**Review of East Kent Maternity Report** The Chief Operating Officer commented that there were some useful comparisons that could be made between Maternity and the Emergency Department due to their recent reviews. He suggested that he look at triangulating the data on this with the Chief Nurse.	BD/23/01/17	Jan 2023	Mar 2023	The Chief Operating Officer and The Chief Nurse have discussed the learnings from interventions **To Close.**	Chief Operating Officer / Chief Nurse

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**6**
Date of Meeting:	**1 March 2023**		

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 January – February 2023**

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.

Please note, all current questions at still open.

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**

November 2022

8.	**Freedom of Information**

Public

9.	**Sustainability**

N/A

10.	**Digital**

N/A

Royal United Hospitals Bath
NHS Foundation Trust

Appendix 1: Governor Log of Assurance Questions

Date:	**18 January 2023**
Source Channel	**Governor People Working Group**
Date Sent & Responder	Sent to NEDs on the 21st of February 2023
Question and ID	**Jan23 -** What assurance could the NEDS give Governors that the Trust is working towards culture change at a core and systematic level to ensure that Staff are retained?
Process / Action	Sent to NED's, awaiting response
Answer	
Closed?	**Open**
Date:	**16 February 2023**
Source Channel	**Governor Memebership and Outreach Working Group**
Date Sent & Responder	Sent to NEDs on the 21st of February 2023
Question and ID	**FEB23-** • Does the Board of Directors utilise member feedback when developing its strategies? • How do NEDs feel that members add value to the RUH? • How could the Council of Governors help to improve this?
Process / Action	Sent to NED's, awaiting response
Answer	
Closed?	**Open**

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Board of Directors	Agenda item:	9
Date of Meeting:	1st March 2023		

Title of Report:	Chief Executive & Chair's Report
Status:	For Information
Board Sponsor:	Cara Charles-Barks, Chief Executive & Alison Ryan, Chair
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
- Strike Action
- Update from Trust Management Executive held on 25th January and 22nd February 2023
- Updates regarding areas of recognition, ongoing developments and new initiatives;
  - ExCEL Accreditation Programme
  - Maternity Incentive Scheme
  - Student Nursing Times Awards
  - New Radiotherapy Late Effects Service Launched
  - Maternity Care Praised by Families
  - Devizes Health Centre
  - Women Urged to Take up Lifesaving Cervical Screening Test
  - Dyson Cancer Centre on Track to Open in Late 2023
  - Accreditation for Cardiology
  - Walk of Life Fundraiser Returns
  - Race Equality Week
- Governor Elections
- Consultant Appointments
- Use of Trust Seal
- Chair's Update

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
Nothing to note	

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 AND CHAIR'S REPORT

1. Performance

Within January we saw a return to improved performance across the reported metrics. The severe pressure felt nationally and locally during December decreased during January with reductions in COVID and Flu cases helping to support better flow through the hospital.

- The Trust lost a total of 1,756 hours in ambulance handovers. This is significant improvement on the December performance.
- RUH 4 hour performance during January was 65.5%, which is a 5% improvement on December and the strongest performance for the last 6 months
- The Trust had an average of 141.6 patients waiting who had no criteria to reside which is broadly the same as in December. The Trust has led a programme of work to reduce the length of time it is taking for patients to be discharged within BaNES over recent months with delays coming down from 17 days to 7.
- Cancer 62 day performance in December improved to 68%. The Trust continues to remain one of the strongest performers within the South West Region.
- During December the Trust reported zero patients waiting over 104 weeks and an improved number of patients waiting over 78 weeks with it further falling to 146.
- The Trust delivered 106% of costed activity against the ERF target in month. This means performance YTD is currently at 106% against the national target of 104%. This figure excludes Sulis activity which is reported separately.

It is important to highlight that during February and March there have and will continue to be national strikes. These strikes will have an impact on the organisations operational performance. Additionally the Trust is currently also responding to a recent norovirus outbreak that has limited some flow during February.

2. 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. In order to manage the cash impact of this, money is being moved between organisations in the system on a non-recurrent basis which will also ensure each organisation has a balanced plan.

The RUH is planning a deficit of £19.3 million prior to this income movement and the actual position at the end of Month 10 was a deficit of £21.0 million, which is £3.9 million worse than planned. 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. The RUH is managing a number of risks within the financial plan that relate to an increase demand on emergency services and a continued high number of patients in the hospital with no criteria to reside, which reduces the available bed base for emergency admissions. Further costs have been spent to maintain the safety of the site over winter and non-recurrent funding has been confirmed to cover these costs. There is a financial recovery plan in place to ensure these costs pressures are brought back in line with plan and this is reducing the expenditure rates across both pay and non-pay costs. Of the full year savings plan (of £14.8 million), £14.8 million of schemes and opportunities have been identified. The key

risks to the delivery of the financial plan are ensuring we maintain elective capacity; managing the impact of increased operational pressures due to the volume of emergency work being undertaken; delivering the savings plan; and managing the impact of inflationary pressures especially in respect of utilities. The financial plan is expected to deliver with the implementation of the recovery plan and the identification of mitigations for £2.0 million of outstanding financial risks.

3. People

The Trust has the lowest sickness absence across the South West and the vacancy rate has decreased to 2.48%, the lowest is has ever been. We continue to see the benefits of the recruitment transformation project with all key performance indicators moving in a positive direction. The national benchmarking results of the 2022 Staff Survey will be presented at the April Board meeting. A programme of work around Equality, Diversity and Inclusion is about to commence with Excellence in Action and details will be presented to a future meeting.

Nominations are open for our annual staff awards with lots of new categories to recognise and celebrate more people than ever before including a Lifetime Achievement Award, a Wellbeing at Work Award, a Working with our Community Award and many more.

4. Industrial Action

The Royal College of Nursing have paused the proposed industrial action that was scheduled to be undertaken from 1st March to the morning of 3rd March, the Trust awaits further notification from the Royal College of Nursing.

The British Medical Association have balloted their junior doctor membership and have confirmed they will take industrial action with a 72 hour full walk out in March. Whilst the Trust awaits confirmation of the dates, the Chief Medical Officer, Chief Operating Officer, Chief Nurse and Director for People and Culture are putting plans in place to respond, however it is acknowledged that services are likely to be impacted by this scale of industrial action.

5. Update from Trust Management Executive held on 25th January and 22nd February 2023

At the meeting held on 25th January, the Trust Management Executive spent the majority of the meeting reviewing and discussing current operational pressures facing the Trust. There were detailed discussions about the Finance Recovery Plans for 2022/23. The Director of Finance shared with us the draft budgets for 2023/24 and we spent some time talking through plans for reducing spend in 2023/24.

At our meeting in February, again the main focus of our discussions were our finances for 2023/24. Rhiannon Hills, our Deputy Chief Operating Officer provided us with an update on the “BaNES Home is Best Transformation Programme”. The Home is Best Transformation Programme is underway in the Bath and North East Somerset (BaNES) locality. It is a collaborative programme supported by BaNES Council, HCRG Care Group, Voluntary Organisations, BaNES Integrated Care Board and the RUH. The overarching aim is to reduce the number of patients in hospital which no criteria to reside (NCtR).

6. ExCEL Accreditation Programme

The ExCEL Accreditation Programme – Excellent Care @ Every Level Accreditation Programme, which assesses the quality and safety of services at a ward level in line with CQC requirements, is continuing to be rolled out. Vascular Studies achieved Silver Accreditation in January 2023.

7. Maternity Incentive Scheme

As detailed in the Maternity Quarterly Report, we are delighted to have achieved the 10 Safety Actions described as part of the Maternity Incentive Scheme. This is testament to the hard work by the Maternity and Obstetric team and this signifies an important step on our improvement journey across maternity services.

8. Student Nursing Times Awards

The Trust has been shortlisted in the Student Nursing Times Awards 2023 for the student nurse placement of the year: hospital. We are delighted to have been shortlisted, and members of the nursing team will attend the awards ceremony in April.

9. New Radiotherapy Late Effects Service Launched

In January we celebrated the launch of the new Radiotherapy Late Effects service, a joint initiative with Macmillan Cancer Support. The service offers help for patients who are experiencing long-term side-effects or complications of radiotherapy. A patient shared his personal story about how his life has been transformed thanks to this support. Patients can self-refer or be referred by a healthcare professional such as their GP.

10. Maternity Care Praised by Families

We are really proud that the Care Quality Commission's National Maternity Survey 2022 showed the RUH as scoring better than others in a number of aspects. These include whether parents feel they are treated with dignity and respect during antenatal care, whether enough information was provided to help parents decide where to have their baby and whether they felt involved in decisions about antenatal and postal natal care. There were no aspects where the RUH scored worse than others.

11. Devizes Health Centre

Early January saw the new integrated health centre open in Devizes, hosting a number of RUH outpatient clinics. The new build is one of the region's first integrated care centres and a number of health and care providers are sharing the space with us, including Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), Wiltshire Health and Care and four of the local GP services. The centre is leading the field in sustainable design, as one of a small number of 'Net Zero' health facilities across England. The site will have an energy EPC rating of A+, and will utilise green technology, such as heat pumps and solar panels, to generate electricity and heat to serve the building.

12. Women Urged to Take up Lifesaving Cervical Screening Test

The RUH led a campaign during Cervical Cancer Week calling on people to come forward for routine tests. Patient Nyssa Edwards, from Pilton in Somerset, was at the heart of our campaign, sharing her personal experience of being diagnosed with cancer after routine screening, despite having no symptoms. Nyssa happily is now recovered, and praised the care she received at the RUH.

13. Dyson Cancer Centre on Track to Open in Late 2023

In January we shared a behind the scenes video from the Dyson Cancer Centre construction site, as work is ongoing to complete the interior structure. The project is on track to open for patients in autumn 2023, and the next milestone will be this summer when the finished building is handed over to the RUH ready for fitting out.

14. Accreditation for Cardiology

Our Cardiology team has been awarded full departmental accreditation by the British Society of Echocardiography (BSE) in recognition of the team's high standards of echocardiography and training. The assessors were extremely impressed with the culture and ethos of the team and praised the team's level of training and commitment to training plans. BSE departmental accreditation is a recognised benchmark of quality and demonstrates that an echo department meets certain quality standards.

15. Walk of Life Fundraiser Returns

RUH charity RUHX announced the return of its flagship event Walk of Life, coming up in May. This is the 18th year the event has been held, and this year sees the addition of the Walk of Fun – an accessible 1km option for children, parents and adults. Walkers can choose specifically which area of the hospital to fundraise for if they wish, and many of our staff join our community for the event.

16. Race Equality Week

In February's Race Equality Week we encouraged the people we work with to join the five day challenge - five thought-provoking exercises that each take five minutes, creating a chance to reflect, understand personal bias and recognise how to make change for the better. We are committed to making improvements for people from ethnic minorities, including our staff and the people we care for.

17. Governor Elections

The Trust's by-election for our North Wiltshire constituency opened on Monday, 13th February and the nomination period will remain open until 28th February 2023. The role of a governor is vital in ensuring that the Trust delivers services that meet the needs of patients, carers, staff and local stakeholders, and that the views of local people are heard and fed back to the Board of Directors. If you are interested in finding out more about the role of a Governor and how to put yourself forward for election, please contact the Membership Office via ruhmembership@nhs.net.

Voting opens on Monday, 20th March and runs until Tuesday, 11th April.

18. Consultant Appointments

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

- Dr Alan Cordey was appointed as a Consultant in Microbiology on 5th January 2023. Dr Cordey currently works at Public Health Wales as a Medical Microbiology Registrar and will start join the Trust in April 2023;
- Dr Louise Wade was appointed as a Consultant in Clinical Oncology on 17th January 2023. Dr Wade currently works at Musgrove Park Hospital as a Specialist Trainee in Clinical Oncology

19. Use of Trust Seal

The Trust Seal was used on the 21st February 2023 in relation to the sealing of a lease of part of Devizes Integrated Care Centre.

20. Chair's Update

In the last two months I have overseen a lot of recruitment, of new consultants, a Managing Director for Wiltshire Health and Care and Non-Executive Directors for the RUH. All were successfully concluded with, I believe excellent appointments all round. In addition, within the BSW system we have been focussing on finance and governance issues. Within our area I have worked closely with BaNES council and the universities on utilising our role as an anchor organisation to improve economic, environmental and physical health of the citizens we serve.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item No:**	**11**
Date of Meeting:	**1 March 2023**		

Title of Report:	**Maternity and Neonatal Safety Report Quarter 3**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author(s):	**Zita Martinez, 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 fully compliant 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. Recruitment has continued at pace. The staffing trajectory continues to demonstrate improvement in staffing levels into Q4. A large number of newly qualified staff are now being supported in their preceptorship period in the acute unit, which now leaves the most significant vacancy in the community areas. Continuity of Carer teams remain suspended except for the most vulnerable families. The temporary suspension of home births continued in Q3. Community births resumed at one midwifery led unit (Frome) from 31 October 22 and the remained are scheduled to open in Q4.

As previously reported to Board of Directors, the Trust reported a cluster of seven cases to HSIB from 22 March 2022 to 14 May 2022 (six week period). As a result HSIB instigated enhanced monitoring and oversight for a 3 month period which ended in August 2022.

HSIB wrote to the Trust on 12 January 2023 to confirm their investigation found no evidence of systemic safety concerns or any underlying issues that require further escalation. Their review contained recommendations for clinical practice which are detailed in this report.

The report acknowledged the successful reaccreditation of the Trusts UNICEF UK Baby Friendly status. Following this there is to be a strategic working group established to plan out ‘next steps’ and to identify key work streams required to apply for ‘Gold’ accreditation.

The Trust appointed Zita Martinez as Director of Midwifery and Dr Claire Park as Obstetric Lead. In addition, Kerry Perkins was nominated and won the Midwife of the Year Award in the MAMMA Academy Awards.

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 – physical environment not 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
	2353	Replacement of ultrasound machine	4
	2359	Maternity Information System IT support/capacity	15
	2396	Obstetric theatre emergency call bells	6
	392	Obstetric and gynaecology workforce risk	15
	2416	Fetal CTG monitoring in community	15
	2417	Maternity triage	20

5.	Resources Implications (Financial / staffing)
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 full 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. Maternity and Neonatal Safety Report Quarter 2 - October 2022. Safer Staffing Report – August 2022. CNST Maternity Incentive Scheme – Year 4 declaration of compliance - December 2022.	

8.	Publication
Public.	

9.	Sustainability
None	

10.	Digital
None	

MATERNITY AND NEONATAL QUARTER 3 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	N

	October	November	December
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-about	✓ 20/10/22	✓ 17/11/22	✓ 15/12/22
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	✗ 85%	✗ 95%	✓ 100%
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)

1. REPORT OVERVIEW

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 Local Maternity and Neonatal System (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 (RUH) is performing against the national ambition.

There were 2 stillbirths in Q3, please refer to section 2.1.

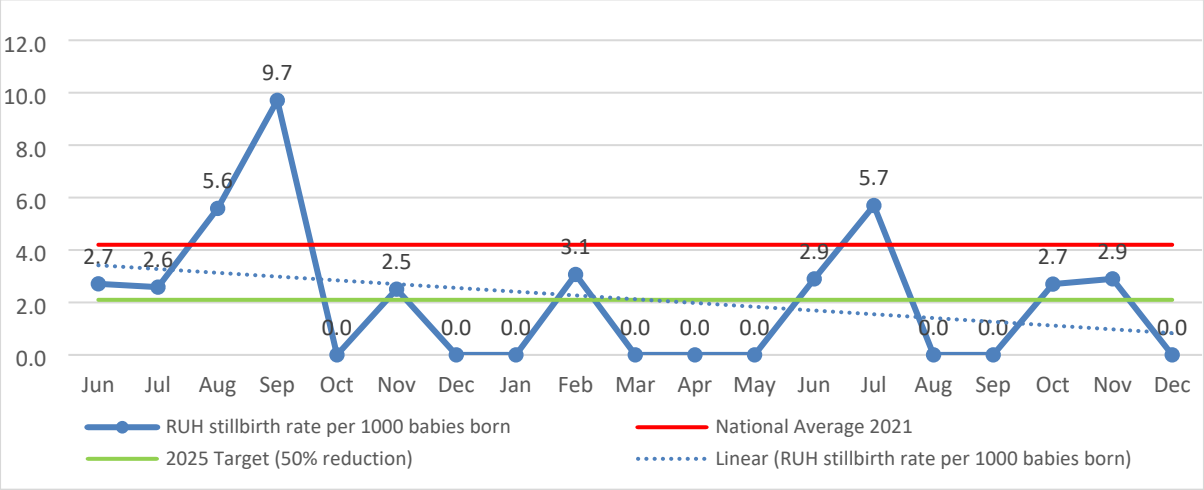


Figure 1. RUH NHS Trust Stillbirth rate per 1000 births over last 18 months

There were no reported neonatal deaths in Q3.

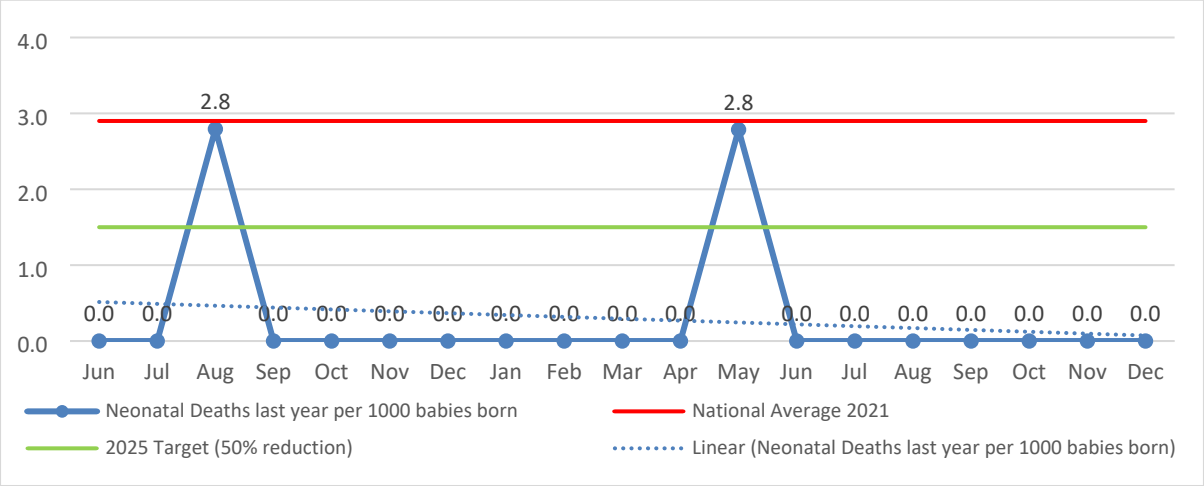


Figure 2. RUH NHS Trust Neonatal Death rate per 1000 births over last 18 months

2.1 PERINATAL MORTALITY SUMMARY FOR QUARTER 3 2022/23

2020/21 (excluding terminations for abnormalities)	Q3	Annual total 22/23
Stillbirths (>37 weeks)	1	1
Stillbirths(>24weeks-36+6weeks)	1	4
Late miscarriage (22+oweeks-23+6weeks)	0	2
Neonatal deaths	0	2
Total	**2**	**9**

Table 1. Perinatal Mortality Summary Quarter 3 2022/23

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 a requirement of Safety Standard 1 of the NHSR Maternity Incentive Scheme year 4.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-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. Births between 22-24 weeks pulled manually and added to the data set submitted to MBRRACE-UK

Perinatal deaths are defined from 22 weeks and include neonatal deaths, but stillbirths are defined from 24 weeks. The rate of stillbirth and perinatal death may therefore be different.

In total there have been 2 perinatal deaths in Q3:

1. Stillbirth - death at term and during the induction of labour, this has been referred and accepted by the Healthcare Safety Investigation Branch (HSIB).
2. Stillbirth – umbilical cord compression.

All cases have been reviewed at the PMRT meeting and actions have been agreed. All parents have been informed of the PMRT review and have contributed to the reviews. PMRT will take place during scheduled meetings in January, February and March as required. PMRT meetings include external panel members to ensure the process is robust and honest.

Actions identified:

- Review Reduced Fetal Movements guideline
- Review triage process (on-going action from a previous case)

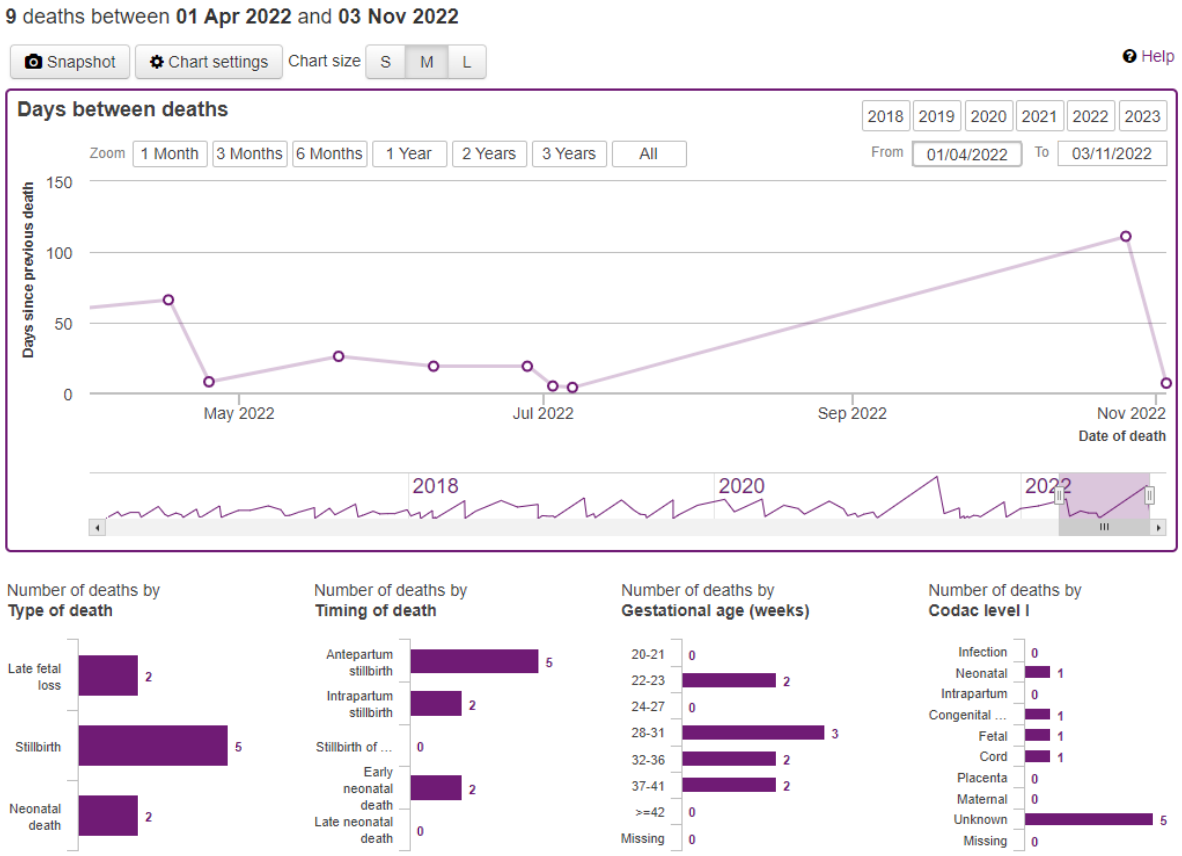


Figure 3. Reporting of RUH NHS Trust Deaths within Organisation
*last perinatal death was in November. PMRT graph will only generate up to date of last death.

2.3 LEARNING FROM PMRT REVIEWS

Table 2 provides an update on the outstanding actions from reported cases in Q1 and Q2. There are no outstanding actions other than those reported in Q3.

PMRT 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	Action plan text	Implementation text	Owner	Target date	Status
81978/1	Cabergoline (medication) was not given to suppress lactation.	Pathway to be updated including Lactation and Loss Standard Operating Procedure.	Bereavement Care Pathway to be updated and disseminated.	Bereavement Midwife.	30/11/22	Complete
82268/1	Reduced Fetal Movement leaflet was not provided in mother's first language.	Staff informed importance of & how to access Reduced Fetal Movement leaflet in different languages.	Staff informed of importance of & how to access Reduced Fetal Movements leaflet in different languages.	Patient Safety team.	30/09/22	Complete

Table 2. Update on actions arising from Q1-Q2 PMRT reviews 2022/23

The Q3 cases have been discussed at the PMRT meeting, their actions and outcomes will be included in the Q4 report. Early assessment of one case suggests that the triage process may have been a factor. This is an area we have identified previously as needing improvement, so work is already in progress to improve centralised triage services in the department. Early identification and risk assessment will support appropriate prioritisation and escalation. Until this work is completed, this has been added to the Trust Risk Register.

3. HEALTHCARE SAFETY INVESTIGATION BRANCH AND MATERNITY SERIOUS INCIDENTS

3.1 BACKGROUND

Healthcare Safety Investigation Branch (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

3.2 HSIB CLUSTER

As previously reported to Board of Directors, the Trust reported a cluster of seven cases to HSIB from 22 March 2022 to 14 May 2022 (six week period). As a result HSIB instigated enhanced monitoring and oversight for a 3 month period which ended in August 2022.

HSIB wrote to the Trust on 12 January 2023 to confirm their investigation found no evidence of systemic safety concerns or any underlying issues that require further escalation.

A review of the findings and recommendations highlighted that communication was a common recommendation category. The communication sub-categories were varied and included communication (three relating to emergency situations), information sharing, translation services and care planning with families.

The action plan will be shared as part of the Q4 report.

3.3 INVESTIGATION PROGRESS UPDATE

Table 3 identifies the referrals made to HSIB during Q3. The outcomes of these reports will feature if future reports.

Ref	Confirmed level of investigation	Date confirmed Investigation	External Notifications and Other Investigations
Ongoing			
107283	Therapeutic cooling following birth. No safety recommendations made to Trust.	18/08/22	2022/18296
108058	Therapeutic cooling following shoulder dystocia at birth. Normal MRI post cooling Ongoing HSIB review.	13/09/22	2022/21156
New referral			
110141	Intrapartum Stillbirth following Propess administration during an Induction Of Labour HSIB Investigation (see 3.4)	10/11/2022	STEIS 2022/25202 PMRT MBRRACE

Table 3. HSIB referrals and ongoing investigations Quarter 3 2022/23

3.4 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.5 MATERNITY SERIOUS INCIDENTS

There were 3 Serious Incidents reported Q3.
Whilst all cases referred to HSIB are automatically investigated by the Trust as a serious incident, the Trust may also investigate a case that does not meet the HSIB criteria, hence the differing cases in tables 3 and 4.

Datix No	Category	Outcome	Immediate Learning
October			
109848	Major Harm	Neonatal Seizures and subsequent HIE following an impacted fetal head and uterine rupture at LSCS.	Ongoing RCA. Declined by HSIB.
November			
110141	Stillbirth	Intrapartum Stillbirth following Propess administration during an Induction Of Labour	Review on-going with HSIB (see 3.2).
December			
111552	Moderate harm – maternal admission to ITU	Maternal Admission to Critical Care - HELLP syndrome	Review in progress.

Table 4. Maternity Serious Incidents Quarter 3 2022/23- Includes all cases of moderate harm or above

4. CONTINUITY OF CARE

4.1 BACKGROUND

Maternity transformation sets out to support the 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

Maternity Continuity of Carer (MCoC) remains paused in line with national guidance. The development and implementation of the long-term workforce plan, which includes recruiting internationally and expanding routes into midwifery which includes the registered nurse to registered midwife pathway. A large number of newly qualified staff are now being supported in their preceptorship period in the acute unit, which leaves the most significant vacancy in the community areas. The Trust remains committed to reintroducing maternity continuity of carer when staffing levels permit, this will be reviewed in Q4.

Antenatal and postnatal continuity of carer continues to be provided where possible, with vulnerable/at risk groups and those from Black Asian and Minority Ethnic groups being prioritised. All intrapartum continuity of carer has been suspended in line with NHSE guidance until safe staffing levels are achieved across the service.

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.

£331,795 was made available through Ockenden funding to the Trust to support the changes required following the initial report in 2020. This was utilised to fund an additional fetal monitoring Lead Consultant post, and mandatory training in fetal monitoring for all maternity staff. Further potential funding sources to support the requirements of the final Ockenden report have not yet been announced.

The Trust compliance in relation to the initial Ockenden report is detailed in table 5.

RAG	IEA	Actions/Mitigations:
IEA 1	Enhanced Safety	
IEA 2	Listening to women & families	
IEA 3	Staff Training and Working Together	Following obstetric workforce review, now fully compliant with twice daily ward rounds >90% including one at night from Jan 23. Face to face training– MDT Emergency Skills Training (PROMPT) now above 90% for some staff groups. Robust trajectory and action plan to maintain compliance.
IEA 4	Managing Complex Pregnancy	

IEA 5	Risk Assessment Throughout Pregnancy	Improvement required to capture documentation of Risk Assessments taking place at every contact. 1. Compliant for routine antenatal appointments. 2. Risk to compliance for ward attenders/Day Assessment Unit/ Midwife led Ultrasound. 3. Digital option being explored regionally to improve the capture at other contact points. 4. Working party meeting to develop action plan. 5. Differences to interpretation of IEA at regional partner Trusts.
IEA 6	Monitoring Fetal Wellbeing	
IEA 7	Informed Consent	
	Workforce element	Obstetric workforce review now completed.

Table 5. Compliance with initial Ockenden Immediate and Essential Actions

5.2 OCKENDEN FINAL REPORT UPDATE – Q3 2022-2023

The Trust is not currently required to submit evidence of compliance and submission date is not yet confirmed.

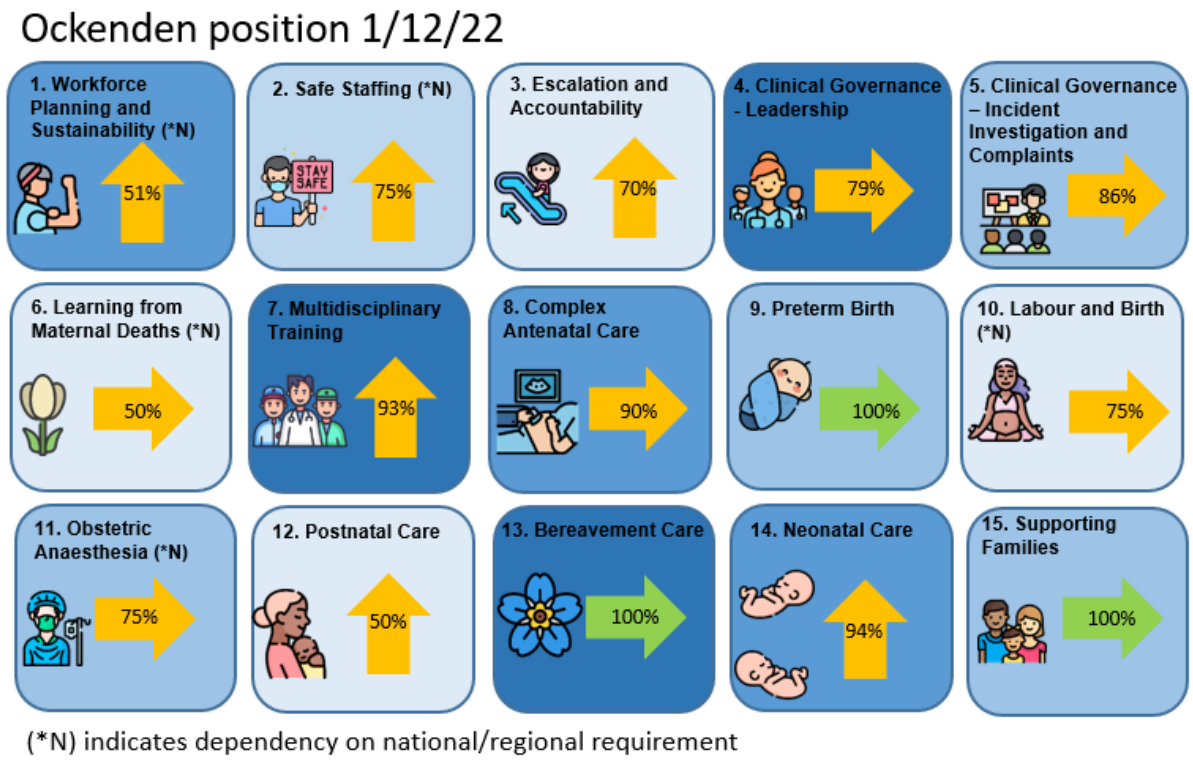


Figure 4. Ockenden Final Report Position - Immediate and Essential Actions

Outstanding and completed locally identified actions are being tracked via a local 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. Compliance with fetal monitoring, neonatal resuscitation and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) is now above the required 90% (figures 5 and 6) for all staff groups, underpinned by an action plan to continue to maintain and improve training rates and compliance.

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

A robust training trajectory has now been developed and a new monitoring and booking system is now in place to ensure current compliance is maintained and continually improved for all mandatory training.

6.2 TRAINING DATA

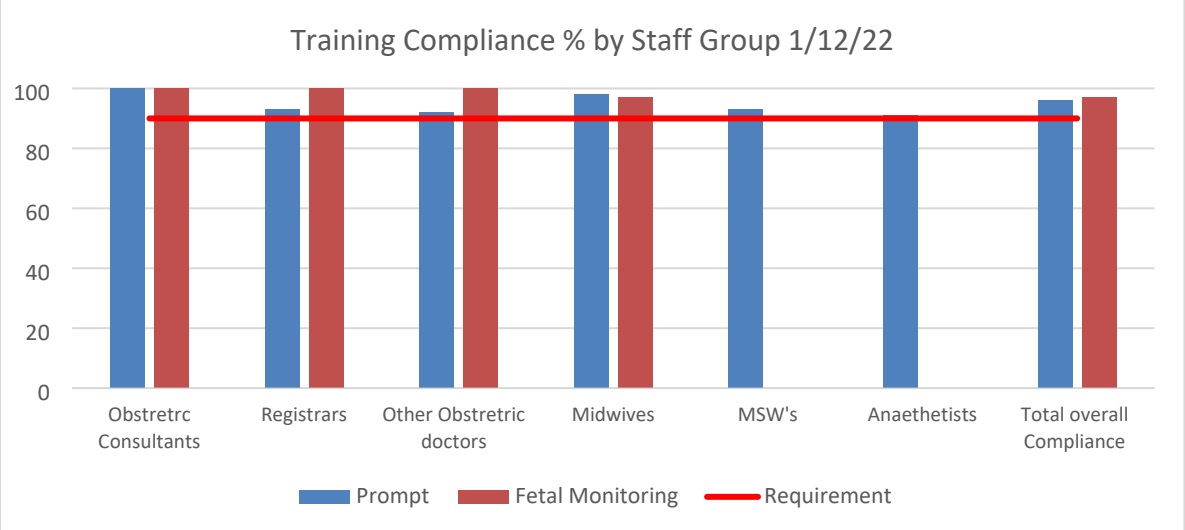


Figure 5. Prompt and fetal monitoring Training Compliance (%) by staff group Q3 2022/23

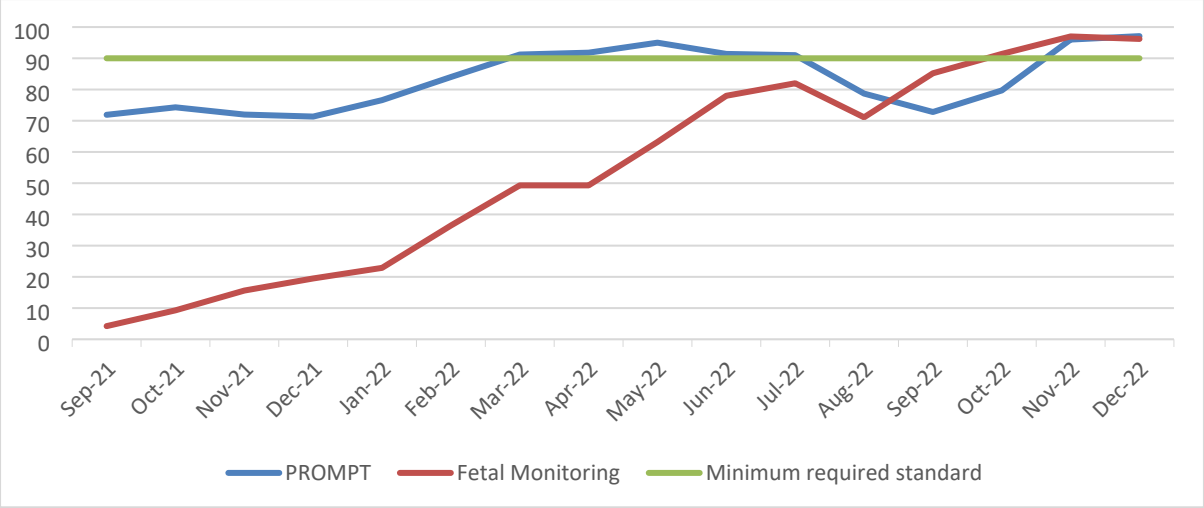


Figure 6. Training Compliance – All staff groups

7. BOARD LEVEL SAFETY CHAMPION MEETINGS

All staff are invited to attend monthly meetings held with the Chief Nurse and the Non-Executive Director (Board Level Safety Champions on 20 October, 17 November and 15 December). The meetings in Q3 were attended by members of the maternity and neonatal team from a range of areas, including community and specialist midwives.

Themes raised included:

- In-house apprenticeship for Maternity Care Assistants/Maternity Support Worker – in discussion
- Community vacancy affecting services and morale – recruitment campaign continues
- Reinstating community and home births – Frome open to births, Chippenham will reopen in March 23, home birth services will recommence in March 23.
- The physical environment of the Day Assessment Unit is not fit for purpose – refurbishment and relocation plans being developed
- Request for weekly bank pay – now completed
- On-call rota principles – on-call plan to be confirmed and progressed
- Birth reflections cessation – service now reinitiated
- Space challenges to undertake midwife sonography clinics – escalated the Divisional Director of Operations

7.1 BOARD LEVEL SAFETY CHAMPION WALKABOUTS

The Board Safety Champions undertook walkabouts across Maternity Services:

- 21 October – Chief Nurse and Non-Executive Director visited the Bath Birth Centre and Day Assessment Unit
- 18 November – Chief Nurse visited Chippenham Maternity Unit
- 16 December – Chief Nurse and Non-Executive Director visited the Neonatal Unit, Bath Birth Centre and Mary ward.

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

Champions meetings.

8. SAVING BABIES LIVES CARE BUNDLE V2

8.1 UPDATE

Full compliance with all elements within Saving Babies Lives Care Bundle Version 2 (SBLCBv2) is a requirement detailed in Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme. A quarterly report, shared with the Board Level Safety Champions provides 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 all 5 elements.

In Q2, the Trust reported non-compliance with Element 1 in relation to Carbon Monoxide monitoring. Evidence to support compliance with Carbon Monoxide monitoring in pregnancy was collated using a manual audit of documentation (figure 7) which is necessary due to a hybrid use of paper and digital records.

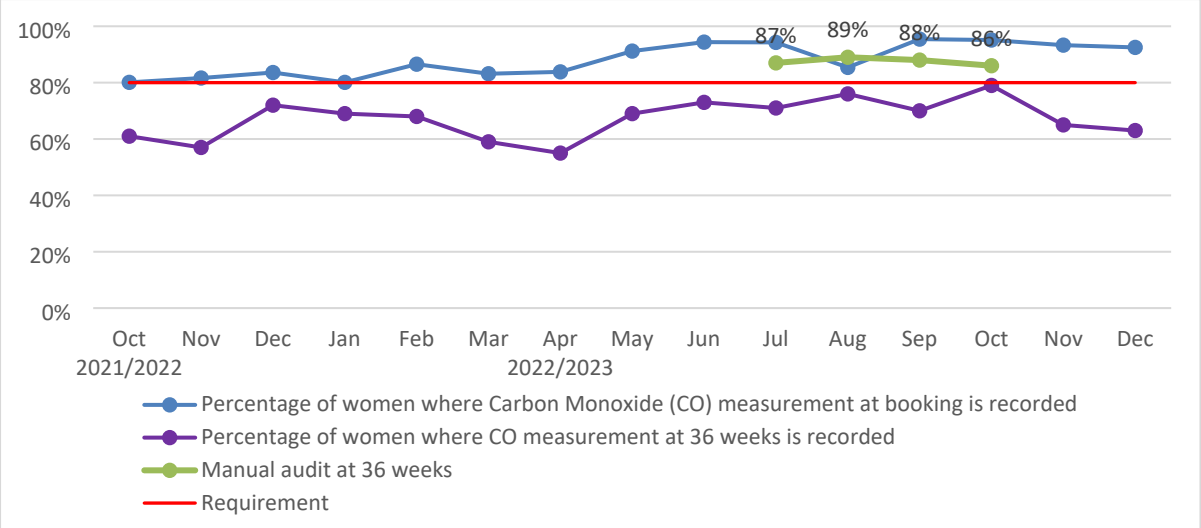


Figure 7. CO monitoring in pregnancy – year to date

The Trust is currently exploring alternative digital options for a maternity information system in partnership with other Bath and North East Somerset, Swindon and Wiltshire Trusts and the LMNS.

9. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q3 2022/23

Following further amendments to the scheme in October 22, the reporting period was confirmed as 5 February 2022 to 2 February 2022. Following a robust assurance process, the Trust has now declared full compliancy with all Maternity Incentive Scheme (MIS) Safety Actions.

	Safety Action	Evidence Summary	Self-assessment
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?	*Quarterly and monthly perinatal quality surveillance reporting demonstrates that the PMRT has been used appropriately.* *The Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries-UK (MBRRACE-UK) MIS report demonstrates full compliance.*	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	*The MSDS MIS report confirms full data quality compliance.* *A maternity digital strategy is in place along with dedicated digital leadership.*	
3	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?	*ATAIN and transitional care pathways are established. These pathways are described in detail in divisional guidelines.* *Ongoing audits and action plans are demonstrated in quarterly reports.*	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	*The principles of Royal College of Obstetrics and Gynaecology (RCOG) Roles & Responsibilities of the Consultant workforce document are embedded.* *Dedicated duty anaesthetic cover at all times.* *Neonatal nursing action plan to meet BAPM staffing compliance. Progress noted against year 3.*	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	*Funded clinical establishment in line with last full BirthRate+ assessment in 2019. 2021 plan disregarded due to suspension of Continuity of Carer (CoC). New BirthRate+ assessment now underway which will require increased funding support in 2023 business planning.*	
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two (SBLCBv2)?	*Each element of the SBLCBv2 has been implemented to the required standard. This is evidenced through audits in quarterly reporting, guidelines, and Trust maternity dashboard.*	
7	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?	*Multiple mechanisms for gathering feedback.* *Evidence of coproduction with Maternity Voices Partnership Plus (MVPP).* *MVPP chair attends maternity governance meetings.* *Terms of reference for MVPP, and minutes of regular Local Maternity and Neonatal System (LMNS) meetings.*	

8	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?	*Training Needs Analysis is in place. A training database and trajectory is maintained to support forward planning and to demonstrate compliance.* *Multidisciplinary training is in place, including all required elements.* *Over 90% of all staff within each staff group are compliant with training for:* • *Maternity emergency multi-professional training* • *Fetal monitoring (including assessment)* • *Neonatal life support*	✓
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	*Perinatal Quality Surveillance Tool in use. Shared with Safety Champions and Board monthly.* *Board level Safety Champions engage with staff at monthly feedback sessions.*	✓
10	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?	*HSIB and NHS Resolution records demonstrate reporting. HSIB referrals included within monthly perinatal quality surveillance reporting to Board.*	✓

Table 6. Maternity Incentive Scheme Update Q3 2022/23

10. SAFE MATERNITY STAFFING

10.1 MIDWIFERY STAFFING

The Trust appointed Zita Martinez as Director of Midwifery and Dr Claire Park as Obstetric Lead.

As of 21 December 2022, the planned vs actual midwifery staffing was -15.66 whole time equivalent (WTE) (of which 6.48 WTE is maternity leave). This gives a substantive vacancy rate -9.18 WTE.

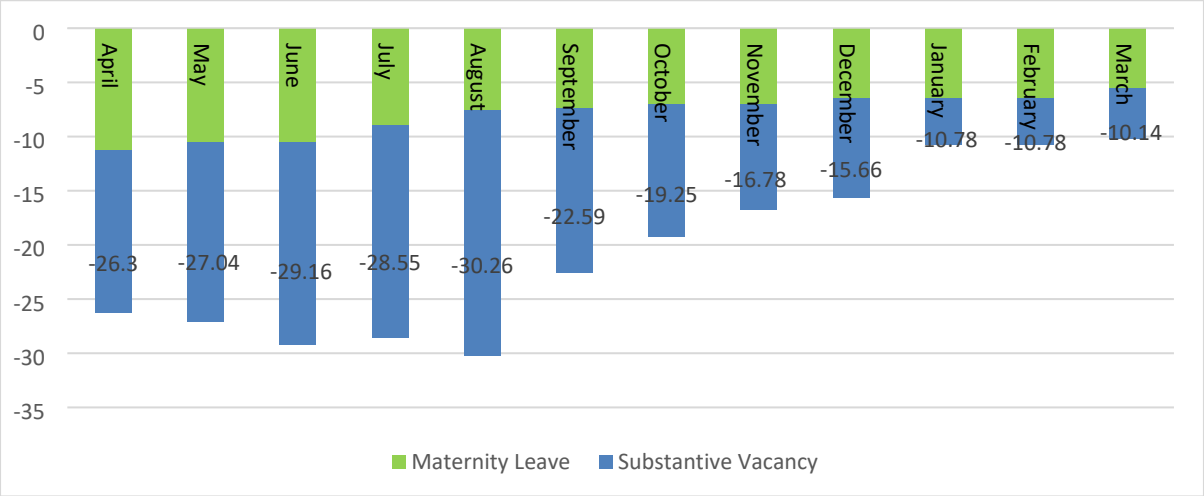


Figure 8. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness) 21-12-22

Measure	Aim	Oct 22	Nov 22	Dec 22
Midwife to birth ratio	≤1:27	1:34	1:31	1:30
Midwife to birth ratio including bank	≤1:27	1:29	1:26	1:27
Supernumerary labour ward coordinator status	100%	99%	100%	99%
1:1 care not provided	0	0	0	0
Confidence factor in BirthRate+ recording	60%	73%	70%	70%

Table 7. Midwifery staffing safety measures

At periods when the labour ward coordinator was not supernummary, no harm resulted.

A large number of newly qualified staff are now being supported in their preceptorship period in the acute unit, which now leaves the most significant vacancy in the community areas.

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:

- Registered nurses undertaking non-midwifery care
- Clinical support provided by members of the midwifery leadership team
- Repeat BirthRate+ assessment underway. The results are expected imminently
- Recruiting to maternity leave moving forward and over-recruiting by 8.9WTE
- Active rolling recruitment campaign
- Implementation of a preceptorship and retention support package
- Career progression improvements for MCAs to MSWs
- System calculation of required headroom, reviewing three years of data for mandatory training, maternity leave, sickness and annual leave (32%)
- Weekly bank pay commenced Trust wide

Next Steps

- Stepped approach to reintroduce community births as safe staffing allows. Frome Birthing Centre re-opened to births on 31 October 22. Resumption of community births and home births across the service will commence at the end of Q4.
- Review of Continuity of Carer provision.
- Complete overhaul of e-rostering, including compassionate rostering.
- Review on-call arrangements for acute unit staff ongoing.

10.2 OBSTETRIC STAFFING

Measure	Aim	Oct 22	Nov 22	Dec 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%	100%	100%

Table 8. Obstetric staffing safety measures

An Obstetric workforce review has now been completed. Effective from January 2023, ward rounds will take place at 0830 hours and 2030 hours, in person, with a third afternoon round in place if required. Consultant attendance at situations detailed in the Royal College of Obstetrics and Gynaecology Roles and Responsibilities of the Consultant Workforce guidance has remained at 100% throughout Q3.

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

11.1 COMPLAINTS/COMPLIMENTS/PATIENT ADVICE AND LIAISON SERVICE/CONTACTS

	Oct 22	Nov 22	Dec 22
Number of formal compliments	1	0	0
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	7	8	9
Complaints	3	2	1

Table 9. Complaints and compliments Q3

Formal complaints within Q3 related to:

- Restrictions in visiting during the pandemic
- Communication with neighbouring Trust impacting on care
- Communication regarding induction of labour
- Communication while in theatre – complex care
- Concerns around management of care in labour
- Dissatisfaction with HSIB findings following review of care

An increase in contacts with the Patient Advice and Liaison Service (PALS) team was noted in 2022, driven primarily by the suspension of community and home birth services. Families raised concerns about the impact this had on their birth choices. A number of PALS contacts related to queries about appointments or scan services.

Local staff training will be undertaken to improve communication and help staff support families with informed decision making and personalised care planning. This is to be introduced in Q4.

12. SERVICE USER INSIGHTS FROM MVPP

Co-production with Maternity Voices Partnership Plus (MVPP) has continued throughout Q3 on a range of antenatal information/birth options films. My Care Hub app (pilot) co-designed with MVPP, launched as a pilot in July 2022 for families in the Chippenham area. This includes signposting to the LMNS website, NHS information and guidance and the RUH webpage. Due to limitations with the digital options, this will be rolled out using a paper personalised care and support plan booklet until such

time as a digital option can be made available to all families.

Feedback from families collated from surveys in September to November 22 has been provided by the MVPP. Themes included:

- Concerns around induction of labour (IOL) communication – Being told this is clinically necessary, but then experiencing delays
- Improvement in care experiences reported post COVID-19
- Call from MVPP for compassionate language, not fear based
- Feeling well informed and not pressured in labour
- Lack of homebirth option
- Birth reflections service highly valued
- Examples of excellent feeding support
- Lack of food for Dads/partners – now available
- Good explanations reported to whole family/Dads
- Clear explanations not always given
- Longer postnatal stay requested

A 'You Said, We Did' format action plan to address this feedback is currently in development.

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

12.1 SERVICE USER INSIGHTS TAKEN FROM A RECENT CQC PEER REVIEW

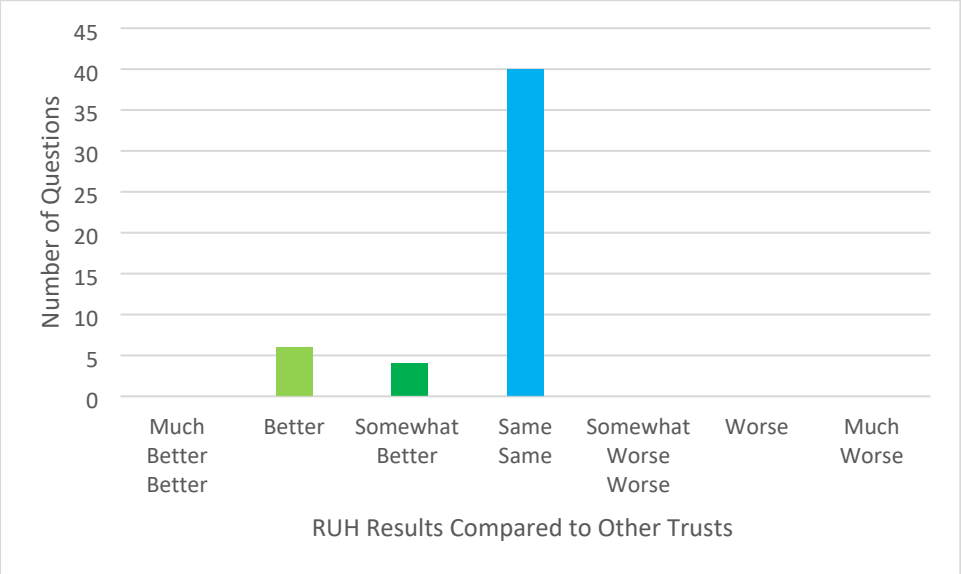


Figure 9. How the RUH scored in the CQC Maternity Survey 2021

214 Royal United Hospitals Bath NHS Foundation Trust patients responded to the CQC Maternity survey. The response rate was 65.64%. Overall, the RUH scored better than most other Trusts relating to care in the antenatal period.

Respondents reported they felt involved in decisions about their care and had appropriate information about the choices available to them. They had confidence and

trust in the staff caring for them in labour, and reported high levels of skin to skin care with their babies after birth.

13. QUALITY IMPROVEMENT PROJECTS / PROGRESS

13.1 MATERNITY TRANSFORMATION INCLUDING BETTER BIRTHS

There remains a lack of national funding to support the local maternity transformation plan to build to build an Alongside Maternity Unit (AMU) and re-design the Day Assessment Unit (DAU). Further plans have been developed to design the AMU and DAU within the current Trust footprint. Agreement of the plans will be finalised in Q4 and architects will be instructed to develop high level plans.

Work is required to understand the impact of health inequalities on the birth outcomes for people from different ethnic groups and areas of deprivation. A maternity health inequalities working group will commence in Q4 and align with the LMNS equity action plan. The purpose of the working group is to develop quality improvement projects supported by champion clinicians.

13.2 PERINATAL MENTAL HEALTH

Ongoing discussions continue regarding the new Pregnancy in Mind (PIM) service that will be piloted within Wiltshire. This is a National Society for the Prevention of Cruelty to Children (NSPCC) 6 week course for women and their partners with low to moderate mental health concerns. Pilot areas will be Trowbridge, Warminster and Westbury. If successful this will be extended to whole of South West. Referrals into service will commence in January 2023.

The Specialist Perinatal Mental Health (PNMH) midwife role has commenced in addition to the birth trauma and loss midwife, providing 1:1 triaging and support and referral to therapeutic support for post-traumatic stress disorder where necessary.

There has been a sustained increase in women with more complex mental health needing referral onto specialist perinatal mental health services as demonstrated in figure 10.

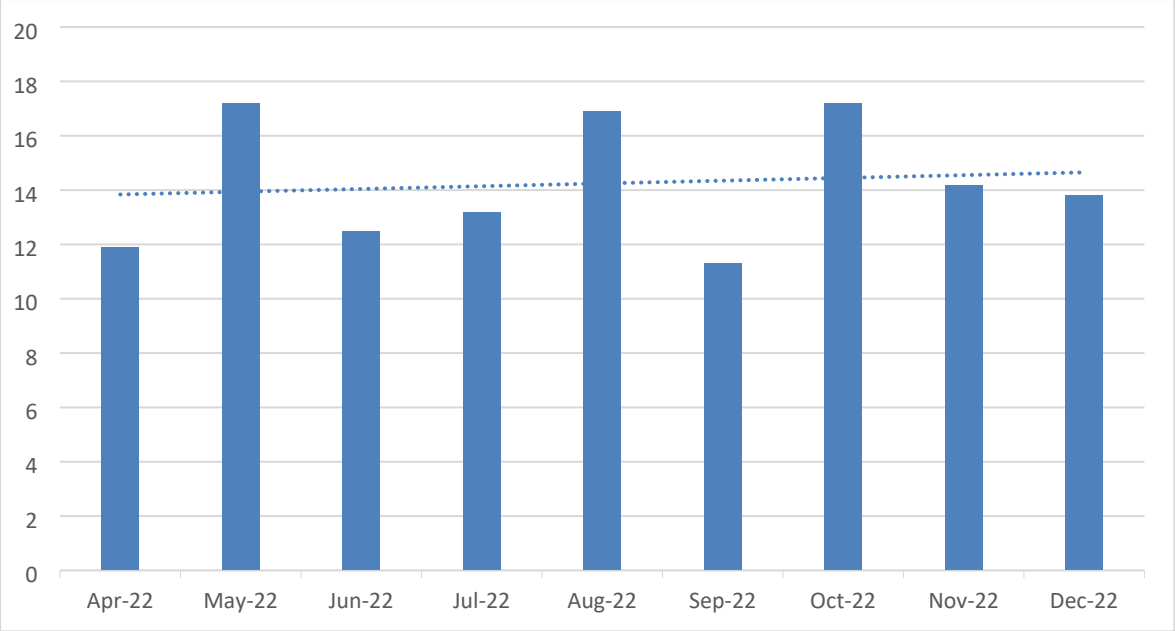


Figure 10. % of completed screening tools prompting referral onto PNMH service year to date 22/23

In Q3 there was one admission 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

The maternity spot check safeguarding audit with a focus on routine domestic abuse enquiry was commenced in Q3. The initial findings are very positive with 92% of women having been asked about domestic abuse and 85% on more than one occasion. This is a big increase from last year's audit when only 58% of women were asked more than once. The full report from the audit will be shared via the Maternity Safeguarding Committee at the end of Q4.

The Named Midwife for Safeguarding has updated the maternity guideline M63, for staff working with pregnant women who misuse substances. The previous separate cannabis guidelines have now been amalgamated into this guideline.

The RUH Independent Domestic Abuse Advisor (IDVA) no longer works for the Trust. Funding has not been secured for a future IDVA role within the Trust. This has also impacted on 7.5 hours per week of Specialist Support Midwife hours as the IDVA had a dual role. This will have an impact on the support that maternity services are able to provide to women with domestic abuse concerns. An alternative solution is being sought.

13.4 INFANT FEEDING AND HEALTH IN PREGNANCY SPECIALIST SERVICES

A key highlight during Q3 was the successful reaccreditation of the Trusts UNICEF UK Baby Friendly status. Following this there is to be a strategic working group established to plan 'next steps' and to identify key work streams required to apply for 'Gold' accreditation.

The Infant Feeding specialist service continued to provide care for women and babies experiencing complexities and the fixed term 'Milk Project' service commenced; enabling women and families living in areas of highest deprivation to access extra, unlimited breastfeeding support. Feedback from the families and maternity staff has been extremely positive.

In addition, provision of tongue tie assessment and division appointments increased from that in Q2 and triage-to-treat times reduced as a result. Telephone audits of service users found a high level of satisfaction with several people specifically highlighting the 'compassion and kindness' they had received in relation to infant feeding and tongue tie support. Volunteer Breastfeeding peer support on Mary ward continued to be well received by families and staff.

Feedback from the MVPP survey was particularly positive in relation to breastfeeding support following caesarean births. Areas for action included looking at how families can be better supported whilst on the postnatal ward and raising awareness of how and where they can seek breastfeeding support following discharge. In response, we have increased communication around the MVPP 'Infant Feeding Padlet' and other local/national resources. Furthermore, work is underway to reframe the 'going home' messages shared with families on the postnatal ward; highlighting how to recognise if their baby is getting enough milk and how to contact a midwife for extra support. To align with this, communications with staff have reiterated the importance of proactively offering feeding support to new parents following discharge from hospital; in particular face-to-face contact and direct observation of feeding. Recruitment of a Lead Maternity Support Worker (MSW) to support MSWs in their role is expected to further enhance this as Infant Feeding support will be a key area of focus.

Q3 saw expected levels of engagement from women for smoking cessation support and service user feedback was exceptionally positive. Face to face support was increased from Q2 with advisors offering women more choice regarding where and when they are seen; e.g. at home, in the hospital, in a community venue. Further work is underway to determine clinical areas in which smoking cessation support can be offered within the RUH.

In line with the wider work around the 'Treating Tobacco Dependency' programme, for which Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) has received national funding in preparation for the implementation the Trust successfully appointed a 'Treating Tobacco Dependency Advisor' (0.4 WTE) and approval of a new standing operating procedure regarding dispensing of nicotine replacement therapy.

14. ADVOCATING FOR EDUCATION AND QUALITY IMPROVEMENT (AEQUIP) AND PROFESSIONAL MIDWIFERY ADVOCACY THEMES

The Professional Midwifery Advocate (PMA) continues to offer restorative support, one to one and in groups, as well as signposting to further sources of support, information and assistance. As a critical part of the advocating for education and quality improvement (A-EQUIP) model, the PMA focuses efforts on empowering midwives to confidently handle situations themselves, improve relationships with peers and managers, and to seek ways to increase service quality, safety and excellence.

Requests for support this quarter were from community and acute staff, ranging from Bands 2-8. All staff self-referred, and much of the support offered was in response to one-to-one requests from midwives, or on an ad hoc basis. Support was also provided to non-maternity nursing staff. The PMA continues to travel to all areas of the service regularly, both in response to requests and merely to raise awareness and build trust.

In addition, the PMA Team Proposal, submitted in September 2022, was accepted and from February 2023, 5 more PMAs will be in post and are currently planning a launch and activities to engage staff.

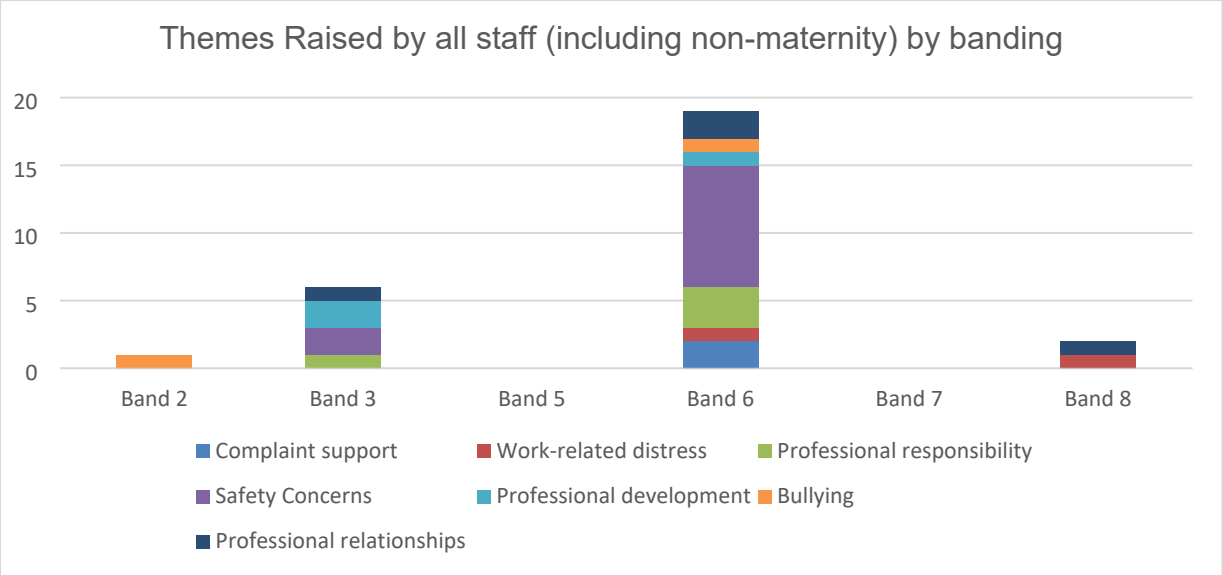


Figure 11. PMA themes raised Q3

Themes Raised

- Safety Concerns
- Bullying
- Professional development
- Complaint support
- Professional responsibility
- Work-related distress

It should be noted that no newly qualified/band 5 midwives sought additional support from the PMA during Q3. This can be attributed to the level of personalised support provided by the preceptorship programme.

15. AVOIDABLE ADMISSION INTO THE NEONATAL UNIT (ATAIN)

There were 3 avoidable admissions of term babies to the neonatal unit in Q3 highlighted at the MDT ATAIN review meetings.

The relationship between the neonatal and midwifery teams continue to help facilitate some enhanced care, particularly with plans of care and early interventions for high risk babies e.g. assisting with thermoregulation and hypoglycaemia issues. This in turn

helps to avoid admissions of the baby to NNU. Reducing avoidable admissions of term babies remains a focus.

15.1 TRUST TRANSITIONAL CARE AND ATAIN RATES

Standard	Oct 22	Nov 22	Dec 22
Audit findings shared with neonatal safety champion	**100%**	**100%**	**100%**
The number of admissions to the neonatal unit that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues	**1** discharge to Mary ward	**0**	**0**
The number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. 34+0 -36+6	**0**	**0**	**0**
% of shifts TCP nurse provided as per TCP staffing model	**89%**	**94%**	**77%**
TCP open	**100%**	**100%**	**100%**
Avoidable term admissions 37+0 weeks gestation and above to the neonatal unit	**0**	**2**	**1**
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	**0**	**2**	**5**

Table 10. ATAIN and TC data Q3 22/23

Seven term babies were transferred or admitted to the Neonatal Unit from other areas in Q3. This was driven by an increase in babies attending the Emergency Department and the Paediatric Assessment Unit with acute respiratory illness.

Three of the five babies required respiratory support/1:1 nursing for severe respiratory compromise. Four of the babies were transferred to a Paediatric Intensive Care Unit.

16. 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 August 2022, the Trust sourced external review from NHSE to review maternity services at the Trust. The review highlighted areas for improvement and areas of good practice focussed around 5 key themes:

- Workforce
- Efficiency
- Safety
- Effectiveness
- Experience

Table 11 provides an update on the required actions.

Recommendation	Status	Update
Increase PMA team, and move to quality and safety team.	In progress	Agreement to proceed. Funding to be confirmed.
Recruit 3rd Maternity Matron.	Complete	Commences in February 2023.
Develop Maternity specific governance team.	Complete	Introduced Quality and Safety Lead Midwife for Maternity Governance role. Commenced January 23.
Remove CTGs from community settings.	Complete	
Review pregnancy loss gestation for care on BBC. Align with National Bereavement Pathway.	Complete	New standing operating procedure in place. Dependant on preferences and safe and appropriate staffing, less than 18 weeks for care under gynaecology and over 18 weeks for care on BBC under obstetrics.
Appropriate pregnancy loss training for gynaecology nurses.	Complete	Training for all staff including Emergency Department nurses.
Swipe access in and out of BBC in-line with other Maternity areas.	Complete	
Review of current distribution and management of Datix.	Complete	Rate of incident reporting low for staffing shortages following review. Benchmarking with LMNS peers shows similar reporting levels/trends. Updated reporting system circulated to all staff.

Table 11. NHSE Action Plan – Key Areas for Action

17. RISK REGISTER

In Q3 Maternity and Neonatal services reported one new risk for Maternity triage services ID 2417.

A centralised triage system is required to ensure appropriate prioritisation of care. Actions are being taken to achieve a centralised system and therefore reduce the risk.

Risk 2175 relating to midwifery staffing vacancies has been closed and this has been merged with two new risks (awaiting approval). The two new risks relate to midwifery workforce and the impact on service provision. These are rated 12 and 8 respectively.

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
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	15
2396	Obstetric theatre emergency call bells	6

392	Obstetric and gynaecology workforce risk	15
2416	Fetal CTG monitoring in community	15
2417	Maternity triage	20

Table 12. Maternity and Neonatal Risk Register

18. RECOMMENDATION

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

APPENDIX 1. MATERNITY PERINATAL QUALITY SURVEILLANCE SCORECARD

		Alert / standard	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Comments
Workforce	Red flags: 1:1 care in labour not provided (Bath Birthing Centre only)	0	0	0	0	0	0	0	0	0	1	0	0	0	Reporting issue. Labour care not affected. No harm.
	Percentage of supernumerary labour ward co-ordinator status (%)	100%	100	100	98	100	97	97	98	100	99	99			Monitoring changed to report by episode (see below). Not involved in labour or 1-2-1 care.
	Labour ward co-ordinator not supernumerary episodes												0	2	(6x episodes per day for Birthrate + recording)
	Confidence factor in BirthRate+ recording	60%	62	62	61	58	60	67	66	67	64	73	70	70	Percentage of possible episodes for which data was recorded
	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		1	0	0	0	0	0	0	0	0	0	0	New metric
	Bath Birthing Centre twice daily round achieved (%)	100%	81	79	94	93	90	93	97	94	100	97	100	100	TIMING OF ROUNDS – to be adjusted from Jan 23
	Midwife to birth ratio (establishment)	>1:27	1:35	1:30	1:32	1:34	1:34	1:34	1:34	1:38	1:35	1:34	1:31	1:30	**Including bank staff rate 1:27**
	Number of women booked onto a Continuity of Carer pathway (%)	>=35%	43.5	44.0	40.9	40.5	43.8	41.3	36.2	37.0	41.7				No national standard in place from Sept 22. Reporting on hold.
Safety	Risk assessment at every contact (Antenatal) (%)		56	55	78	56	71	51	51	47	48	58	61	60	Risk assessment at Booking 100%. Documentation focus. New IT systems being explored regionally. Working group developed.
	Stillbirth number	Actual	0	1	0	0	0	1	2	0	0	1	1	0	N.B. 1x SB incorrectly reported here in Aug.
	Neonatal deaths	Actual	0	0	0	0	1	0	0	0	0	0	0	0	
	Moderate Datix and above		2	0	2	5	2	3	0	1	2	1	1	1	
	HSIB		0	0	1	4	2	0	0	1	1	1	1	0	
Feedback	Number of compliments		4	1	1	1	1	4	3	0	2	1	0	0	
	Online compliments				291				*	*	*	1			Manual count of positive feedback via social media

	Number of PALS contacts/concerns		15	8	6	8	18	9	6	6	7	7	8	9	
	Complaints		1	3	2	1	1	3	1	1	1	3	2	1	
Training	PROMPT/Emergency skills all staff groups (%)	>90%	76.6	84.0	91.2	91.8	95	91.4	91	78.7	79.5	82.4	96	97.1	See detail on training page
Training	Percentage staff received fetal monitoring in labour training **(new from Sept 2021)** (%)	>90%	22.88	36.44	49.3	49.3	63.2	78*	82*	71.1	83.1	94.8	97	96.2	
Training	New-born life support (NBLS) (%)	>90%	77.8	89.0	91.2	92.2	96	91	91	77.5	79.5	82.4	96	97.1	
Training	Percentage of staff who have successfully completed mandatory CTG fetal monitoring annual competency assessment (%)	>90%	26.06	36.44	49.3	49.3	63.2	70.4	73	71.1	83.1	94.8	97	94.6	
	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	1	Nil	Nil	Nil	Nil	Nil	Nil	Normal HSIB surveillance now resumed

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**1 March 2023**		
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:	**Niall Prosser, Deputy Chief Operating Officer** **Tom Williams, Head of Financial Management** **Jenny Turton, Associate Director 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 Performance as at the end of January 2023, 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.

Operations

January had periods of significant pressure but across every measure within the Trusts performance measures in the IPR the Trust delivered performance improvements. During the month the Trust had an average of 37 COVID cases, although peaking at 71 and 141 Non Criteria to Reside patients. There were also a number of strikes that took place.

- The Trust lost a total of 1,756 hours in ambulance handovers. This is more than half of the previous month
- RUH 4 hour performance during January was 65.5%, which is a 5% improvement on December and the strongest performance for the last 6 months.
- The Trust had an average of 141.6 patients waiting who had no criteria to reside. The Trust has seen a reduction in the length of time it is taking for patients to be discharged within BaNES as improvements in pathway and capacity come on line.
- Cancer 62 day performance in December improved to 68%. The Trust continues to remain one of the strongest performers within the South West Region.
- During January the Trust reported zero patients waiting over 104 weeks and an improved number of patients waiting over 78 weeks with it further falling to 146.
- The Trust delivered 106% of costed activity against the ERF target in month. This means performance YTD is currently at 106% against the national target of 104%.

Within the February performance data we will be able to highlight the impact of both

RCN and Ambulance strikes.

Finance

- The RUH delivered a deficit of £21.0 million against a plan of £17.1 million.
- The number of Non Criteria to Reside patients remains high with an average of 142, 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.
- Agency usage is 3.6% of total pay costs and is therefore above the 3% target.
- Elective activity of 106% of 2019/20 levels has been achieved year to date.
- £11.1 million of savings have been delivered against a plan of £11.1 million year to date.
- 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 have been spent to maintain the safety of the site over winter and non-recurrent funding has been confirmed to cover these costs. The financial plan is expected to deliver with the implementation of the recovery plan and the identification of mitigations for £2.0 million of outstanding financial risks.

Workforce

- The RUH establishment in January stands at 5368.70 whole-time equivalents (WTE) at month 10.
- Vacancies at the end of January were 133.3; the vacancy rate has decreased to 2.48%, which is a positive variance against the target of 4.00%. International nursing recruitment continues to contribute significantly to the improved position.
- Staff turnover is at 11.39%, against a target for staff turnover at 11.00%; the Facilities team are developing a number of initiatives which is anticipated will help with the retention of staff across the Trust, if successful.
- Sickness absence in December was 5.75% against the target of 4.20% which is a marked increase on 4.61% in December. Anxiety, stress and depression were the main causes of sickness absence during the month. The Trust has the lowest sickness rates in the South West.
- The Nurse Agency spend as a proportion of the Registered Nursing pay bill is showing a significant increase from 3.07% in December to 7.65% in January.
- The percentage figure for Appraisal completion is 90%; all parts of the RUH remain significantly below this target. Reporting and value added remain issues for non-compliance. Focussed work still continues to support completion.
- Mandatory and Statutory Training (MaST) training compliance levels are at 86.0%, against a revised target of 85.00%. Information governance compliance has reduced fractionally to 75.7%.

Quality

This report highlights performance against the Trust patient safety, quality and patient experience priorities. These have been identified through the Quality and Patient Experience Improving Together A3s. The Quality A3 describes the harm that could be caused to patients if consistently high quality and safe care is not delivered.

Data for January shows the Trust met the performance targets for the following measures:

- Patient safety incidents – rate per 1,000 bed days
- Serious incidents with overdue actions
- Number of falls resulting in significant hard (Moderate to Catastrophic)
- Number of Hospital Acquired Pressure Ulcers Category 4
- Pseudomonas Aeruginosa

The Trust is under-performing for the following objective and tracker measures:

- Healthcare Associated Infections

  The Trust remains above trajectory for *Clostrioides Difficile*, E coli and Klebsiella infections. There were 9 *Clostrioides Difficile* reported in January 2023, 8 E coli and 5 Klebsiella infections.

  COVID-19: There were 137 COVID-19 positive cases detected during January 2023 with 44 of these confirmed as COVID-19 8+ days infections. There were 2 mortalities associated to a nosocomial COVID-19 infection. Both cases have COVID recorded on part 1 of the death certificate.

  A number of actions are being undertaken to reduce Hospital Acquired Infections, which include:
  - The creation of 23 additional new en-suite facilities across wards, which is scheduled to be completed by the end of March 2023.
  - 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 thematic review has been undertaken for the RUH C-difficile hospital onset cases reported to date. This was reported to the Quality Governance Committee in February 2023. There is no evidence of cross infection between cases on wards during periods of increased incidence.
  - IPC team members remain active members of the Bath, North East Somerset, Swindon and Wiltshire, Healthcare Acquired Infection reduction collaborative. Four workshops are scheduled to progress a system wide approach to addressing the issues.
  - A plan to improve patient hydration within the Trust is being taken forward by working in collaboration with Public Health to launch a hydration campaign across BaNES. A Hydration Improvement Group has commenced within the Trust.
  - Procurement are trialling a new cannula. If successful the company will provide a comprehensive training and support package to staff.
  - The Trust continues to apply NHSIE guidance underpinned by local risk assessment to reduce COVID-19 spread.
  - Review of the Root Cause Analysis (RCA) template for COVID-19 mortality to focus on omissions or gaps in care that could result in a serious incident.

- Number of Hospital Acquired Pressure Ulcers
  There were 3 category 2 pressure ulcers in January 2023, increasing the total to 22, which is 12 over trajectory. There were 2 medical device related pressure ulcers reported and one related to the inappropriate application of anti -embolic stockings on a high risk patient.

  A number of actions are being undertaken to further reduce pressure ulcers which include:
  - Increasing awareness of the correct process for requirement, measurement and care of a patient with anti-embolic stockings.
  - Refreshing awareness of the non-concordance with pressure ulcer care protocol.

Other Quality Metrics of note:

- Falls
  There was one fall resulting in moderate harm in January 2023. This incident is being investigated as part of the falls serious harm process and part of the weekly tracker measures linking falls data with safer staffing analysis.

  A number of actions are being taken to reduce falls which include:
  - Continuation of a working group to develop guidance for alternative footwear to slipper socks – 'Stop the Socks' campaign.
  - Weekly tracker measures are in place linking falls data with safer staffing analysis.
  - 5 wards signed up to Reconditioning Games with the Emergency Care Improvement Support Team (ECIST). A total of 8 Gold medals have been awarded across 4 wards.
  - The improvement Cycle of Plan, Do, Study, Act, has been applied on one ward to create an advice checklist for carers/relatives of personal belongings to support the safety of patients (e.g. footwear, clothing).
  - Changes to the recording of Lying and Standing Blood pressure on Millennium - to launch Feb 2023.

- Safeguarding actions
  The safeguarding slide focuses on the actions required following the Unannounced CQC inspection of Medical Care including meeting Levels 2 and 3 Adult Safeguarding Mandatory Training targets. The Trust remains below target for levels 2 and 3. Face to face training sessions for Level 2 commenced in February 2023. All staff still requiring Level 3 training are booked onto future training sessions with 26 staff booked on to a session on 21 February. In addition to this, the Senior Sisters, Charge Nurses and Matrons undertake daily, weekly and monthly inspections of care to deliver improvements to safeguarding requirements for mental capacity, best interest decisions and Deprivation of Liberty safeguards. The Clinical Friday session on 17 February will be focused on assessing adherence and understanding of these safeguarding requirements.

- Patient Experience

- The Trust received 28 formal complaints in January.
- 53% of complaints closed during January met the required timescale of 35 working days. This has deteriorated since December.
- The number of PALS contacts in January was 373 - key themes are: Appointments, Communication and Information, and Clinical Care and Concerns

- Maternity
  - The Midwife to Birth Ratio is 1:33, which reduces to 1:30 when bank staff are included against a standard of 1:27.
  - The Daily multidisciplinary team ward round was 77% for January 2023, compared to 100% in November and December 2022, the reason for this is being investigated.
  - The Maternity Fill rate for December was 90.4% for day staff and 95.9% for night staff which shows an improvement from December. The average fill rate for care staff has also increased with 66.5% for day staff and 98.5% for night staff.
  - The Midwifery Band 5/6 vacancy rate is -12 WTE, inclusive of maternity leave, which is forecasted for Feb to be -13.40 WTE.

2.	Recommendations (Note, Approve, Discuss)

The Trust Management Executive is asked to note the report and discuss current performance, risks and associated mitigations.

3.	Legal / Regulatory Implications

Trust Single Oversight Framework.

Quality: 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)

The Integrated Performance Report is linked to the Board Assurance Framework and Risk Register.

Quality: A failure to demonstrate systematic quality improvement in the delivery of patient care could risk the Trust's registration with the Care Quality Commission.

5.	Resources Implications (Financial / staffing)

Operational and financial risks as set out in the paper.

Quality: Funding awaited for hand-held devices in ED for deteriorating patient safety priority.

6.	Equality and Diversity
None identified.	

7.	References to previous reports
Standing agenda item. Quality: Monthly updates to Quality Board and Trust Management Executive.	

8.	Freedom of Information
Private	

9.	Sustainability
None identified.	

10.	Digital
None identified. Quality: Deteriorating patient priority identifies actions requiring IT input that links to the Trust's Digital Strategy. New E obs Deteriorating patient form to go live.	

Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report – February 2023

(January 2023 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 10

The RUH, where you matter

Executive Summary I

	Performance Indicator	Performing	Outside Tolerance	Last 12 Months											
				Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Breakthrough Objective	Trust Vacancy WTE (Unit 4)	<=233.6	>260.2	153.3	166.1	398.9	316.8	322.0	347.3	267.2	307.3	240.0	194.9	150.9	133.3
Contextual Information	Trust Establishment WTE (Unit 4)			5167.5	5167.5	5382.5	5320.7	5320.7	5368.7	5368.7	5368.7	5368.7	5368.7	5368.7	5368.7
Contextual Information	Substantive WTE (Unit 4)			5014.3	5001.4	4981.6	5003.8	4998.6	5021.4	5101.4	5061.4	5128.7	5173.8	5217.7	5235.4
Key Standard	Vacancy Rate	<=4.4%	>4.9%	2.97%	3.21%	7.41%	5.95%	6.05%	6.47%	4.98%	5.72%	4.47%	3.63%	2.81%	2.48%
Key Standard	In Month Turnover	<=0.92%	>1.00%	0.92%	1.31%	0.97%	0.88%	1.06%	0.99%	1.14%	1.09%	0.83%	0.55%	0.78%	0.50%
Key Standard	Rolling 12 Month Turnover	<=11.0%	>12.0%	10.25%	10.88%	11.00%	11.23%	11.61%	11.81%	12.05%	11.75%	11.72%	11.78%	11.74%	11.39%
Contextual Information	Bank Use (Staffing Solutions Data)			258.3	266.3	279.4	281.1	256.8	278.4	261.5	284.3	343.6	300.4	261.9	288.6
Contextual Information	Agency Use (Staffing Solutions Data)			104.3	142.9	122.3	129.9	146.9	138.0	130.9	126.0	109.1	85.3	80.8	100.7
Key Standard	Agency Spend as Proportion of Total Pay Bill	<=2.5%	>3.5%	3.22%	2.95%	4.26%	3.78%	4.61%	6.56%	5.40%	3.87%	3.37%	2.98%	3.50%	3.44%
Key Standard	Nurse Agency Spend as Proportion of Registered Nursing Pay Bill	<=3.0%	>4.0%	6.58%	8.12%	11.66%	7.09%	9.36%	11.04%	12.08%	8.46%	11.46%	5.50%	3.07%	7.65%
Key Standard	In Month Sickness Rate (Actual) - Reported 1 month behind	<=4.6%	>5.1%	5.50%	6.69%	6.10%	4.66%	5.28%	6.28%	4.57%	4.44%	5.02%	4.61%	5.75%	
Contextual Information	In Month Sickness - Estimated Cost (£m)			£0.74m	£1.05m	£0.92m	£0.70m	£0.81m	£1.00m	£0.68m	£0.66m	£0.78m	£0.71m	£0.94m	
Key Standard	Rolling 12 Month Sickness Rate - Reported 1 month behind	<=4.3%	>4.8%	4.87%	5.10%	5.31%	5.38%	5.48%	5.62%	5.59%	5.55%	5.49%	5.43%	5.43%	
Tracker	Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.23%	1.22%	1.19%	1.17%	1.11%	1.05%	0.99%	0.98%	0.99%	0.99%	1.01%	
Contextual Information	In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.24%	1.10%	0.95%	1.02%	0.94%	1.04%	0.90%	1.00%	1.05%	1.00%	1.05%	

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Sickness Absence	Overall sickness data levels have improved again, to 4.61%, whilst the annual rate remains above target at 5.43%; the proportion attributable to anxiety, stress and depression has risen slightly.	The data shown includes the impact of seasonal flu and by the COVID pandemic and seasonal flu. Vaccination continues to be encouraged. Where sickness absence is attributable to stress / burnout staff are encouraged to access the wellbeing support made available. Work to develop a 'Wellness Centre' at the RUH has begun.
Agency Spend	Overall agency spend as a proportion of the total pay bill deteriorated slightly (from 2.98% to 3.50% in December), this being driven, to some extent, by strike action. Nursing agency as a proportion, improved to 3.07%.	Work continues to find alternatives to bringing in Registered Mental Health nurses through agencies and to increase the proportion of substantive staff, particularly through International Nurse Recruitment.

Executive Summary II

	Performance Indicator	Performing	Outside Tolerance	Last 12 Months											
				Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Tracker	BME likelihood of being appointed from shortlisting - comparative ratio to 1 White (WRES 2) - Rolling 3 months	>=1.0	<0.8	0.57	0.63	0.72	0.66	0.62	0.64	0.63	Not Available	Not Available	Not Available	0.87	0.86
Contextual Information	BME WTE (%) at Band 6 or7			11.51%	11.49%	11.65%	11.47%	11.57%	11.43%	11.74%	11.98%	12.48%	12.47%	12.53%	12.83%
Contextual Information	BME WTE (%) at Band 8A to 9			3.24%	3.23%	3.56%	3.67%	4.39%	4.41%	4.42%	4.67%	4.76%	5.09%	5.08%	5.25%

	Performance Indicator	Latest Month Target	Outside Tolerance	Last 12 Months											
				Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Key Standard	Appraisal Compliance Rate	>=90.0%	<85.0%	59.94%	61.10%	62.66%	66.14%	66.50%	69.65%	71.85%	72.88%	72.96%	74.75%	75.51%	72.73%
Contextual Information	BME Appraisal Compliance Rate	>=90.0%	<85.0%	58.64%	61.05%	64.77%	68.51%	69.09%	71.73%	74.00%	72.95%	73.93%	75.07%	76.37%	75.00%
Key Standard	Mandatory Training Compliance (exc Bank)	>=90.0%	<85.0%	85.60%	85.20%	84.90%	85.60%	85.80%	85.70%	85.10%	85.40%	85.80%	86.40%	86.50%	86.00%
Key Standard	IG Training Compliance	>=95.0%	<90.0%	79.50%	77.20%	75.80%	76.70%	77.20%	75.80%	75.30%	75.50%	77.40%	77.80%	76.70%	75.70%

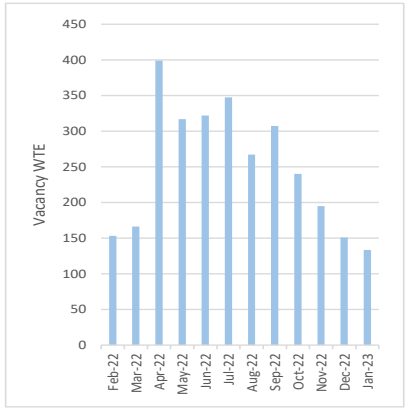
Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Equality and Diversity – BME staff at Band 8a	The rise in proportion of BME staff at Band 8a has stalled.	This indicator is being discussed at the RUH Diversity and Inclusion Steering Group to further promote work to support positive action for BME staff through wider advertising, improved recruitment and selection processes, and development programmes to support BME staff to participate in succession planning.
Appraisal rates	A modest increase in appraisal rates to 75.51%, however, appraisal rates are significantly below the 90% target	A planned deep-dive into appraisal rates by Division and team has begun. The intention will be to continue the upward trajectory such that appraisal rates increase steadily in Q4 and that 90% is attained and can be maintained during 2023/24.

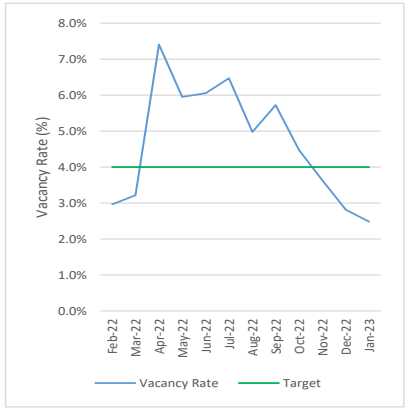
Breakthrough Goal| Reduction in Vacancy WTE

Trust Vacancy Position

WTE

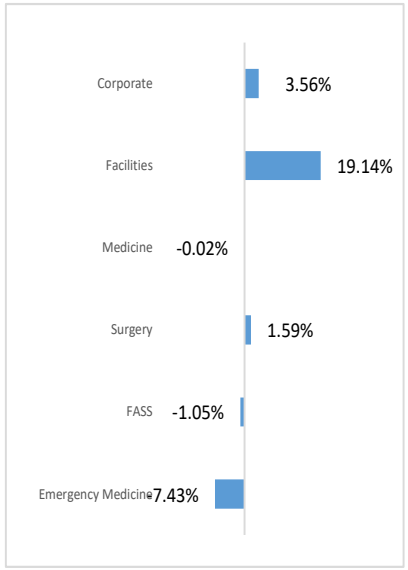


Vacancy Rate

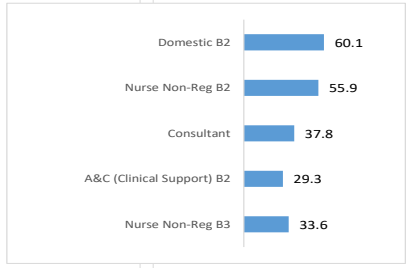


Current Vacancy WTE	133.3	Current Vacancy Rate	2.48%

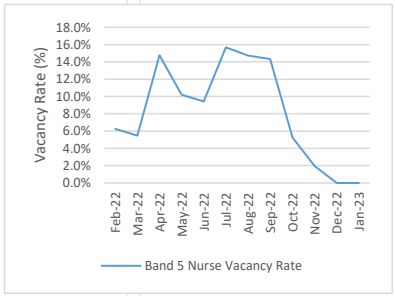
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

• Based on Unit 4 data the Trust now has a vacancy of 133.3.0 WTE, which is equivalent to 2.48%. This places the Trust on course to achieving the ambition of cutting vacancy to under 4% by the end of the Financial Year.

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

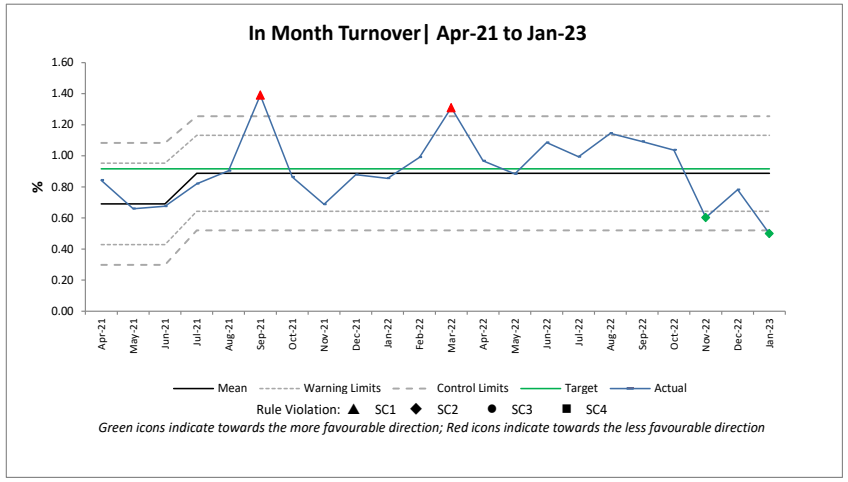
• Facilities continues to have the largest vacancy of the main Divisions, with this reflecting the vacancy associated with cleaning staff.
• Although Trust vacancy is trending down, a number of directorates have seen vacancy WTE increase since the start of the financial year. Exlcuding the COVID Directorate and directorates that remain over-established, the top 3 directorates for vacancy increases are Therapy Services, Older People's Unit and Human Resources.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Vacancies	Overall vacancy rates continue to fall, vacancies are now at the lowest rate since February 2022. This masks particular issues, such as the cleaning workforce.	The overall position on vacancies is well below target; the Operating Plan for 2023/24 will require workforce plans to address key shortages. Work is beginning to develop Divisional Workforce Plans, to be aggregated into an overall RUH Workforce Plan, for 2023/24, and with outline plans for the following four years. Improvement work in the Recruitment Team continues, to reduce time to hire.

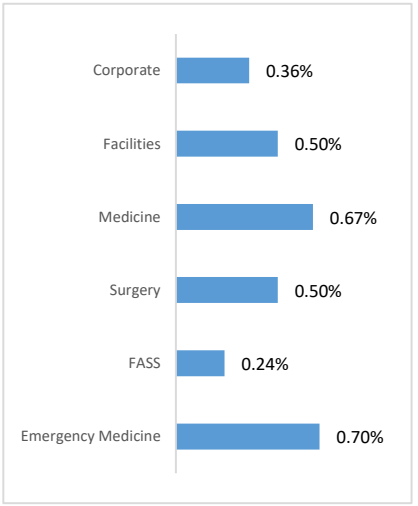
Key Standard| Turnover Rate

In Month Turnover - Trust

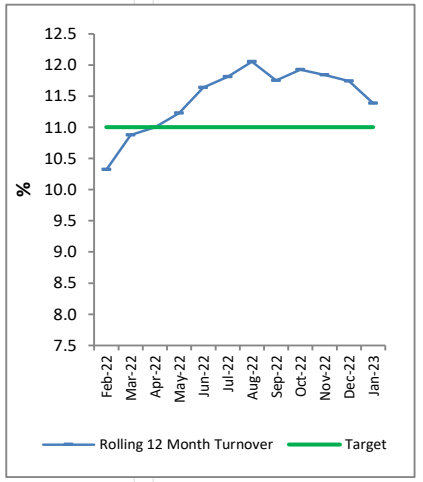


Turnover Rate	0.50%

In Month Divisional Turnover



Rolling 12 Months Turnover - Trust



Turnover Rate	11.39%

Is standard being delivered?

- As it stands, in month turnover in December was 0.50%. This is within the expected parameters as outlined by the SPC chart and below target.
- Rolling 12 month turnover remains fairly static on the position for last month at 11.39%.

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

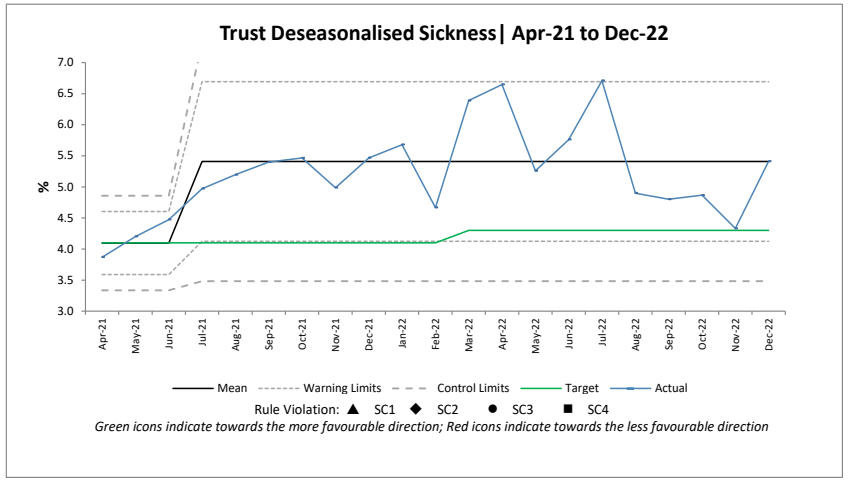
- Emergency Medicine had the highest in month turnover of the Divisions at 0.70%.
- At 14.15%, Facilities has the highest rolling 12 month turnover figure of the main divisions.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Staff Turnover / leavers	Overall turnover rates are near to target, with the exception of the Facilities Workforce (17%).	Further analysis is underway regarding reasons for leaving, by staff group and by Division. Work is being piloted in the Facilities Team to consider how to retain staff, supported by the Board decision to address the 'real living wage' for people employed on Agenda for Change Band Two.

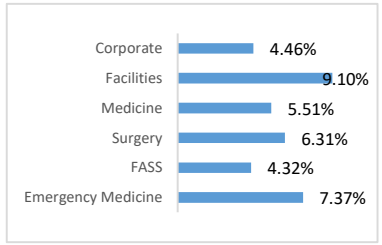
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

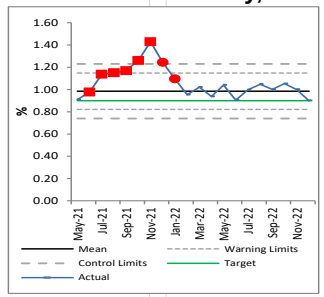


In Month Actual	In Month Deseasonalised	Rolling 12 Months
5.75%	£0.94m	5.43%

In Month Divisional Sickness Rates



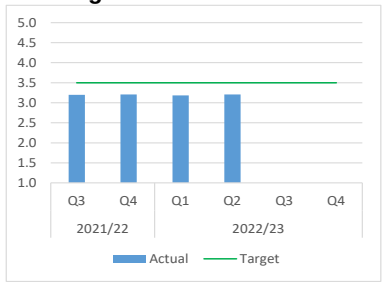
Anxiety, Stress & Depression - Trust



Absence Rate

0.90%

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	1	
Physical assault	-	1	-	-	1	1	1	
Slip, trip, fall same level	3	3	3	-	3	2	1	
Struck against	-	1	-	-	-	-	1	
Struck object	2	1	-	-	1	-	-	
Fell from height	-	-	1	-	-	-	-	
Another kind of accident	-	1	1	-	-	-	1	
Total	5	10	7	3	10	6	5	

Is standard being delivered?

• The sickness absence rate for November is 5.75%. This figure is above target, and is an increase on the position last month.

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

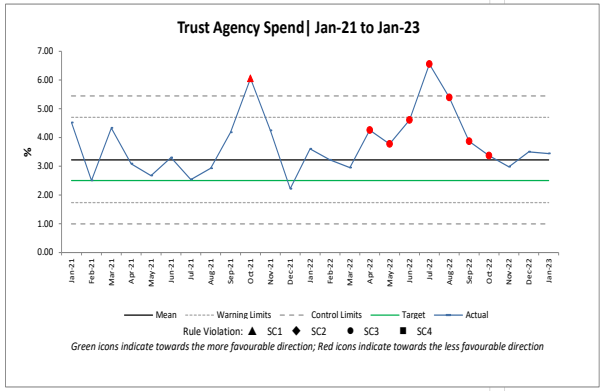
'• The covid absence rate continues to fall and now stands at 0.62%. At 3.99%, the non-covid absence has exceeded the 3.5-3.8% range where it had been for all months in the calendar year to date. • Anxiety,stress and depression absence rate has remained static at 1.0%, nonetheless with over 1500 WTE days lost in November this was the main cause of absence.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Absence	Overall absence rates continue to be above the 4.2% target	The vaccination programmes for COVID and flu have been mitigating the risks from these conditions. Preventative work is focused on anxiety and stress, with staff being encouraged to access support. Work is underway to develop a Wellbeing Centre at the RUH Our work on culture and addressing incivility is anticipated to have a positive impact on absence levels and will be evaluated.

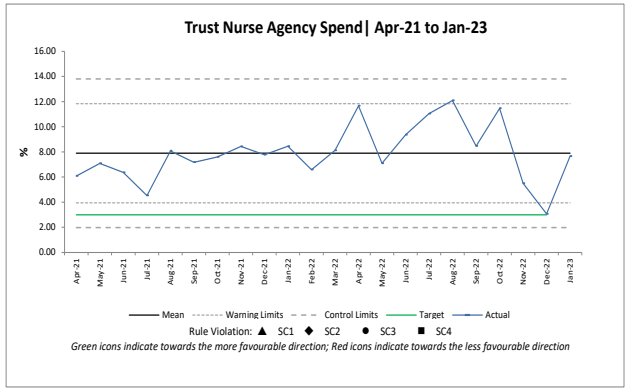
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill



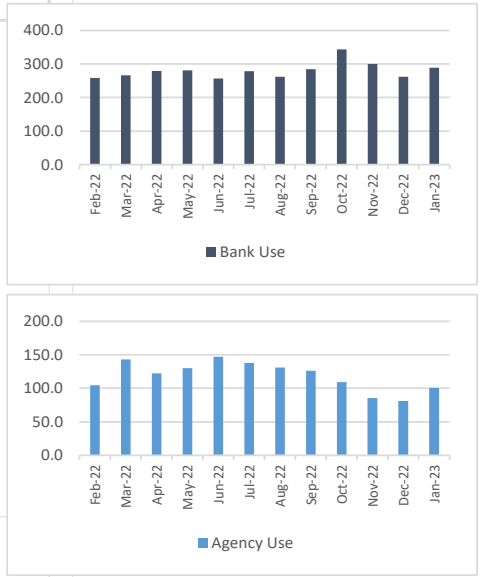
Proportion	3.44%

Nurse Agency Spend as Proportion of Total Registered Nursing Pay Bill



Proportion	7.65%

Bank & Agency Use – Staffing Solutions Data



Is standard being delivered?

- The overall agency spend was 3.44% of the total pay bill.
- Nurse agency spend is up considerably on last month at 7.65% of the nursing pay bill.

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

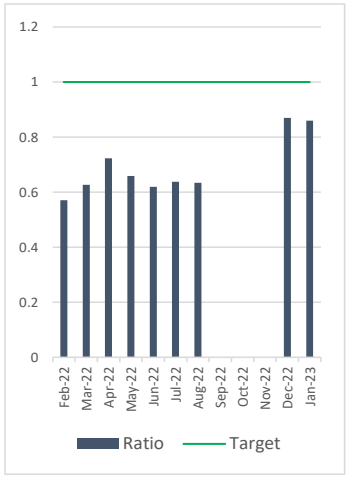
- The vast majority of agency spend was related to registered nursing.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Agency usage	The trend is for nurse agency spend is at target, however, overall agency saw the expected deterioration in December.	Agency usage is reduced primarily by filling vacancies and encouraging the use of the Staffing Solutions (Bank) workforce rather than filling gaps through agency. We have improved our approach to medical staffing by introducing a new supply route, through 'Locum's Nest'. Further work regarding how the Bank functions is underway.

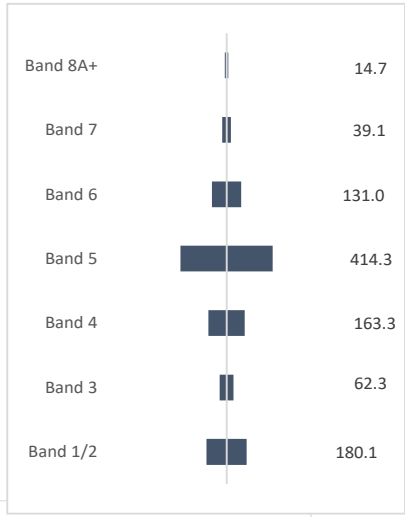
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill



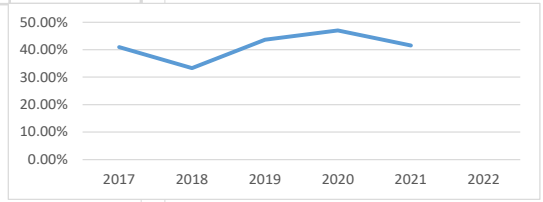
Proportion	0.86

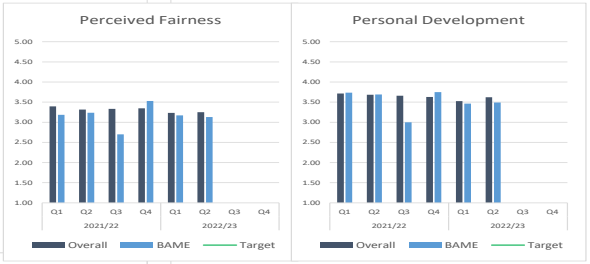
se Agency Spend as Proportion otal Registered Nursing Pay Bill



Proportion	

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

• Following the implantation of Trac, the last 2 available periods to report have both been below the target with the current ratio at 0.86. However this is an improvement on data from taken from NHS Jobs.

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

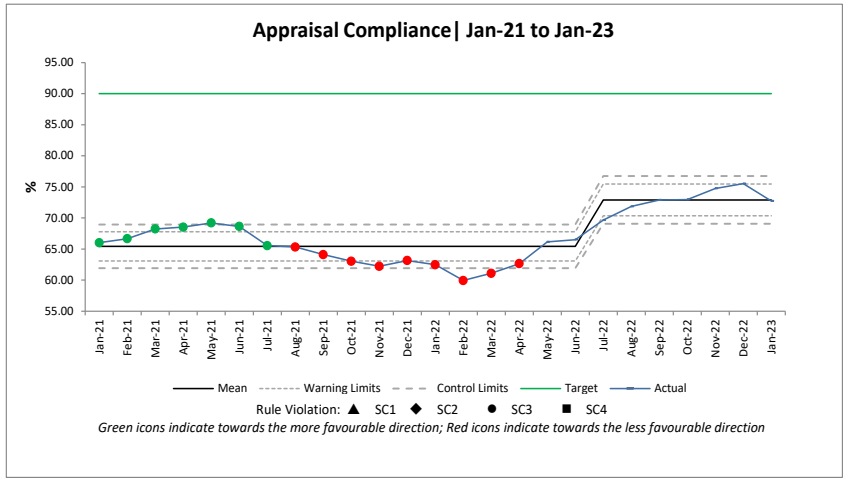
• Facilities is the highest contributor with a ratio above target at 1.17. Medicine is the poorest performing division with a ratio of only 0.59, which is considerably less than the other main divisions.

Countermeasure Summary

Countermeasure/Action	Owner

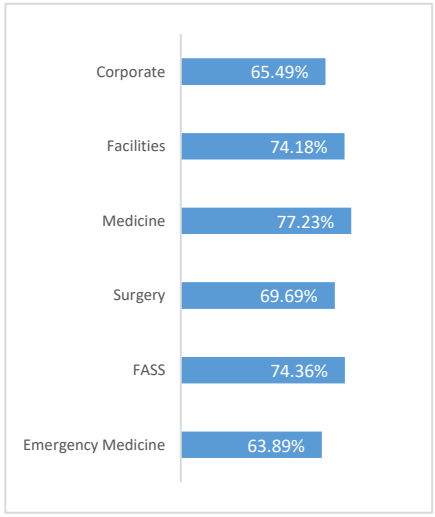
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	72.7%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff 72.3%

M&D Staff 77.4%

Consultants 92.8%

White 72.5%

BME 75.0%

Is standard being delivered?

• Appraisal compliance deteriorated from last months figure of 75.5% and now stands currently at 72.7%.

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

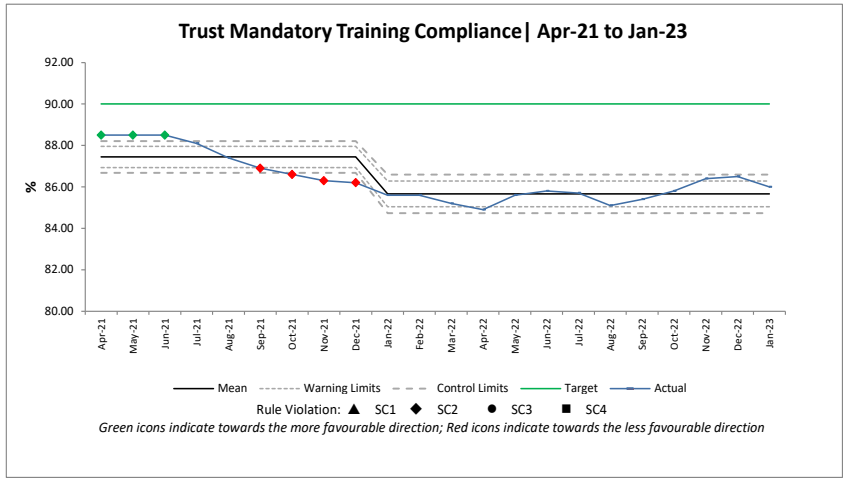
• Emergency Medicine (63.9%), followed by Corporate (65.5%) had the poorest compliance rates of the main Divisions.
• AfC compliance rate (72.3%) continues to fall short of Medical Staff (77.4%)

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Appraisal rates	This measure has improved slightly, but remains significantly below target.	Work is beginning to boost appraisal up-take, through providing improved appraisal systems, better feedback methods and by highlighting this requirement in Divisions and providing training. Some structural re-design work is planned to ensure appropriate 'span of control' (at or below 8 people to line manage) so that all staff have a clearly identified line manager, with sufficient time to provide regular supervision and appraisal.

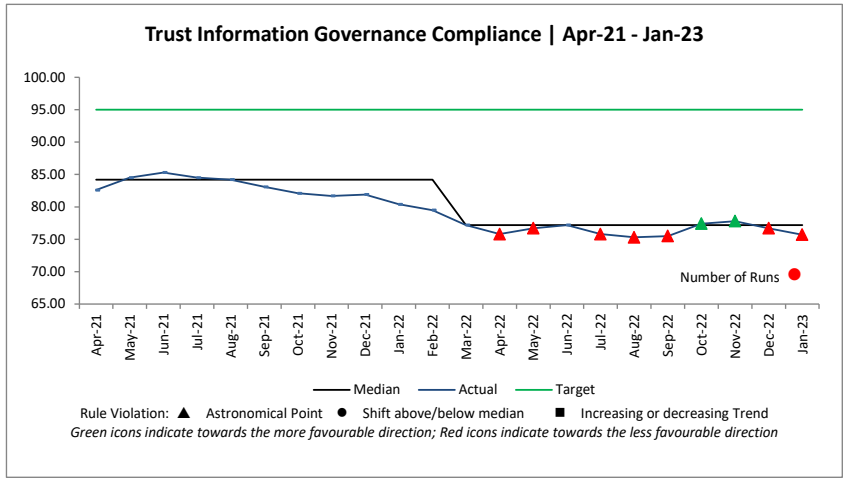
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



Compliance Rate	86.0%

Information Governance Training Compliance Rate - Trust



Compliance Rate	75.7%

Is standard being delivered?

• Overall mandatory training compliance (excluding bank) is fairly static at 86%.
• IG training compliance now stands at 75.7% well below its 95% target. Due to a continuous deterioration in IG compliance since Mar-22 the process has been re-based to reflect this poorer standard.

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

• As has been the case for some time, Facilities has the lowest compliance rates of the main Divisions for both overall mandatory training and IG training.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
MaST training rates	This target has been adjusted to 85%.	Work is underway to streamline the MaST Programme, such that compliance is facilitated, both by placing a reduced training requirement upon staff and making learning materials more accessible, through the new Learning Management System (LMS)

The people we care for

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Operations Report

Month 10

The people we care for

The RUH, where you matter

Executive Summary: Performance

Royal United Hospitals Bath NHS
NHS Foundation Trust

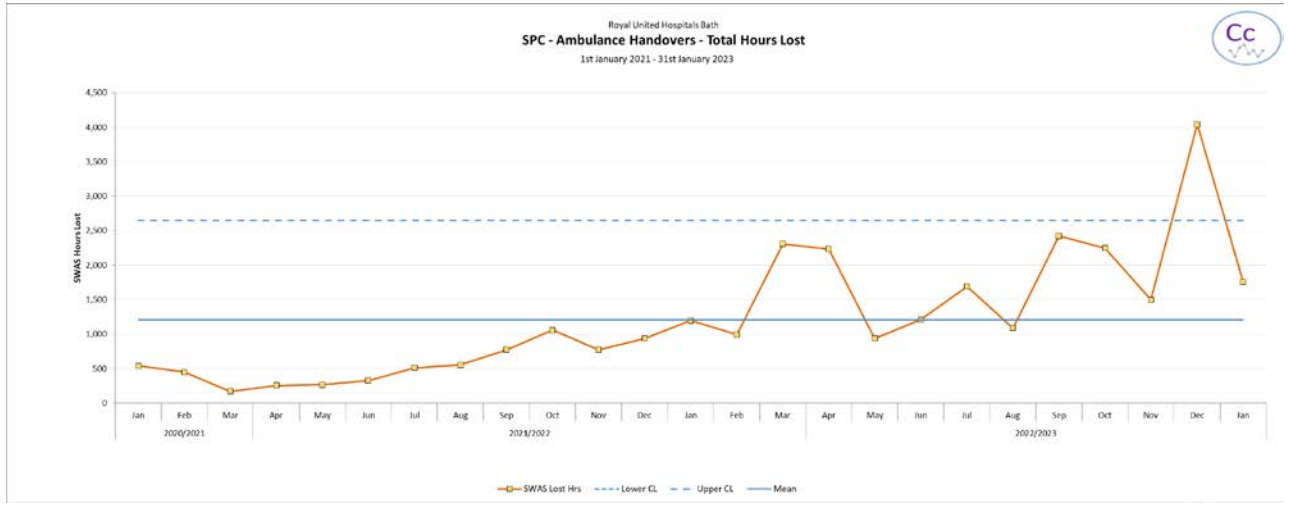
Strategic Goal		Performance Indicator	Target		2021/22						Trend	Movement From Previous Month
			Performing	Under Performing	Aug	Sep	Oct	Nov	Dec	Jan		
Trust Goals	People in our Community	Ambulance Handover Delays	>=39	<39	446	722	784	592	1007	476		
Breakthrough Objectives	People We Care For	4 Hour Performance (Total RUH Footprint, including MIU & Booked)	>=95%	<95%	65.2%	61.5%	60.6%	62.0%	60.1%	65.5%		
	People in our Community	Non Criteria to Reside	<=62	>62	135	129	155	130	141.9	141.6		
Key Standards	People We Care For	RTT - Incomplete Pathways in 18 weeks	>=92%	<92%	61.1%	59.4%	58.8%	59.2%	58.5%	60.2%		
		62 day urgent referral to treatment of all cancers	>=85%	<85%	62.7%	73.6%	68.4%	66.3%	68.0%	(LAG 1)		
		Diagnostic tests maximum wait of 6 weeks	<=1%	>1%	37.6%	40.8%	42.8%	41.9%	50.0%	49.3%		

Measures requiring focus and a countermeasure summary this month are;

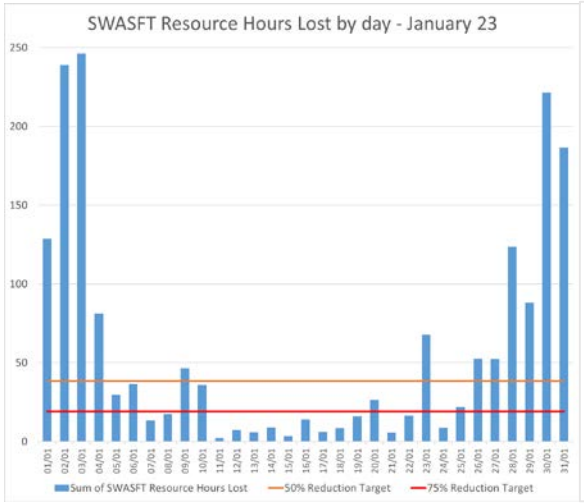
Measure	Change	Executive Summary
Ambulance Handover	↓	In January the Trust lost a total of 1,756 hours in ambulance handovers, an improvement on the previous month. The Trust still had significant challenges at the beginning of the month but saw improvements in both flow, and Ambulance handover delays during the middle of the month. This led to improvements in the ambulance handover position.
4 Hour Performance	↑	RUH 4 hour performance during January was 65.5%. This is a 5% improvement on December and the highest performance in the last 6 months. Flow challenges at the beginning and end of January had an impact on 4 hour performance. Additionally demand within Urgent Care remained very high, with demand still outstripping commissioned capacity.
Non Criteria to Reside (NC2R)	↓	During January the Trust had an average of 141.6 patients waiting who had no criteria to reside. This is a worsening position and still significantly above the system target of 74. The Trust is seeing reductions in the length of time patients are waiting to leave the hospital once they become fit for discharge with the average wait for pathway within BANES as pathway 1 has dropped from 18 days to 7 days, work is focused on further reducing this to 48 hours.
Referral to Treatment	↑	During January the Trust had no patients waiting longer than 104 weeks. The number of pts waiting over 78 weeks further decreased to 146. The biggest contribution to the decrease was from Gastro. The risk to 78 weeks remains being driven by Gastro, General Surgery and Cardiology.
Cancer 62 Days	↑	Performance in December for 62 improved slightly to 68%. Urology and Colorectal remained the largest contributors of breaches in month accounting for two thirds of total Trust breaches. Waiting times for diagnostic imaging and reporting remained a key factor in breaches, and LATP biopsy waiting times for prostate patients specifically.
Diagnostics	↓	January > 6 week performance was 49.3%, which is an improvement in performance when compared to previous month. Significant improvements into Ultra-Sound, MRI and echo.
Elective Recovery	↑	Trust delivered 106% in month against the 104% ERF, putting YTD at 106%. The Trust continues to perform well on day cases and outpatients. Inpatient activity remains lower but the Trust is aiming to start some orthopaedic operating at the RUH site in February.

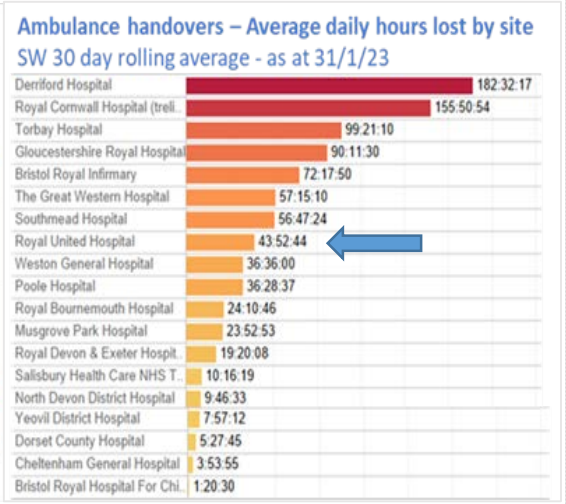
Trust Goal | Ambulance handover delays

Historic Data: hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

In January the Trust lost a total of 1,756 hours in ambulance handovers, a significant improvement in performance.

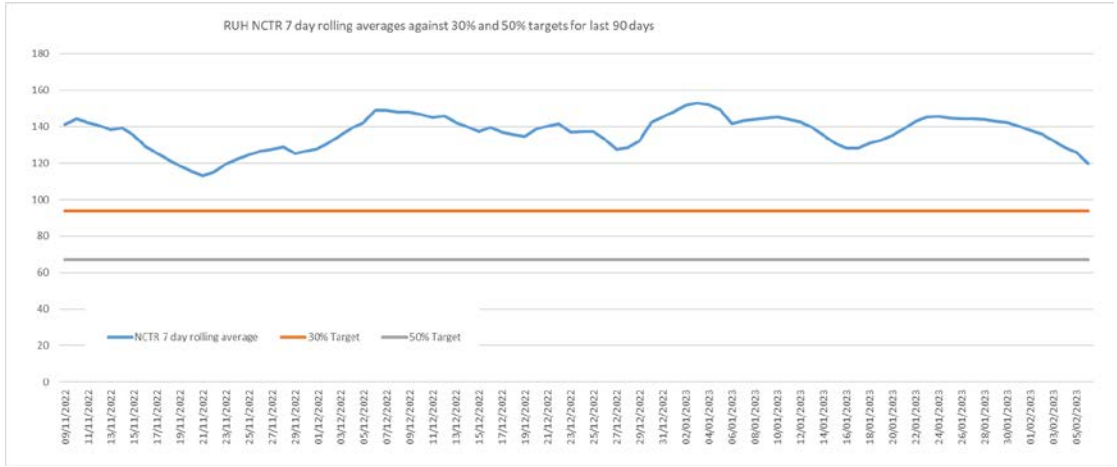
What's the top contributor for under/over achievement?

- During January the Trust started the month with 71 beds occupied with COVID but this dropped to an average of 37 during the month. The Trust also had an average of 141.6 NC2R pts, which is 0.5 better than December.
- As the graph in the top right demonstrates the Trust saw two periods of peak demand at either end of the month.
- The trust continued to use of ACA to support Trust position whilst also utilised its Fracture Clinic to support ambulance handover delays.
- During January the Trust also utilised up to 60 additional beds to try and support flow out of ED.

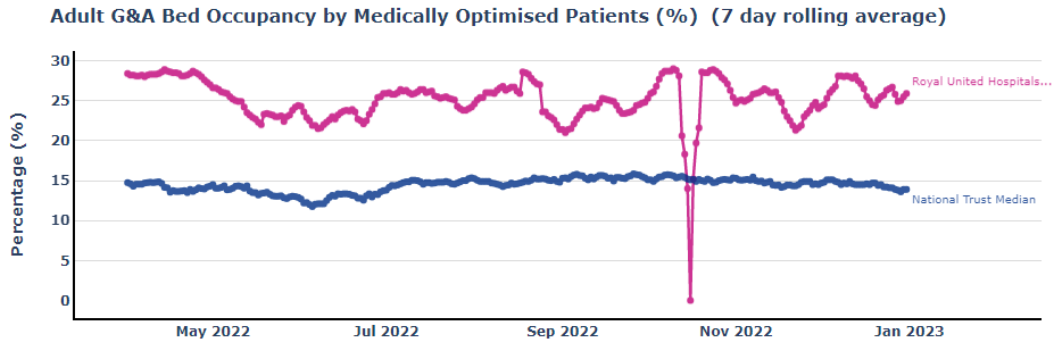
Countermeasures / Actions	Owner	Due Date
Utilise boarded beds to support maintaining flow	Prosser	Quarter 4
Reviewing the ACA model to identify potential different ways of managing and enhancing the offering	ED leadership team	In progress
Additional beds being opened within the RUH and within the community to support flow	Prosser	Quarter 4
Continue to drive improvements in NC2R position to release beds	Prosser	February 23

Breakthrough Goal | Non criteria to reside

Historic Data: as of 08/02/23



Supporting data



Is the standard being delivered?

During January, the Trust had an average of 141.6 patients waiting who had no criteria to reside this is 0.6 pts improvement. This remains above the system target and trajectory. Graph top right demonstrates the percentage of total beds occupied by NC2R patients. This demonstrates that the Trust has one of the most challenged position within the country. We have seen improvements in early February.

We are starting to see a reduction in the Length of time patients are waiting for the NC2R pts in BANES to be discharged with pathway 1 going from 18 to 7 days. This is a precursor to total waits going down.

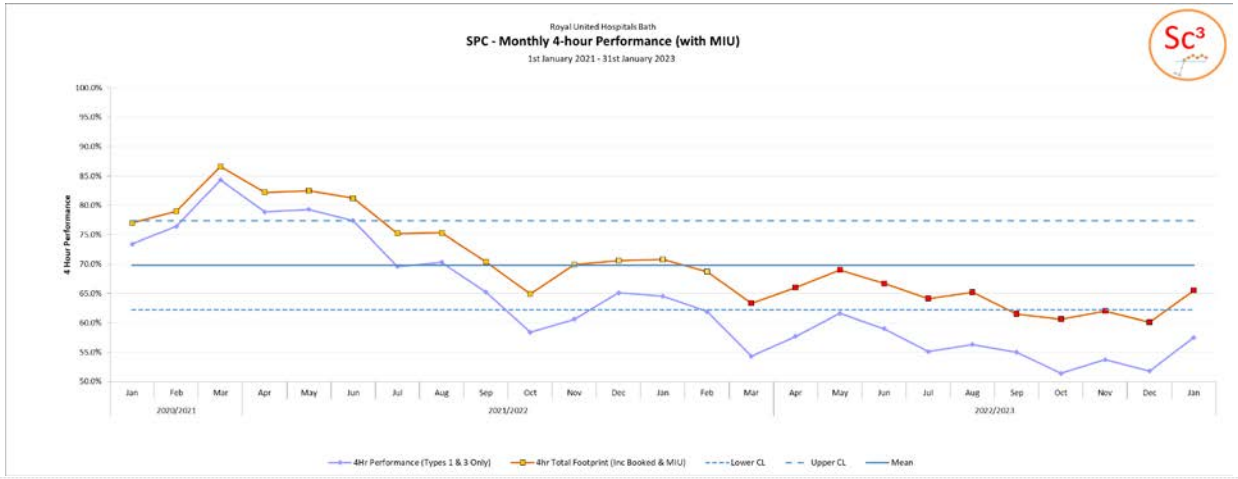
What's the top contributor for under/over achievement?

- The system opened additional capacity in November but not to the level within the initial plan as South Newton beds have not yet come online.
- The RUH has delivered an increase in both Hospital at Home and ART+ and is working on increasing both services capacity during Q4.
- Higher number of patients being discharged on a pathway 2 increasing demand for bedded care.

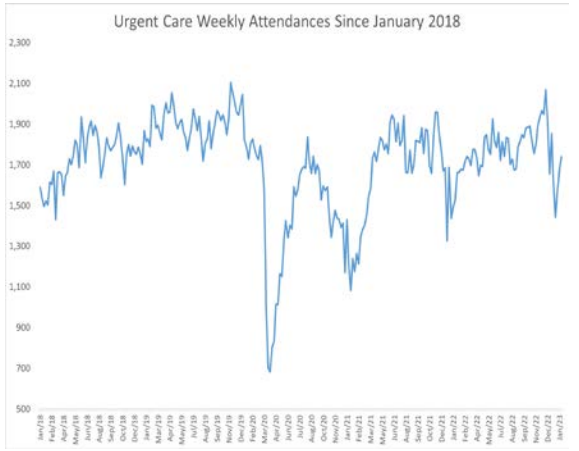
Countermeasures / Actions	Owner	Due Date
United Care BaNES and Council commissioned Domiciliary care to close current capacity gap. UCB to recover position.	Dolman-Sellars	Feb 22
Opening of south newton beds	WH&C	Jan - 23
Developing plans to expand ART to 40 pts and H@H to 35 pts in Q4. (H@H wont impact on NC2R but will support flow) and reduce time to discharge down to 48 hrs for pathway 1	Project Leads	Quarter 4

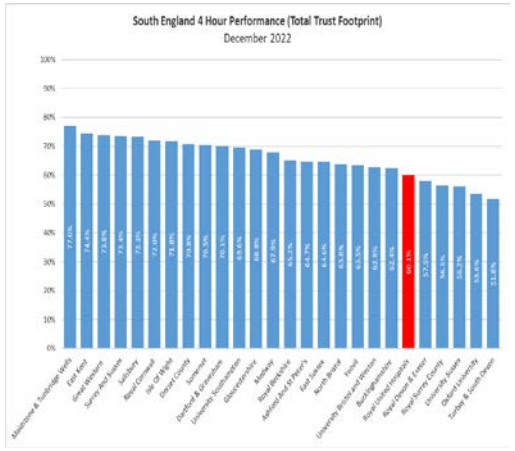
Key Standards | 4 hour Emergency Standard

Historic Data



Supporting data





Is the standard being delivered?

RUH 4 hour performance during January was 65.5% at Trust wide level and 57.5% within the RUH footprint. This is an improvement against performance seen over several months and the strongest performance for 6 months.

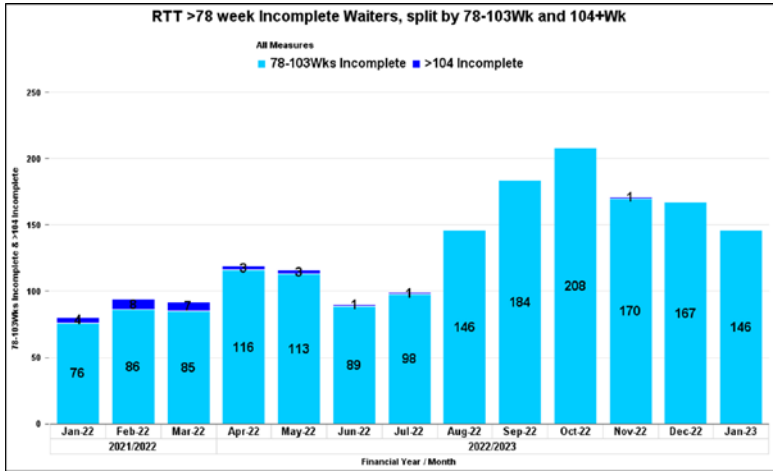
What's the top contributor for under/over achievement?

- The Trust bed occupancy has been peaking at 98.9% compared to a national average of 97% during peaks in January. This is limiting the Trusts ability to respond to the demand within ED.
- Demand levels in January slightly decreased, although have remained at average levels during 22/23 levels eg250 attendances per day.
- The Trust continues to see the impact of the flow challenges linked to high percentage of its bed base being to support Non Criteria to Reside patients. Flu and COVID as this continues to limit the bed availability for patients to be admitted into the hospital. This is delaying the discharge time for ED and leading to patients breaching the 4 hour clock.

Countermeasures / Actions	Owner	Due Date
Development of Medical staffing business case to support delivery of activity in 23/24	Forsyth, Prosser	In progress
Launching pilot for streaming within urgent care	Fouracre	Quarter 4
Work with AWP to progress their business continuity incident impacting on staffing and MH provision.	Prosser	Quarter 4
Continue to recruit to urgent care vacancies and medical staffing gaps	Laird, Fouracre	Feb 22

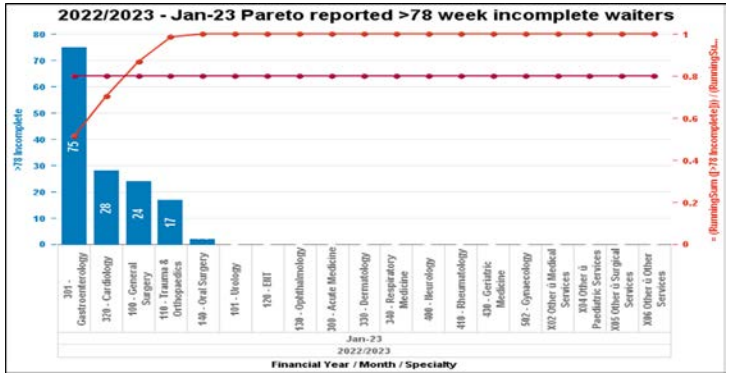
Key Standards | Referral to Treatment

Historic Data



Supporting data

Pareto 78+ (inc. 104+) by Specialty



Is the standard being delivered?

- In Jan the Trust had 146 patients waiting over 78 weeks, improvement on December 22.
- No patients waiting over 104 weeks .
- RTT performance was 60.2% in Jan, up from 58.5% in Dec

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

- Of the 146 Open 78+ Waits are in Gastro has 52%, Cardiology 19%, General Surgery 16% and T&O 12%.
- Cardiology, General Surgery and Oral Surgery 78+ Wait count has started to come down, meanwhile Gastro has increased from 57 to 75 in January
- Progress continues with the cohort of Trust Waits with the *potential* to be 78+ if not stopped before Mar'23. Jan ended with 389, down from 648 at the end of Dec. Oral Surgery made the greatest contribution to the overall reduction with –61

Countermeasures / Actions	Owner	Due Date
General Surgery insourcing agreed starting Jan 23 with theatre lists identified for Feb/Mar 23 -	S Roberts	Jan 23
Additional clinics being provided to reduce wait to first appointment	B Isaac	Ongoing
Cardiology recovery plan review	H Cox	Jan 23
Gastro locum in place and providing additional outpatient clinics.	R Weston	Ongoing
3 x per week 78 week risk meetings in place	J Dando	Ongoing

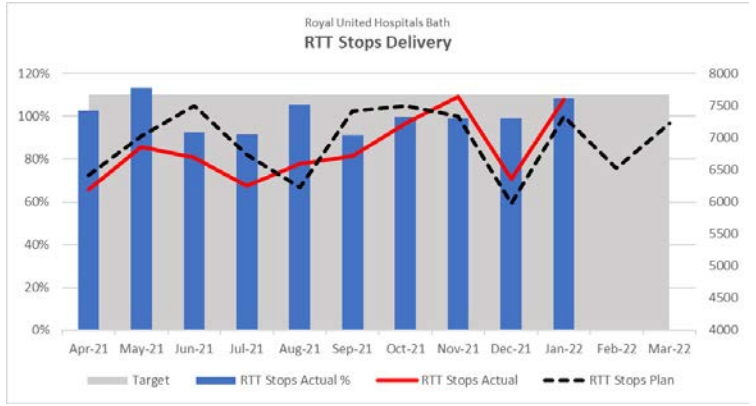
Key Standards | Elective Recovery

Historic Data

		M10	YTD
Division	Specialty	Perf %	Perf %
FASS	Day Cases	157%	108%
FASS	Elective	77%	111%
FASS	Elective XSBD	88%	121%
FASS	Follow up outpatient	125%	129%
FASS	New outpatient	114%	116%
FASS	Outpatient procedures	110%	129%
FASS	**Total**	**118%**	**118%**
Medicine	Day Cases	125%	122%
Medicine	Elective	129%	82%
Medicine	Elective XSBD	6%	72%
Medicine	Follow up outpatient	115%	119%
Medicine	New outpatient	108%	108%
Medicine	Outpatient procedures	101%	102%
Medicine	**Total**	**115%**	**114%**
Surgery	Day Cases	137%	103%
Surgery	Elective	51%	86%
Surgery	Elective XSBD	186%	263%
Surgery	Follow up outpatient	108%	94%
Surgery	New outpatient	96%	106%
Surgery	Outpatient procedures	105%	91%
Surgery	**Total**	**94%**	**96%**
RUH	**Total**	**106%**	**106%**

Supporting data

RTT Stops Delivery



Is the standard being delivered?

- RTT Stops delivery 108% against target of 110% in January
- Trust delivered 106% in month against the 104% ERF, putting YTD at 106%

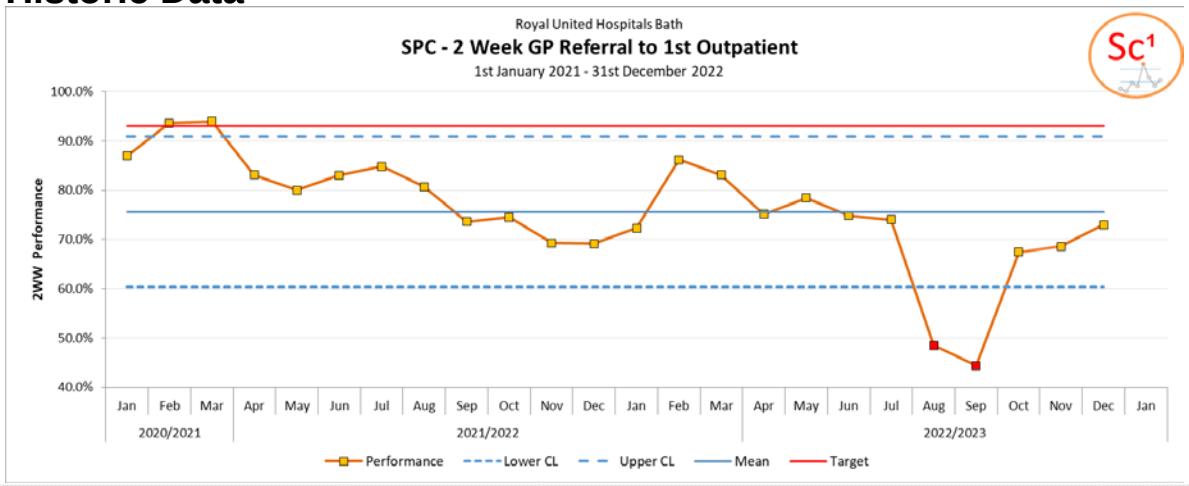
What's the top contributor for under/over achievement?

- Both IP and OP RTT stops high – 106% and 109% of 2019/20 respectively
- High Daycase delivery at 109%. Inpatients lower. Orthopaedic elective bed capacity remains closed
- Outpatient volumes remain high notably in Gastroenterology, Cardiology, Ophthalmology and Paeds
- OP procedures at 82%,which is an improvement on December
- MRI and CT above 120% target. Echoes at 119% and exceeded 1500 scans, which is their highest volume this year

Countermeasures / Actions	Owner	Due Date
Modular theatre at Sulis	S Sethi	Feb 23
ENT and Ophthalmology procedure recording recovery plan in place	S Roberts	On going
General Surgery in sourcing	S Roberts	Jan 23
Ophthalmology recovery plan – additional patients added to outpatient clinics and theatre lists	S Roberts	on going

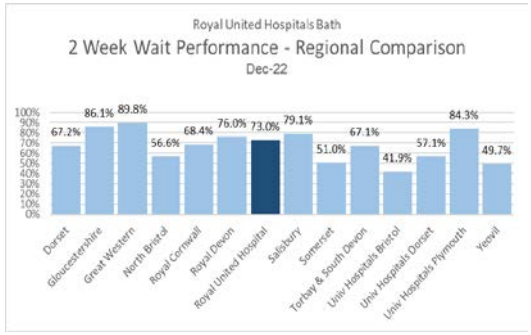
Key Standards | Cancer 2 week wait

Historic Data

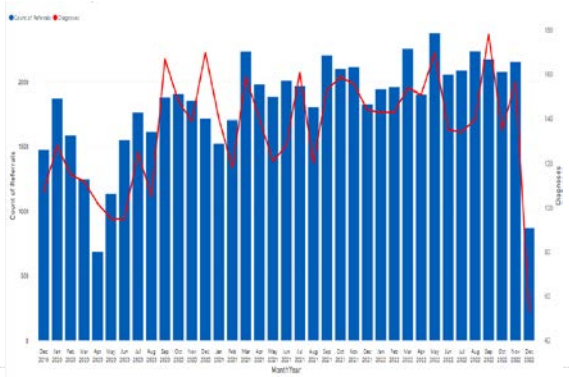


Supporting data

2 week wait Regional Comparison



2 week wait demand and diagnoses



Is the standard being delivered?

In December performance improved again to 73.0%.

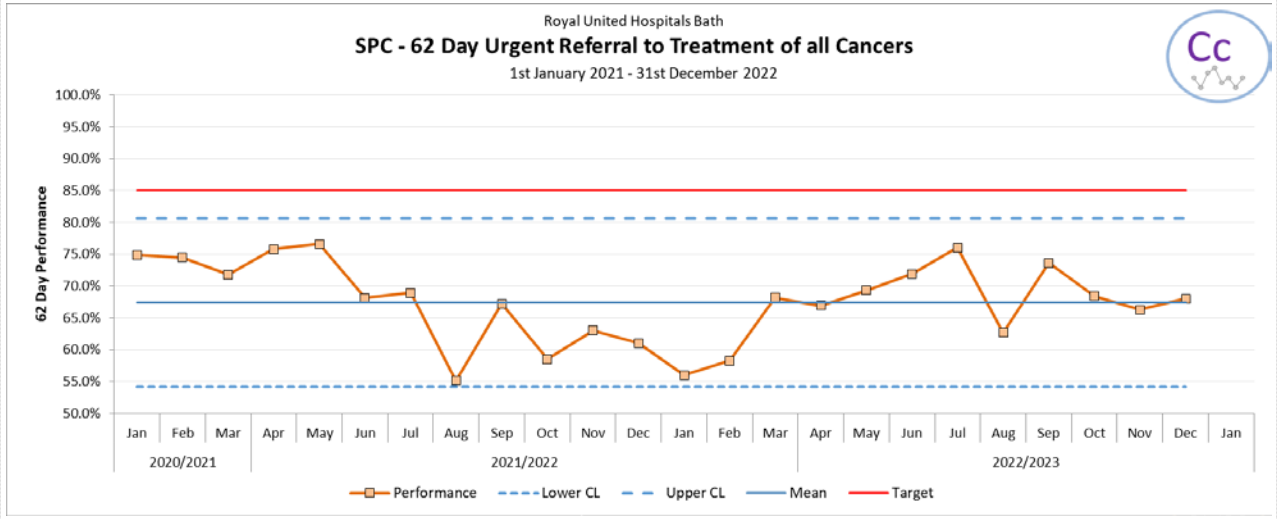
What's the top contributor for under/over achievement?

- Colorectal remained the biggest contributor of breaches but improved their performance from 21% in November to 49% in December.
- Most Colorectal breaches were due to long waiting times for first telephone or face to face outpatient appointments. These waiting times issues have now been resolved with most patients offered an appointment within one week. There were also breaches for patients undergoing endoscopy on *straight to test* pathways.
- Colorectal 2ww demand reduced in month, a common seasonal reduction.
- Urology breaches increased in month, predominantly for patients seen through the haematuria clinic. Performance has been impacted due to substantive consultant vacancies, alongside a considerable demand increased over the past year.
- Ability to increase clinic capacity impacted by strikes.

Countermeasures / Actions	Owner	Due Date
Colorectal – Revised 2ww referral form going live in January	M Bullock	January 23
Colorectal – Locum consultant remain in place – prioritisation of 2ww capacity	N Lepak	Ongoing
Urology – Two consultants appointed – start date April and May 23	J Dando	Completed
Urology – Review long term radiology capacity for haematuria clinics	J Dando	March 23
Urology - Additional flexi capacity being provided by WLI	J Dando	Ongoing

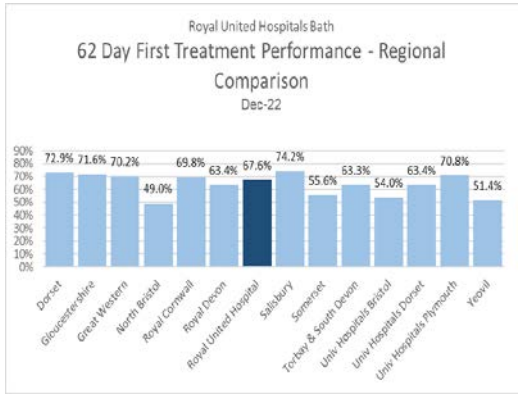
Key Standards | Cancer 62 days

Historic Data

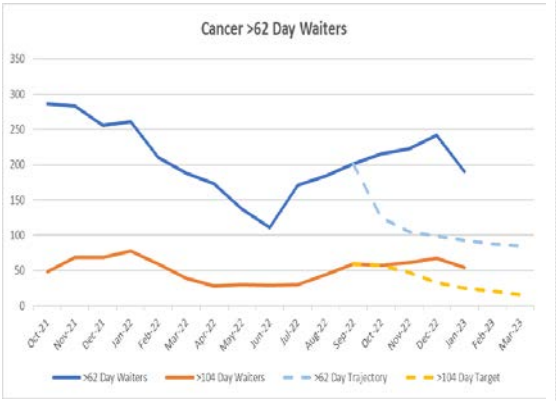


Supporting data

62 Day Regional Comparison



RUH 62 Day Backlog



Is the standard being delivered?

In December performance improved to 68%.

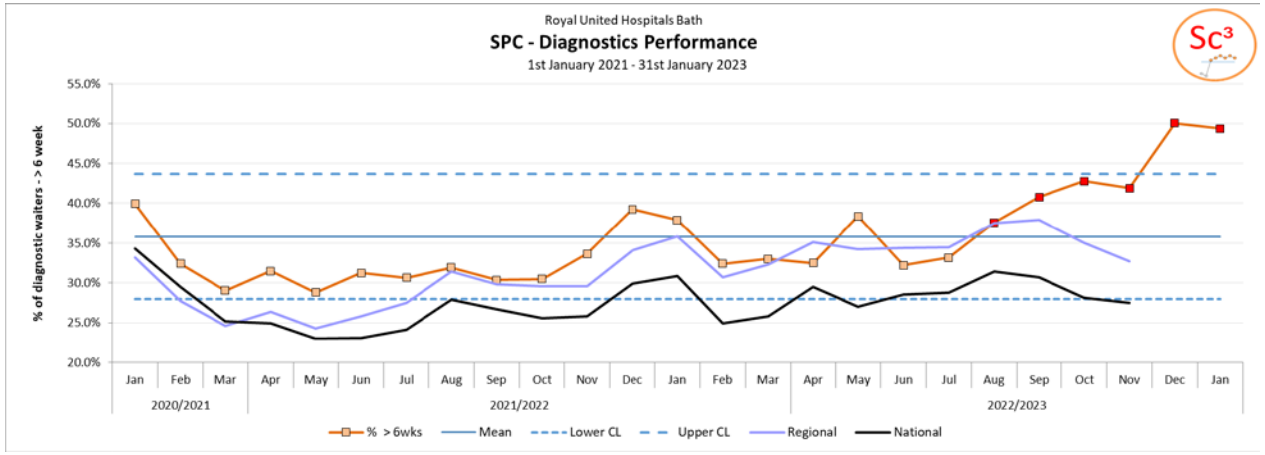
What's the top contributor for under/over achievement?

- Urology remained the top contributor of breaches. 70% of Urology breaches were for patients with prostate cancer. Delays with MRI reporting and LATP biopsies remained the most common reasons for breaches.
- Colorectal recorded the second largest amount of breaches but remained the most challenged tumour site recording performance of 23%. Waiting times for initial diagnostics are a consistent factor in the majority of breaches.
- The number of colorectal patients going straight to a diagnostic test has improved considerably in month to around 40-45% of all 2ww referrals.
- >62 day waiters improved considerably. Colorectal continue to account for over half of all patients over 62 days but the number has reduced dramatically in the past month as a result of the improvements made in the early diagnostic pathway.
- 62 day waiters may be at risk of increasing due to a focus on 78 week patients.

Countermeasures / Actions	Owner	Due Date
Urology – MRI scanning and reporting capacity alignment with PSA clinics	N Aguiar	Feb 23
Urology - Additional WLIs and bank providing LATP capacity.	J Dando	Ongoing
Colorectal – Increase GA endoscopy lists	B Colleypriest S Roberts	Feb 23
Colorectal – Backlog clearance plan for CTC reporting	N Aguiar	Complete
Colorectal – Consultant-led results review sessions planned for March	N Lepak	Mar 23

Key Standards | Diagnostics 6 weeks

Historic Data



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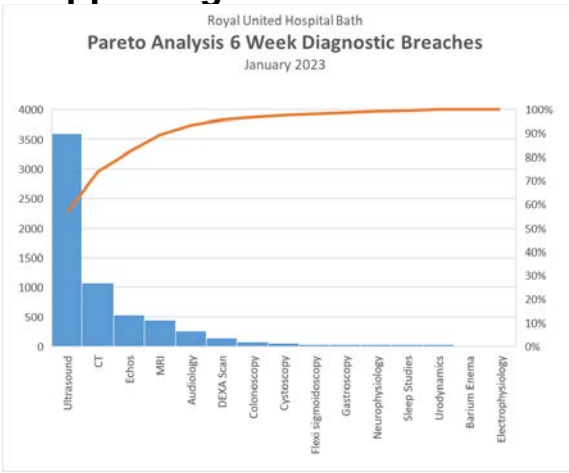
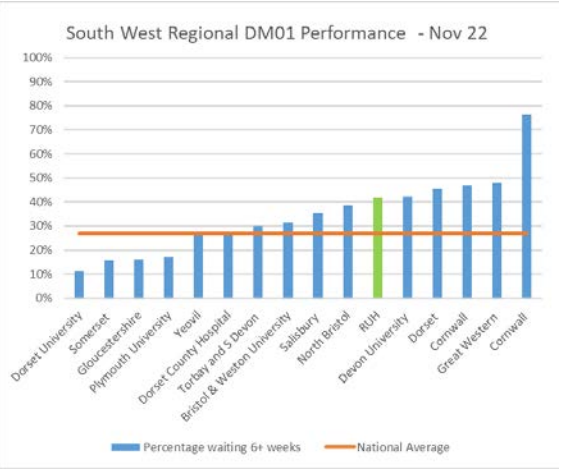




Is the standard being delivered?

January > 6 week performance was 49.3%, which represents a 0.6% improvement when compared to previous month (-216 breaches).

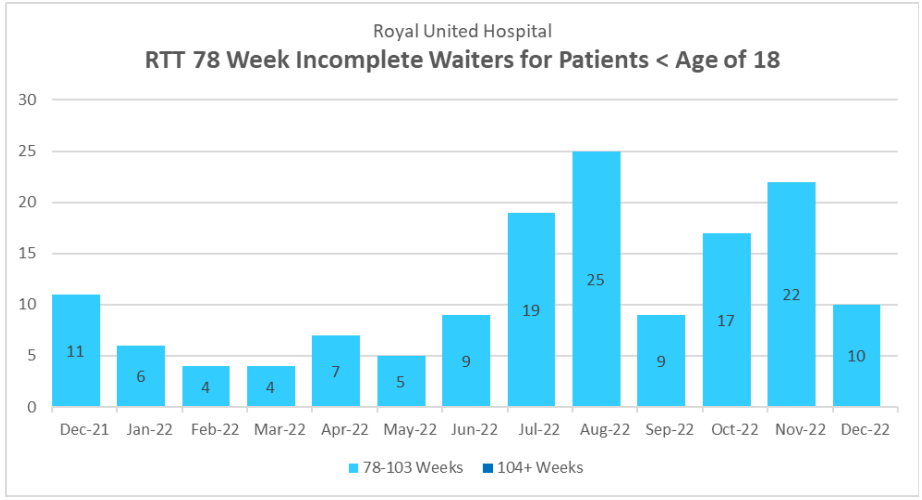
What's the top contributor for under/over achievement?

- Top contributors: Ultrasound, CT and Echocardiography.
- Improvement in performance driven by MRI (-125 breaches), USS (-123 breaches) and Echo (-161 breaches).
- Decline in performance in-month for CT, Audiology and Dexa.
- Reduction in the number of patients >52 weeks (1 breach reported – dated in February).
- Reduction in referrals waiting > 26 weeks.
- Increase in both clinically urgent (2WW) and >78 week requests reducing capacity for routine investigations. CT is the most impacted modality.

Countermeasures / Actions	Owner	Due Date
Modalities working with BIU (Sadie) on recovery trajectories and link with WLMDS	N Aguiar / S Pyecroft	Feb-23
Exploring options to accelerate USS recovery	N Aguiar	Feb-23
Service review commenced within Respiratory labs. 3rd Respiratory – works in progress	M Warner-Holt	In progress
Plan for administrative resources to support Echo booking.	M Beech / B Isaac	Feb-23
Audiology additional Room capacity and revised trajectory	A Bassadone / S Fox	Feb-23
Review and early action: • > 52 weeks referrals booking • > 26 weeks breaches review and booking	J Pegram /J Saddington / N Aguiar	Mar-23

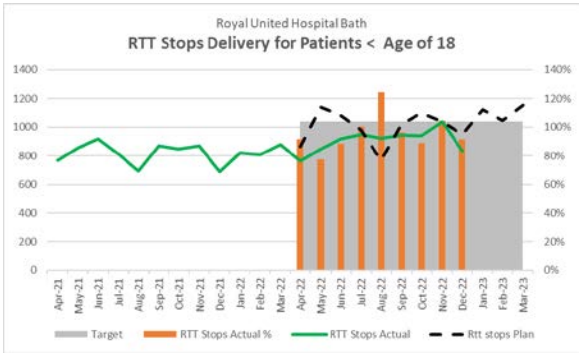
Key Standards | Paediatrics

Historic Data

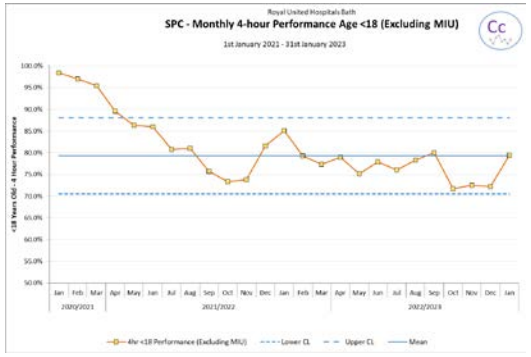


Supporting data

Stops v Plan



4 hr performance



Is the standard being delivered?

- RTT December reflected 5 paediatric patients over 78 weeks. This is a decrease of 5 patients from December position
- Cancer 2ww - There were no 2ww patients seen in December.
- Cancer Diagnostics – 50% One patient breached the 28 day standard due to waiting times for diagnostic imaging in the Breast Unit. The patient was non-cancer.

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

- Oral surgery make up 4 out or 5 to the paediatric waiting list over 78 weeks. All patients have confirmed TCIs.

Countermeasures / Actions	Owner	Due Date
New Day Surgery working group set up to optimise performance – increased dental booking to 8 cases per list	Goodwin	In progress
Additional theatre lists re-prioritised for paediatric oral surgery to support 78 week reduction trajectory	Gillett	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

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Quality Report

February 2023 (January 2022 data)

The RUH, where you matter

Executive Summary | Quality

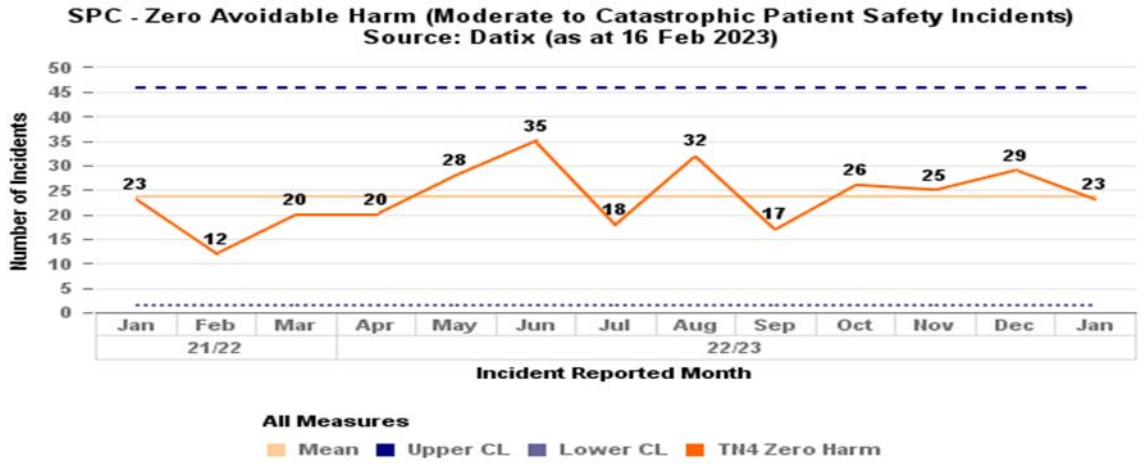
Strategic Goal		Performance Indicator	Description	Target		2021/22			2022/23										Trend
				Performing	Under Performing	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Trust Goals	People We Care For	Zero Avoidable Harm	Reported Patient Safety incidents resulting in significant harm (moderate to catastrophic), excl. rejected			23	12	20	20	28	35	18	32	17	26	25	29	23	
Breakthrough Objectives	People We Care For	Healthcare Associated Infections Excluding COVID, Norovirus & Flu	MRSA, MSSA, E coli, C diff (Healthcare Onset and Community Onset), Klebsiella spp, Pseudomonas aeruginosa	<=11	>11	19	21	26	20	18	13	15	21	23	21	37	17	25	
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	47	44	49	51	41	44	45	48	55	59	55	56	55	
		Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	5	3	2	2	3	2	1	3	1	3	3	4	2	
		Number of falls resulting in significant harm (Moderate to Catastrophic)		<=1	>=3	2	4	2	5	3	7	1	2	1	1	7	1	1	
		ED time to triage	Percentage of ED attendances triaged within 15 minutes			65.7%	57.0%	47.7%	48.1%	51.8%	50.2%	48.2%	54.7%	53.5%	56.1%	58.0%	52.9%	61.5%	
		Falls per 1000 bed days	Includes all falls			7.2	6.0	6.9	7.0	6.9	6.5	6.5	6.1	6.0	6.2	5.3	7.0	6.4	
		Medication Incidents per 1000 bed days	All Incidents			6.5	7.9	5.7	5.8	6.0	5.2	5.7	6.6	7.5	6.9	7.0	6.5	6.8	
		Number of Patients given medication by scanning device				0	0	0	0	0	0	0	0	0	0	0	0	0	
		Early Identification of Deteriorating Patient				17.7%	20.3%	20.3%	19.9%	18.0%	17.7%	19.4%	20.8%	21.0%	19.7%	21.9%	18.5%	22.8%	
		Number of COVID nosocomial infections				18	23	42	32	8	34	110	15	33	61	9	78	44	
		Number of Hospital Acquired Pressure Ulcers Category 2	Includes Medical Device Related	<=2	>2	2	4	3	0	5	5	7	1	1	4	1	3	3	
		Number of Hospital Acquired Pressure Ulcers Category 3 & 4	Includes Medical Device Related	0	>0	1	0	0	0	1	3	0	3	0	3	1	0	0	
		Infection Control - Influenza Outbreaks				0	0	0	0	1	0	0	0	0	0	0	3	0	
		Infection Control - Norovirus Outbreaks				0	0	0	0	0	3	0	0	2	0	0	1	0	
		Mixed Sex Accomodation Breaches					4	0	0	8	3	16	16	17	14	11	18	9	

Measures requiring focus and a countermeasure summary this month are;

Measure	Executive Summary
Healthcare Associated Infections	There were 25 Healthcare Associated Infections in January 2023. o There were 9 cases of *Clostrioides Difficile* with 58 cases so far for 2022/23 compared to a trajectory of 42 o There were 8 E coli infections for January 2023 compared to a monthly trajectory of 6.3 with 84 cases for 2022/23 compared to a trajectory of no more than 76 o There were 5 hospital associated Klebsiella infections reported during January 2023 with 28 infections for 2022/23 compared to a trajectory of no more than 26 o There were 3 hospital onset Methicillin-Susceptible Staphylococcus Aureus (MSSA) blood stream infection during January 2023.
Number of Hospital Acquired Pressure Ulcers Category 2	There were 3 Category 2 Pressure Ulcers in January 2023.
Mixed Sex Accommodation Breaches	There were 9 Mixed Sex Accommodation breaches for January 2023, all within Critical Care.

Trust Goal | Zero avoidable harm

Historic Data



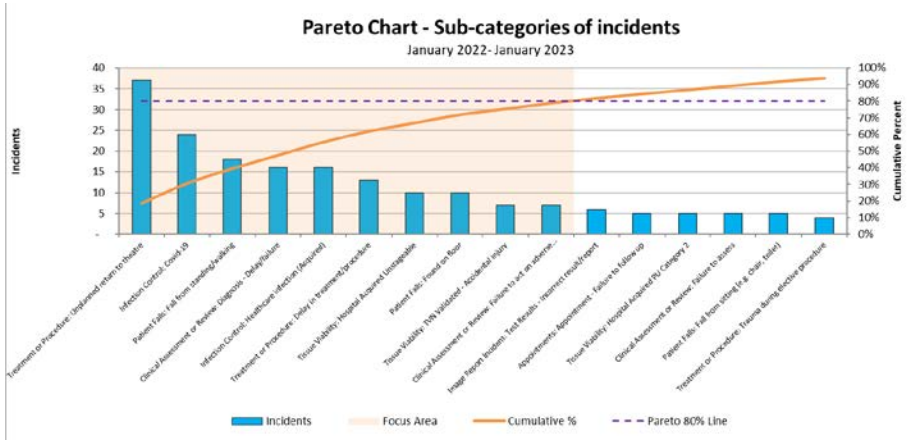
Is the standard being delivered?
In January 2023 there were 23 reported moderate to catastrophic incidents compared to a target of no more than 30 incidents.

What's the top contributor for under/over achievement?
The top contributors for incidents reported for January 2023 were: Infection Control (n=5), Treatment or Procedure (n=4), Clinical Assessment or Review (n=4), Image Report Incident (n=3).

For Infection Control, the top reported sub-category of incident was COVID-19 (n=3), followed by Healthcare Acquired Infection (n=2). For Treatment or Procedure, the top reported sub-category of incident in January was unplanned return to theatre (n=3). For Clinical Assessment or Review, there were 2 cases of Deep Vein Thrombosis or Pulmonary Embolism during hospital stay or within 60 days of hospital admission.

The most frequent types of reported incidents between December 2021 and December 2022 are unplanned returns to theatre (n=37), COVID-19 (n=24) and falls – from standing / walking (n=18).

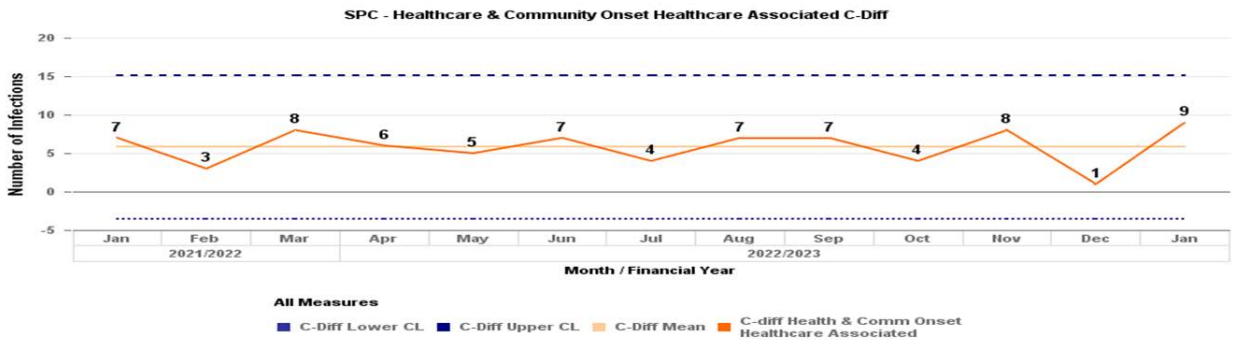
Supporting data



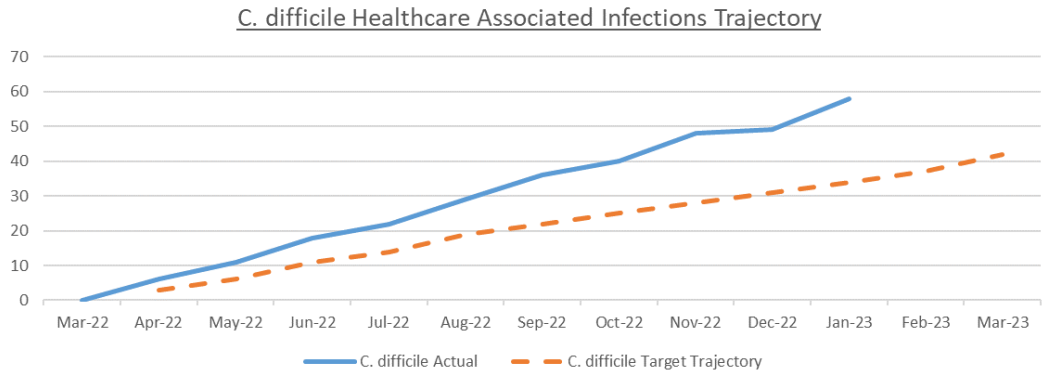
Countermeasures / Actions	Owner	Due Date
Patient Safety Programme (PSP) with 5 priorities monitored through PSSG.	Priority Leads	Oct-23
Refreshed A3 and Driver diagram developed by each PSP priority team.	Priority Leads	Mar-23
PSP priorities to be included in Divisional performance measures.	Improving Together Lead /Divisional triumvirates	Mar -23
Monthly meeting Divisional Governance and Patient Safety Lead to develop template report top contributing themes.	Divisional Governance Leads/Trust PS Lead / PS Nurses	Feb-23
PSIRF project group meeting monthly and starting Diagnostic and Discovery phase in line with national requirements.	Trust Patient Safety Lead	Apr-23

Breakthrough Objective | *Clostridioides Difficile*

Historic Data



Supporting data



Is the standard being delivered?
There were 9 cases of Clostridioides Difficile (CDI) reported during January, all of which were healthcare onset infections. 58 cases have been reported against the trajectory of 42 (trajectory has been breached).

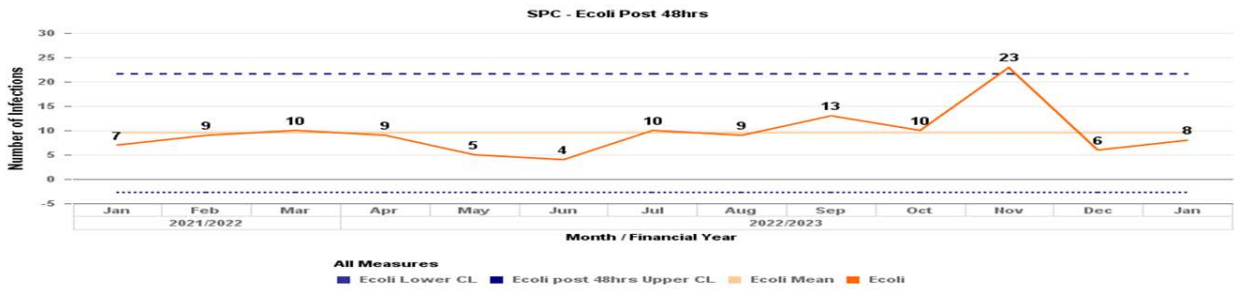
What's the top contributor for under/over achievement?
There was one period of increased incidence on Parry ward, which involved 2 patients being detected with CDI with 28 days.
Learning: Antimicrobial compliance met guidance. Delays in the completion of ward level RCAs. Hand washing technique at ward level was not consistently achieving the expected standard every time.

Trust	Rate (Dec 22)	Rate YTD
SW rate	**16.28**	**27.74**
RUH	**5.67**	**31.46**
GWH	5.57	21.42
SFT	14.42	20.35
Gloucester	30.91	34.13

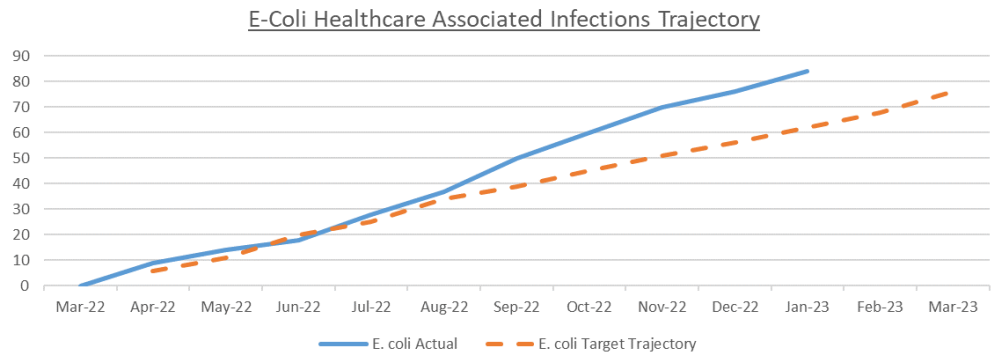
Countermeasures / Actions	Owner	Due Date
IPC team members to remain active members of the BSW HCAI reduction collaborative. 4 workshops scheduled to progress a system wide approach to addressing the issues.	IPC	Aug-23
Review of cleaning standards, staffing levels and effectiveness of the mop system.	Estates & Facilities / IPC	Mar-23
Focus on adherence to effective hand decontamination techniques.	IPC and ward leaders	Apr-23

Breakthrough Objective | E coli

Historic Data



Supporting data



Is the standard being delivered?

There were 8 healthcare associated E coli infections reported during January 2023. This is above the monthly trajectory of 6.3 cases per month, with the annual count to date being 84 against a trajectory of no more than 76 infections during 22/23. This trajectory is breached.

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

The 8 cases were associated to: Hepatobiliary (n=1), Gastrointestinal (n =1). Lower urinary tract infection (UTI) (n=3), UTI with catheter (n=1) and no root cause identified (n=2). A focus on hydration is being developed with BANES public health team and the Integrated Care Board (ICB) to prevent UTIs and improve access to correct treatment plans. This is a long term project and will take time to see any impact.

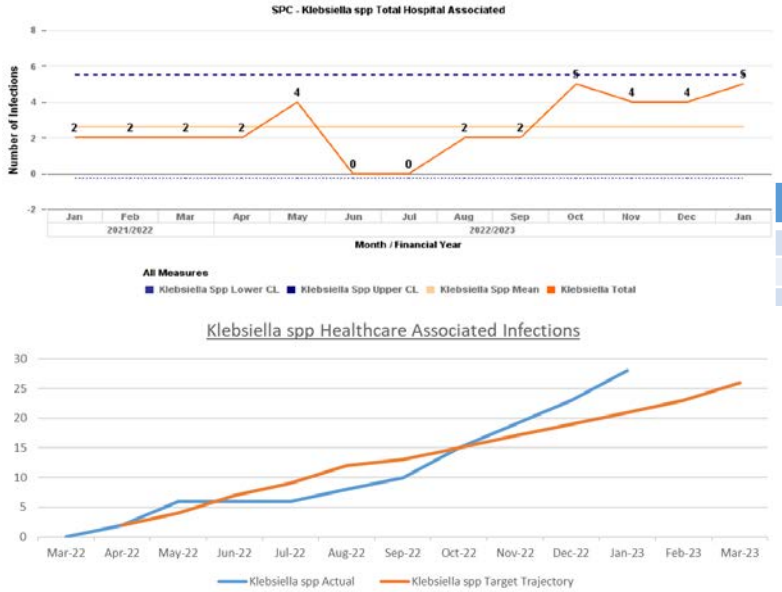
Benchmarking data:

Trust	Rate (Dec 22)	Rate YTD
SW rate	**29.3**	**33.82**
RUH	**34.02**	**49.29**
GWH	51.44	44.47
SFT	21.63	20.32
Gloucester	7.73	29.28

Countermeasures / Actions	Owner	Due Date
Hydration Improvement Group commenced – needs to link into the resources that are being developed with PH.	Matron / Quality Improvement Centre	May-23
Review of urinary catheter care practice and discharge processes as a preventive measure to infection developing- share learning with ICB.	Continence team/ IPC and matrons	May-23
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	Jan-23

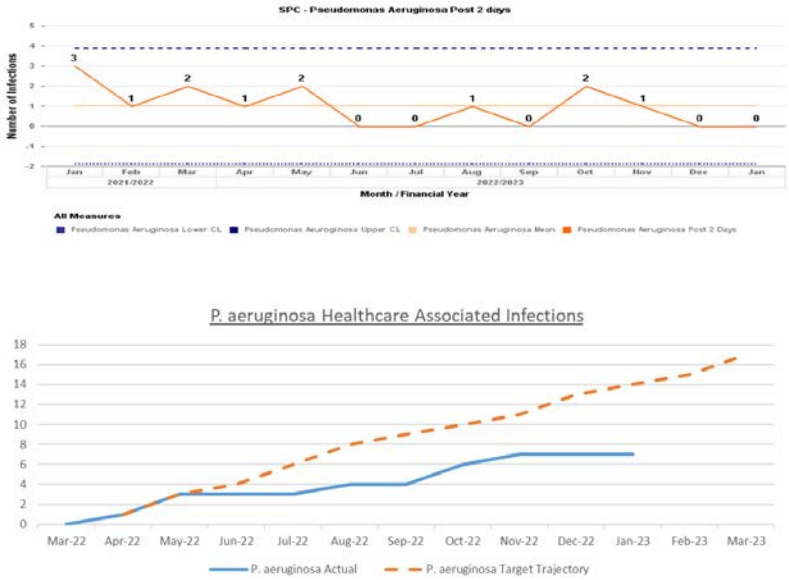
Breakthrough Objective | Klebsiella and Pseudomonas

Performance (Klebsiella)



Trust	Rate (Dec 22)	Rate YTD
SW rate	**10.09**	**11.26**
RUH	**22.68**	**14.93**
GWH	11.43	11.62
SFT	7.21	6.54
Gloucester	7.73	7.8

Performance (Pseudomonas)



Trust	Rate (Dec 22)	Rate YTD
SW rate	**3.91**	**5.28**
RUH	**0**	**5.1**
GWH	11.43	7.09
SFT	0	6.46
Gloucester	7.73	6.08

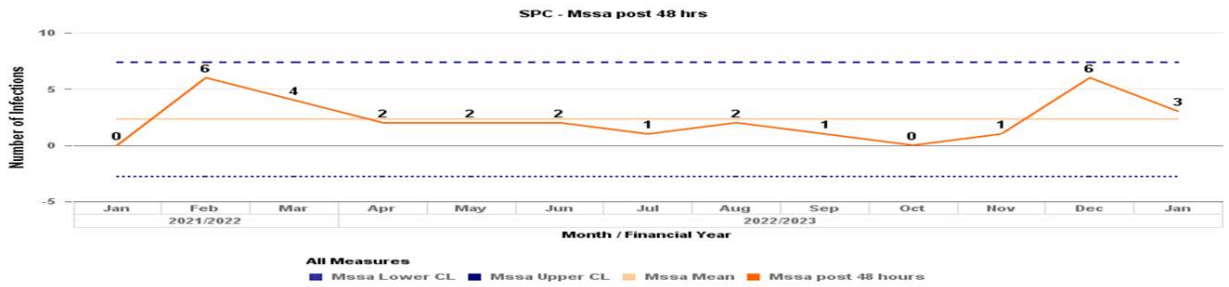
Is the standard being delivered?
There were 5 hospital associated Klebsiella infections reported during January 2023 with the annual count to date being 28 against the annual trajectory of no more than 26 infections during 22/23.
There were 0 Pseudomonas Aeruginosa reported during January with the annual count to date remaining 8 against the trajectory of 17 for 22/23.

What's the top contributor for under/over achievement?
The cases for Klebsiella were associated to: lower urinary tract infection with no catheter (n=1), LUTI with catheter (n=1), Hepatobiliary (n=1), Respiratory (n=1, unknown (n=1). There was no cases of Pseudomonas Aeruginosa.

Countermeasures / Actions	Owner	Due Date
Continue wider working with Public Health and the ICB collaborative to increase the messaging regarding adequate hydration for patients to reduce urinary tract infections (UTI). This is now an on going collaborative.	IPC and Trust Hydration Lead	Mar-23
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	Jan-23

Breakthrough Objective | MSSA

Historic Data



Supporting data

Trust	MSSA (Dec 22)	Rate YTD
SW rate	**16.93**	**17.1**
RUH	**39.69**	**14.05**
GWH	17.15	25.87
SFT	7.21	9.75
Gloucester	7.73	17.37

Is the standard being delivered?
There were 3 hospital onset Methicillin-Susceptible Staphylococcus Aureus (MSSA) blood stream infection during January 2023.
Endocarditis (n=2), line associated infection (n=1).

Review of the cannulation and venepuncture policy remains outstanding.

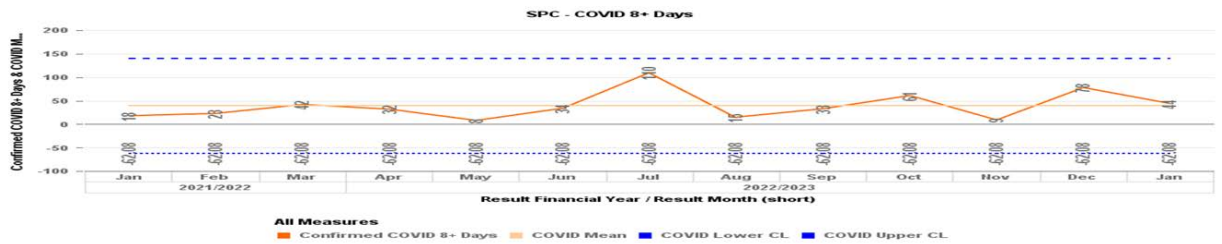
What's the top contributor for under/over achievement?
None of the 3 cases were linked to one specialist area, and there were no obvious steps omitted that could have prevented these cases occurring.

*The cannula trial was not successful and is on hold until a suitable replacement product comes to market.

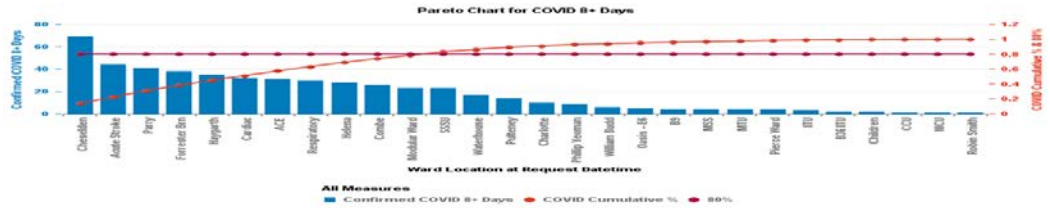
Countermeasures / Actions	Owner	Due Date
Procurement are trialling a new cannula with staff, if successful the company can provide a comprehensive training and support package to staff.	Procurement	Mar-23
Review the policy for the insertion and management of lines, taking into account the Practice versus Guidelines assessment of cannulation and PVC care/maintenance.	Training Department / Matrons	Jan-23

Breakthrough Objective | Confirmed COVID-19

Historic Data



Supporting data



Is the standard being delivered?
There was 137 COVID positive cases detected during January. 44 of these cases were confirmed as COVID-19 8+ days infections.

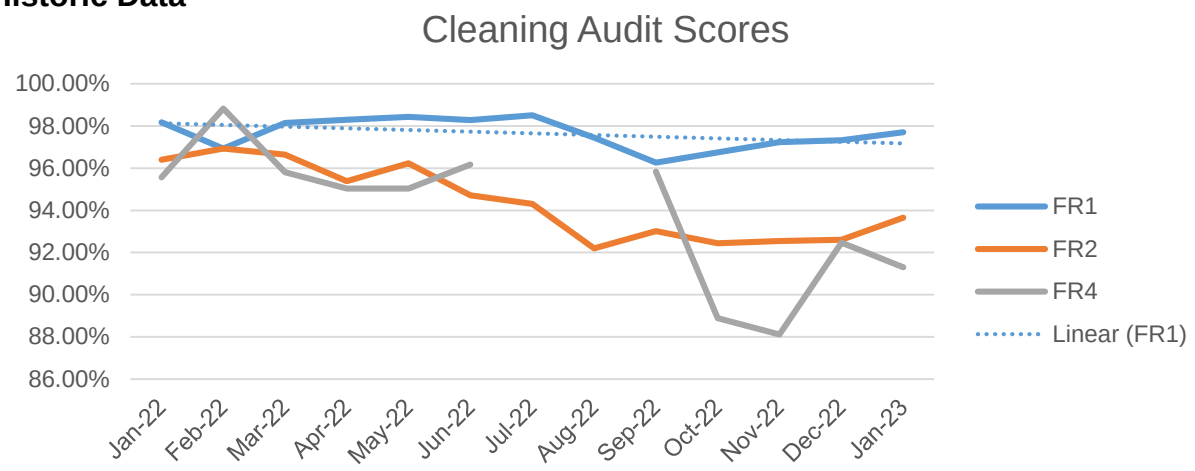
What's the top contributor for under/over achievement?
There were 2 mortalities associated to a nosocomial COVID-19 infection. Both cases have COVID-19 recorded on part 1 of the death certificate.

The BANES COVID-19 rate decreased to 18.63 in January 2023 from 112.79 per 100.000 during December.

Countermeasures / Actions	Owner	Due Date
COVID contact bays being maintained with exposure testing on day 3 to released beds earlier.	IPC	NA
Review of asymptomatic COVID-19 testing as funding is withdrawn to labs, which includes contact screening.	IPC and Microbiology	Apr-23
Review the RCA template for COVID-19 mortality to focus on omissions or gaps in care that may lead to a Serious Incident.	Clinical risk and IPC	Mar-23

Breakthrough Objective | Cleaning

Historic Data



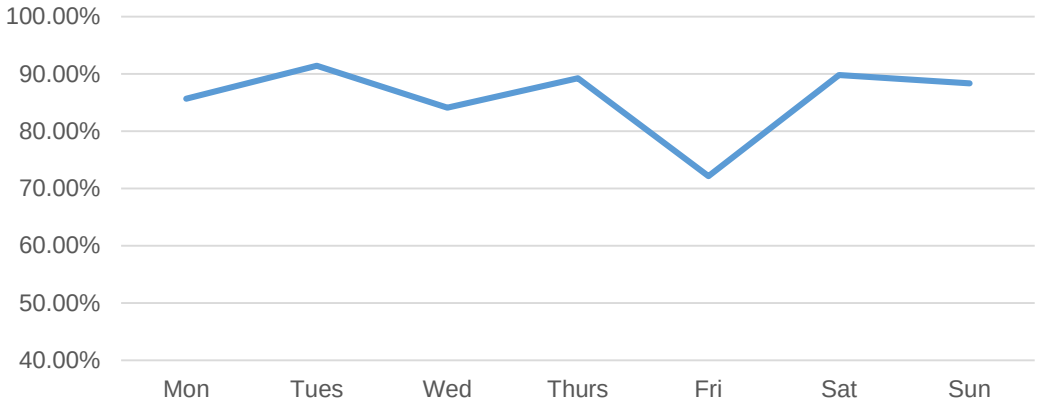
Is the standard being delivered?

Functional Risk (FR) 1 – 97.71% (target 98%) – Audits are conducted weekly
FR2 (wards) – 93.65% (target 85%) – Audits are conducted monthly

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

- Staffing gaps
  - Recruitment – 29.79 WTE vacancies (13.68%)
  - Unfilled hours - Shift fill rate 85.47%
  - Agency usage – 22.02% of shifts filled by agency staff.
- Staff training:
  - A training room has set up for new starters, which will provide a new style of induction before going to a live environment.
  - The supervisor role is key to supporting staff and ensuring they adhere to the training standards and schedules.

Supporting data



Countermeasures / Actions	Owner	Due Date
Cleaning standards group commenced and is meet monthly until cleaning standards are able to be maintained.	Estates and facilities	Completed
Detailed action plans for 1 star clinical areas.	Facilities	Completed
Improved management of temporary staffing.	Facilities	Completed
Recruitment in vacancies.	Facilities	Mar-23
Staff training to follow new cleaning schedules which incorporate required cleaning frequencies.	Facilities	Feb-23

Tracker Measures | Patient Safety Incidents per 1,000 bed days

Historic Data

Is the standard being delivered?
Overall, there is a trend of increased incident reporting with 55 incidents reported per 1,000 bed days in January.

What's the top contributor for under/over achievement?
Family and Specialist Services are the top contributor to reporting of patient safety incidents per 1,000 bed days with the highest number of incidents for Obstetrics.

The top reported patient safety incidents are Admission (n=192), followed by Patient falls (n=118) and Medication (n=86). The majority of the admission incidents are for excessive trolley waits in Medicine and Surgery Divisions (n=158).

Supporting data

Countermeasures / Actions	Owner	Due Date
PSIRF driver diagram completed.	Trust PS Lead/ PSIRF project Lead	Feb -23
PSIRF Subgroup established to map roles and analyse existing patient safety roles.	Deputy Chief Nurse/ Divisional Directors of Nursing	Mar-23
PSIRF Subgroup established to review current process and future PSIRF process.	Trust PS Lead/ Risk Lead/Assurance Lead	Mar-23
Complete PSIRF stakeholder mapping to assign level of interest and influence for key staff involved in PSIRF implementation.	Assurance Lead/Risk Management Lead	Feb-23
Development of a communication plan.	Trust Coms Lead/ PM PRIRF	Mar- 23

Tracker Measures | Serious incidents with overdue actions

Historic Data

Is the standard being delivered?
There were 3 Serious Incidents with overdue actions for January 2023, compared to a target of less than 5.

What's the top contributor for under/over achievement?
There are 2 Serious Incidents with overdue actions in Surgery Division that remain open. All overdue actions continue to be followed up with the leads for each action.

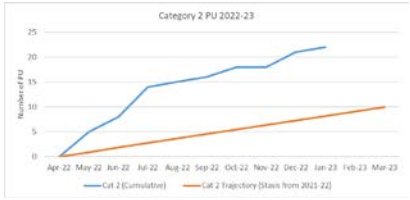
Supporting data

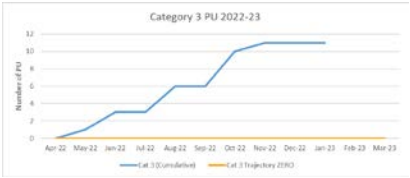
Datix ID	Category of SI	Division	Action details	Due date
100237	Patient Falls	Surgical Division	Updating of internal transfer policy with acknowledgement of need to: Review of internal transfer process and sharing of policy with the clinical site team.	31/12/2022
105915	Clinical Assessment or Review	Surgical Division	Duty of Candour and sharing with the patient: Feedback investigation report and action plan to the patient in person in line with their wishes	15/12/2022

Countermeasures / Actions	Owner	Due Date
Monthly report produced for each Division summarising any overdue actions and these are followed up with the leads for each action.	Head of Quality Assurance	Monthly update
Report of SI actions due for completion over the following month (to prompt more timely and proactive review of SI actions) has been trialled in Family & Specialist Services – to roll out to all Divisions.	Head of Quality Assurance	Mar-23

Tracker Measures | Pressure Ulcers

Historic Data





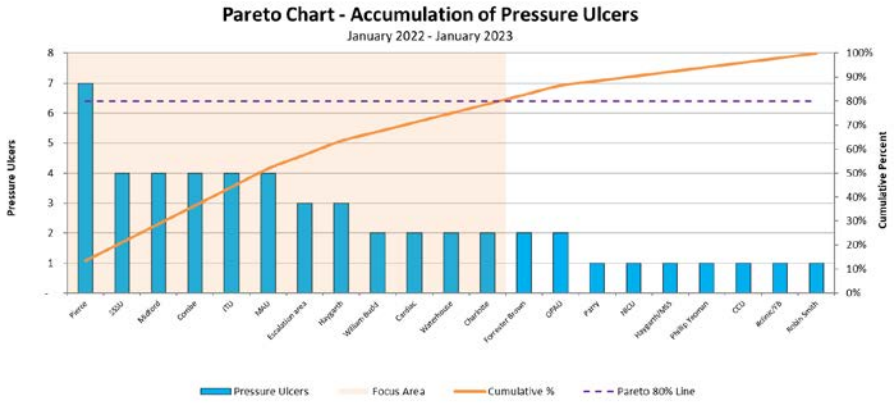
Is the standard being delivered?

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.
The Trust is over trajectory for all categories with the exception of category 4.
There was one category 2 pressure ulcer on Coronary Care Unit where the patient had full capacity but was declining care, their first PU in 10 years. NICU reported a medical device related PU on an extreme pre-term baby with no lapses in care and William Budd reported pressure damage due to poorly fitting anti-embolic stockings.

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

The top contributors for total number of pressure ulcers are: Pierce and Critical Care.
Key themes are patient non-concordance and lack of skin checking under stockings.

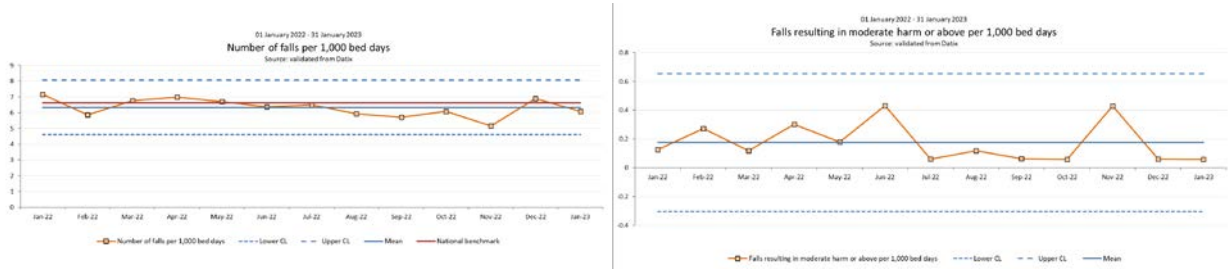
Supporting data



Countermeasures / Actions	Owner	Due Date
Awareness of the correct process for requirement, measurement and care of a patient with anti embolic stockings.	TVNs	Mar-23
Refresh awareness of the non-concordance with pressure ulcer care protocol.	TVNs	Mar-23

Tracker Measures | Falls

Historic Data

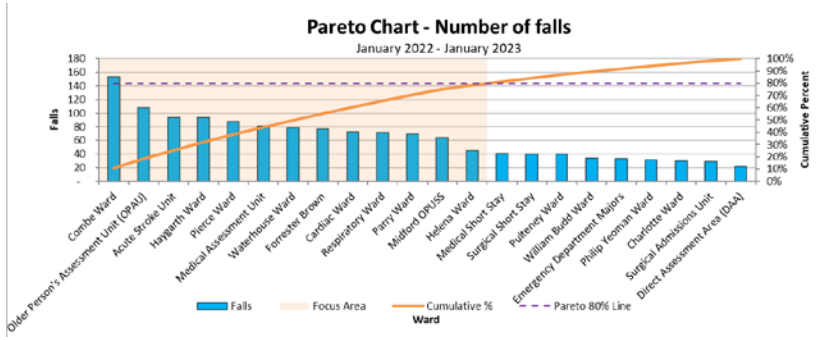


Is the standard being delivered?

There was one fall resulting in moderate harm in January, against a target of 3 per month: this was for Pulteney ward. This incident is being investigated as part of the falls serious harm process and part of the weekly tracker measures linking falls data with safer staffing analysis.

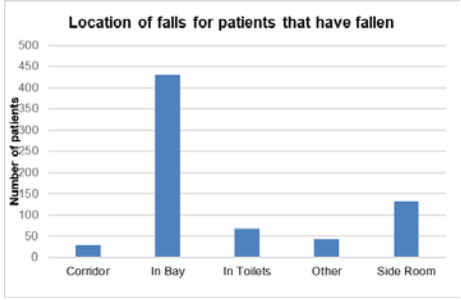
What's the top contributor for under/over achievement?

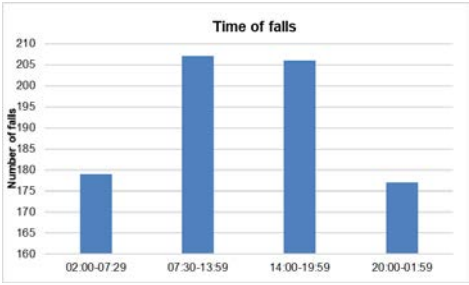
The pareto chart shows the top contributors to falls. The Quality Improvement Team provide targeted support for the wards with high numbers of falls.



Supporting data

Analysis of trustwide data from datix over last 6 months identifies :
61% of falls occur in bays and 54% occur between the hours of 07.30 and 19.59

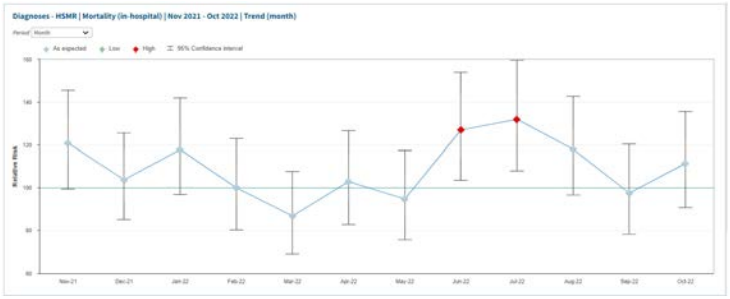




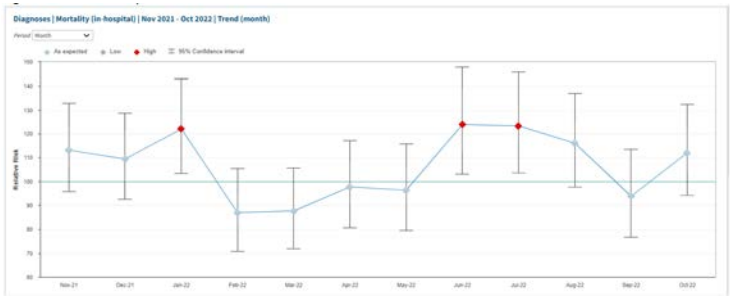
Countermeasures / Actions	Owner	Due Date
Working group continues for 'Stop the Socks' campaign.	QI Falls Lead	Ongoing
Weekly tracker measures linking falls data with safer staffing analysis.	Senior Nurse QI	Ongoing
Reconditioning games - total of 8 gold medals awarded to Midford, Cheseldon, Oasis and Combe.	QI Falls Lead	Ongoing until April 2023
Refresh of the Falls A3 completed.	Senior Nurse QI & Falls lead	Completed
PDSA on OPAU advice checklist for carers/relatives of personal belongings to support the safety of patients (e.g. footwear, clothing).	QI Falls Lead	Feb-23
Stop the socks campaign – secured funding for slippers to PDSA on OPAU.	QI Falls Lead	Feb-23
Review of the current falls elearning programme – consider elearning for healthcare as alternative.	QI Falls Lead	Mar-23
Changes to the recording of Lying and Standing Blood pressure on Millennium launch Feb 2023.	Senior Nurse QI	Feb-23

Quality | Mortality

Historic Data



HSMR

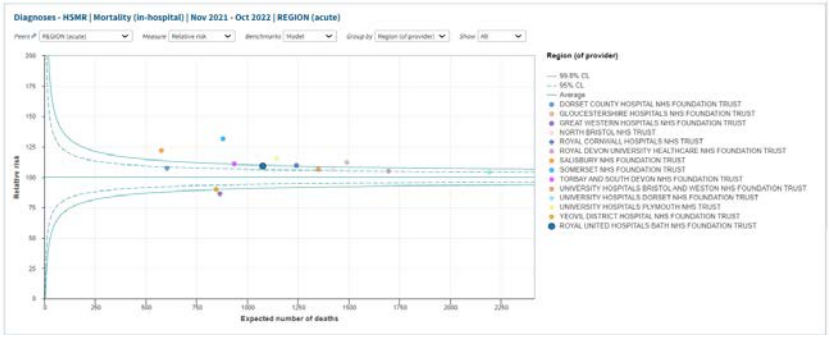


SMR

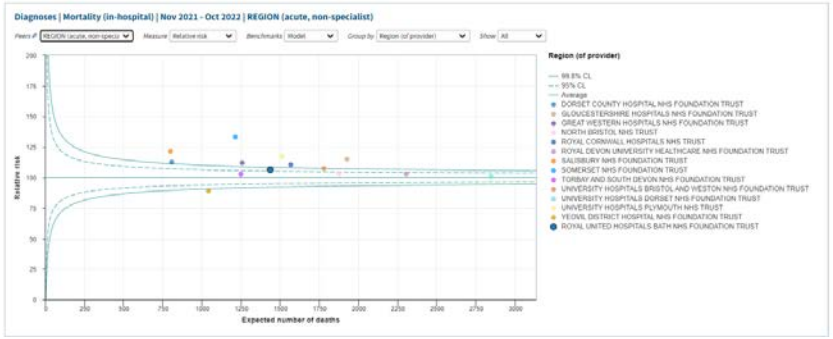
Is the standard being delivered?
The Trust is statistically significantly higher than expected for Hospitalised Standardised Mortality Rate (HSMR) (108.9) and SMR (106.6) for the rolling 12 month period to October 2022.

What's the top contributor for under/over achievement?
A backlog in coding is impacting the mortality ratios. The figures for October are likely to change due to the large number of unclassified diagnosis groups. The Trust is one of seven in the region with an HSMR that is statistically significantly higher than expected. Both the weekday and weekend HSMR are statistically significantly higher than expected but weekend performance is not statistically significantly worse than weekday performance.
Standardised Mortality Ratio (SMR): National and regional trends are most likely related to the COVID-19 pandemic & potentially connected issues such as workforce pressures and changes in patient behaviours (generally due to delays). The Trust is

Supporting data



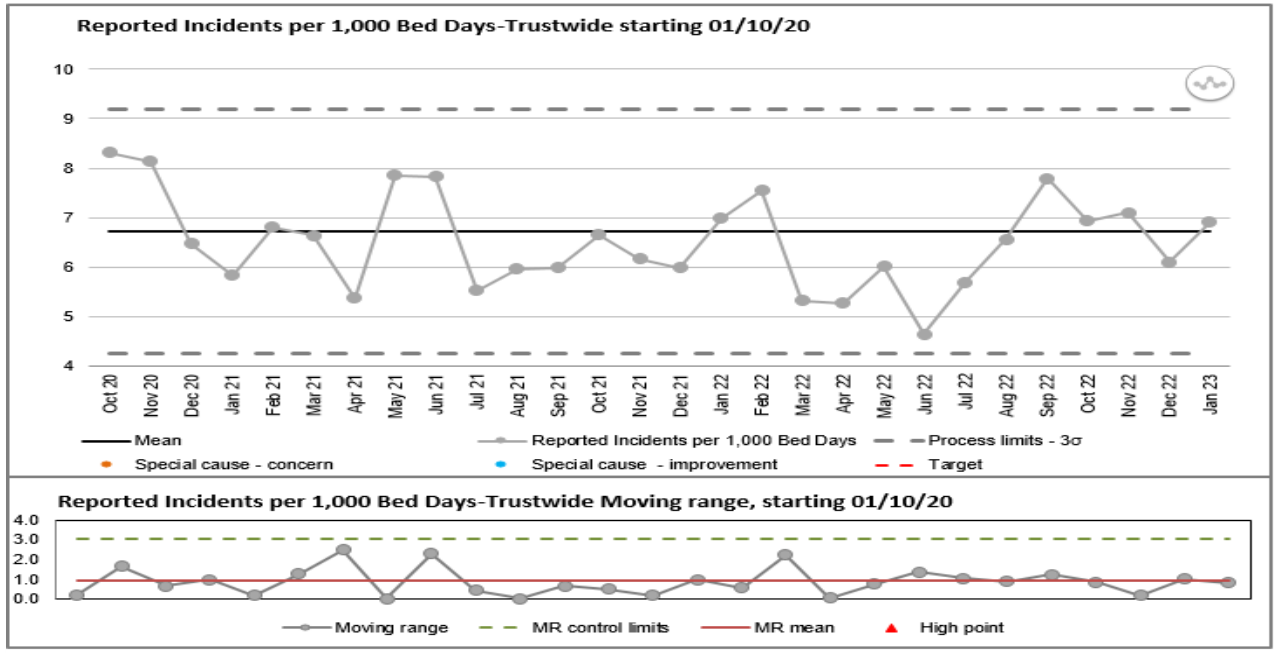
HSMR

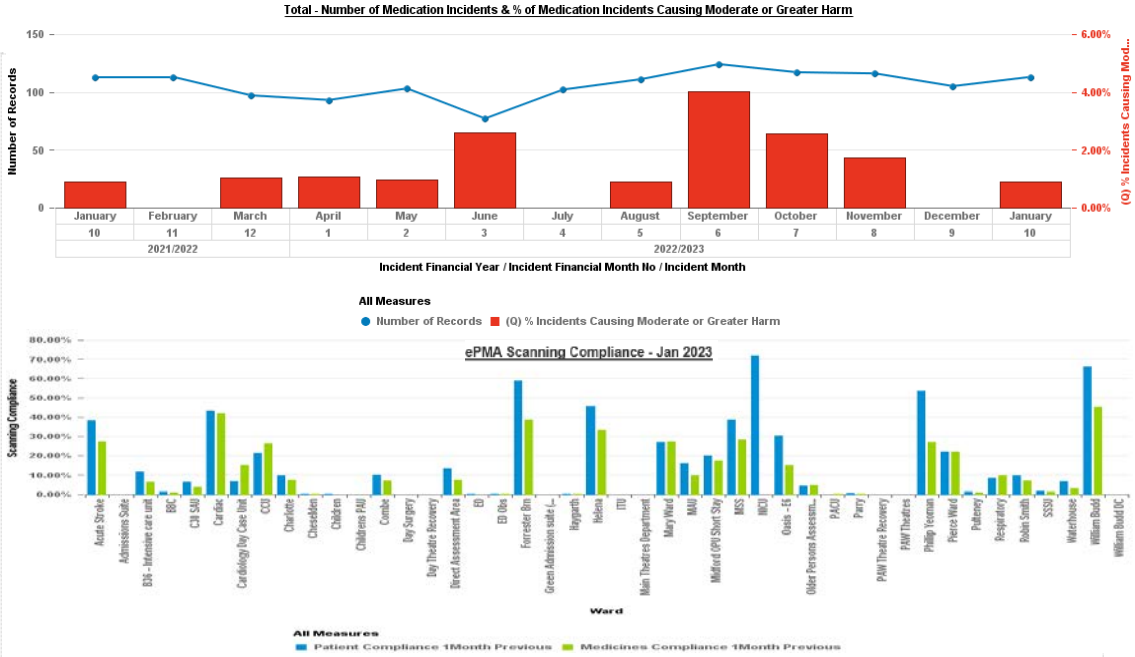


SMR

Countermeasures / Actions	Owner	Due Date
Review of deaths from Sepsis and AKI over the weekend and weekdays highlighted that there was no difference in pathway survivors, but those that died entered the organisation in extremis	Trust Patient Safety Lead	Completed
Review of data and run a case mix comparison against regional and national peers, looking at age, method of admission, diagnosis, morbidities, and frailties.	Senior Consultant, Telstra Health	Feb-22
Conduct postcode weekend analysis to analyse the HSMR situation in terms of weekdays	Senior Business Analyst	Feb-22

Quality | Medicines Safety





Is the 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.
- Process for escalation of medicines-related mod-severe harm incidents agreed with Divisional Patient Safety Leads has been embedded.

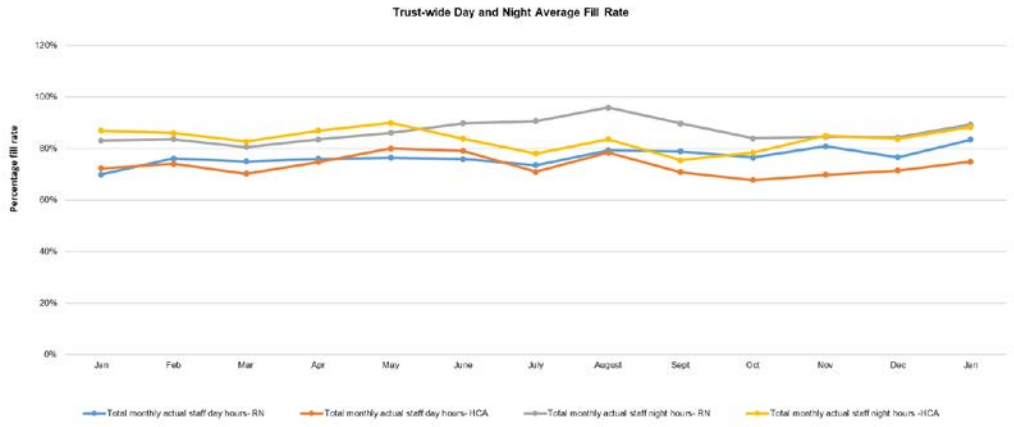
What's the top contributor for under/over achievement?

- Medication incidents: for information only – reported incidents/1,000 bed days reported incidents within normal variation. No action required.
- Barcode Scanning: Medicines compliance 14.8%. William Budd top contributor (45.4%), Mary ward is the most improved ward (16.1% to 27.1%).

Countermeasures / Actions	Owner	Due Date
Onc/Haem SI investigation has been finalised and alert added to ARIA e-prescribing system	F&SS Patient Safety Lead	N/A
SACT safety group to be set up	Director of Pharmacy & Medicines Optimisation	May-23
Review of Medical Gas Designated Nursing Officer training	DivDoNs/Pharmacy	Dec-23
Lack of secure medicine storage in escalation areas to be addressed	DivDoNs	April-23

Quality | Safer Staffing

Historic Data



Is the standard being delivered?

Compared to the 90% target, in January 2023:

- The percentage fill rate for registered nurses was 83% for day hours and 89% for night hours.
- The percentage fill rate for HCAs was 75% for day hours and 88% for night hours.

What's 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, fill rate and increased sickness during January. This has included ward outbreaks and reduced flexibility of staff movement.
- Review of shifts requiring temporary staffing fill and the allocation of workforce.
- Surgical Short Stay are working to dependency and occupancy. Night capacity has reduced to max 8 patients.
- Changes in December to Philip Yeoman as non–elective and additional staff required.
- New establishment delivers an increase to night RN numbers to increase RN to patient ratio.

Supporting data: 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	74%	75%	82%	78%
Cardiac Ward	83%	87%	92%	87%
Charlotte Ward	62%	100%	74%	107%
Cheselden Ward	74%	60%	100%	97%
Children's Ward	87%	35%	104%	43%
Combe Ward	82%	74%	76%	105%
Coronary Care Unit	92%	71%	100%	94%
Emergency Department	81%	75%	90%	86%
Forrester Brown Ward	72%	68%	82%	95%
Haygarth Ward	86%	64%	103%	100%
Helena Ward	104%	85%	101%	110%
ITU	85%	78%	118%	58%
MAU	70%	85%	75%	120%
Medical Short Stay	122%	81%	134%	100%
Midford OPUSS	76%	71%	101%	75%
NICU	74%	85%	84%	84%
OPAU	94%	84%	95%	93%
Parry Ward	105%	85%	86%	100%
PAW Mary / BBC	91%	68%	96%	98%
Philip Yeoman Ward	75%	72%	81%	78%
Pierce Ward	90%	81%	98%	97%
Pulteney Ward	64%	87%	83%	85%
Respiratory Ward	73%	64%	73%	91%
Robin Smith Ward	71%	78%	77%	77%
SAU	79%	76%	85%	92%
Surgical Short Stay	77%	72%	64%	51%
Waterhouse Ward	96%	51%	86%	86%
William Budd Ward	98%	85%	60%	90%

Countermeasures / Actions	Owner	Due Date
Review patient assessment for those requiring a mental health specialist nurse/enhanced care, Matrix for mental health at printers and PDSA undertaken and at the printers.	DDoN - Medicine	Feb-23
Develop a business case for an Enhanced Care Team, submitted to business planning and awaiting outcome.	Vulnerable Adult Lead	Complete
E-Roster work continues and is being well received. Work was paused for both half term and the industrial action but despite this remains on target.	Workforce Utilization & Safe Staffing Lead	Nov-22 (project ongoing)
Develop a dedicated support program for Internationally Educated Nurses (IEN) following NMC registration, recruitment is underway, with new Clinical Practice Educators appointed. Work to detail the content of the support program is underway.	IR Lead & ADON for workforce	TBC
Review of temporary staffing process and reduction in high cost agency. Process in place for all agency via DDON in place. Risk of increased agency usage due to escalation and strike planning. Roster reviews commenced.	CNO & DDON	Complete (ongoing monitoring)

Update on safeguarding actions following unannounced CQC inspection of Medical care

Safeguarding Training

Subject	Compliance (at 14 Feb 23)	Target
Safeguarding Adults Level 2	81.6%	90%
Safeguarding Adults Level 3	64.2%	90%

Safeguarding Adults Training:

Levels 2:

- Safeguarding level 2 training – face to face from February 2023.
- Compliance has decreased slightly from 81.9% in December 2022 to 81.6% in February 2023

Level 3:

- All staff requiring training have been booked on to future training sessions.
- Compliance has decreased slightly from 66.1% in December 2022 to 64.2% in February 2023

Monthly Senior Sister, Charge Nurse / Matron inspection

Section	Compliance (Jan-23)
Ward Environment	95%
Information Governance	88%
Notices / display of information	89%
Sharps and resus checks	93%
Medicines	87%
Infection Prevention and Control	96%
Vulnerable patients	80%

Safeguarding audits (results from monthly Matron inspection)

Audit standard	Compliance (Jan-23)
ReSPECT / TEP form completed.	85%
Mental capacity assessment for TEP / ReSPECT decisions completed.	76%
Where the patient lacks capacity to consent to serious medical treatment and / or change of accommodation / discharge plans, the MCA forms have been completed.	67%
Where a MCA form has been completed, a best interest decision form has been completed.	74%
Where the patient has been unable to consent to remain in hospital, the Deprivation of Liberty Safeguards (DoLS) authorisation has been completed.	83%

The inspections ensure issues are identified and resolved or escalated by the Senior Sister, Charge Nurse/Matron in real time. Variance in percentage scores is expected with improvement using Improving Together methodology.

Executive Summary | Patient Experience

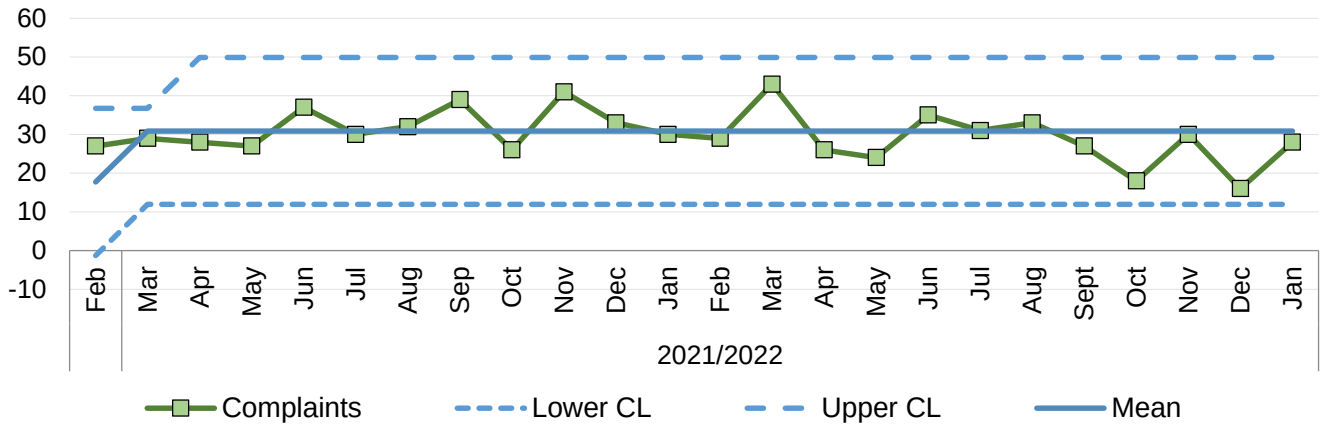
Strategic Goal		Performance Indicator	Description	Target		2021/22			2022/23										Trend
				Performing	Under Performing	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Trust Goals	People We Care For	Number of Formal Complaints		<30	>=30	29	32	44	28	28	34	33	39	30	18	31	16	28	
Tracker Measures	People We Care For	Overall Patient Experience (FFT)	Proportion responding 'good' or 'very good'	>=95%	<95%	98.2%	96.6%	95.7%	96.4%	94.5%	93.7%	95.7%	97.1%	96.5%	95.2%	96.3%	93.9%	95.8%	
		% of Complaints responded to within target		>=90%	<90%	42.3%	44.4%	52.4%	61.1%	69.4%	82.4%	52.4%	60.9%	57.9%	64.5%	76.0%	77.3%	52.6%	
		Number of re-opened complaints		<=3	>3	2	3	4	3	3	3	2	2	1	6	2	3	2	
		PALS Response Time	% of Responses within 2 days			-	-	-	79.6%	80.5%	64.0%	72.0%	65.0%	62.0%	61.0%	62.0%	66.0%	60.0%	
		Number of Compliments				44	15	18	15	15	92	36	31	58	10	47	24	43	
		Number of Family Liaison Service Contacts				72200.0%	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 January. Overall, 53% of complaints closed during January met the required timescale of 35 working days (10/19). This metric has deteriorated this month primarily due to the focussed work completed by the Family and Specialist Services Division to address the backlog in their complaint responses. The numbers of re-opened complaints remains stable. The reasons for exceptions in this measure are: Focused work in Family and Specialist Services Division to address backlog in responses, this means that all of the responses did not meet the 35 day working target Delays in the final review process for 2 cases.
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 days. With PALS contacts in excess of 400 every month, enquiries responded to within 2 working days remains at just over 60%. The numbers of PALS contacts in January was 373. The reasons for the timeframe exceptions are mostly due to: Workload of clinicians causing delays in responding The volume, complexity and logging of cases A review of the team resources and benchmarking with other Trusts has been completed. Two PALS and Complaints Officers have joined the team. 70% of PALS enquiries were responded to within 5 working days. 60% of PALS enquiries were responded to within 2 working days.

Trust Goal | Patient complaints

Historic Data



Response Rate	Medicine	Surgery	F&SS	Corporate
Completed within timescale	83% (5/6)	83% (5/6)	0% (0/6)	0% (0/1)

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

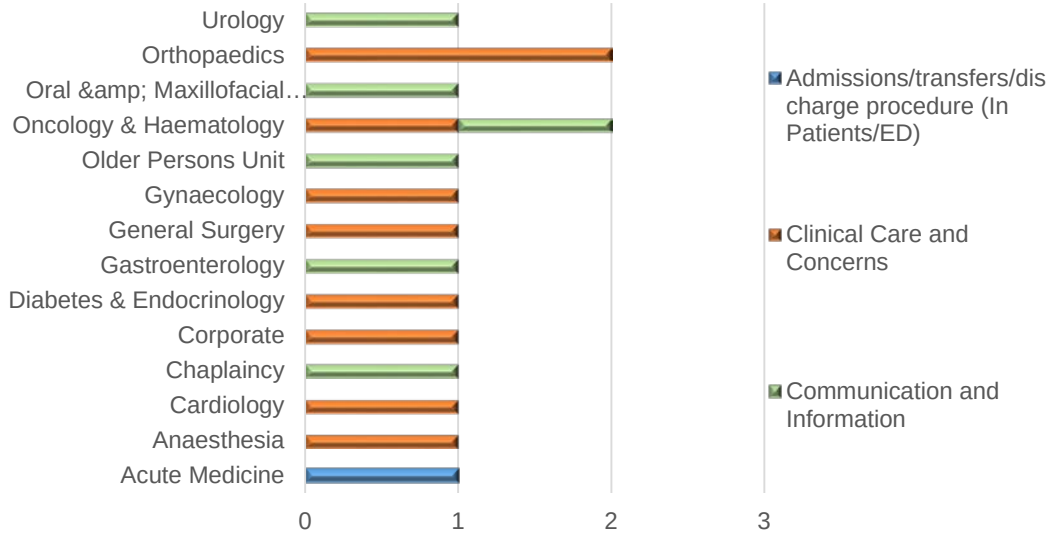
Is the standard being delivered?
The Trust received 28 formal complaints in January 2023. This is 2 less than January 2022 and 3 less than the mean average for the rolling 24 months.

Underperforming >=34, Performing <30.

What's the top contributor for under/over achievement?
Clinical Care and Concerns accounted for 68% (n=19) of complaints. Orthopaedics (n=4), Oncology & Haematology (n=3) and General Surgery (n=3) accounted for 53% of Clinical Care complaints. The complaints related to inappropriate care/treatment, coordination if medical treatment, wrong diagnosis and privacy and dignity.

53% of complaints closed during January met the required timescale of 35 working days (17/22). This is a deterioration from last month (77%)

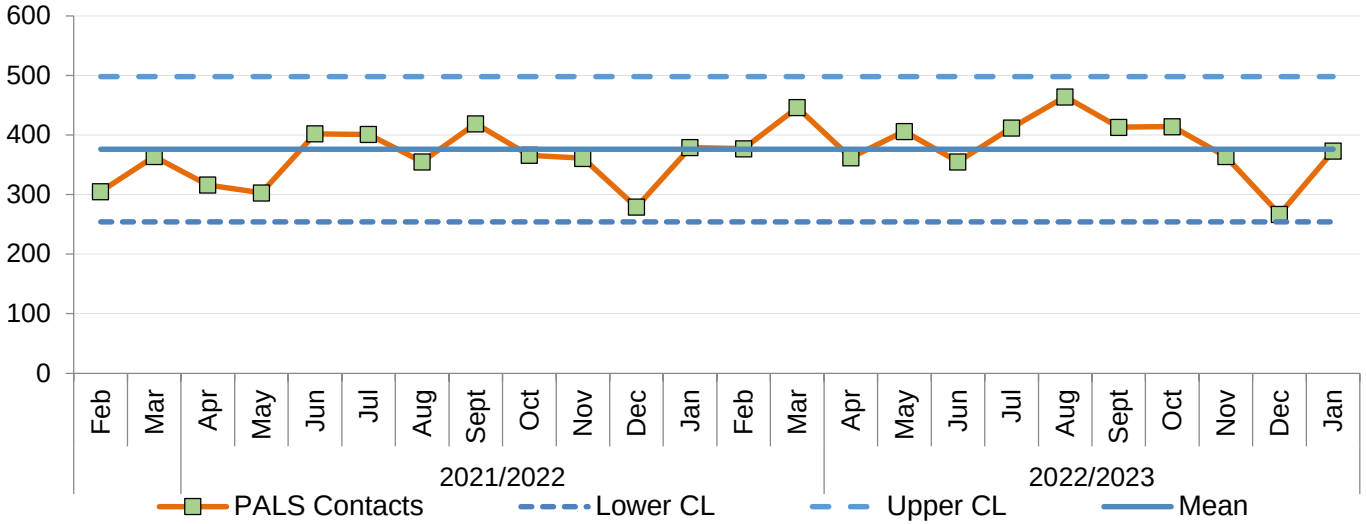
Supporting data



Countermeasures / Actions	Owner	Due Date
Continue to support the Family and Specialist Services Division work to address complaints backlog.	Patient Safety Lead	Ongoing
PALS outreach service commenced – 70 patients seen in first week and feedback provided to ward Sister/Charge Nurse. Plan for 6 ward visits per week	Complaints Lead	Ongoing
Plans for single point of access for patient support and complaints/concerns continue.	Complaints Lead	1 April 2023

Tracker Measure | PALS

Historic Data



Is the standard being delivered?

Situation report: There were 373 contacts with PALS in January 2023.

KPI: Performance against 48hr standard resolution timeframe 60% of cases were resolved in 48 hours or less; a further 12% were resolved in 6 days and 12% between 7-14 days. 16% of the complex cases took more than 14 days.

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

Appointments (n=51). The highest number of enquiries related to the length of time patients were waiting for new and follow up appointments 56% (n=29). Hotspot areas for the month were Children's (n=4) and Orthopaedic (n=3) Outpatients.

Communication and information (n=38). The highest number of contacts concerned inappropriate/inaccurate/incomplete correspondence 16% (n=6). These were spread across different departments/wards.

Clinical care and concerns (n=31). The highest number of contacts were around inappropriate care and treatment 19% (n=6). These were spread across different departments/wards.

Supporting data

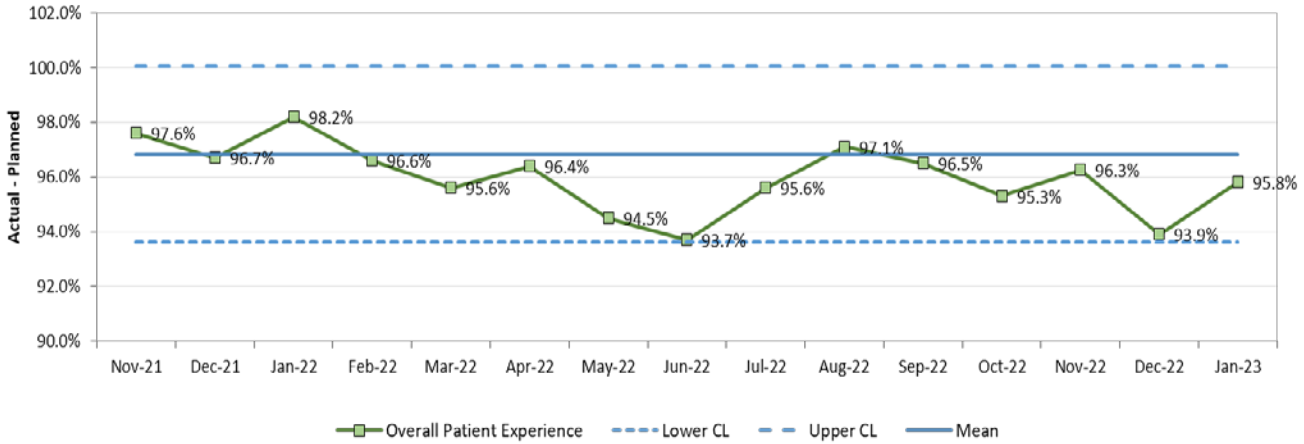
- 100 Required resolution (37%)
- 130 Requested advice or information (49%)
- 13 Compliments (5%)
- 24 Provided feedback (9%)
- 28 Clinical Care and Concerns
- 21 Communication and information
- 19 Appointments

Countermeasures / Actions	Owner	Due Date
Cardiology outpatients are undertaking a review of PALS contacts to support with service improvements around communication of test results and appointment wait times.	Cardiology Specialty Managers	March 2023
Family Liaison Facilitators have been successfully recruited to post. This will help support wards with communication between patients and their family/carers, with a focus on ED, MAU and OPAU.	Interim Divisional Director of Nursing Medicine	February 2023

Patient | Friends and Family Test

Historic Performance

Royal United Hospital
1st November 2021 - 31st January 2023
SPC Overall Patient Experience
Source: eQuest (as 9th February 2023)



Is standard being delivered?

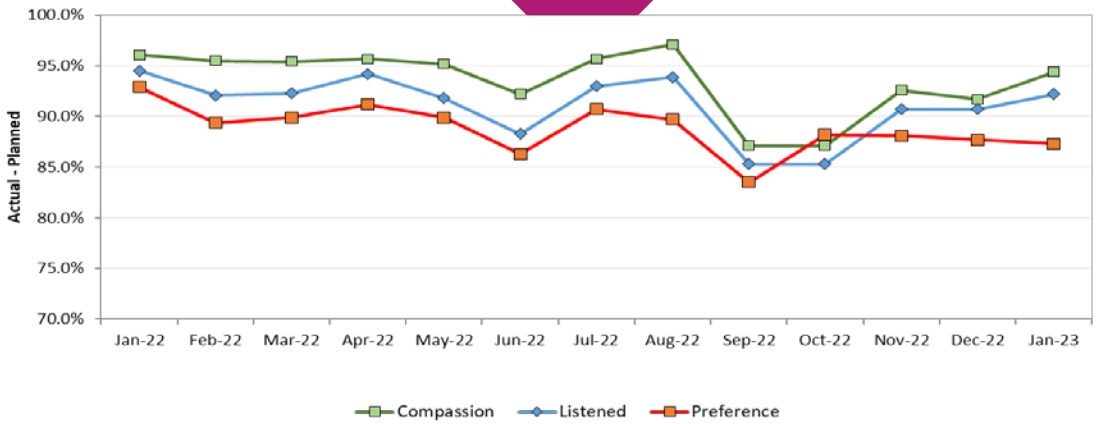
The proportion of patients across the Trust that responded positively (very good or good) about their overall experience this month was 95.8%. Above the 95% target on the scorecard. This is broken down by Division in the chart below.

What is the top contributor for under/over-achievement of the standard?
The number of responses using FFT across the Trust is low. The Patient Experience Team are working to identify an electronic solution to increase FFT responses.

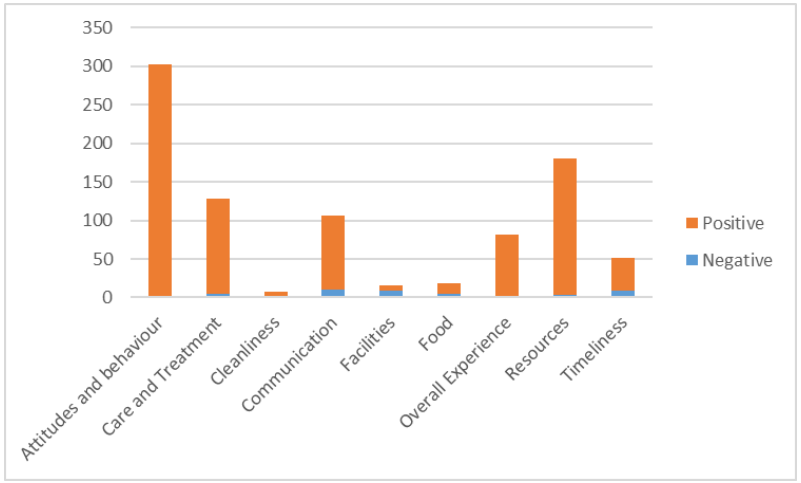
FFT responses September 2022	'Overall how was your experience of our service?'			
	Medicine Division	Surgery Division	F&SS	Corporate (ED)
Very good/ good	93.7% (389) ↓	98.8% (166) ↑	99.3% (144) ↑	77.7% (7) ↑
Poor/ very poor	2.9% (12)	1.2% (2)	0.7% (1)	22.3% (2)
Neither good nor poor	3.4% (14)	0% (0)	0% (0)	0% (0)

Royal United Hospitals Bath

% Treated with Compassion, Listened to, and Staff Considered their Preferences, Needs and Values



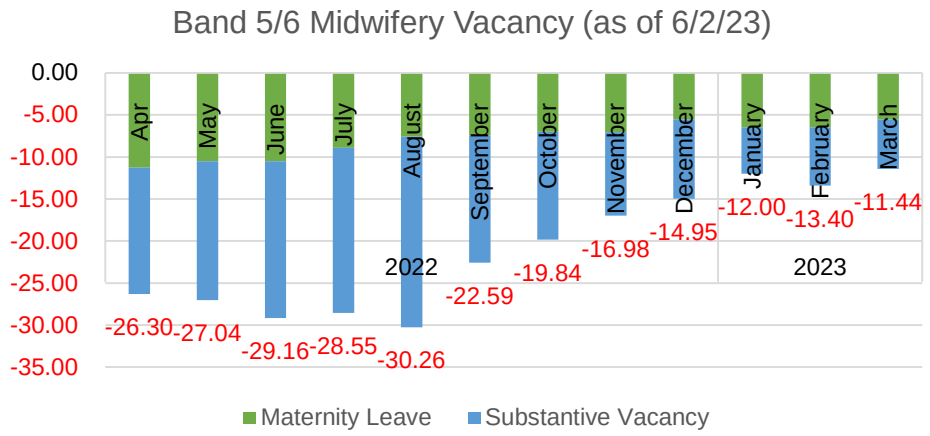
Themes - Patient experience comments collected via FFT in January 2023:



As in December 2022, January 2023 FFT Positive feedback – top three themes are:
Attitudes and behaviour of staff (n=302), Resources (Staff) (n=177) and Care and Treatment (n=124).
In January 2023 FFT Negative feedback – top three themes are:
Communication (n=10), Facilities (n=9) and Timeliness (n=9).

Maternity | Workforce

Historic Data



Is the standard being delivered?

- 1 to 1 care in labour was achieved at all times.
- Supernumerary Labour Ward coordinator status not maintained on 2 occasions. Not involving labour or 1-2-1 care. No harm.
- The Midwife to birth ratio is improving.
- There is a -12 WTE midwifery workforce gap including maternity leave.

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

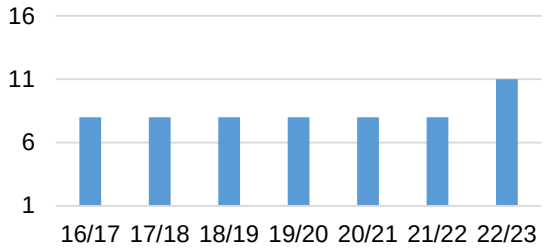
- Vacancy rate.
- Maternity leave.
- Challenges in recruiting midwives.
- Challenges with retaining midwives.
- Sickness.
- Accuracy of data capture for fill rates (MSW day rate).

Supporting data

Average Shift Fill Rates

		Nov 22	Dec 22	Jan 23
Midwives	Day	88.5%	82.0%	90.4%
	Night	93.2%	92.5%	95.9%
MCA/MSWs	Day	58.2%	51.8%	66.5%
	Night	81.8%	72.6%	98.5%

Total number of obstetric consultants (WTE)



Countermeasures / Actions	Owner	Due Date
Bid to recruit 8 International Midwives approved. Six new international midwives recruited this month. Due to commence in staged approach from April 2023 onwards.	DOM	Complete
Repeat BirthRate+ assessment commenced.	DOM	Complete
2 x WTE locum posts covering maternity leave have now been extended for 12 months to allow for future business planning.	Clinical Director Maternity	Complete
Moving from 60hrs to 98hrs consultant presence as per Royal College of Obstetrics and Gynaecology (RCOG) recommendations.	Clinical Director Maternity	Complete
Change from 1:8 to 1:11 staffing model. This will allow for: Change in evening ward round time to 8.30pm. Splitting the on-call daytime rota between Obstetrics and Gynaecology in daytime as per Ockenden recommendations.	Clinical Director Maternity	Complete
Continuing work with NHSI to establish the longer term workforce plan for acute/community sites & continuity of carer. Awaiting BirthRate + report.	DOM	Feb-23
Working with BSW Academy to widen routes into Midwifery. Five funded MSc nursing conversion places available.	DOM	Complete
First international midwife recruited.	DOM	Complete
Completion of obstetric workforce review.	Clinical Director Maternity	Complete

Maternity | Workforce

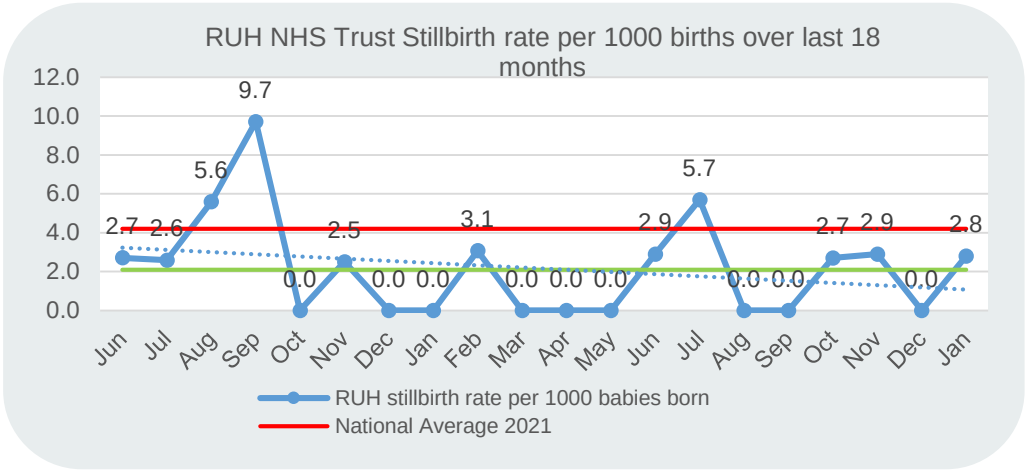
	Target	Threshold			Nov 22	Dec 22	Jan 23	SPC	Comment
		Green	Amber	Red					
Midwife to birth ratio	1:27	<1:28		>1:30	1:31	1:30	1:33	F	Linked to vacancy – see figure including bank
Midwife to birth ratio (including bank)	1:27	<1:28		>1:30	1:26	1:27	1:30	?	Reviewing deteriorating ratio vs. improving shift fill rates
Labour ward coordinator not supernumerary episodes	0	0		>1	0	2	0	?	
1:1 care not provided	0	0		>1	0	0	0	P	
Confidence factor in BirthRate+ recording	60%	>60%		<50%	70%	70%	67%	?	Percentage of possible episodes for which data was recorded
Consultant presence on BBC (hours/week)	98	>97			60	60	98	H F	Meeting RCOG recommendation from Jan 23
Daily multidisciplinary team ward round	90%	>90%		<80%	100%	100%	77%	?	Second ward round taking place on night shift from Jan 23
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0	L P	

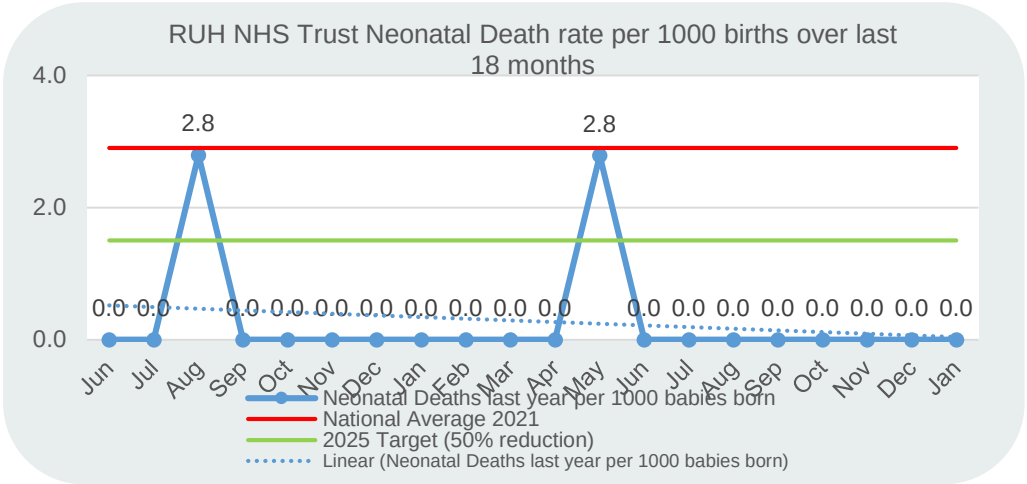
What is SPC?
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation to guide appropriate action. A recommendation of the East Kent Report, is that measures are analysed and presented using SPC to identify the 'signals among noise'.

SPC - Variation	
H L	Special cause – concerning variation
H L	Special cause – improving variation
↗ ↘	Special cause – neither improving or of concern
	Common cause

SPC - Assurance	
P	Consistently meets target
?	Hit and misses target subject to random variation
F	Consistently fails to meet target

Maternity | Perinatal Deaths





- All perinatal deaths 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. A quarterly update paper is shared with the Board of Directors.
- Postmortem resumed routine service from 12 weeks in November 22 (except specific clinical indications)
- 1 perinatal death reported in January – 24 week stillbirth - unknown cause. Will be reviewed at PMRT.

PMRT Action Plans Update for Royal United Hospital Bath NHS Trust from reviews of deaths 2022-2023

Perinatal Case ID	Issue Text	Action plan text	Implementation text	Person responsible	Target date	Completed
81978/1	Cabergoline was not given to suppress lactation.	Pathway to be updated including Lactation and Loss SOP.	Bereavement Care Pathway to be updated and disseminated.	Bereavement Midwife	30/11/22	Yes
82268/1	Reduced fetal movement leaflet was not provided in mother's first language.	Reminder sent on how to access Reduced Fetal Movement leaflet in different languages.	Reminder sent to all staff on how to access Reduced Fetal Movements leaflet in different languages.	Patient Safety team	30/09/22	Yes

Maternity | Serious Incidents

New Cases for January 2023

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
11302	30/01/2023	Moderate harm (risk level under review)	Maternal re-admission with wound de-hiscence requiring surgical repair.	Currently awaiting maternal notes to return to undertake an MDT review and validate level of harm.	N/A	N/A

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
111552	12/12/2022	Moderate harm – maternal admission to ITU	Maternal Admission to ITU.	On-going RCA	N/A	2022/27044
108198	16/09/2022	Moderate harm	Management of a suspected eclamptic fit.	On-going RCA	N/A	2022/21155
109848	26/10/2022	Major Harm	Neonatal seizures and subsequent HIE following an Impacted fetal head and uterine rupture at lower segment caesarean section.	Ongoing RCA	N/A	2022/25209
103325	12/04/2022	Unavoidable Death	Maternal death following a diagnosis of cerebral venous sinus thrombosis.	Ongoing RCA due at SI panel 16/02/2023	N/A	2022/8613

Maternity Safety Support Programme	N/A	**Coroner's regulation 28**	N/A

Maternity | Health Care Safety Investigation Branch (HSIB)

Case Cluster Q1 of 2022 review and feedback

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. HSIB investigated all cases referred to them over a three month period until the end of August 2022. This included all babies that had a normal MRI scan after they had been cooled.

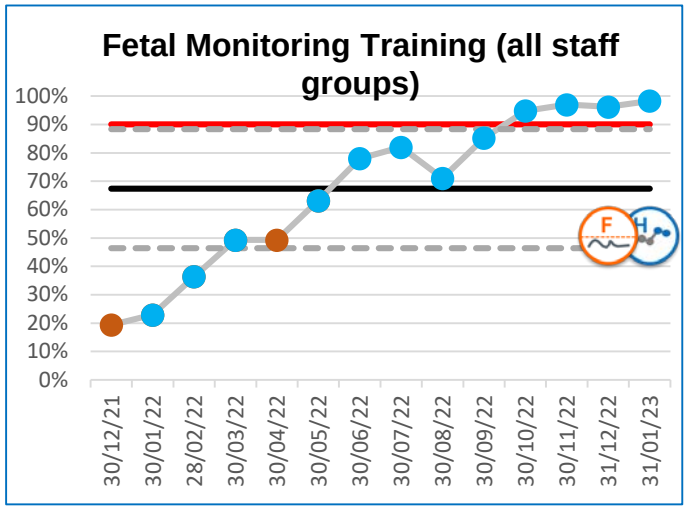
HSIB Case Cluster Findings

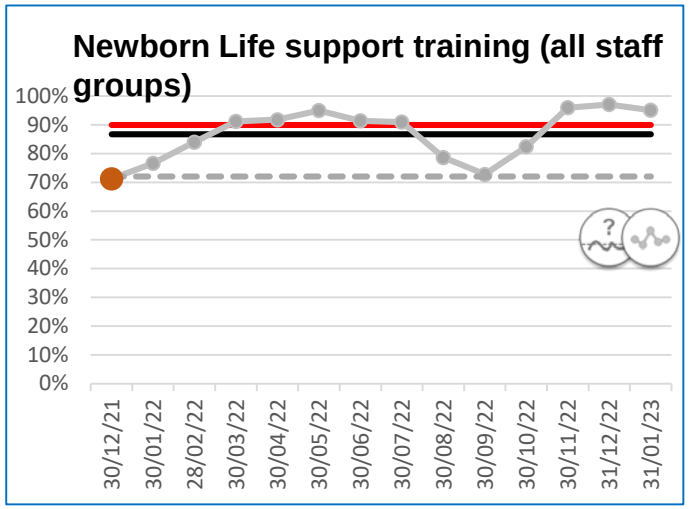
- No clear themes across all cases.
- No safety recommendations in 2/4 cases that progressed.
- Communication was a theme in 2/7 recommendations, and 5/15 findings.
- HSIB confirmed their investigation found no evidence of systemic safety concerns or any underlying issues that require further escalation.
- HSIB considers it would be beneficial for the Trust to focus on communication recommendations.

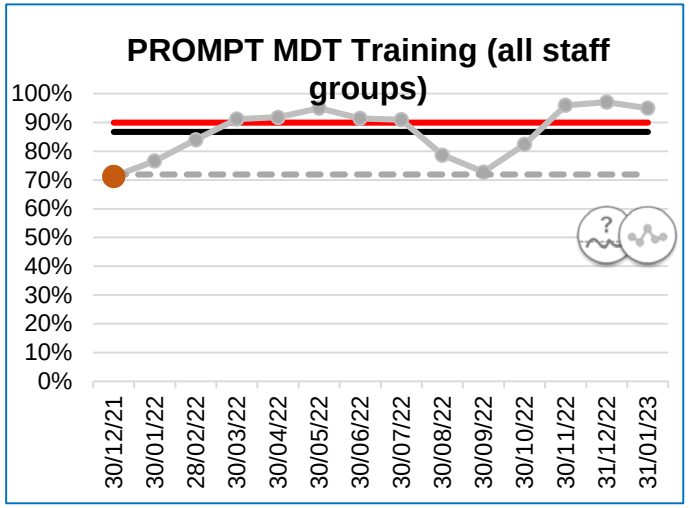
HSIB Ongoing Maternity and Neonatal Reviews

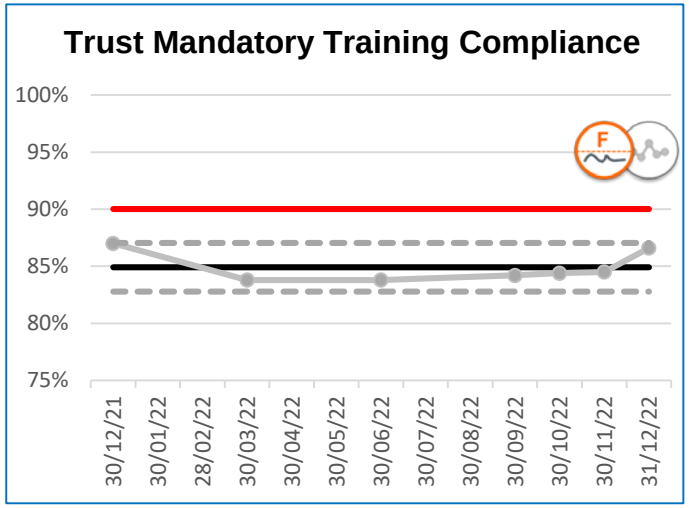
Case Ref (Datix)	Date	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
107283	18/08/22	Therapeutic cooling following birth	First draft of report received and returned to HSIB factual accuracy assessment. No safety recommendations made to Trust.	MI-01255	2022/18296
108058	13/09/22	Therapeutic Cooling following shoulder dystocia at birth-Normal MRI post cooling proceeding at parental request.	Ongoing HSIB review.	MI-014673	2022/21156
110141	02/11/22	Intrapartum stillbirth following Propess administration during an Induction of Labour	Ongoing HSIB review.	MI-017511	2022/25202

Maternity | Well-led: Training









Training
Compliance monitoring and booking system now in place supporting future compliance. Updated Training Needs Analysis awaiting formal departmental ratification. Compliance data being sent to all MDT leads monthly to ensure good information sharing between all staff groups.

Countermeasures/actions:
Additional training dates secured for period of peak staffing changes (doctor change over/midwifery pins/new starters). These will run in Sept, Oct and Nov 2023. Long-term plans to introduce additional dates in Feb and March but no room capacity for 2023.
PROMPT train the trainer – 22 March to develop faculty and improve standard of training for MDT teams.
Bespoke refresher skills sessions available for community staff: Skills drills and newborn life support ahead of community births being fully reinstated. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs).
Additional skills sessions available to newly qualified staff and senior students.

Risks:
Consultant compliance for Jan/Feb – due to staff returning from maternity leave we will see consultant compliance drop. Linked in with Obstetric Lead to ensure staff are supported to book on their return to maintain full compliance.
The use of our own compliance tracker as opposed to using ESR data – ESR still reflects theatre teams which impacts on our compliance. Linking in with ESR and Theatres to find a resolution to this for transparency and information sharing.

Maternity | Effective

Maternity Incentive Scheme – Year 4		
SA1	Submission to PMRT	Amended MIS year 4 published October 2022. Revised reporting period 5/5/22 - 2/2/23 Triumvirate review of all evidence completed to support full compliance with all ten MIS safety actions 23/11/22 Board presentation 11/1/23 ICB and Safety Champions review of all evidence completed to support full compliance 23/2/23 **Final submission to NHS Resolution formally declaring full compliance 26/1/23** Deadline 2/2/23
SA2	Digital and data Quality	
SA3	TC and ATAIN	
SA4	Clinical workforce	
SA5	Midwifery workforce	
SA6	SBLv2	
SA7	Feedback and MVPP	
SA8	Training	
SA9	Assurance to Board	
SA10	HSIB and NHS EN Scheme	

Ockenden Initial Report		
IEA1	Enhanced Safety	
IEA2	Listening to Women and Families	
IEA3	Staff Training and Working Together	Q21 – 90% MDT Training **– now complete** Q22 - Consultant ward rounds **– now complete**
IEA4	Managing Complex Pregnancy	
IEA5	Risk Assessment in Pregnancy	Q30 - Risk Assessment **– non-compliant** • Compliant for routine antenatal appointments. • Risk to compliance for ward attendance/DAU/MW USS. • Digital option being explored regionally to improve the capture at other contact points. • Differences to interpretation of IEA at regional partner Trusts. • MDT working group set up to review standards and standardise approach.
IEA6	Monitoring Fetal Wellbeing	
IEA7	Informed Consent	
	Workforce Planning	Q45 – Clinical Workforce Planning **– now complete**
	Guidelines	

Fully Compliant

Working Towards

Non-Compliant

The people in our community

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 10

The people in our community

The RUH, where you matter

Finance Director Focus

RUH Position
The Trust is £3.9 million worse than plan at the end of January which is a deterioration in the month of £0.2m.
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 increased and a reduction in expenditure has been seen in agency spend; discretionary spend; and additional capacity. Progress is being made on these schemes and the run rate has reduced.

Elective Recovery
The elective recovery position is performing well with 106% of 19/20 levels being delivered. 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 have been spent to maintain the safety of the site over winter and non-recurrent funding has been confirmed to cover these costs. The financial plan is expected to deliver with the implementation of the recovery plan and the identification of mitigations for £2.0 m of outstanding financial risks.

BSW
The BSW system are managing a number of financial risks relating to the operational pressures across the system but are continuing to forecast achievement of the financial breakeven position at the end of the financial year. A total of £6 million of risks (including the £2m net risk for the RUH) are being managed across the system.

2023/2024 Planning
National planning guidance has been received setting out the planning assumptions for 2023/2024. Financial plans for 2023/2024 are being developed and it will be a significant challenge to achieve the national expectation of a break even position.

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	Oct-22	Nov-22	Dec-22	Jan-23
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	£(2,170)k	£(2,702)k	£(3,652)k	£(3,894)k
	Forecast delivery of Group financial plan	Forecast variance from year to date plan	<=0	>0	£0	£0	£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	£(16.42)m	£(17.90)m	£(19.74)m	£(20.96)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	£5.392m	£7.163m	£9.544m	£11.111m
	Delivery of QIPP against plan	Performance against plan	<=100%	>100%	48.0%	61.0%	115.0%	137.6%	116.0%	96.0%	96.0%	104.0%	101.7%	110.4%	99.8%
	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%	3.4%	3.0%	3.6%	3.4%
	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%	3.1%	3.0%	3.6%	3.2%
	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	156	130	142	142
	No COVID admissions	Average number of beds occupied by COVID patients	<=30	>30	64	35	19	28	72	26	24	50	16	40	36
	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%	5.60%	3.40%	2.90%	3.50%
	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	£1.542m	£1.906m	£1.585m	£1.595m
	Increase productivity	Implied productivity based on financial and operational performance (Quarterly)	>=3%	3%	-20%	-15%	-22%	-22%	-23%	-23%	-23%	-23%	-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%	96%	111%	105%	106%
	Non elective activity	Performance against planned levels of activity (Value Based)	>= 100%	< 100%	n/a	92.0%	102%	103%	107%	108%	114%	109%	111%	113%	110%
	Delivery of capital programme	Variance from year to date planned capital expenditure (exc IFRS16 from M7)	+ or - 1%	><1%	n/a	13.6%	15.0%	17.4%	7.5%	16.4%	14.1%	19.0%	14.4%	15.4%	12.9%
	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+ or - 1%	><1%	n/a	0	0	0	0	0	0	0	1%	1%	1%
	Delivery of planned cash balance	Variance from year to date planned cash balance (exc system alignment funding received from M7)	+ or - 10%	><10%	n/a	(8.8%)	(6.4%)	(7.3%)	12.5%	30.2%	8.6%	17.9%	10.7%	(4.8%)	(20.2%)

Executive Summary

- The RUH is £3.9m adverse to plan with a deficit of £21.0 m against a plan of £17.1m. The number of non-criteria to reside patients has remained high with an average of 142 and continues to create operational pressures. Agency usage as a proportion of total pay costs is 3.6% and therefore above the 3% target. The year to date elective recovery performance is 106% of 2019/20 levels which is above the target of 104%. A fixed level of funding has been confirmed to the end of the financial year as the claw back rule has been removed across all commissioners.

- The Trust is managing risks through the finance recovery plan totalling £6.00m (£4.00m in the RUH and £2.00m at Sulis). The key schemes continue with actions being taken and improvements have been seen in nurse agency usage and the identification of QIPP schemes. There remains £2.0million of risks to be managed this financial year.

- £11.1 m of savings have been delivered year to date against a plan of £11.1m of which £6.1m were non-recurrent. This is broken down into under-recovery of £2.2m against transformation programmes, £0.3m over-recovery against divisional programmes and an additional £1.9m non-recurrent savings. The full £14.8m target has now got identified plans. £3.7m of the QIPP savings are due to be delivered in the last two months of the year.

- Pay for the RUH is over plan in month by £1.4m (£15.9m year to date). All the clinical divisions have overspent this month, partly as a result of Bank Holiday cover and the creation of additional capacity to respond to emergency demand.

- Capital expenditure was £33.6 million at Month 10 which was £8.7 million less than planned however this includes IFRS16. Excluding IFRS16 the position is £4.1 million less than planned

- The closing cash balance for the Group was £40.6 million which is £13.9 million higher than the plan sent to NHSE/I.

True North | Breakeven position

Statement of Comprehensive Income	Total							
	202210			YTD			FY	
Period to 202210	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Forecast £'000
Commissioner Income (NHSE/CCG)	32,794	34,484	1,690	326,543	336,976	10,433	392,045	404,602
Other Patient Care Income	1,900	1,862	(38)	18,140	21,595	3,455	21,808	25,932
Other Operating Income	2,478	4,562	2,083	24,476	32,772	8,297	37,577	45,716
Income Total	37,172	40,908	3,736	369,160	391,344	22,184	451,430	476,250
Pay	(23,969)	(25,488)	(1,519)	(242,316)	(259,798)	(17,482)	(290,261)	(310,769)
Non Pay	(11,828)	(13,033)	(1,205)	(120,635)	(128,208)	(7,572)	(144,362)	(149,159)
Depreciation	(1,798)	(1,720)	78	(17,775)	(17,203)	572	(21,372)	(21,685)
Impairment	0	(309)	(309)	0	0	0	0	0
Expenditure Total	(37,594)	(40,550)	(2,955)	(380,727)	(405,209)	(24,483)	(455,995)	(481,613)
Operating Surplus/(Deficit)	(422)	358	780	(11,567)	(13,866)	(2,299)	(4,565)	(5,363)
Other Finance Charges	(600)	(499)	101	(5,962)	(5,754)	208	(7,163)	(7,265)
Finance Charges	(600)	(499)	101	(5,962)	(5,754)	208	(7,163)	(7,265)
Surplus/(Deficit)	(1,022)	(141)	881	(17,529)	(19,620)	(2,091)	(11,728)	(12,628)

Adjusted Financial Performance								
Add back all I&E impairments/ (reversals)	0	309	309	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	(1,022)	167	1,189	(17,529)	(19,620)	(2,091)	(11,728)	(12,628)
Retain impact of DEL I&E (impairments)/ reversals	0	(309)	(309)	0	0	0	0	0
Remove capital donations/grants I&E impact	46	(1,076)	(1,122)	466	(1,337)	(1,803)	(7,572)	(6,672)
DEL Impairment Adjustment	0	0	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) including PSF as per accounts	(976)	(1,218)	(242)	(17,063)	(20,957)	(3,894)	(19,300)	(19,300)
Adjusted financial performance surplus/(deficit)	**(976)**	**(1,218)**	**(242)**	**(17,063)**	**(20,957)**	**(3,894)**	**(19,300)**	**(19,300)**

System Adjustment	0	1,608	1,608	0	16,083	16,083	0	19,300
Adjusted financial performance for the purposes of system achievement	**(976)**	**391**	**1,367**	**(17,063)**	**(4,874)**	**12,189**	**(19,300)**	**(0)**

Tracker Measure | Sustainability Savings

2022.23 SAVINGS PLANS

	Internal Annual Plan	YTD Plan	YTD actual	YTD variance	Forecast Outturn	Forecast Variance to Plan	Recurrent	Non-Recurrent (NR)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Transformation Schemes								
Outpatient Productivity	158	126	0	126	0	158	0	0
Home First	0	0	0	0	0	0	0	0
Medicines Management	779	1,287	131	1,155	254	525	131	0
Agency and Recruitment - Nursing	1,461	1,230	256	974	354	1,106	256	0
Agency and Recruitment - Medical	500	389	0	389	0	500	0	0
Theatre Efficiency	383	382	0	382	0	383	0	0
ICU Capacity	1,300	929	3,392	(2,463)	4,592	(3,292)	1,592	1,800
ICU Transformation Target	1,500	900	0	900	0	1,500	0	0
Investment Review - TIG	934	876	776	100	934	0	776	0
Elective Recovery (Orthopaedics)	200	133	0	133	0	200	0	0
Cleaning / Catering Income	275	240	229	11	275	0	0	229
Portering	75	65	0	65	0	75	0	0
Sulis Transformational Target	500	389	0	389	0	500	0	0
Workforce Processes	0	0	0	0	0	0	0	0
To be identified	149	12	0	12	0	149	0	0
Sub Total Transformation	8,214	6,957	4,784	2,174	6,409	1,805	2,755	2,029
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Divisional / Sulis QIPP								
Surgery	1,420	815	1,569	(753)	2,027	(607)	719	850
Medicine	1,678	677	1,075	(398)	1,129	549	183	893
Emergency Medicine	249	0	137	(137)	195	54	0	137
FaSS	775	531	643	(112)	767	8	643	0
ERM	325	252	246	6	295	30	139	107
Corporate	639	203	208	(5)	239	400	166	42
Sulis	500	389	22	367	22	478	22	0
Procurement stretch target	0	458	0	458	0	0	0	0
COVID	1,000	854	556	298	637	363	305	251
Sub Total Divisional	6,586	4,179	4,456	(277)	5,310	1,276	2,176	2,280
ERF Efficiency	0	0	0	0	0	0	0	0
Divisional Recovery Efficiencies	0	0	0	0	850	(850)	0	0
Non Recurrent slippage	0	0	1,871	(1,871)	2,231	(2,231)	0	1,871
Total QIPP	14,800	11,136	11,111	25	14,800	0	4,930	6,181

Countermeasure /Action – Completed	Owner
Budget have been reviewed and non-recurrent savings identified by the Divisions. Additional savings have been identified within Ophthalmology in Surgery due to a cheaper drug now being used	Project Leads

Countermeasure /Action – Future Actions	Owner
Schemes to support targets are being worked up with Finance and Project Leads as part of the budget setting programme for 2023/24	Project Leads / Finance

Tracker Measure | Sustainability – Capital (RUH and SULIS)

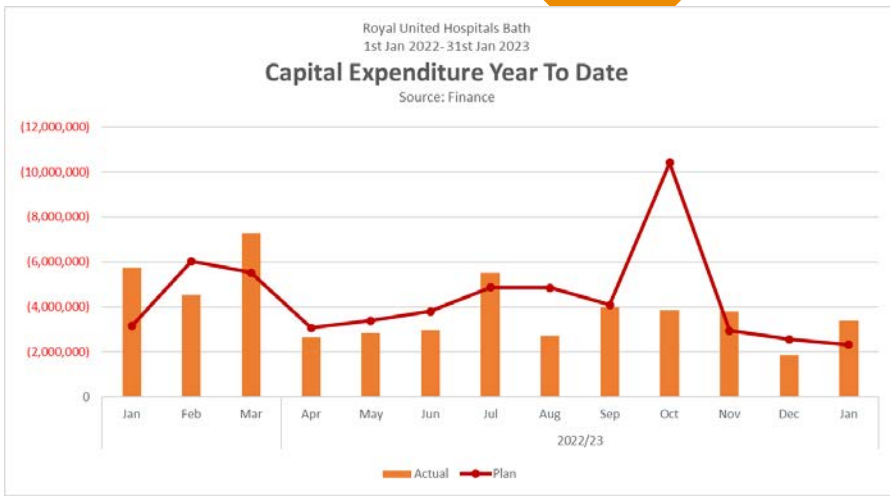
Capital Programme

Capital Position as at 31st January 2023	Annual Plan	Forecast	Year to Date Plan	Year to Date Actuals	Year to Date Variance
	£000s	£000s	£000s	£000s	£000s
Internally Funded schemes	(12,795)	(13,295)	(10,631)	(8,204)	2,427
IFRS 16 Lease Schemes	(6,236)	(6,236)	(6,236)	(1,653)	4,583
IFRS 16 Leases for Regional Orthopedic Centre	0	(39,652)	0	0	0
External Funded (PDC & Donated):					
Cancer Centre PDC	(22,530)	(22,530)	(21,765)	(20,624)	1,141
Regional Orthopaedic Centre PDC	(823)	(823)	(823)	(770)	53
Digital PDC	(1,214)	(1,214)	(108)	(113)	(5)
Other PDC	(185)	(185)	(85)	0	85
CPOA Ward Project (PDC)	(1,600)	(1,600)	0	(173)	(173)
Donated	(7,531)	(3,899)	(2,670)	(2,053)	617
Total	**(52,914)**	**(89,434)**	**(42,318)**	**(33,590)**	**8,728**

Is standard being delivered? No
What is the top contributor for under/over-achievement?

Trust funded programme is £7.0m under plan to date.

External funded schemes The forecast outturn will utilise the full PDC funding available this year.



Countermeasures completed last month

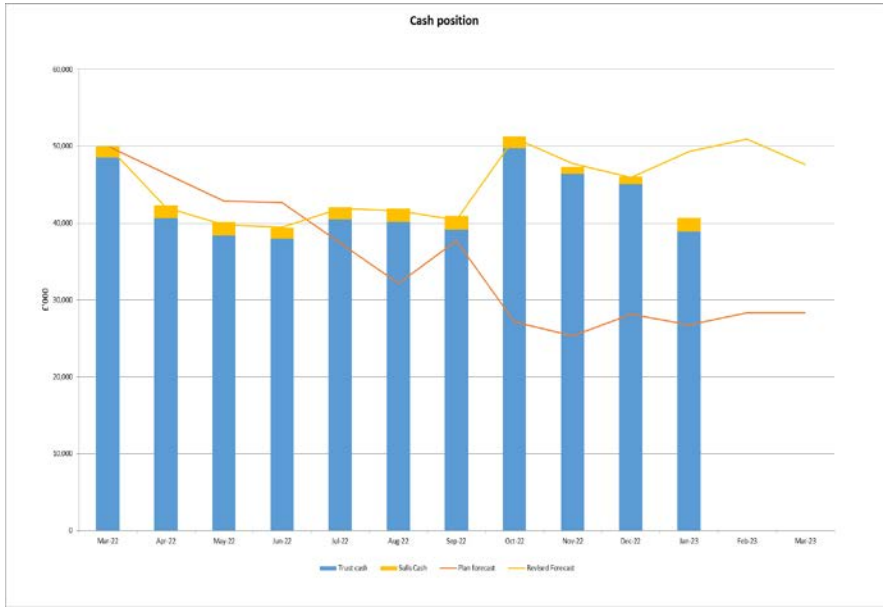
Countermeasure /Action	Owner
Cost Pressure on Sulis MRI & CT project to be confirmed	Head of Capital Projects

Countermeasures for the month ahead

Countermeasure /Action	Owner
CPMG to continue to monitor delivery of projects and schemes as approach year end	Head of Financial Services
Capital cover for IFRS16 leases to be determined with region	Deputy Director of Finance & Head of Financial Services

Tracker Measure | Sustainability – Cash (RUH and SULIS)

Group Cashflow statement against Month 12



Cashflow statement	
	£'000
Operating Surplus/(deficit)	2,218
Depreciation & Amortisation	17,202
Income recognised in respect of capital donations (cash and	(2,053)
Impairments	0
Working Capital movement	(11,322)
Provisions	(119)
Cashflow from/(used in) operations	**5,926**
Capital Expenditure	(33,239)
Cash receipts from asset sales	0
Donated cash for capital assets	2,053
Interest received	705
Cashflow before financing	**(30,481)**
Public dividend capital received	21,557
Movement in loans from the DHSC	(312)
Capital element of finance lease rental payments	(2,304)
Interest on loans	(112)
Interest element of finance lease	(309)
PDC dividend (paid)/refunded	(3,510)
Net cash generated from/(used in) financing activities	**15,010**
Increase/(decrease) in cash and cash equivalents	**(9,545)**
Opening Cash balance	**49,989**
Closing cash balance	**40,445**

Is standard being delivered for cash? No
The closing cash balance is £40.6 million which is £13.9 million higher than the planned NHSI return submitted for 2022-23.

Countermeasures completed last month

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

Countermeasures for the month ahead

Countermeasure /Action	Owner
Update 2023-24 cash forecast in line with draft plan	Financial Accountant

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

	31/12/2022 Actual £'000	31/01/2023 Actual £'000	Mv't in month £'000
Non current assets			
Intangible assets	6,653	6,561	(92)
Property, Plant & Equipment	267,213	269,388	2,175
Right of use assets - leased assets for lesse	28,576	28,144	(432)
Trade and other receivables	2,739	2,179	(560)
Non current assets total	**305,181**	**306,273**	**1,091**
Current Assets			
Inventories	6,805	6,962	157
Trade and other receivables	24,988	23,813	(1,175)
Cash and cash equivalents	46,112	40,445	(5,667)
Current Assets total	**77,905**	**71,221**	**(6,684)**
Current Liabilities			
Trade and other payables	(59,744)	(53,426)	6,320
Other liabilities	(15,929)	(13,344)	2,584
Provisions	(192)	(239)	(47)
Borrowings	(5,038)	(5,061)	(23)
Current Liabilities total	**(80,903)**	**(72,070)**	**8,833**
Total assets less current liabilities	**302,183**	**305,423**	**3,240**
Non current liabilities			
Provisions	(1,856)	(1,669)	187
Borrowings	(31,874)	(31,366)	507
TOTAL ASSETS EMPLOYED	**268,453**	**272,388**	**3,934**
Financed by:			
Public Dividend Capital	226,432	228,900	2,468
Other reserves	0	(0)	(0)
Income and Expenditure Reserve	2,115	3,582	1,467
Revaluation reserve	39,906	39,906	0
Total Equity	**268,453**	**272,387**	**3,934**

The Group Balance Sheet (RUH and Sulis)

Month 10 against month 9 movement:

- Capital has increased in line with reported capital spend less depreciation.
- Cash has decreased between months.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Board of Directors**	**Agenda item:**	**13**
Date of Meeting:	**1 March 2023**		
Title of Report:	**Quality Governance Committee (QGC) Chair's upward report**		
Status:	**For Information**		
Board Sponsor:	**Ian Orpen, Non-Executive Director and Chair of QGC**		
Author:	**Roxy Milbourne, Deputy Head of Corporate Governance**		
Appendices	**Appendix 1: Attendance Matrix**		

1. Purpose

This report summarises the discussions, recommendations and highlighted risks and approvals made by the Quality Governance Committee (QGC) on 13th February 2023, to provide the Board of Directors with an update of the Committee's activities.

2. Background

The Quality 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.

3. Summary Agenda

The agenda of the Committee meeting can be seen below. The agenda items are linked to the Trust's Board Assurance Framework risks and it is highlighted whether or not there are any further actions arising from each agenda item.

No.	Agenda item	BAF Mapping	
		BAF no.	Actions arising? Y/N
1.	Board Assurance Framework		N
2.	Patient Story	1	N
3.	Quality Report	1	Y
4.	Trust Quality and Safety Group Upward Report	1	N
5.	Health Inequalities Update	-	N
6.	Divisional Governance Reports	All	N

4. Items for escalation to the Board of Directors

Patient Story

The Committee were joined by the Lead for Patient and Carer Experience and PALs Team who provided an overview of the feedback they had received from patients and their families.

The team explained that there had been an increasing number of contacts with PALS, but the Trust wanted to move from being reactive to proactive in supporting staff to address concerns at ward level and gain real-time feedback from patients about their experience in hospital. As a result, they have increased staffing resources in PALS using existing funds. The outreach service started on 6th February and PALS staff have spoken to more than 70 patients in the first week and made 5 ward visits.

The team will now work with Family Liaison Facilitators to identify and resolve any communication/support issues, raise awareness of PALS outreach service with volunteers and ensure there is a robust process in place for completing actions/feedback loop.

Hospital Standardised Mortality Ratios (HSMRs)
The Committee discussed in detail the Quality Report. During this discussion it was agreed that the Committee should have a 'deep dive' into Hospital Standardised Mortality Ratios (HSMRs) at its meeting in May. This needs to be a key area of focus for the Trust – it is important to understand clearly whether or not the number of deaths occurring in the hospital are at the expected level. The Trust's key contact at Telstra is to be invited back.

Medicine Assurance Group
The Committee learnt about a new group that was being established called Medicine Assurance Group. This group would ensure better oversight on medicine safety and security – another key area of focus for the Trust and this Committee. Confirmation is to come back to this Committee once it is up and running.

Sulis Clinical Governance
The Committee received a report from the Trust Quality and Safety Group. The Committee noted the unique governance relationship between the Trust and Sulis regarding the modular theatre, commenting that this could be seen as a forerunner to the Orthopaedic Elective Centre. KPMG are currently working on future governance options and this would be included in their work.

Health Inequalities update
Question raised as to how the Trust truly becomes an anchor organisation. There is a need to consider in the first instance how the Trust is perceived both within the local health economy and in the wider community. Work has already started with the ICB on diabetes as an example with the shift towards a more proactive community based model of care. This needs to become the default model for other conditions.

5.	Key Decisions

The key decisions made were:

- Following the Quality Report, the Committee agreed to review HMSR at their meeting in May where it would form the majority of the meeting.

6.	Governance and Other Business

N/A this month

7.	Future Business

It was agreed that the Committee would monitor progress against the following items at its next meeting:

- Infection, Prevention and Control Board Assurance Framework update
- Clostridioides difficile thematic review

8.	Attendance Matrix

The Committees attendance matrix can be seen at appendix one overleaf.

9.	Recommendations

The Board is asked to note this report.

Appendix 1: Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Nigel Stevens	Non-Executive Director *(Chair until Aug 22)*												
2.	Ian Orpen	Non-Executive Director *(Chair from Nov 22)*												
3.	Anna Mealings	Non-Executive Director (until October 22)												
4.	Paul Fairhurst	Non-Executive Director (from October 22)												
5.	Alison Ryan	Chair of the Trust (temporary from Dec 22)												
6.	Cara Charles-Barks	Chief Executive												
7.	Antonia Lynch	Chief Nurse												
8.	Bernie Marden	Medical Director (until October 2022)												
9.	Richard Graham	Interim Chief Medical Officer (Oct 22)												
10.	Andrew Hollowood	Chief Medical Officer (from December 22)												
11.	Ade Kadiri	Head of Corporate Governance												
12.	Jaspal Phull	Governance Lead, Surgical Division (until August 22)												
13.	Justine Barnett	Governance Lead, Surgical Division (from October 22)												
14.	Fenella Maggs	Governance Lead, Medical Division (until December 22)												
15.	Jonathan Frost	Governance Lead, FASS (until December 22)												
16.	Jane Farey	Governance Lead, FASS (From February 23)												
17.	Simon Andrews	Divisional Director of Nursing, Surgery												
18.	Sarah Lidgett	Divisional Director of Nursing, Medicine												
19.	Olivia Ratcliffe	Divisional Director of Nursing, FASS												

Attended | **Apologies & Deputy Sent** | **Apologies**

Please note:

- The Divisional Directors' of Nursing were added to the Committee from November 2022.
- From February 2023 the committee will meet monthly.

Report to:	**Public Board of Directors**	**Agenda item:**	**14**
Date of Meeting:	**1 March 2023**		
Title of Report:	**Finance and Performance Committee Chair's Update Report**		
Status:	**For Discussion**		
Board Sponsor:	**Jeremy Boss, Non-Executive Director and Chair of Finance and Performance Committee**		
Author:	**Katie Mcclean, Executive Assistant**		
Appendices	**Appendix 1: Attendance Matrix**		

1. Purpose

This report summarises the discussions, recommendations and highlighted risks and approvals made by the Finance and Performance Committee on 23 January 2023, to provide the Board with an update of the Committee's activities.

2. 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.

3. Summary Agenda

The agenda of the Committee meeting can be seen below. The agenda items are linked to the Trust's Board Assurance Framework risks and it is highlighted whether or not there are any further actions arising from each agenda item.

No.	Agenda item	BAF Mapping	
		BAF no.	Actions arising? Y/N
	2022/23 Financial & Operational Performance BAF Risks		
	Managing the budget - Estates	7	
	Integrated Performance Report	4, 5, 7, 11, 13 + 14	Y
	Achieving 78 weeks by year end	4 + 13	Y
	Finance Vision		
	Internal audit management response – Getting the basics right internal audit update	11	Y
	Work Plan		Y

4. Items for escalation to the Board of Directors

The Committee discussed the BAF for 23/24, the number of risks had gone from 8 to 6.

The Committee received an update on the Estates budget and felt assured that they were doing all they could to meet their targets. It was noted that backlog maintenance had increased significantly in the last few years and is projected to rise further.

The Committee received an update on the integrated performance report and heard that the number of hours lost to ambulance handovers was still high. There had been a marked increase in demand in ED, including a 27% increase year on year in Urgent Care attendances. The Trust was being asked to focus on 78 week waits, this would

affect the 2 week wait performance. Colorectal was the are most challenged for 2 week waits. The operational performance outlook remains challenging with FLU, COVID, Strep A, exceptional demand in ED and difficulties in discharging patients.

The Committee had an update on the Trusts Financial position noting an increase in the overall deficit position for RUH due to winter pressures and some stabilisation at Sulis. The recovery plan was discussed including how the risks to meeting the year end forecast were being managed and a further longer-term plan to address the challenges into next year.

The meeting received an update on the BSW system financial picture and continued risks to the system.

The Committee received an update on the Finance vision.

The Trust had scored themselves with a 3/5 on the HFMA checklist, The scores have been reviewed by Internal Audit who concluded that the scoring was appropriate and the action plan addressed the issues.

5. Key Decisions

The key decisions made were:

- Financial position to be discussed at the next Trust Board and to confirm that for now it is reasonable to stay with the current forecast for the year end, but there remain significant risks to its achievement.
- Noted financial pressures due to the HCA Band 2 to Band 3 rebanding exercise currently underway.

6. Governance and Other Business

The Work plan was reviewed and approved by the Committee.

7. Future Business

- Budget approval (pre Board) for 23/24 plan
- Urgent care strategy
- Lessons learnt from Winter
- Direct Engagement
- Cisco Hardware and Support
- Linen and Laundry Services
- Acute Hospital Alliance Electronic Patient Record
- Finance strategy

8. Attendance Matrix

The Committees attendance matrix can be seen at appendix one overleaf.

9. Recommendations

The Board is asked to note this report.

Appendix 1: Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Jeremy Boss	Non-Executive Director & Chair of FPC												
2.	Adewale Kadiri	Head of Corporate Governance												
3.	Andrew Hollowood	Chief Medical Officer												
4.	Antony Durbacz	Non-Executive Director												
5.	Bernie Marden	Chief Medical Officer												
6.	Cara Charles-Barks	Chief Executive												
7.	Joss Foster	Director of Strategy												
8.	Libby Walters	Director of Finance & Deputy Chief Executive												
9.	Nigel Stevens	Non-Executive Director												
10.	Paul Fairhurst	Non-Executive Director												
11.	Simon Sethi	Chief Operating Officer												

Attended | **Apologies & Deputy Sent** | **Apologies**

Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**1 March 2023**		
Title of Report:	**Non-Clinical Governance Committee (NCGC)**		
Status:	**For Discussion**		
Board Sponsor:	**Sumita Hutchison, Non-Executive Director**		
Author:	**Stephanie Spottiswood, Executive Assistant**		
Appendices	**Appendix 1: Attendance Matrix**		

1. Purpose

This report summarises the discussions, recommendations and highlighted risks and approvals made by the Non-Clinical Governance Committee (NCGC) on 2 February 2023, to provide the Board with an update of the Committee's activities.

2. Background

The NCGC 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.

3. Summary Agenda

The agenda of the Committee meeting can be seen below. The agenda items are linked to the Trust's Board Assurance Framework risks and it is highlighted whether or not there are any further actions arising from each agenda item.

No.	Agenda item	BAF Mapping	
		BAF no.	Actions arising? Y/N
1.	Apologies		
2.	Minutes of the meeting held on 31 Oct 2022		
3.	Action Log & Matters Arising		
4.	BAF Risks: • 2022/23 Risks • 2023/24 Proposed Risks		
5.	Digital Strategy Update (not Cyber Update)		
6.	Estates Backlog Maintenance Update	Strategic Priority 4 Risk # 6	
7.	Cleaning Update		
8.	Health & Safety • Q2 2022/23 Health & Safety Report • Q3 2022/23 Incidents & Litigation Report		
9.	External Agency Visits		
10.	Key Points for Summary to BoD		
11.	Meeting Evaluation and Agenda Items for Next Meeting		
12.	Any Other Business		

4.	Items for escalation to the Board of Directors

1. Board Assurance Framework:
   - Sustainability was a strategic objective for 2023/24, and would be added to the BAF, with discussions to look into broadening the scope of Sustainability.
   - The Sustainability focus of Net Zero would require significant investment to manage the associated risks. It was important to leverage support from Trust staff and the community to move the Sustainability agenda forward.

2. Digital Update:
   - Important to distinguish strategic digital ambition and the reality of the funding envelope.
   - The priority was to take a strategic approach to capital allocation going forward, in conjunction with ensuring balanced prioritization.
   - The narrative was important in bringing the digital and financial reality closer.
   - RUH paperless inpatient records to be escalated.
   - This committee had a unanimous view on the importance with proceeding with paperless inpatient records.

The Director of Strategy suggested that the Finance and Performance Committee (FPC) was a key route for this topic to be raised as the capital plan was tabled at FPC. There was no discussion planned at Trust Management Executive as yet. The only discussion that had taken place was to review the prioritisation of non-strategic capital, which was being done on a risk base. £7m was allocated to urgent high risk non-strategic capital; paperless inpatient records would come under strategic capital, which had a £5m allocation.

3. Estates Backlog Maintenance:
   - Synergy between the Estates strategy and Clinical strategy.
   - The site footprint was an intrinsic part of discussions in terms of the direction of the clinical strategy.
   - It was important to recognise all the factors involved, and the competing demands on capital.

4. Cleaning:
   - New induction and training programs being developed after the implementation of the new National Standards.
   - Requested evidence of how the Improving Together methodology had been applied, and how members of the cleaning staff were helping to shape the process.

5.	Key Decisions

1. Board Assurance Framework:
   - Sustainability was a strategic objective for 2023/24, and would be added to the BAF, with a broader scope.

- The Sustainability focus of Net Zero would require significant investment to manage the associated risks. It was important to leverage support from Trust staff and the community to move the Sustainability agenda forward.

2. Digital Update:
   - The Committee had a unanimous view on the importance of proceeding with paperless inpatient records.

6.	Governance and Other Business

1. Cleaning:
   - Ensure the People Committee had clear site and discussions in terms of cleaning staff retention, recruitment and culture.

7.	Future Business

Sustainability to be added to the next meeting in April, bringing together discussions and thoughts from a Sustainability workshop on 22 March.

8.	Attendance Matrix

The Committees attendance matrix can be seen at appendix one overleaf.

9.	Recommendations

The Board is asked to note this report.

Appendix 1: Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Sumita Hutchison	Non-Executive Director + Chair												
2.	Ade Kadiri	Head of Corporate Governance												
3.	Anthony Durbacz	Non-Executive Director												
4.	Brian Johnson	Director of Estates & Facilities												
5.	Cara Charles-Barks	Chief Executive												
6.	David McClay	Chief Digital Officer												
7.	Ian Orpen	Non-Executive Director												
8.	Joss Foster	Director of Strategy												
9.														
10.														
11.														
12.														
13.														
14.														

Attended **Apologies & Deputy Sent** **Apologies**

Royal United Hospitals Bath
NHS Foundation Trust

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Report to:	Board of Directors	Agenda item:	16
Date of Meeting:	1st March 2023		

Title of Report:	Freedom To Speak Up Guardian Annual Report
Status:	For discussion and noting
Board Sponsor:	Alfredo Thompson, Director for People and Culture
Author:	Louisa Hopkins Freedom To Speak Up Guardian
Appendices	-

1. Executive Summary of the Report

This report provides an update on the progress the Trust continues to make including:

- FTSU Group assessment of the current position.
- Performance over the last 4 years which highlights confidence in Speaking Up is increasing.
- Work with Black Asian Minority Ethnic colleagues, highlighting current barriers to speaking up.

2. Recommendations (Note, Approve, Discuss)

- Discuss and note the Freedom to Speak Up update.
- Support on going work to ensure an open and transparent culture of speaking up is achieved in the organisation.
- Support the work underway to ensure Black and ethnically diverse staff can safely report concerns.
- Note the improvements in the numbers of staff speaking up.
- Note that the RUH was short listed for National HSJ awards supported by The National Guardians Office (NGO).
- Approve recommendations in Section 4 in response to NGO survey results.

3. Legal / Regulatory Implications

The Trust is required to meet the following legal/regulatory requirements in relation to raising concerns:

- NHS contract (2016/17) requirement to nominate a Freedom to Speak Up Guardian.
- National NHS Freedom to Speak Up raising concerns policy (2022)
- NHS Constitution: The Francis Report emphasises the role of the NHS Constitution in helping to create a more open and transparent reporting culture in the NHS which focuses on driving up the quality and safety of patient care.

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

The implementation of effective practices ensuring that staff are able to raise concerns and are protected when they do will ensure that the Trust guards against legal claims against it. Failure to develop and implement the requirements of the legal and regulatory framework requirements may lead to reputational and finance losses.

5.	Resources Implications (Financial / staffing)
There is currently one funded WTE Lead Freedom To Speak Up Guardian supported by 18 volunteer champions from a variety of job roles throughout the organisation. An Associate Guardian post is imminently being appointed to further support staff. The Champion team encourage staff to raise concerns, share themes with the FTSU Group and signpost concerns to the Guardian.	

6.	Equality and Diversity
The Raising Concerns Policy complies with the Public Sector Equality Duty. A more thorough Equality Impact Assessment is underway. The FTSU Lead is working through this with the EDI Lead and it will be provided for the next report. Staff disclose to the Freedom to Speak up service protected characteristics of disability, pregnancy, maternity, religion, LGBTQ+ race and age.	

7.	References to previous reports/Next steps
November 2021 report to Board of Directors – Freedom To Speak Up - Update	

8.	Freedom of Information
Public Board.	

9.	Sustainability
-	

10.	Digital
-	

1. Purpose

The purpose of this report is to update Board on Freedom to Speak Up (FTSU) activities at Royal United Hospitals Bath NHS Foundation Trust (RUH) over Q1,2,and 3, providing information on the nature of the concerns raised including relevant internal data.

2. Background

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis' report 'The Freedom To Speak Up' (2015 www.freedomtospeakup.org.uk/the-report/). These recommendations were in response to Sir Robert's finding that the culture in the NHS did not always encourage or support workers to raise concerns that they might have about quality and safety of care provided, potentially resulting in poor experiences and outcomes for patients and colleagues.

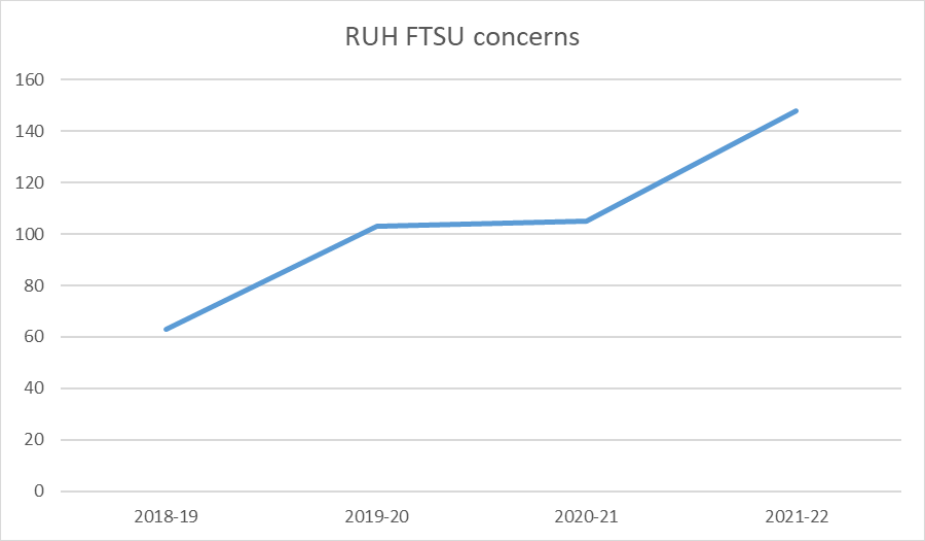
Concerns can be raised about anything that gets in the way of providing good care. When things go wrong, it is important to ensure that lessons are learnt and improvements made. Where there is the potential for something to go wrong, it is important that staff feel able to speak up so that potential harm is avoided. Even when things are going well, but could be even better, staff should feel confident to make suggestions and that these are taken on board. Speaking up is about all of these things.

The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC and NHSI/E.

The Trust Vision for Freedom to Speak Up is:

To promote and maintain an open and transparent culture across the Trust, ensuring that all members of staff feel safe and confident to speak up about issues that concern them.

A Freedom to Speak Up Guardian has been in place at the RUH since October 2016. The service has a committed team of champions who support and signpost to the Guardian. Concerns have gradually increased as outlined in the graph below:



A promotional video for members of staff has been created and can be accessed here: https://youtu.be/CneEBsB5AIM

3. National Guardians Office (NGO)

Highlights over the 2021/22 period include:

- A new national guardian Dr Jayne Chidgey-Clark was appointed in December 2021 as Dr Henrietta Hughes stepped down.
- Progress continues to be made to improve the speak up culture across a range of organisations. There are now more than 820 Freedom to Speak Up Guardians in over 500 organisations who have handled nearly 75,000 speak up cases to date, allowing workers to speak up who might otherwise not be heard.
- Support and development has improved for FTSU Guardians including revised training for new Guardians, refresher training for existing Guardians, and a refreshed Network Chair role in 2022.
- A new role Mentor role has been introduced to support success of FTSU services. The FTSU Guardian from RUH has been selected to be one of these mentors and is actively supporting other Guardians from different organisations.
- There is a new National Speaking up Policy. The RUH policy is currently under review to ensure alignment with national guidance.

4. NGO Freedom to Speak Up Annual Survey 2021

The annual NGO FTSU survey was carried out identifying key areas for future focus, in particular Senior Leaders' essential role in Freedom to Speak Up.

Recommendation	RUH's current Position	Meeting expectations Y/N?
Senior leaders should deepen their support for speaking up by taking action to demonstrate learning from	Current RUH processes in place. Board Assessment tool will test and add further assurance.	No *Recommendations to organisation for success:* Instigate Follow up

speaking up, tackling detriment, and supporting further cooperation within organisations on all matters related to speaking up.	With each case managers are educated on FTSU culture and safe speaking up for all staff. Training is available and essential for all staff. Currently staff share inconsistencies and report fear of speaking up due to fear of detriment from their mangers/ culture of the organisation.	training for leaders Theme current data to support areas where staff report fear of speaking up Ensure Restorative Just Culture is embedded with consistency so all staff can benefit and the organisation can learn Re visit and identify touch points in current leadership programmes where psychological safety and FTSU can be included
There should be visible action on detriment for speaking up wherever this is reported.	Current process- staff can report detriment at any time. All detriment cases are reported and shared with NED Lead for FTSU to be investigated.	Yes
The frequency and status of training on speaking up matters should be reviewed so that guardians and leaders can satisfy themselves that workers and those who support them have the knowledge and skills they need to speak up, listen up, and follow up, well.	Current training regime in place that seeks to address any staff barriers. Current training targets are over and above expectation.	Yes
Senior leaders should take the necessary steps to tackle the perception that speaking up is futile, including ensuring appropriate action is taken when individuals speak up and that they are offered timely and meaningful feedback.	Open communication from Senior leaders encourage staff to speak up. Execs and senior managers refer staff and encourage staff to access FTSU. Current Staff survey results show improvement.	Yes

The full report can be found with the link below:
https://nationalguardian.org.uk/wp-content/uploads/2022/03/2021-FTSUGuardian-Survey-Report.pdf

5. FTSU Guardian Activity

5.1 National Work

The FTSU Guardian has continued to actively engage with the National Guardian's Office, including acting as SW Chair report to National Guardians Office when needed, completing data requirement, contributing to surveys.

The RUH was short listed for National HSJ awards which was supported by The National Guardians Office. Further discussions are in place with National Guardians Office to nationally highlight RUH work and achievements.

Amanda Pritchard, Ruth May and Professor Stephen Powis have written a joint letter to NHS leaders in response to the Ockenden report. The letter includes a paragraph which states:

"The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months."

RUH listening events took place bringing an increased awareness of FTSU to staff and themes shared with leaders for learning and support.

5.2 Regional work

The FTSU Guardian regularly attends regional network meetings and is in regular contact with the Guardians across the SW region. This is key for peer support, benchmarking and working together to push the Speaking Up agenda forward as part of the BSW partnership.

Comparisons in current cases (obtained from NGO website):

RUH NHS FT	Salisbury NHSFT	Great Western Hospitals NHS FT
126	99	12

The FTSU Guardian provides ongoing mentorship to new and existing Guardians Nationally.

6. Local work

The National Guardian's Office has launched in April 2022, with Health Education England, training for all workers and managers with the view that organisations need to bring this training to staff attention.

As previously reported, this training is essential for all staff at the RUH. To date, over 60% of staff are trained. In addition, the FTSU Guardian will visit areas and adapt and provide training, ensuring all staff have access.

The FTSU Guardian is well supported by the communications team, who will regularly share information for all staff. Posters, leaflets and information are readily available for all staff.

Staff are referred to FTSU by senior leaders. The service is promoted in RUH question and answer sessions FTSU. There is a noted increase that speaking up is valued and appreciated in the RUH.

7. FTSU data

The FTSU service continues to be a busy service with staff accessing it from a range of job roles, bands and areas in the organisation. Please see appendix 1 for assurance.

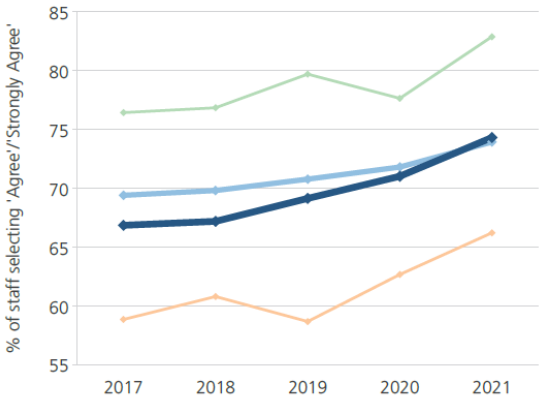
As previously reported, confidence in speaking up is improving in the organisation. This data shows the increased confidence staff have with raising concerns in the organisation with a rise of 3.4% to Q17a. As 2022 Staff survey data is released we will update these changes.

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Raising concerns

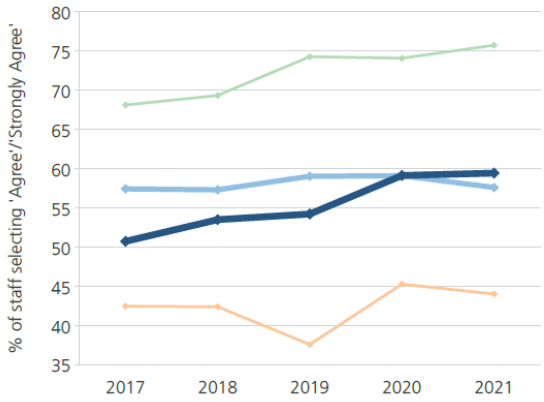
NHS

Q17a
I would feel secure raising concerns about unsafe clinical practice



	2017	2018	2019	2020	2021
Best	76.4%	76.9%	79.7%	77.7%	82.9%
Your org	66.9%	67.2%	69.2%	71.0%	74.3%
Average	69.4%	69.8%	70.8%	71.8%	73.9%
Worst	58.9%	60.8%	58.7%	62.7%	66.2%
Responses	2,228	2,258	2,091	2,308	2,502

Q17b
I am confident that my organisation would address my concern



	2017	2018	2019	2020	2021
Best	68.1%	69.4%	74.3%	74.1%	75.7%
Your org	50.8%	53.5%	54.2%	59.2%	59.5%
Average	57.4%	57.3%	59.1%	59.1%	57.6%
Worst	42.5%	42.4%	37.6%	45.3%	44.1%
Responses	2,221	2,253	2,094	2,304	2,492

45

In accordance with National Guardain's Office guidance, we have adjusted our data collection to include concerns with an element of staff safety. To date, 25% of concerns have an element of staff safety.

8. Update on themes of cases Q1, 2, 3

As previously reported, during 2019/20 limited concerns were raised by Black and ethnically diverse staff. We continue to support staff with the service providing a secure, trust worthy option for staff to engage with. 16.1% of cases raised by Black and ethnically diverse staff in Q 1, 2, 3. We continue to increase diveristy in our champion team to ensure support is available to all staff and note the WRES data in the organisation has a comparison of 16.2% with a current FTSU team of 45% Black and ethnically diverse staff.

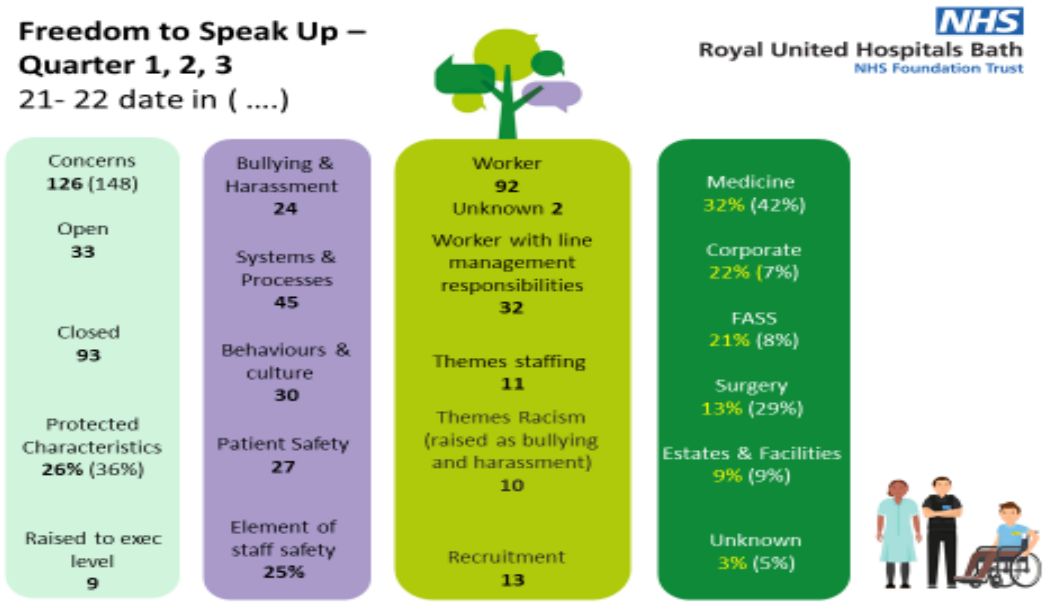
As previously reported, FTSU as a service has had many conversations seeking to support Black and ethnically diverse staff concerns in the organisation.

FTSU has found a theme of Black and ethnically diverse staff finding it hard to have a safe process to raise racism outside of the bullying and harassment policy. This theme has been noted by the Director for People and Culture, the Equality, Diveristy and Inclusion Lead and Inclusion team. Further work is under way to address this and a further update will be provided in the next report.

It was previously reported that Midwives were speaking up about pressures and staffing levels. A series of listening events took place during August- November to provide sustained support and to promote FTSU. Feedback and adjustments are in process from the Midwifery Leadership Team. FTSU training continues to be included on the PROMPT training day that supports all staff working in the department.

Recruitment practices continue to be a reported theme for FTSU. Staff offer a range of concerns and are being captured for learning. An example of learning having taken place is poor recruitment processes improving systems in a highlighted area to provide improved trust and experience.

9. Improved Speaking up at the RUH



FTSU has continued to support teams with listening events and conducted events in five different areas between Q1-3. Improvements have been noted where FTSU as a service has not been accessed, and managers are the trusted option and voice that they feel safe to speak directly.

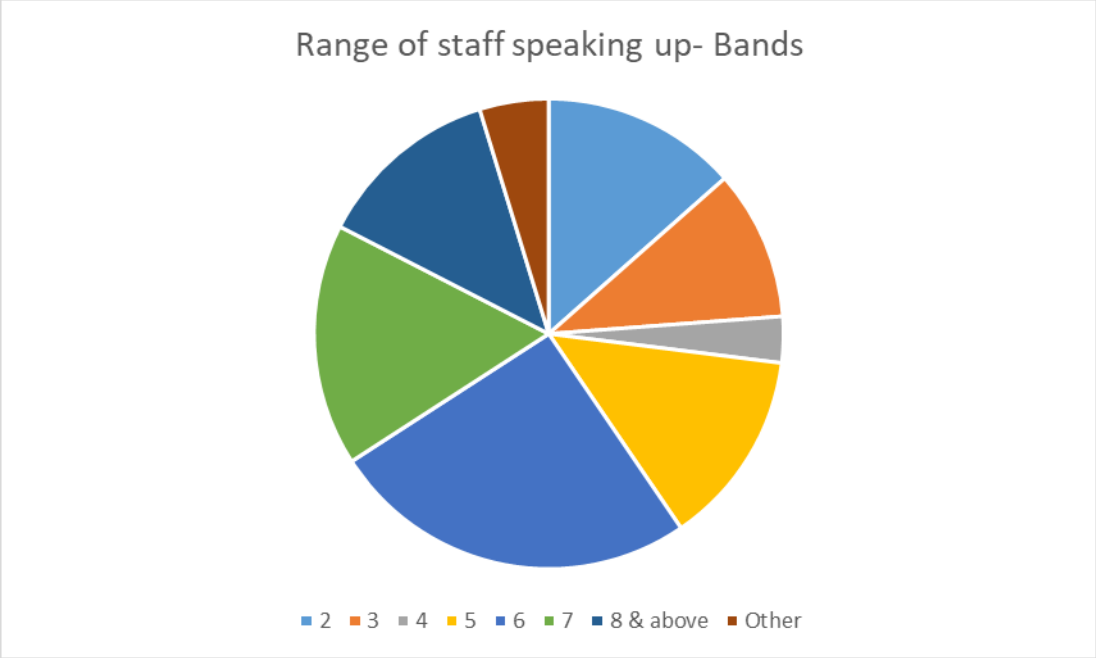
In other situtaions listening events have provided valuable insight into team dynamics for further support to be implemented.

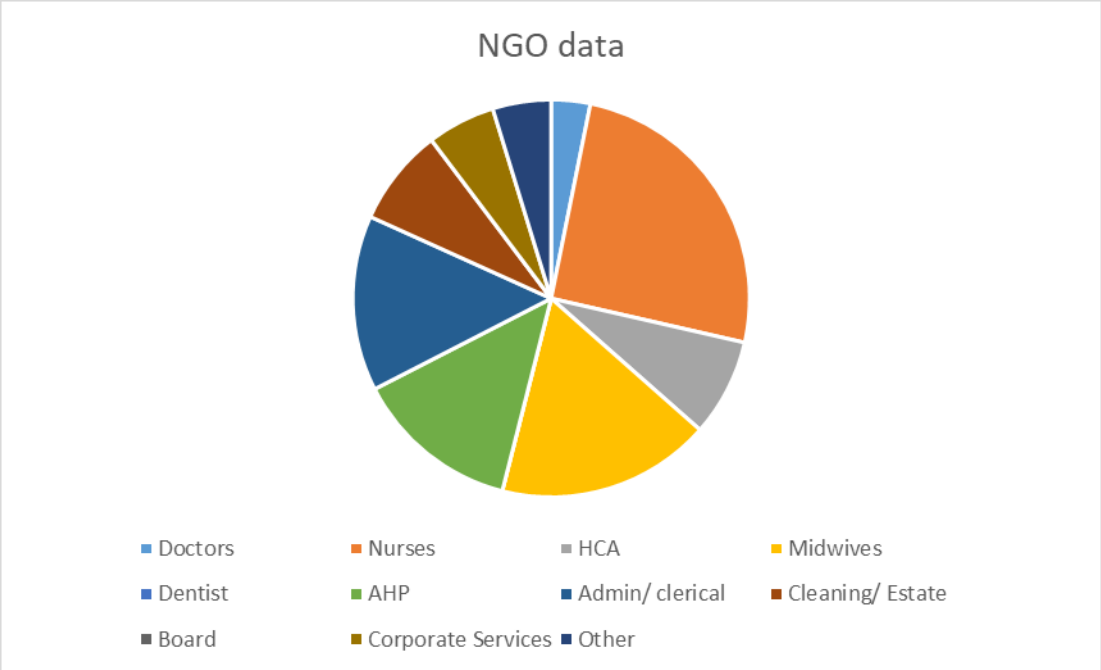
Breakdown of data by division and reason for concern:

2022 DATA Q1,2,3 % total cases	**Medicine 32%**	**Corporate 22%**	**FASS 21%**	**Surgery 13%**	**Estates and Facilities 9%**	**Unknown 3%**
Patient Safety	26%	8%	55%	11%	0	0
Bullying and Harassment	33%	21%	4%	21%	8	13%
Behaviours and Culture	30%	37%	10%	17%	6%	0%
Systems and processes	29%	20%	29%	7%	13%	2%
Total cases	40	28	26	17	11	4

The increase of cases in FASS is the result of an increase in midwifery staff speaking up.

Appendix 1 – Staff Groups accessing the FTSU Service





Royal United Hospitals Bath
NHS Foundation Trust

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Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**1 March 2023**		

Title of Report:	**RUH Medical Revalidation System Annual Report 1 April 2021 – 31 March 2022**
Status:	**For Approval**
Board Sponsor:	**Mr Andrew Hollowood, Medical Directors**
Author:	**Dr Stewart Redman, Appraisal Lead**
Appendices	**Appendix 1: A framework of quality assurance for responsible officers and revalidation**

1. Executive Summary of the Report

The purpose of this report is to provide assurance to the Board on the key requirements for compliance with the Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time.

Completion of the template will therefore:
a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Mr Andrew Hollowood, Medical Director & Responsible Officer and Sarah Richards, Deputy Responsible Officer are now in post and continues to be supported by the Responsible Officer Advisory Committee.

The Trust pays for the PrepIT system which facilitates on-line appraisals and data collection and pays for twice yearly appraiser training. We are in the process of connecting our Appraisal IT system to the GMC system which will allow us to automatically have updated Revalidation dates and more easily see any doctors connected on GMC but not on our appraisal system.

We trained 10 appraisers in the past year to increase from 40 to 50 appraisers. However there has been further attrition in gross numbers of appraisers. A business case requesting additional funding for appraisals has been submitted that acknowledges those individuals appraising more than the designated 6 appraisees per year.

At 31 March 2022 the Trust registered 382 (75 not know, we believe these may be honorary contracts) doctors with a prescribed connection. A total of 243 appraisals where undertaken from 1 April 2021 to 31 March 2022.

There are a number of actions in Section 6 that have been identified to continue improvement during 2023/24.

2.	Recommendations (Note, Approve, Discuss)
The Board is requested to review and approve the annual board report and statement of compliance for responsible officers and revalidation.	

3.	Legal / Regulatory Implications
The Framework of Quality Assurance can be submitted as evidence for CQC inspections. It is a regulatory requirement for the Trust to review and demonstrate compliance with the Responsible Officer Regulations and assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
What are the risks arising or identified in the report. Risks need to be added to the risk register in advance of submitting the report and the risk number stated.	

5.	Resources Implications (Financial / staffing)
Resource: There is a risk that appraisers may leave the Trust due to lack of financial resourcing. Resource: There is a risk that the cost of licences for the online appraisal system will rise in line with the increasing number of Doctors in the Trust.	

6.	Equality and Diversity
An equality impact assessment had been completed. Consistent implementation of Trust policies ensured that equality and diversity standards were achieved. Outcome of concerns were audited as part of the WRES annual report and any appropriate actions taken forward.	

7.	References to previous reports/Next steps
Report to Board in January 2022	

8.	Freedom of Information
Public	

9.	Sustainability
None	

10.	Digital
None	

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2022

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None
Comments: Mr Andrew Hollowood PhD FRCS in post since November 2022 as Chief Medical Officer
Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: None
Comments:
The Responsible Officer is supported by the Responsible Officer Advisory Committee comprising of:

Mr Andrew Hollowood, Medical Director & Responsible Officer
Sarah Richards, Deputy Responsible Officer
Dr Stewart Redman Appraisal Lead
Joanna Hole, Lay Member
Lucy Tainton & Debra Scoplin, Appraisal & Revalidation Admin Support
Alison Stead Medical Staffing Manager
The Trust pays for the PrepIT system which facilitates on-line appraisals and data collection and pays for twice yearly appraiser training.
Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: None
Comments: The Trust records all information relating to medical practitioner revalidation in a web enabled medical revalidation system. A system is in place to ensure that the records are checked monthly in order to maintain accurate records.
The Trust uses the interface from the Electronic Staff Record to check all the medical practitioners are registered appropriately with their designated body.

We are in the process of connecting our Appraisal IT system to the GMC system which will allow us to automatically have updated Revalidation dates and more easily see any doctors connected on GMC but not on our appraisal system. Action for next year: Update on progress with connecting to GMC system.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: 3 yearly ‘Medical Appraisal Policy’’ review in progress for January 2023 Comments: Review and ratification is in process Action for next year: Confirm policy has been reviewed and ratified.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Review of peer review methodology across our ICS to inform next steps.

Comments: A peer review takes place when deciding on content of the training and that this has been discussed at MWFP Group/JLNC ie number of appraisers and appraisers representing all staff groups.

We have consulted with Salisbury Foundation Trust and Great Western Hospital appraisal teams to discuss a wide range of topics related to our appraisal systems. One outcome is that we are exploring offering joint Swindon/Bath on-line appraiser training which will increase the accessibility for our appraisers.

Action for next year: Update on progress of on-line appraiser training.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None

Comments: For Trust Drs, if they wish to be revalidated by us (some stay on HEE list as they plan to return to training in the 5 year cycle), we write to the previous responsible officer (as we do for Consultants, Locum Consultants, SAS Drs.) to ask if there are any concerns etc. Support is the same as for trainees.

All other grades of staff have an annual appraisal, the outputs of which can feed into the appraisal system in the organisation they have their prescribed connection with.

Action for next year: None

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those

Action from last year: None

Comments: The majority of doctors have returned to an annual appraisal cycle following the pausing of appraisal during Covid. We have contacted all the doctors in the Trust with outstanding appraisals to ask them to either complete their appraisals by March 31st 2023 or update us with their situation. Those with valid reasons (sick leave, maternity leave, sabbaticals, etc) will now be marked as "Missed Approved". This will allow us to identify the "Missed Not Approved" appraisals and more actively manage these.

Action for next year: Build understanding of the "Missed Approved/Not Approved" categorisation across the permanent medical workforce to help boost appraisal numbers. Set up a system to manage the Missed Not Approved appraisals

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: More communication on the need for appraisal planned.

Comments: See answer for question 6

Action for next year: As above

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: The Trust has the following policy 'Medical Appraisal Policy' due for review January 2023

Comments: A review and ratification is in progress.

Action for next year: Ensure policy is ratified.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None

Comments: We trained 10 appraisers in the past year to increase from 40 to 50 appraisers. However there has been further attrition in gross numbers of appraisers. As a comparison GWH has 100 trained appraisers. As a consequence a number of appraisers will appraise more than 15 colleagues a year.

The appraisers are paid 0.125 PAs for 6 appraisals but to cover the number of doctors needing appraisals some are asked to do far more than this (up to 30).A business case requesting additional funding for appraisals has been submitted that

organisations that have not yet moved to the revised model may want to describe their plans in this respect.

acknowledges those individuals appraising more than the designated 6 appraisees per year. Currently, a number of higher volume appraisers are not taking on new appraisees until approval leading to a shortage of appraisal slots.

Benchmarking for the renummeration of appraisers is discussed at Higher level Responsible Office meetings There is a rage of payments per with some trusts allocating 0.25 PAs for 6-8 appraisals with Cheltenham allocating 0.5 PAs per 10 appraisals,.

Action for next year: Approval of the Medical Appraisal business case following which train more appraisers (there is a cost associated).

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: ASPAT scoring has been under taken and will be fed back to appraisers prior to the appraiser training sessions later this year.

Comments: ASPAT scores of appraisal outputs have again been fed back to appraisers along with qualitative feedback from appraisees to appraisers. This is also reviewed at the ROAC. There continues to be twice yearly RUH appraiser update half day meetings to maintain appraiser CPD

Action for next year: Continue as above

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Any issues arising will be taken forward by the Medical Director to the Board or the relevant governance group depending on the nature of the issue. An annual Appraisal Revalidation Framework Assurance paper will be submitted to the Trust's Board. Comments: In addition to the annual report there will be a review of the process by the Higher Lever Responsible Officer in the next 6 months to assess the process and quality of appraisals. The report following will be presented to Board. Action for next year: Continue review of the revalidation and appraisal process with onward reporting to Board.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2022 (source: ESR)	**382 (75 not known)**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**243**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**139**
Of which were new starters with less than 12 months service during the period:	**63**
Of which were due an appraisal during the period but no record of appraisal completed:	**76**
Total number of agreed exceptions	**Not previously undertaken by the Trust**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None Comments: Revalidation dates are prepped up to a month or two in advance for the regular ROAC meetings by the Administration team. If all evidence is in place and there are no concerns the RO will recommend Revalidation Action for next year: None

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None Comments: The ROAG meets monthly to review all individuals about to revalidate. Triangulation with appraisal complaints and incidents determines the progress through revalidation. All efforts are made to ensure individuals are engaging with the system. In the event of a non-engagement individuals will be informed both verbally and in writing. Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None Comments: Each department has medical and/or nursing clinical governance leads who regularly meet and oversee clinical governance issues within their department. They employ a variety of reporting mechanisms to monitor performance (e.g. data from incidents, SJRs, complaints, PALS, ward dashboards) and facilitate local quality improvement and disseminate learning (e.g. by newsletters, teaching sessions etc.) The departmental leads attend Divisional Clinical Governance meetings and report to the Divisional Governance Leads. At the divisional meetings division-wide themes and opportunities for learning and development are reviewed. The Divisional Clinical Governance Leads sit on SI Review Panels, Clinical Outcomes Group, and report up to Quality Board and the Operational Governance Committee.

Action for next year: 1) Ongoing dissemination of learning, and development of ways of recording and demonstrating that this learning has been effective.

2) Streamline duplications between Quality Board and Operational Governance committee

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None

Comments: Issues raised regarding doctors' competency are dealt with as appropriate either informally or by using the Department of Health's document 'Maintaining High Professional Standards in the Modern NHS'. The Trust has a 'Managing Conduct Policy' which mirrors 'Maintaining High Professional Standards in the Modern NHS' and is the mechanism by which all issues of conduct are dealt with. In addition the Trust has a 'Managing Capability Concerns of Medical and Dental Staff Policy'

All doctors complete a formal Trust 360 and patient feedback process and reflect on the outputs with their appraiser, once every 5 years (as per GMC guidance)

Action for next year: Review of 'Managing Capability Concerns of Medical and Dental Staff Policy'

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: Yes there is a procedure and policy in place 'Managing Capability Concerns of Medical and Dental Staff Policy' alongside the 'Freedom to Speak Up: Raising Concerns Policy'.

Action for next year: Confirm review of 'Freedom to Speak Up: Raising Concerns Policy'

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be

Action from last year: None

Comments: Quality Assurance of medical appraisal at the RUH continues to be peer approved with external training of the Trust's Medical Appraisers. This has been reinforced by feedback to both appraisees and appraisers during regular update meetings with the Responsible Officer and Appraisal Lead. In addition, annual appraisals completed during the revalidation year are only signed off if a completed 360 degree feedback is undertaken from both patients and colleagues covering full scope of practice. We have mandated that the peer and patient feedback occurs in year four of a five year cycle. Following sign off, revalidation year appraisals are scrutinised by the Responsible officer so that a recommendation can be made to the GMC. Where the recommendation has been to seek deferral of revalidation, this has been because of insufficient evidence was found to support a recommendation of revalidation (almost always because 360 feedback and reflection have not been completed).

Analysis of numbers, types and outcome of concerns is audited as part of the WRES annual report and any appropriate actions are taken forward.

Action for next year: None

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: To review the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers to streamline and standardise

Comments: In line with 'Maintaining Professional Standards', where an issue is raised formally, other employing organisations are informed of the nature of the concerns we are investigating.

Action for next year: To confirm review this process to streamline and standardise has this been undertaken

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None

Comments: Our policies and procedures are designed to ensure equity and fairness in line with 'Maintaining Professional Standard's and an Equality Impact Assessment is completed whenever policies are written or updated.

requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: None

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None

Comments: All post and pre employment checks for all staff including locums are in line with NHS Employers Guidance. Framework agencies are used initially if agency doctors are required, this ensures all appropriate pre-employment checks are in place with CV's checked by the appropriate consultant to ensure the agency doctor has the appropriate qualifications.

If non-framework agencies are used, Staffing Solutions Department ensures all appropriate pre-employment checks are carried out.

Action for next year: None

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

- A review of peer review methodology across our ICS has been initiated.
- Medical Appraisal Policy 3 yearly review in January 2023 in progress
- Improved use of Appraisal 2020 model - There is an updated version of this. The Trust has met with our IT supplier to explore options around introduction but are not planning to introduce in the short term as focus is on increasing appraisal uptake and ensuring appraiser numbers are correct
- Continued appraisee communication on the need for appraisal planning.
- Completed the ASPAT scoring feedback to appraisers prior to the appraiser training sessions which will be on quality assurance/feedback.
- Quality governance issues identified and taken forward by the Medical Director to the Board or the relevant governance group depending on the nature of the issue.

Actions still outstanding

Commented [RS1]: We have initiated this and hope to build on this in the future

Commented [RS2]: ?Alsion can update as to where this is at

Commented [RS3]: We have done this but yet more required!

Commented [RS4]: done

- To review the process for transferring information and concerns quickly and effectively between the Responsible officer in our organisation and other Responsible officers to streamline and standardise

Current Issues

Currently, a number of higher volume appraisers are not taking on new appraisees until approval leading to a shortage of appraisal slots.

New Actions:

- Update on progress with connecting IT system to GMC system.
- Update on progress of on-line appraiser training.
- Build understanding of the “Missed Approved/Not Approved” categorisation across the permanent medical workforce to help boost appraisal numbers.
- Set up a system to manage the Missed Not Approved appraisals
- Implement reporting of ‘Total number of agreed exceptions’
- Approval of Medical Appraisers remuneration business case required to support a new cohort of appraiser training
- Continues review of the revalidation and appraisal process with onward reporting to Board
- Ongoing dissemination of learning, and development of ways of recording and demonstrating that this learning has been effective.
- Streamline duplications between Quality Board and Operational Governance committee
- ‘Managing Capability Concerns of Medical and Dental Staff Policy’ has been reviewed, ratified and published.
- ‘Freedom to Speak Up: Raising Concerns Policy’ has been reviewed, ratified and published.
- Confirm ‘Medical Appraisal Policy’’ has been reviewed, ratified and published.

Section 7 – Statement of Compliance:

The Board of the Royal United Hospitals Bath NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Royal United Hospitals Bath NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _

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