Bundle Public Board of Directors 1 May 2024

0 Agenda
- 0.0 - DRAFT Public BoD Agenda May 24 v2.0 - 29.04.24

1 Chair's Welcome and Apologies
Paran Govender
Andrew Hollowood

2 Declarations and Conflicts of Interests

3 Written questions from the public

4 Minutes of the Board of Directors meeting held in public on 6 March 2024
- 4.0 - DRAFT - Public BoD Minutes March - v1.3 - 01.05.24

5 Action Log
- 5.0 - DRAFT Public BoD Action List March 24 v1.1

6 Governor Log of Assurance Questions and Responses (For Information)
- 6.0 - Governor Log of Assurance Questions v1.1 - 23.04.24
- 6.1 - Governor Assurance Log 2024 - 19.04.24

7 Items discussed at Private Board

8 Patient Story
- 8.0 - Patient Story cover sheet to Board of Directors 23.4.24 JAL Final

9 CEO and Chair's Report
- 9.0 - CEO Public BoD Report 01.05.24

10 Integrated Performance Report
- 10.0 - Trust Board IPR Cover Sheet April 2024
- 10.1 - Trust Board IPR Slides April 2024

11 MIS Combined Maternity and Neonates Quarterly Report Q3
- 11.0 - Matneo 2023 Q3 Final v4
- 11.1 - Q3 Report 202324.docx ATAIN Final
- 11.2 - Still birth and perinatal mortality report Q3 appendix 23-24

12 Delegation of Authority to Sign Off Quality Accounts
- 12.0 - Quality Account Coversheet for Board of Directors v1

13 Quality Governance Committee Upward Report
- 13.0 - QGC Upward Report to Board March 24 v1.2 - 24.04.24

14 People Committee Upward Report
- 14.0 - Apr 24 PC Upward Report

15 Research and Development Strategy
- 15.0 - Research Strategy Coversheet Board Apr24 v1.1
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16 Year End Position
- 16.0 - Year End Summary Public Board 01.05.24

17 Non-Clinical Governance Committee Upward Report
- 17.0 - Upward Report to Board NCGC 1 May 2024

18 Finance and Performance Committee Upward Report
- 18.0 - FPC Upward Report - 23.04.24

19 Audit and Risk Committee
- 19.0 - Upward Report Audit Risk Ctte 140324

20 Board Assurance Framework Summary Report
- 20.0 - Front Cover BAF for Board May 2024

20.1 - Board Assurance Framework Summary May 2024 - 2025

21 Any Other Business

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 MAY 2024, 13:00 – 16:00
VENUE: PAVILION FUNCTION ROOM, KINGSWOOD SCHOOL UPPER PLAYING FIELDS, LANSDOWN ROAD, BATH, BA1 9BH

Item	Item	Presenter	Enc.	For
OPENING BUSINESS				
1.	Chair's Welcome and Apologies: Paran Govender, Andrew Hollowood	Alison Ryan, Chair	Verbal	-
2.	Declarations and Conflicts of Interests		Pres.	-
3.	Written questions from the public		Enc.	I/D
4.	Minutes of the Board of Directors meeting held in public on 6 March 2024		Enc.	A
5.	Action Log		Enc.	A/D
6.	Governor Log of Assurance Questions and Responses (For Information)		Enc.	I
7.	Items discussed at Private Board		Verbal	I
8.	Patient Story	Toni Lynch Chief Nursing Officer	Pres.	I/D
9.	CEO and Chair's Report • ICS Update	Cara Charles-Barks, Chief Executive	Enc. / Verbal	I
10.	Integrated Performance Report	Joss Foster, Chief Strategic Officer	Enc.	I/D
The People We Care For				
11.	MIS Combined Maternity and Neonates Quarterly Report Q3	Zita Martinez, Director of Midwifery	Enc.	I/D
12.	Delegation of Authority to Sign Off Quality Accounts	Toni Lynch, Chief Nursing Officer	Enc.	I
13.	Quality Governance Committee Upward Report	Ian Orpen, Non-Executive Director	Enc.	I/D
The People We Work With				
14.	People Committee Upward Report	Paul Fairhurst, Non-Executive Director	Enc.	I/D
The People in Our Community				
15.	Research and Development Strategy	Kelly Spencer, Head of Research Operations	Enc.	A
16.	Year End Position	Pippa Ross-Smith, Deputy Chief Financial Officer	Enc.	I/D
17.	Non-Clinical Governance Committee Upward Report	Sumita Hutchison, Non-Executive Director	Enc.	I/D

18.	Finance and Performance Committee Upward Report	Antony Durbacz, Non-Executive Director	Enc.	I/D
19.	Audit and Risk Committee Upward Report	Paul Fox, Non-Executive Director	Enc.	I/D
Governance				
20.	Board Assurance Framework Summary Report	Christopher Brooks-Daw, Director of Governance / Chief of Staff	Enc.	I/D
CLOSING BUSINESS				
21.	Any Other Business	Alison Ryan, Chair	Verbal	-
Date of Next Meeting: Wednesday 3 July 2024, 13:00 – 16:00 Pavilion Function Room, Kingswood School Upper Playing Fields, Bath, BA1 9BH				

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE PUBLIC BOARD OF DIRECTORS
WEDNESDAY, 6 March 2024, 13:00 – 16:00
VENUE: PAVILION FUNCTION ROOM, KINGSWOOD SCHOOL UPPER PLAYING FIELDS, LANSDOWN ROAD, BATH, BA1 9BH

Present:

Members

Alison Ryan, Chair
Alfredo Thompson, Chief People Officer
Andrew Hollowood, Chief Medical Officer and Deputy Chief Executive
Antonia Lynch, Chief Nursing Officer
Antony Durbacz, Non-Executive Director
Cara Charles-Barks, Chief Executive
Christopher Brooks-Daw, Director of Governance / Chief of Staff
Jocelyn Foster, Chief Strategic Officer
Libby Walters, Chief Financial Officer
Nigel Stevens, Non-Executive Director
Para Govender, Chief Operating Officer
Paul Fairhurst, Non-Executive Director
Paul Fox, Non-Executive Director
Sumita Hutchison, Non-Executive Director

In attendance

Lucy Kearney, Head of Communications.
Michael Loffler, Finance Management Trainee Apprentice *(shadowing the Chief Financial Officer)*
Public Governors
Roxy Milbourne, Interim Head of Corporate Governance.
Pete Dixon, Membership and Governance Administrator *(minute taker)*

Apologies

Hannah Morley, Non-Executive Director
Ian Orpen, Non-Executive Director

BD/24/03/01 Chair's Welcome and Apologies

The Chair welcomed everyone to the meeting, and confirmed that apologies had been received from Hannah Morley and Ian Orpen, Non-Executive Directors.

BD/24/03/02 Declarations of Interest

The Board of Directors confirmed that they had no additional interests to declare.

BD/24/03/03 Written questions from the public

It was confirmed that there had been no questions submitted by the public.

BD/24/03/04 Minutes of the Board of Directors meeting held in Public on 10 January 2024

The minutes of the meeting held on 10 January 2024 were approved as a true and accurate record.

BD/24/03/05 Action List and Matters Arising
There were no actions to close on the action list.

BD/24/03/06 Governor Log of Assurance Questions and Responses
The Chair noted that the log of assurance questions was on the agenda for information.

BD/24/03/07 Item Discussed at Private Board of Directors meeting.
The Chair reported that the Trust had been awarded a grant of £21 million to make the site carbon neutral by 2030, however stressed that the Trust would need to find £3 million to be able to be qualify for the grant which presented a small risk.

The Chair explained that the Director of Research and Development had presented the draft Research Strategy during the private meeting, and that the final strategy would be presented at the May Public Board of Directors meeting.

BD/24/03/08 Patient Story
The Chief Nursing Officer introduced the patient story, the video highlighted the work which had been undertaken by staff to reintroduce the Trust Surgery Day Case unit. The video showcased the positive experience patients had using the facility, and emphasised the work the team had done to create a positive culture and patient centred approach to care within the unit.

The Chief Medical Officer explained that the Unit had increased the opportunities the Trust had to provide patients care and had changed the way the Trust would be able to provide care for them moving forwards.

The Chief Operating Officer confirmed that two years ago 75% of the Trusts performance occurred via day surgery, the new unit had increased the Trusts score to 84%. The Trust aimed to increase its score to 90%. She explained that the Trust benchmarked well nationally and against peers.

Nigel Stevens shared his appreciation of all the hard work the team had undertaken to achieve this, and stated that three areas stood out to him; the Team were always looking to improve patient care, the depth of patient feedback which the team had collated, and the patient centred approach to care which the staff had created.

Paul Fairhurst enquired if Saturday working hours would be formally introduced to staff. The Chief Operating Officer stated the Trust would investigate this for the 2024/25 business plan, and would be treated as core business.

The Chair asked if the Trust would need to pay staff at a premium rate if they worked on a Saturday. The Chief Medical Officer confirmed that the Trust would not need to pay consultants the premium rate. The Chief People Officer stressed that staff who were on the agenda for change pay scheme would be paid at premium rate.

The Board of Directors noted the patient story.

BD/24/03/09 CEO and Chair's Report

The Chief Executive presented her Chief Executive report and made the following key points;

- The Trust had invested heavily in a wide range of staffing groups, which enabled the Staff vacancies rate to decrease to its lowest rate of 2%.
- The Trust had reduce the amount of temporary staff it used and the overall head count, which had saved the Trust money.
- The recent industrial action caused a significant reduction in elective activity and meant some appointments and procedures needed to be rescheduled.
- There was a recent media story relating to a matter before the employment tribunal which members may have seen. The story also raised issues regarding patient experience and safety in particular regarding waiting times for oral cancer patients, appropriate use of NHS resources and procedures and approach to whistleblowing. All the issues were investigated at the time they were raised. The prioritisation of cancer patients was done in accordance with clinical guidelines and clinical leadership and was found to operating properly. Action was taken on matters unrelated to patient safety on appropriate use of NHS resources and procedures. The Trust does not use non-disclosure terms in settlements, but does ensure that staff uphold their duty of patient confidentiality. The Trust welcomes staff and patients raising concerns as a key route to learning and improving and does not discipline people for raising concerns. In order to provide assurance regarding patient safety concerns raised in 2023, the Royal College of Surgeons were invited to perform a note review of all cases from 2017 to current. This had been completed and would report its findings in 6-8 weeks.
- The Trust would be submitting an expression of interest to be part of "Martha's rule" trial, which would enable patients and their families to have 24/7 access to rapid review if a patient had suspected sepsis.
- Helena Ward had become the first ward at the Trust to be awarded Gold Excellent Care at Every Level (EXCEL) accreditation, which recognised the hard work the multi-professional team had been undertaking regarding patient care and to have created an environment which had enabled staff to thrive.

Antony Durbacz enquired if the Critical Care Team would be on a constant standby to assist with "Martha's care", or if they would be undertaking other work instead. The Chief Nursing Officer explained that the Clinical Outreach Team would be undertaking their normal role, as well as responding to any queries regarding Martha's rule. She highlighted that the team created a bridge for patients who had been discharged from the critical care wards.

The Board of Directors noted the report.

BD/24/03/10 Integrated Performance Report (IPR)

The Chief Nursing Officer provided an overview on the Integrated Performance Report and made the following key points

Workforce

The Trust had received the Staff Survey results but were under embargo until the 7th March 2024, an action list had started to be develop to overcome the challenges which the results of the survey had highlighted.

The Trusts vacancy rate had reached its lowest rate of 1.6%, and had seen a decrease in the turnover of staff. Agency spend was at 1% compared to the target rate of 3.5%, nursing agency spend rate was at 0.82% compared to the target rate of 3.2%. Sickness levels had remained the same as the previous month, but had reduced overall in a rolling 12 month period.

Quality
The Trust had not recorded any falls resulting in significant harm to patients in December but did record two category two hospital acquired pressure ulcers. The Trust birth to midwife ratio rate had been 1:23, which was an improvement on the previous months score, and had recorded no incidents where the label co-ordinator was not supernumerary and no incidents where 1:1 labour care had not been provided.

Operational Performance
The Trust's 62 day performance regarding elective care had improved to 71.2%, however Colorectal, Urology and Skin still presented the Trust with a challenge. The Trust had seen an average of 272 patients attend the emergency department, compared to 227 for the same period of time in 2023. The Trust had lost a total of 2279 hours in ambulance handover time, which was linked to higher bed occupancy rate of 94.8%. The Industrial action and mid-month rise in recorded infections had impacted bed capacity at the Trust with 55 case of flu and 19 cases of covid being recorded.

The Trust reported 4 hour a mapped performance of 66.4% and unmapped at 58.2%, which was below the trajectory for 76% delivery by the end of March 2024 nationally and 70% locally. The Trust had a greater focus in February, including non-admitted performance improvement, speciality response, and management plan within 2 hours and weekly breach review by the clinical divisional triumvirates.

Finance
The Trust had undertaken a large amount of work to reduce its expenditure in order to breakeven by the end of the 2023/24 financial year. The current best case scenario for the Trust would be a deficit of £3.5 million, however based on the current trajectory the Trust would end the current financial year with a deficit of £6.8 million, with a year to date the deficit £9.3 million. The Industrial action which had taken place in January had cost the Trust £2.3 million.

Antony Durbacz asked for clarification regarding the redflags in staffing incidents. The Chief Nursing Officer confirmed the roster system tracked how many nurses and health care assistants should be on shift and how many were on shift. She explained that there would be times when the staffing levels would not meet the need of the patients based on a variety of reasons. The system allowed staff to raise redflags when this occurred and explain the risks involved and the consequences, this would trigger matrons to be notified of the risks and determine if staff needed to be moved accordingly. The fill rates in the report were the important figure and a good indicator of safety at the Trust, she explained that the system enabled nurses to provide real time feedback about issues which effected them.

The Chief Operating Officer explained that the Trust's 4 hour of standard of care regarding patients attending the emergency department, was currently at 76% against

the targeted rate of 95%, and currently the Trust would reach the target of 76% in the next financial year. She explained that reaching the targeted rate would be a challenge for the Trust but would endeavour to achieve it. Antony Durbacz enquired if there would be any consequence for not reaching the target rate of 76%. The Chief Executive Officer confirmed that the Trust would not be able to access national legacy grant money, if the target was not met.

Paul Fairhurst asked what the Trust targeted percentage was regarding agency spend. The Chief People Officer confirmed that the Trusts aim was to avoid using agency staff where possible and felt the Trust could work towards agency free areas, especially in non-clinical corporate areas.

Sumita Hutchinson enquired how the Trust would improve Staff Health and Wellbeing. The Chief People Officer explained it was a point of frustration for him personally and a cultural challenge at the Trust, he felt that the best health and wellbeing intervention was to improve the quality of relationship between managers and their employee and getting the basic right for staff. He further explained that the Trust had invested in a team to investigate staff burnout.

Sumita Hutchinson wanted assurance that the Board of Directors would monitor the pressures that staff faced and how it affected their health and wellbeing. The Chief People Officer provided assurances that the Board would continue to monitor it via the People Committee.

The Board noted the Integrated Performance Report.

BD/24/03/11 Quality Governance Committee Upward Report.
On behalf of Ian Orpen, Nigel Stevens explained that the Committee had received a report from the Deputy Chief Medical Officer regarding the Trust's review of patient waiting list and the quality assessments. It has also received an in-depth presentation regarding the new Patient Serious Incident Review Framework (PSIRF).The Director of Midwifery provided the Committee with an update highlighting the quality improvement plan which the Midwifery Team had utilised to decrease rates of Postpartum (PPH) at the Trust.

The Chief Nursing Officer explained that the maternity team had undertaken work in response to the East Kent Report, and looked at all the insights which had been classed as low harm. The work had identified that the Trust could be an outlier for PPH, it changed the time of medication administration which decreased the chance of PPH occurring.

The Chair enquired if the Maternity Team had used the Learning Together Methodology to create their improvement programme and shared learning. The Chief Nursing Officer confirmed it had used the learning methodology and shared the results with the Local Maternity and Neonatal System.

The Board noted the upward report.

BD/24/03/12 Learning from Deaths Report Q2

The Chief Medical Officer provided the Board of Directors a summary of the report, he explained the report was the mechanism the Trust used on how to identify how patients died within the organisation, and highlight opportunities that may have been missed. The Trust had seen an improvement in the number of reviews which had taken place, however several areas still provided a challenge, one of which was gastroenterology.

The report highlighted that the Trust had four case of poor patient care, one of which related to a serious incident which had now been closed, another one had been investigated and found that the patient's death could have been avoidable. The Trust had two open in case in medicine and surgery.

The Trust had 16 inquests open, 35 inquests had been concluded, one inquest had required a member of staff to be in attendance. The Trust had one regulation 28 which had previously been reported to the Board of Directors, the Trust had gone back to the coroner regarding this, but as of the meeting had not had a response.

Paul Fairhurst asked what action had occurred regarding consultant staff availability in oncology. The Chief Medical Officer explained that large amount of additional administrative work in which consultants had to undertake was a problem across the Trust as a whole. He explained that recruiting administrators would help free consultants availability. Oncology had a specific issues due to limited amount of staff but the Trust was looking to overcome these via a recruitment drive.

Antony Durbacz asked if there was an option to modify the process, which would help with this but which would not produce too much risk. The Chief Medical Officer confirmed that the Deputy Chief Medical Officer was currently undertaking a review of the Quality process.

The Chair asked if anyone had quantified the data regarding productivity and how it had effected learning from Deaths. The Chief Medical Officer explained the best thing the Trust could do, was to ensure that it learnt from every death and make sure mistakes were not repeated.

The Board of Directors noted the report.

BD/24/03/13 Medical Revalidation Annual Statement

The Chief Medical Officer apologised that the statement had not gone via the People Committee before being presented to the Board of Directors. He explained that this was due to the Trust waiting for a high level review to take place, however it had been placed on hold due to industrial action. The Trust had seen an increase in the number of appraisals, and the amount of training which they had received. He stressed that consultants were aware that having one appraisal in a five year period would no longer be acceptable, and to date the Trust had not had to red flag any member of staff for not completing their appraisal.

Sumita Hutchison asked what the process behind revalidating consultants was and the data involved in it. The Chief Medical Officer explained that the Trust used a wide range of data, which included complaints and any associated incidents relating to the

consultants, as well as gaining information from clinical leads and line managers, to help triangulate all the data.

Antony Durbacz sought assurance that all consultants took part in this process. The Chief Medical Officer confirmed that appraisals were for the individual to engage with, he explained the Trust tried to avoid deferring appraisals unless that there was a valid reason behind it.

Antony Durbacz asked how the Non-Executive Directors could support the Executive Team with this process. The Chief Medical Officer confirmed he would reflect on this outside of the meeting.

The Board approved the annual report and statement of compliance for responsible officers and revalidation.

BD/24/03/14 Bi-Annual Nurse Staffing Review

The Chief Nursing Officer provided a summary of the review and explained that the Trust Staffing levels were aligned with targets the Board of Directors agreed in 2022. There had been one significant change in July 2023 where the Trust had agreed to utilise Band 6 Junior Sisters on all wards to help increase clinical leadership, this would take 12 months to achieve but would not need an increased level of investment.

The Care Quality Commission had performed an unannounced inspection of Medical Care in July 2023, the report included a 'should take' action which stated 'the Trust should continue to recruit additional Health Care Assistants (known as Health Care Support Workers within the Trust) to ensure establishment levels were met'.

The Trust fill rates were now at the targeted rate, and was finalising its annual staffing review, which would be presented at a future Board of Directors meeting.

The Board of Directors approved the paper.

BD/24/03/15 People Committee Upward Report

Paul Fairhurst explained that the Trusts 2023 gender pay gap report had not been discussed at the People Committee meeting but had agreed that NEDs who attended the committee, the Chief People Officer and the Deputy Chief People Officer could discuss it at their monthly meeting together. The meeting noted that the Trust had delivered against its commitment, and had delivered all bar one of its actions from the previous year's report. It was agreed that a local equality impact analysis would take place in clinical areas and would be presented to the People Committee at the same time as the Gender Pay Gap report to ensure that the data could be triangulated.

The Board noted the upward report.

BD/24/03/16 People and Culture Strategy 6 monthly update

The Chief People Officer provided an overview of the Trust's People & Culture Strategy and explained that the Trust agreed in 2022 the People Plan which aimed to ensure that people who worked at the Trust would be advocates for it and would recommend the Trust as a place to work. The Trust would deliver the people plan via four work streams;

Safe and inclusive environment, people feeling valued within the workplace, getting the basics right first time, and setting up staff for success.

Paul Fox asked where the Trust had scored regarding staff recommending the Trust as a place to work. The Chair explained that this information was embargoed until the 7th March 2024.

The Board of Directors noted the Trust's progress against the agreed People Plan, the workforce risks being addressed, and how the People Plan addressed workforce risks.

BD/24/03/17 RUH Anti-Racism Statement

The Chair welcomed the Head of Equality, Diversity and Inclusion to the meeting, she played the Anti-Racism video which had been created.

She explained that the Trust's Anti-Racist Statement set out the commitment and determination to make the RUH a place in which everyone could thrive. The statement had been written following two Board-development sessions and had been co-created with colleagues through the EDI networks. The Anti-Racism Statement contained a clear 'statement' of purpose and intent, to highlight that the Trust would be committed to being an anti-racist organisation.

The Chief People Officer thanked the large group of staff who had been involved to create the statement, it had taken 7 months of engagement which would set the Trust aside compared to its peers.

The Chair asked if the Intensive Care Team who featured in the video had created it from their own initiative. The Head of Equality, Diversity and Inclusion confirmed the team had worked together with the Trust Freedom To Speak Up Guardian to create it.

Paul Fairhurst felt the Board would need to continually reflect on how it would deliver the commitment it had made to embed anti-racism into the Board's own structures, processes and decision making

The Chief Executive thanked the Head of Equality, Diversity and Inclusion and the team for all of the hard work which had gone into creating the video and the statement.

The Board of Directors approved the Trust's Anti-Racism Statement and noted that the Council of Governors would review the Statement at their meeting next week.

BD/24/03/18 Non-Clinical Governance Committee Upward Report

Sumita Hutchison provided an overview of the upward report and explained that the Trust had a spent 2.4% on digital turnover compared to its peers, the solution to which was to utilise what the Trust had already in place. The Digital systems needed to be aligned with each other, which included a robust governance structure. She explained that the Trust only had two PA's of consultant time regarding clinical engagement. The Chief Medical Officer disagreed with this point, he highlighted that work had taken place, with a significant number of digital PAs and consultants who had identified themselves.

The Board of Directors noted the upward report.

BD/24/03/19 Finance and Performance Committee Upward Report

Anthony Durbacz gave an overview of the Finance & Performance Committee upward report to the meeting, he highlighted that the committee undertake a lot of work, and that the focus was to seek assurance that the Trust would hit its projected trajectory. The Committee was concerned about the Business plan, due to the size of the task the Trust was trying to achieve from a financial point of view, the second aspect of it, was that advice and guidance operationally had not yet been disclosed nationally.

The Board of Directors noted the upwards report.

BD/24/03/20 Charities Committee Upward Report

Sumita Hutchison explained that the Trust was still waiting for funding regarding the Green Heart. The Trust's Internal investment improved to £3.5 million, compared to £2.6 million from last year, and that the robotics' campaign had been achieved ahead of schedule due to the hard work from RUHX.

Nigel Stevens asked how the Trust compared to other charities. The Chief Strategic Officer explained that the Trust was being more efficient as a charity compared to previous years, and that the Trust had benchmarked well. The Chair felt that compared to other organisation the RUHX was very effective.

The Chief Medical Officer confirmed that he would be running the Bath Half Marathon on Sunday 17th March 2024 in aid of RUHX.

The Board of Directors noted the upward report.

BD/24/03/21 Any Other Business

No other business was discussed.

The Meeting closed at 15:05

Royal United Hospitals Bath
NHS Foundation Trust

Agenda Item: 5

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY 6th March 2024

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB600	No actions					

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**6**
Date of Meeting:	**1 May 2024**		

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 questions May 2024**

1. Executive Summary of the Report

This report provides 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 (NEDs). Governors are required to hold the NEDs to account for the performance of the Board and this is one way of demonstrating this.

One question (FEB24) was closed by the Council of Governors at their meeting on 14 March 2024. Six new questions (MAR24.1, MAR24.2, MAR24.3, MAR24.4, MAR24.5 and MAR24.6) were raised after the last report was presented in March 2024.

The Chief Nursing and Chief Medical Officers have provided a response to MAR24.1 and MAR24.2. Questions MAR24.3, MAR24.4, MAR24.5 and MAR24.6 were submitted to the Membership Inbox on 13 March 2024, and they have been submitted to the relevant Board members for response. Due to the detailed nature of the questions the Board members are still in the process of formulating a response and this will be circulated to the Council of Governors in due course.

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.)

There are no risks on the risk register.

5. Resources Implications (Financial / staffing)

There are no resource or financial implications.

6. Equality and Diversity

All Governors no matter their background can input into the NED questions.

7. References to previous reports

March 2024.

8. Freedom of Information

Public

9.	Sustainability
Governors have asked questions on various topics including sustainability.	

10.	Digital
Governors have asked questions on various topics including digital.	

Royal United Hospitals Bath
NHS Foundation Trust

Appendix 1: Governor Log Assurance Questions

Date:	**4 March 2024**
Source Channel	**Email Sent to the Membership Inbox on 4 March 2024.**
Date Sent & Responder	Sent to Toni Lynch, Chief Nursing Officer and Jason Lugg, Deputy Chief Nursing Officer on 4 March.
Question and ID	**MAR24.1 -** Can the Governors receive clarification regarding the reported days without pressure ulcers on Peirce Ward, given the conflicting figures provided by various sources including Quality Governance Committee, social media and the Governor Quality Working Group. The discrepancies in the reported data undermine confidence in the accuracy and integrity of the information provided.
Process / Action	Sent to Toni Lynch, Chief Nursing Officer and Jason Lugg, Deputy Chief Nursing Officer on 4 March. Response circulated on 27 March 2024.
Answer	Thank you for your email and assurance question relating to pressure ulcer data for Pierce Ward. I have reviewed the Quality Reports and the minutes for each of the meetings and I do understand how the presentation of data could be confusing. My summary is as follows: •There was no Quality Report presented at the Board of Directors meeting in November 2023. I therefore assume that any reference to the number of days that Pierce Ward was pressure ulcer free was verbal. •At the December 2023 Quality Governance Committee, the data presented was from September 2023. There was no specific reference in the Quality Report to the number of days the Pierce was pressure ulcer free. Again I can only assume that any reference was verbal in nature. •Reporting at the Governors Quality Working Group in February used the January Quality Report which was November 2023 data. I recall verbally stating at the meeting that the number of days Pierce Ward had been pressure ulcer free was likely to be higher but I had been on leave and was not familiar with the latest data. I am sorry for the confusion that this has caused. Toni or I will often provide a verbal real time position which will be different to the Quality Report as the data is reported 2 months in arrears to allow for analysis and validation. I am sure the Governors will agree that there has been a significant improvement in pressure ulcer care on Pierce Ward and this is something to be celebrated.
Closed?	Open. To be closed at the Council of Governors meeting on 13 June 2024.

Date:	**5 March 2024**
Source Channel	**Email Sent to the Membership Inbox following Strategy and Business Planning Working Group on 8 February 2024**
Date Sent & Responder	Sent to Chief Medical Officer, Deputy Chief Medical Officer and Physician Associate Leads
Question and ID	**MAR24.2 -** 1. How does the Trust address the significant pay disparity between Physician Associates, Anaesthetic Associates and Junior Doctors, ensuring alignment with the triple aim duty? 2. What provisions has the Trust made to address potential unfair pay claims related to the employment of Physician Associates and Anaesthetic Associates? 3. How does the Trust ensure sustainable employment of Physician Associates and Anaesthetic Associates considering any funding incentives and the triple aim duty? 4. How does the Trust ensure patients are adequately informed about Physician Associate and Anaesthetic Associate roles to facilitate informed decision-making, aligning with the triple aim duty? 5. How will the Trust monitor and address Never Events associated with Physician Associates and Anaesthetic Associates to ensure patient safety and quality of care, in line with the triple aim duty? 6. What measures are in place to ensure that Physician Associates and Anaesthetic Associates work within their defined scope, considering the triple aim duty? 7. How are PAs deployed and supervised at RUH, ensuring alignment with the trust's objectives and the triple aim duty? 8. How is it viable for doctors to supervise Physician Associates and Anaesthetic Associates considering the triple aim duty? 9. What measures are in place to ensure equitable access to training and development opportunities for all staff members, considering the long-term implications for the development of our future senior medical staff and alignment with the triple aim duty? 10. Will the Trust suspend further recruitment of Physician Associates and Anaesthetic Associates until evidence is provided that their roles are safe, cost-effective and aligned with the triple aim duty of improving health outcomes, enhancing service quality and ensuring resource sustainability?
Process / Action	Sent to the Chief Medical Officer, Deputy Chief Medical Officer and Physician Associate Leads on 5 March for response. Response circulated via email on 13 March 2024.
	1. Pay scales are agreed nationally, with PAs and AAs on Agenda for Change (AfC) and junior doctors on doctors' national contracts. This means we cannot amend nationally set pay scales. There are no AAs employed in the Trust and there are no plans to establish these posts. All new posts in the Trust are reviewed prior to advert to determine what professional is the most appropriate to ensure we meet the triple aim duty. Most PAs in the Trust are in posts that we were unable to fill with alternative clinical professionals, so they fulfil an otherwise unmet need. 2. The RUH uses the NHS job evaluation scheme, which allows NHS jobs to be matched to nationally evaluated profiles, based on information from job descriptions and person specifications. There are two nationally evaluated profiles for Physician Associates, both used by the RUH and can be found here. Aligning job descriptions to national profiles minimises the risk of equal pay claims. 3. There are currently no funding incentives in hospitals to employ PAs or AAs. If incentives are forthcoming in the future, we would only employ PAs if we could ensure a clear plan for sustainability once any incentive ends. All posts are reviewed before they are advertised through well-established processes, and this would be the same for any PA expansion. 4. In common with all clinical staff, PAs are expected to introduce themselves to all patients and wear an identity badge with their name and role. They are expected to explain their role in their team and that they are not a doctor (but work as part of the medical team under the supervision of a doctor). We are currently exploring if a trust uniform for PAs would be helpful for the general public. 5. All Never Events are investigated and reviewed at Trust level. If an event involves a PA, it will be investigated in the same way as any other event. Part of this investigation will always include the roles of all those involved to determine if an inappropriate level of clinician contributed to the issue. 6. All PAs currently employed within the Trust have a clearly defined scope of practice, individualised to their area of work. Every PA has a named Consultant supervisor responsible for monitoring their work to ensure they do not work outside their scope of practice. Further we ensure that they have appropriate training to do the role. Any issues with PAs being asked to work beyond this can be escalated to the departmental lead or the trust PA lead. We have a Consultant Geriatrician who is our Trust PA Lead to oversee this new role.

Answer	7. There is not a lead PA currently in the Trust but there is a Consultant who leads on PA development. There are 3 PAs in Haematology working on the ward, day unit and in clinic. They have consultant supervision at all times to ensure safe practice. They also all have a named educational supervisor, responsible for ensuring they have regular appraisals and career progression. They were appointed following a business case to expand the Haematology department and to deal with gaps in service provision. They provide weekend cover for the Haematology ward with a Consultant always in the building supervising them. There are 2 PAs in General Surgery. They have a named supervisor and work as part of the surgical team ensuring patient care is provided in a timely manner. One of these PAs works predominantly on the in-patient wards supporting the FY1 doctors, the other supports the colorectal 2week wait pathway triaging referrals against a set protocol. Both have a dedicated Consultant supervisor. There are 2 PAs in the Stroke Department (less than full time as one PA has teaching commitments in University of the West of England). They support the medical team in providing care for ward patients. They have a named supervisor and work on the ward with a team of Advanced Care Practitioners and Specialty Doctors plus a supervising Consultant of the day. There is one PA in Breast Surgery. This post has started recently and they remain in training. Ultimately the aim is for this PA to support the clinical team in providing care for outpatients and inpatients. They have a named supervisor and are currently supernumerary in their role. All the PAs currently employed are in post to support the other clinicians. They can perform blood tests, insert cannulas and provide clinical assessment of differentiated patients. They are able to complete admin tasks otherwise done by doctors such as discharge letters and discharge discussions with patients and their families. This saves time and helps support doctors being able to attend training such as clinics and procedure lists. There will be clear pathways for career progression for PAs within each department (under development currently). These pathways will be reviewed centrally to ensure they do not negatively impact training for doctors. 8. As a Trust, we have only put PAs in post when there was a need that could not be met by an alternative or where meeting that need with a doctor would negatively impact upon their medical training. Every department employing PAs has a clear plan in place to ensure that supervision of PAs does not negatively impact on doctors' workload. For instance, in Haematology, employing PAs to work at weekends means the Consultant on the ward can focus on the clinical review of patients while the PA supports this. In General Surgery the PA triaging 2ww referrals mean the registrars have more training time in theatre. 9. Each department is responsible for training for all staff within the department. All departments are aware of the need to ensure doctors in training can access their required education to ensure they develop to be consultants in the future. In most departments employing PAs, they are used to support trainees rather than compete for training opportunities. The aim of the trust in future is to ensure that any new PA post clearly specifies how the post will support trainees to meet their educational requirements as well as improving patient care. In this Trust, we have a long history of employing Nurse Practitioners who support the medical teams and provide local knowledge to ensure the best care for patients. The expectation is that PAs will do the same in future. PAs should be appointed as well as doctors, in a supporting role both for patients and clinicians, while also ensuring PAs have access to career development to aid retention. 10. The Trust has not committed to suspending further recruitment of PAs but all proposed posts need to be scrutinised and authorised by the Deputy Medical Director (Workforce.) Specific need for these roles needs to be articulated by the specialty as well as the positive impact they will have on doctors and medical training. For assurance purposes a job description, clear supervision and line management will be established (as currently). New legislation whereby the GMC will become a multi-professional regulator will help assure patients, colleagues and employers that PAs are appropriately educated, qualified and safe. The GMC is clear that they are not doctors, and can't replace them but can play an important role within a multidisciplinary team.
Closed?	Closed at the Council of Governors meeting on 14 March 2024.

Date:	**13 March 2024**
Source Channel	**Email Sent to the Membership Inbox on 13 March 2024.**
Date Sent & Responder	Sent to the Chief Nursing Officer for response on 18 March 2024
Question and ID	**MAR24.3 -** 1. Can assurance be provided that the hospital administration is actively addressing concerns raised by cleaning staff regarding safety, workload, and training adequacy? 2. How confident are we that measures are in place to enable cleaning staff to feel safe and supported in raising concerns through appropriate channels? 3. Can assurance be given regarding efforts to ensure that new cleaning staff receive sufficient training to perform their roles effectively and safely, considering the recommended duration compared to the current duration? 4. How assured are we that the hospital is effectively managing staffing shortages to prevent cleaning staff from frequently working alone without necessary support? 5. Can assurance be provided that protocols are in place to facilitate assistance from clinical staff for cleaning tasks involving heavy furniture and equipment? 6. How confident are we that the hospital is ensuring proper utilisation of the new microfibre mop system, including the necessary frequency of steam cleaning? 7. Can assurance be given regarding strategies to mitigate the absence of a dedicated level 2 cleaning team and the associated workload and efficiency challenges for cleaning staff? 8. How assured are we that cleaning staff consistently adhere to infection control protocols, including the proper removal of PPE when exiting level 2 rooms/zones? 9. Can assurance be provided that procedures are in place to ensure the safe transportation of dirty mops and microfibre cloths to prevent contamination of patient and public areas? 10. How confident are we that the hospital effectively monitors and enforces compliance with protocols for the transportation of cleaning equipment to minimise the risk of cross-contamination in patient care and public areas? 11. Can assurance be provided re the hospital's response to the reported escalations in infection levels, including any measures being taken to investigate contributors such as cleaning standards, and the implementation of corrective actions where necessary?
Process / Action	Sent to Toni Lynch, Chief Nursing Officer for response on 18 March 2024.
Answer	
Closed?	Open

Date:	**13 March 2024**
Source Channel	**Email Sent to the Membership Inbox on 13 March 2024.**
Date Sent & Responder	Sent to the Chief People Officer, Paul Fairhurst and Sumita Hutchison, Non-Executive Directors for response on 18 March 2024
Question and ID	**MAR24.4 -** How does the trust ensure that 'Freedom to Speak-Up' effectively safeguards employees who raise concerns, especially in light of recent reports in media about a senior staff member alleging that they were sacked for whistleblowing?
Process / Action	Sent to the Chief People Officer, Paul Fairhurst and Sumita Hutchison, Non-Executive Directors for response on 18 March 2024
Answer	
Closed?	Open

Date:	**13 March 2024**
Source Channel	**Email Sent to the Membership Inbox on 13 March 2024.**
Date Sent & Responder	Sent to Toni Lynch, Chief Nursing Officer for response on 18 March 2024.
Question and ID	**MAR24.5 -** Drawing from the lessons learned from the Mid Staffordshire scandal, and in light of recent concerns regarding potential compromises to safe staffing levels and patient safety amidst financial considerations, could the Board reaffirm its commitment to guiding strategic direction and ensuring that executive decisions prioritise patient safety above financial targets? Specifically, could the Board provide insights into the overarching strategies in place to maintain safe staffing levels, monitor workload pressures, and support staff well-being, thereby upholding the trust's duty of care to both patients and employees, while actively mitigating risks associated with historical incidents such as Mid Staffordshire? Furthermore, acknowledging the decision to delay replacing the Director of Estates & Facilities, and entrusting the responsibility to the Director of Nursing on an interim basis, how does the Board plan to ensure that essential functions are adequately overseen during this transition period, while proactively addressing any potential gaps in expertise to safeguard against adverse impacts on patient care and safety?
Process / Action	Sent to Toni Lynch, Chief Nursing Officer for response on 18 March 2024.
Answer	
Closed?	Open

Date:	**13 March 2024**
Source Channel	**Email Sent to the Membership Inbox on 13 March 2024.**
Date Sent & Responder	Sent to Paran Govender, Chief Operating Officer for response on 18 March 2024.
Question and ID	**MAR24.6 -** Can the governors be provided with assurance that steps are being taken to address these concerning incidents and improve the care and dignity of patients during ambulance handovers?
Process / Action	Sent to Paran Govender, Chief Operating Officer for response on 18 March 2024.
Answer	
Closed?	Open

Royal United Hospitals Bath
NHS Foundation Trust

Date:	**20 February 2024**
Source Channel	**Email Sent to the Membership Inbox / Membership and Outreach Working Group**
Date Sent & Responder	Sent to NEDs on 27 February 2024
Question and ID	**FEB 24-** Have the NEDs received assurance and reassurance that the Trust is working closely with the ICS, and in particular BaNES Council, to address the discharge of patients from hospital to more appropriate community settings?
Process / Action	Sent to NEDs on 27 February 2024. Response provided by Nigel Stevens, Non-Executive Director on 5 March 2024.
Answer	The NEDs through both Board meetings and assurance committees have continually reviewed actions in hand to improve discharge options and consequently reduce the numbers of patients who fall into the Non-criteria to Reside category. The NEDs have been provided with evidence of significant work that has taken place with all key stakeholders, most notably BaNES to manage the complex pressures, both operational and financial, facing all agencies. NEDs have also noted that significant improvements in the relationships between key stakeholders has lead to advances in discharge management, but recognise the significant challenges still faced. NEDs will continue to focus on these very important issues including some of the changes happening in local care provision.
Closed?	Closed at the Council of Governors meeting on 14 March 2024.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**8**
Date of Meeting:	**1 May 2024**		

Title of Report:	**Patient Story**
Status:	**For discussion**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Sharon Manhi, Lead for Patient and Carer Experience**
Appendices	**None**

1. Executive Summary of the Report

Patient stories help to bring patient experiences to life. They help us to understand what we are doing well and where we need to improve.

The Trust is committed to listening and acting on what matters most to patients and their families. This supports the Trust vision for '*the people we care for'* making them feel safe, cared about and always welcome.

The purpose of presenting a patient story to the Board members is to:

- Set a patient focussed context to the meeting
- By filming patient stories, making them more accessible to a wider audience
- For Board members to reflect on the impact of the lived experience for the patient and their family and its relevance to the Trust's strategic objectives.

Patient/family and staff experience of adolescent mental health on the Children's ward.

This is the story of a 12 year old girl 'M' and her mum Fiona's experience of the care she received during her admission to the Children's ward on 14 February 2024 until she left hospital on 15 April 2024.

Following concerns about her severe weight loss 'M' was referred by her GP to the RUH. She was diagnosed with Avoidant Restrictive Food Intake Disorder (ARFID).
Fiona felt that decision-making and communication between the Child and Adolescent Mental Health Services (CAMHS) and the RUH could have been more effective and that this led to delays in the care and treatment of her daughter.

Background and context

The Royal College of Paediatrics and Child Health (RCPCH) report that childhood mental health problems are common and increasing across the UK. It is estimated that almost one in in five (18%) children aged 7-17 has a probable mental disorder, a 50% increase from 12% in 2017. While some of this reflects longer-term trends, the COVID-19 pandemic had a stark impact on the mental health of many children and young people across the country.'

Impact on the Children's ward staff

1. **Environment** – the layout of the ward and the difficulty of having adolescents

with mental health needs being cared for alongside younger children. The challenges include maintaining the privacy of young people; having a separate quiet space.

2. **Education and training needs** – the clinical teams and nursing leadership have identified the need for additional training to care for young people with mental health needs.
3. **Changing workforce needs** – some hospitals have successfully recruited mental health support workers. These staff may assist with tasks such as medication, crisis intervention, facilitate therapeutic activities and provide emotional support.
4. **Collaborative working** – there are opportunities for clinical teams internally and externally to work more in partnership to support young people with mental health needs.

Actions and next steps

- A review of the **ward environment** will be undertaken in terms of identifying a suitable clinical areas to provide mental health care.
- **Review swipe access out of the ward** – there is swipe access to get into the ward and most but **not all areas** of the ward have swipe access to get out.
- **Making every day count** – improved working with external teams.
- Young people with **lived experienced** are working with staff to develop training in communicating skills.
- **Conflict de-escalation training** is the delivery of personal safety and conflict management training.
- **Review of the staffing skill mix** and recruitment of mental health support workers.

2.	Recommendations (Note, Approve, Discuss)
The patient story is for discussion.	

3.	Legal / Regulatory Implications
Health and Social Care Act 2012 to improve accountability and empower patients Health and Care Act 2022 to support collaboration and partnership working to integrate services for patients. The Care Act 2014 recognising the equal importance of supporting carers and the people they care for.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)
A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.	

5.	Resources Implications (Financial / staffing)
The impact of the COVID-19 pandemic has resulted in an increase in the numbers and acuity of young adolescents with mental health problems and attempted self-harm being admitted to the Children's ward. This has an impact on the emotional and physical wellbeing of the ward staff.	

6.	Equality and Diversity
Ensures compliance with the Equality Delivery System (EDS).	

7.	References to previous reports
Monthly Quality Reports and Quarterly Patient Experience reports to the Trust's Quality & Safety Group, Quality Governance Committee and the Board of Directors.	

8.	Freedom of Information
Public.	

Report to:	Public Board of Directors	Agenda item:	9
Date of Meeting:	1 May 2024		

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 finance, people and performance
- Finance
- People
- RUH Reduces Carbon Footprint by Switching Nitrous Oxide Delivery
- RUH in the top 20 best NHS Hospitals to work for in the country
- RUH granted planning permission to build the Sulis Elective Orthopaedic Centre
- Royal National Hospital for Rheumatic Diseases (RNHRD) recognised as a Centre of Excellence for treating Paget's disease
- RUH Maternity Services retain outstanding rating from the CQC
- Unannounced CQC inspection of the Surgical Division
- Outpatient Improvement Programme team shortlisted for HSJ Digital Award
- RUH opens refurbished Cath Lab for Cardiology patients
- RUH celebrates £21.6m grant for energy efficiency projects
- New Dyson Cancer Centre at the RUH welcomes first patients
- ICU Improvement Works
- Lansdown Restaurant Refurbishment
- RUH Membership
- Consultant Appointments
- Chairs 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

Elective Recovery for March showed another positive position with value of activity against 19/20 of 111% and against 23/24 plan of 106%. The positive financial position was reflected in our activity figures with 109% of 19/20 and 102% of 23/24 plan. ENT income increased by £85k compared to £32k over last month; this is driven by case mix change (including inpatients) and a higher volume of outpatient attendance. Gastroenterology increased slightly on income earned with the total rising by £83k to £235k in month. Oncology was driving the small increase in month, with income up £15k from February.

In February, 62 Day performance was 67.6%. Urology recorded the most breaches, the majority of whom were patients with prostate cancer. Breaches were due to a combination of longer waiting times for MRI, biopsy and surgery. The December/January junior doctor strike also led to delays in first diagnostics for some patients. Colorectal remained the specialty with the most challenged performance with breaches due to outpatient and diagnostic waiting times as well as for Oncology appointments. Skin performance was impacted by delays to excisions and an increased number of patients undergoing biopsies before primary treatment, leading to extended pathways. The 62 day backlog position recovered during February and March, ensuring the Trust overachieved against the end of year fair shares target.

RUH 4-hour performance in March was 69.8% (mapped) and 62.2% on the RUH footprint (unmapped). This is an improved position from February, however did not meet the revised H2 trajectory submitted to NHS England of 76.0% for March. Attendances during March increased further than the previous month to 9,246 (February 7961 and March 2023, 7830), which was above the upper control limit and the highest number of attendances the RUH has seen in one month.

There had been an increase in ambulance conveyed patients (2,392) compared to previous months (February 2,082 and January 2,309). Urgent Care saw an improved 4-hour performance in March, achieving 80.2%, however Majors saw a small reduction compared to the previous month. The Urgent and Emergency Care improvement plan will be refreshed in April 2024 in line with the national operating guidance to achieve 78% performance. Improvements in month include - senior operational and nursing staff linking with the site team in place 08:00 – 22:00 to drive performance and planning at 2 hours from patients' arrival, including UTC performance improvement to 80% (ambition to sustain 85%), non-admitted performance improvement with clinical specialty response as part of the Trust-wide response and clinical division review of breach analysis to direct improvement focus.

2. Finance

The NHS is required to achieve an in-year break even position for the 23/24 financial year. At the end of October, we were forecasting a year end run rate deficit of c.£20m. To improve this position a recovery programme of £11m was devised requiring a significant amount of work to be undertaken in reducing expenditure with the aim of achieving a breakeven position. The recovery programme encompassed initiatives such as reduced temporary staffing usage, reduced head count, additional elective activity and controlled spending on goods and services. This enabled the RUH to turnaround it financial position and deliver against its -£3.5m deficit financial control total, whilst supporting the system to

deliver an NHSE agreed -£17.9m control total. In achieving this position, the RUH delivered £23.5m in Quality, Innovation, Productivity & Prevention - QIPP efficiencies.

3. People

Throughout the past few months the Trust have worked incredibly hard to plan for the next financial year which is now underway. As previously described a great deal of emphasis has been placed on planning our workforce for the 2024/25 financial year. We now have submitted a refined 2024/25 workforce plan that underpins our new approach; integrating finance, activity and performance plans.

Our managers within the Trust have been continuously involved with our workforce planning approach this year, ensuring they have the best support for their areas.

The plans for this financial year continue with the cost effective use of resources through RUH Staffing Solutions (our Bank), including limited reliance on Agency Workers. On occasions when we need to use an agency worker, we'll adopt best practice utilising framework suppliers demonstrating compliance with clear exit plans to minimise spend.

As the Workforce Plans are finalised, we will be communicating them out everyone, to build understanding of how the workforce planning process can enable teams to make the best possible use of resources.

Underpinning everything we do is our People Plan. As a portfolio of work, the People Plan has been captured in eleven programmes, spanning a three-to-five-year period, with associated projects. Each programme and associated projects has been defined and was approved by the People Committee in March 2024.

Here are some highlights from our programmes that enable delivery of the People Plan:

<u>People Plan Programme 1 – Foundations</u>

We are currently developing the People Hub, which is our 'one stop shop' in the People Directorate for managing HR and medical workforce queries. The team has started work on a set of new manager guidance for the main HR policies. The first guidance to be published will be later this month (April 2024) for Supporting Attendance. The HALO case management system has been procured and we are planning scope and implementation. A Service Directory is also being developed to explain to staff and managers what support they can expect from the People Hub.

In January 2024, the onsite nursery reopened. Work is also ongoing to re-open the staff gym. Getting pay right: Team structure, new processes and training with the Recruitment Team completed, to improve getting pay right for new joiners. The next stage is working on improvements for leavers and existing staff.

Nutrition & hydration: A new hydration station has opened in the Atrium and the Lansdown refurbishment was completed in April 2024. Rest & break areas: Staff break areas on Forrester Brown and Helena have been refurbished with the rest area on Waterhouse ward nearing completion.

<u>People Plan Programme 4- Diverse and Inclusive</u>

The 2023 Staff Survey results showed a very slight improvement in our scores on 'inclusivity' (but not enough to be statistically significant). The Trust also launched its Anti-Racist statement in March 2024. Work is underway to undertake targeted team

development interventions (in collaboration with HR) to address identified issues, including Emergency Medicine. The planned introduction of Report and Support in May 2024, to be linked with RUH People Hub – will allow better and swifter support to areas most affected by discrimination.

People Plan Programme 7 – Leadership
A work plan went to the March 2024 People Committee bringing together the currently disparate leadership development offers (amongst other things) clearly defined leadership cohorts; leadership development programmes for each cohort; enhanced visibility of external leadership programmes; and profession specific pathway models for leadership development.

Despite gradual progress and continued promotion with improved technology (Learn Together), we have been unable to achieve the required 90% appraisal uptake. A session is planned for April 2024 to engage wider stakeholders and understand the root cause of low appraisal uptake.

People Plan Programme 8 – Workforce Planning
To complement the workforce plan described earlier, an improvement tool called the Calderdale Framework is being implemented. This Framework is an evidence based workforce transformation tool which can be used to rapidly identify skill sets required by services and their populations. Training dates are in place at the RUH for April and May 2024.

People Plan Programme 9 – Talent Acquisition
This quarter we'll also be launching our employer value proposition to showcase all that the RUH has to offer to current, potential and future employees supporting attraction, engagement and retention.

A central Vacancy Control and Agency Reduction Panel continues to support having the right people, in the right posts against our workforce plans. The new controls and scrutiny are a fundamental element of the financial recovery plans.

People Plan Programme 10 – Temporary Staffing
The Agency Reduction plan continues to support the Trust to be within or below our internal target position. The work supports managers to develop exit plans for agency workers by recruiting substantively, if required or moving high cost workers onto the Bank, moving to framework suppliers to secure price caps which all supports financial savings and increased compliance.

The South West Regional Agency Rate card for nursing is going live in April 2024 with a further planned stepped reduction in July to reach NHS price cap. A Bank rate review is also underway to ensure we operate a fair and transparent approach to our rates which demonstrates value for money and competitive within labour market.

We enter the new financial year with excitement and enthusiasm in delivering the People Plan and ensuring it continues to support the vision of being one of the top three Trusts that staff recommend as a place to work.

4. RUH Reduces Carbon Footprint by Switching Nitrous Oxide Delivery

The RUH has reduced 2% carbon emissions by a simple switch to using portable gas canisters reducing our N2O usage from 2million litres to 13,500 litres a year. The staff led

project has made a huge contribution to the Trust's ambitious sustainability targets by decommissioning its entire nitrous oxide manifold which is the system that delivers the gas to the pipelines around the hospital.

5. RUH in the top 20 best NHS Hospitals to work for in the country

In the latest NHS Staff Survey, colleagues have rated the RUH as one of the best hospitals to work for in the whole of England and top three in the South West. Nearly 2,500 people – or 68% of those surveyed - said they would recommend the RUH as a place to work. That's 600 more than the previous year, and puts the RUH 18th out of 122.

The RUH's NHS Staff Survey results also show that an increase of nearly 500 people say they look forward to going to work, 530 more said they feel trusted to do their job, and 440 more said they are able to make improvements happen.

The RUH is 6th nationally for colleagues saying they have frequent opportunities to show initiative, and 8th for being kind and understanding towards each other.

6. RUH granted planning permission to build the Sulis Elective Orthopaedic Centre

Sulis Hospital, Bath will soon be able to perform an additional 3,750 non-emergency, orthopaedic operations for NHS patients each year, following a successful planning application submitted by the RUH.

The plans, which were approved by B&NES Council on 6th March, will see a new wing built at Sulis Hospital, a fully operational independent hospital owned by the RUH that treats both NHS and private patients.

The Sulis Elective Orthopaedic Centre (SEOC) will act as an NHS elective surgery hub. The new development, which has secured £25m in national NHS funding, will be a centre of excellence, working to national best-practice standards and providing high-quality care. Surgery at the site will be protected from disruption and cancellations caused by surges in emergency hospital admissions because Sulis does not have an emergency department. This means that the SEOC will enhance the resilience of services into the future.

7. Royal National Hospital for Rheumatic Diseases (RNHRD) recognised as a Centre of Excellence for treating Paget's disease

The RNHRD has been recognised as the first Centre of Excellence in the South West for its treatment of patients with Paget's disease and its research into the condition. The coveted honour, from the Paget's Association, recognises the RNHRD's diagnostic and treatment facilities, the clinical expertise of its staff, the number of patients cared for and its involvement in Paget's disease research.

8. RUH Maternity Services retain outstanding rating from the CQC

RUH maternity services are in the top three per cent in England following a recent inspection by the Care Quality Commission (CQC) which saw the team retain its 'outstanding' rating. Following the inspection in November 2023, inspectors found examples of outstanding practice relating to the RUH's commitment to continuously improving services, patient experience and the supportive environment provided for staff.

The development of a maternity and neonatal communication plan to improve engagement with staff was noted as 'outstanding practice', as was our Maternity Development Panel,

which supports staff to develop their own projects and ideas to further improve the care we provide for our community.

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

9. Unannounced CQC inspection of the Surgical Division

The CQC undertook an unannounced inspection of the Surgical Division on 20 and 21 March 2024.

The CQC undertook the inspection under the single assessment framework, focussing on elements of safe, effective, caring and well-led. The Trust awaits the draft report from the CQC.

10. Outpatient Improvement Programme team shortlisted for HSJ Digital Award

The RUH outpatient Improvement Programme team have been shortlisted for a HSJ Digital Award for their work to roll out DrDoctor across the Trust.

The project has been shortlisted in the Supporting Elective Recovery Through Digital category and recognises the impressive improvements that DrDoctor has helped us achieve.

DrDoctor is a Patient Engagement Platform (PEP) that enables the RUH to communicate more effectively with patients. Some of the features that are already live include reminders about upcoming appointments and appointment letters sent via text message or email. The platform was launched to RUH patients in September 2023 and already this has seen 4,560 fewer missed appointments, and saved more than 21,000 letters being posted.

11. RUH opens refurbished Cath Lab for Cardiology patients

The RUH's oldest cardiac catheterisation lab, also known as a cath lab, has been completely transformed to bring it up to date with the latest state-of-the-art equipment. The three-month project has seen the first GE Allia IGS 520 Pulse lab in the country installed, providing cutting edge technology for the people we care for.

The new kit gives staff access to the latest treatment and diagnostic technology a cath lab can offer, including a reduction in the X-ray radiation dose delivered to patients undergoing tests. This particular lab was tailored to provide enhanced support to the implantation of pacemakers and complex devices like cardiac defibrillators.

12. RUH celebrates £21.6m grant for energy efficiency projects

A £21.6million decarbonisation grant will bring the RUH one step closer to achieving its net zero goals.

The multimillion pound cash boost, awarded by the Department for Energy Security and Net Zero as part of the Salix Public Sector Decarbonisation Scheme phase 3c, will fund improvements including more environmentally friendly lighting, insulation, and heating and cooling controls.

Most of the vital funds will be used to de-steam much of the RUH's 52-acre site, a process that will see the hospital's ageing heating systems replaced with more energy-efficient options such as heat pumps. Together, these initiatives will make the hospital more sustainable, and a more pleasant environment for all those who use it.

When the proposed improvements are completed, by 2026, they will result in an estimated 24% annual reduction in carbon emissions over which the RUH has direct control. This equates to just over 3,400 tonnes of carbon dioxide – the equivalent of just under 1,000 return flights to Seoul, or more than 150,000 car journeys from Bath to London, every single year.

13. New Dyson Cancer Centre at the RUH welcomes first patients

The new Dyson Cancer Centre welcomed its first patients on Monday, 22 April 2024. The purpose built centre brings together many of the RUH's cancer services under one roof to provide a cancer services hub for over 500,000 people in the South West.

The new centre is backed by over £40m in Government funding as part of the New Hospital Programme. The Dyson Cancer Centre was also supported by an additional £10m fundraising campaign from RUHX, the hospital's official charity, including a £4m donation from the James Dyson Foundation and £1m by the Medlock Charitable Trust

A key feature of the new centre is the Macmillan Wellbeing Hub, supported by a £1.5m donation from Macmillan Cancer Support. The three storey hub will provide a welcoming, non-clinical space designed around the needs of patients and their families. It will also include comfortable accommodation where relatives and loved ones can stay overnight.

14. ICU Improvement Works

On 17th April work began to combine the two separate intensive care units at the RUH into one newly-refurbished space.

The second intensive care unit, B36, was opened during the pandemic. This additional capacity is still much needed in order to support us to provide the best possible care to our sickest patients, however, there are challenges to running two separate ICUs – especially as one is downstairs and one is upstairs.

The new ICU single footprint space will greatly improve patient flow and experience and also provide a more seamless experience for staff.

The single ICU is being created by expanding B36 into B41 ward. To mitigate this loss in inpatient capacity we've opened Ward 4 at St Martin's Hospital. We have also closed B36 during these works, so all intensive care patients are being cared for in B12 ICU.

Work is due to finish by winter 2024, at which point B12 will be used as a 13-bedded ward providing additional capacity during our busier months.

15. Lansdown Restaurant refurbishment

The Lansdown Restaurant at the RUH is now reopen following a renovation. Using feedback from the staff survey, the restaurant is now more modern and efficient, with a grab and go area and self-check-outs. The menu has also been refreshed and there are more healthy and affordable options than ever before.

Over 1,000 people use the Lansdown each day so these improvements will have a big impact on both the people we care for and the people we work with.

16. Membership

We are always actively seeking new members to help us shape the future of the hospital and directly influence the development of our services for the better.

Membership is a great way for our staff, patients and local community to help improve how the hospital is run, as well as many aspects of the healthcare that we provide. It is completely free and is a great way to show your support for the RUH. There are three different levels of involvement for you to choose from, simply sign up here: https://secure.membra.co.uk/RoyalBathApplicationForm/

17. Consultant Appointments

The following Consultant appointments were made since the last report to Board of Directors:

Dr Robert Penders, Doctor in Specialty Training Year 7 at North Bristol NHS Trust was appointed as a Consultant Anaesthetist (Chronic Pain and Anaesthetics) on 26th February 2024. Dr Penders will start at the Trust on 21st August 2024.

Dr Elizabeth Robinson, Specialty Trainee at North Bristol NHS Trust was appointed as a Consultant Radiologist on 4th March 2024. Dr Robinson's provisional start date is August 2025.

Dr Nisha Verasingam and Dr Victoria Medland were appointed as Consultants in Obstetrics and Gynaecology on 11th March 2024. Both are already working at the Trust as Locum Consultants.

Ms Louise Capaldi, Locum Consultant, was appointed at a Consultant in ENT on the 13th March 2024 and started at the Trust substantively on the 1st April 2024.

18. Chairs Update

During the last two months, in addition to the normal round of consultant interviews, we held a meeting of the Council of Governors and I conducted the appraisals of the Non Executive Directors. I also chaired the Steering Group of the wide consortium of NHS, local authority and voluntary sector community service providers in BaNES Swindon and Wiltshire preparing a bid for the renewal of those services next year. Discussions on closer working in the Acute Hospital Alliance within BSW to create more productive and responsive services also continued. I also had the great pleasure of showing the Dyson Cancer Centre to a number of those who had contributed to its successful completion. All commented on what a welcoming and supportive place it was.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**1 May 2024**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Information**		
Board Sponsor(s):	**Alfredo Thompson, Chief People Officer** **Paran Govender, Chief Operating Officer** **Toni Lynch, Chief Nursing Officer** **Pippa Ross-Smith, Interim Deputy Chief Financial Officer**		
Author(s):	**Jane Dudley, Deputy Chief People Officer** **Rob Eliot, Head of Quality Assurance** **Tom Williams, Head of Financial Management**		
Appendices	**None**		

1. Executive Summary of the Report

The report provides an overview of the Trusts Performance as at the end of March 2024, aligned to our 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.

Workforce

- The RUH establishment in March 2024 (Month 12) was 5699 whole time equivalents (WTE), (from 5700 WTE in February 2024).
- The staff-in-post figure decreased slightly to 5619 (from 5643.9 WTE in Month 11) resulting in a vacancy rate of 1.41% (significantly inside our target position of 4.0%).
- Agency spend as a proportion of the total pay bill decreased to 1.12% (from 2.2% in M11) still significantly within the local target of 3.5% and the system target of 3.7%.
- Nurse Agency spend as a proportion of the Registered Nursing paybill decreased to 1.57% (from 2.16% in M11).
- Staff turnover decreased to 8.33% (from 8.52% in M11) a continued positive variance against a target of 11.00%.
- Sickness absence increased slightly at 4.47%. Anxiety, stress, and depression remained the main causes of sickness absence at 1.20%.
- Global majority likelihood of appointment reduced slightly (0.56%) and remains below target against a range of 0.8 to 1.25, anything other than 1.00 means that global majority applicants have a less then equal chance of appointment.
- The target percentage figure for Appraisal completion is 90%; the March figure remained static 77.07% (from 77.05% in M11).
- Mandatory and Statutory Training (MaST) training compliance levels reduced to 90.40%. Information governance compliance reduced to 87.70%.

Actions are being taken to improve support to the RUH workforce and workforce performance:

Recommend the RUH as a place to work.

67.86% recommended the Trust as a place to work in the 2023 National Staff Survey. This places the Trust in the top quartile for its benchmark group, ranking 18th overall nationally. Staff Survey action plans are being developed in Divisions. Central work streams include: IHI Framework for Joy in Work, EDI projects to increase engagement, team development options for struggling areas.

The People Plan 'Programmes on a page' were approved by the March 24 People Committee and the work oriented to ensure that we improve the key performance indicator of 'recommending the RUH as a place to work' is being prioritised.

People Plan Programme 1 – Foundations

We are currently developing the People Hub, which is our 'one stop shop' in the People Directorate for managing HR and medical workforce queries. The team has started worked on a set of new manager guidance for the main HR policies. The first guidance to be published will be later this month (April 2024) for Supporting Attendance. The HALO case management system has been procured and we have our first meeting with the supplier on the 22nd April to discuss scope and implementation. A Service Directory is also being developed to explain to staff and managers what support they can expect from the People Hub.

In January 2024, the onsite nursery reopened. Working is also ongoing to re-open the staff gym. Getting pay right: Team structure, new processes and team training with Recruitment Team completed to improve getting pay right for new joiners. Next stage is working on improvements for leavers and existing staff.

Nutrition & hydration: New hydration station has opened in the Atrium and Lansdown refurbishment completed in April 2024. Rest & break areas: Staff break areas on Forrester Brown and Helena have been refurbished. Rest area on Waterhouse ward near completion.

People Plan Programme 4- Diverse and Inclusive

The 2023 Staff Survey results showed a very slight improvement in our scores on 'inclusivity' (but not enough to be statistically significant). The Anti-Racist statement launched in March 2024. Work is underway to undertake targeted team development interventions (in collaboration with HR) to address identified issues, including emergency medicine. The planned introduction of Report and Support in May 2024, to be linked with RUH People Hub – therefore better, swifter support to areas most affected by discrimination.

People Plan Programme 7 – Leadership

A work plan went to the March People Committee bringing together the currently disparate leadership development offers (amongst other things) clearly defined leadership cohorts; leadership development programmes for each cohort; enhanced visibility of external leadership programmes; and profession specific pathway models for leadership development.

Despite gradual progress, we have been unable to achieve the required 90% appraisal uptake. A session is planned in April 2024 to engage wider stakeholders

and understand the root cause of the low appraisal uptake.

People Plan Programme 8 – Workforce Planning

To support with workforce planning an improvement tool called the Calderdale Framework is being implemented. Training dates are in place for April and May 2024.

People Plan Programme 9 – Talent Acquisition

Our Employee Value Proposition launches in May 2024 to support the vision of being one of the top 3 Trusts that staff recommend a place to work. This includes work underway to ensure recruitment collateral has the new look and feel. Trust led Vacancy Control and Agency Reduction Panel continues to supports having the right people, in the right posts against our workforce plans. The new controls and scrutiny are supporting the Trust financial recovery plans.

People Plan Programme 10 – Temporary Staffing

The Agency Reduction plan continues to support the Trust to be within or below our internal target position for the last 8months. The work supports Managers to develop exit plans for agency workers by recruiting substantively, if required or moving high cost workers onto the Bank, moving to framework suppliers to secure price caps which all supports financial savings and increased compliance.

The South West Regional Agency Rate card for nursing going live in April 2024 with a further planned stepped reduction in July to reach NHS price cap. A Bank rate review is also underway to ensure we operate a fair and transparent approach to our rates which demonstrates value for money and competitive within labour market

Quality & Safety

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.

The Quality Report routinely reports on performance measures where the performance thresholds are not met or where there is a trend to indicate worsening performance.

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

- Number of Hospital acquired pressure ulcers cat 2
- Number of Hospital acquired pressure ulcers cat 3 & 4
- PALS response time

Under-performing:
The Trust target threshold for category 2 hospital acquired pressure ulcers is no more than 10 2023/24. The current situation up until the end of February is 20 category 2 pressure ulcers, 10 over the threshold. Of the 20 investigated, 16 were found to have

lapses in care which is 6 over the threshold.

The Trust operates a zero tolerance for category 3 and 4 pressure ulcers. The month of February reported two bringing the total to 16 avoidable category 3 pressure ulcers. It has been over 5 years since the Trust reported an avoidable category 4 pressure ulcer.

Main themes are variance from standard in skin assessment, escalation and repositioning. These themes are being addressed by the Divisions via the Tissue Viability Steering Group.

All contacts to our PALS service are acknowledged within 2 working days. The data on the scorecard refers to the cases that are open and then closed within 2 working days. From 1st April 2024 data will be collected for cases being acknowledged within 2 days and this information will be used when the scorecard is refreshed.

Maternity Update
The birth to midwife ratio continues to remain stable following investment in the midwifery establishment aligned to the Maternity investment business case. There have been no episodes of 1:1 care in labour not being provided or the supernumerary status of the Labour Ward Co-ordinator being impacted.

The BR+ acuity data does however, evidence an increase in the percentage of time when staffing did not meet acuity (38%), safety was maintained by redeployment of staff across the acute and community service as per the staffing escalation policy. There was also an increase in red flag incidents, largely associated with delayed inductions of labour (IOL). This has prompted a review of the current Red Flag acuity triggers alongside the IOL working group to ensure system, regional and national alignment, this is due to be presented at May Maternity and Neonatal Governance.

A deep dive has been undertaken into Maternity support worker fill rates; these do not accurately reflect the clinical shift cover. The misalignment appears to be due to a significant number of optional tiles on the roster affecting the overall shift fill percentage. On-going work with the health roster team is underway to remove historic tiles and separate clinical areas to reflect accurate fill rates moving forward.

There has been a further reduction in the MDT ward round compliance due to the transition from paper to digital capture. There is continued support in place to ensure the digital tool capture is effective and monthly monitoring via the Maternity and Neonatal Governance committee, if there continues to be continued capture issues in March 2024 the intention will be to return to a paper-based process.

In February, there was 1 stillbirth at 38+2 days of pregnancy. This will receive a full PMRT review. No immediate concerns have been raised at MDT review. There have been no MNSI new (Maternity and Newborn Safety Investigations) referrals made in February.

The formal publication of the CQC maternity survey was in February 2024; the service received a 57% response rate; with all actions from 2022 survey seeing an increase in responses. There was only one area with a statistically significant decrease from the

2022 survey, this related to women and birthing people being offered a choice about where to have their baby. This result may have been impacted by the community birth suspension which was in place in February 2022. The actions to address this decrease in experience are being monitored through the Maternity Insights triangulation Group.

Performance

Elective Recovery Fund update

March showed another positive position with value of activity against 19/.20 of 111% and against 23/24 plan of 106%. The positive financial position was reflected in our activity figures with 109% of 19/20 and 102% of 23/24 plan. ENT income increased by £85k compared to £32k over last month; this is driven by case mix change (inc inpatients) and a higher volume of OP attendance. Gastro increased slightly on income earned with the total rising by £83k to £235k in month. Oncology was driving the small increase in month, with income up £15k from February

Cancer

In February 62 Day performance was 67.6%. Urology recorded the most breaches, the majority of whom were patients with prostate cancer. Breaches were due to a combination of longer waiting times for MRI, biopsy and surgery. The December/January junior doctor strike also led to delays in first diagnostics for some patients. Colorectal remained the specialty with the most challenged performance with breaches due to outpatient and diagnostic waiting times as well as for Oncology appointments. Skin performance was impacted by delays to excisions and an increased number of patients undergoing biopsies before primary treatment, leading to extended pathways. The 62 day backlog position recovered during February and March, ensuring the Trust overachieved against the end of year fair shares target

Urgent Care

RUH 4-hour performance in March was 69.8% (mapped) and 62.2% on the RUH footprint (unmapped). This is an improved position from February however did not meet the revised H2 trajectory submitted to NHS England of 76.0% for March.

Attendances during March increased further than the previous month to 9,246 (February 7961 and March 2023, 7830), which was above the upper control limit and the highest number of attendances the RUH has seen in one month.

Increase in ambulance conveyed patients (2,392) compared to previous months (February 2,082 and January 2,309). Urgent Care saw an improved 4-hour performance in March, achieving 80.2%, however Majors saw a small reduction compared to the previous month.

The Urgent and Emergency Care improvement plan will be refreshed in April 2024 in line with the national operating guidance to achieve 78% performance. Improvements in month include - Senior operational and nursing staff linking with the site team in place 08:00 – 22:00 to drive performance and planning at 2 hours from patients' arrival, including UTC performance improvement to 80% (ambition to sustain 85%), non-admitted performance improvement with clinical specialty response as part of the Trust-wide response and clinical division review of breach analysis to direct

improvement focus.

Finance

The NHS is required to achieve a break even position this financial year. The BSW ICS have been working on a plan to achieve breakeven however the impact of Industrial Action since December 23 has resulted in a deficit of £7.9 million; this includes a deficit of £3.49 million for the RUH. This is an improvement of £4.1 million from the previous month. This was predominantly achieved through increased delivery through Elective Recovery and the full delivery of QIPP schemes.

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

3.	Legal / Regulatory Implications
Trust Single Oversight Framework.	

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

5.	Resources Implications (Financial / staffing)
As set out in the paper.	

6.	Equality and Diversity
The impact on health inequalities due to the operational performance needs to be closely monitored. It is important that we don't increase health inequalities when access times are long.	

7.	References to previous reports
Standing agenda item.	

8.	Freedom of Information
Private	

9.	Sustainability
None identified.	

10.	Digital
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

April 2024 (March data)

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Operational Performance Report

April 2024 – (March 2024 Data)

The RUH, where you matter

RUH Priorities 23-24

Trust Goals

The people we work with

- Percentage of staff recommending RUH as a place to work

The people we care for

- To achieve 'much better than expected' score and best in class for our region for overall patient experience

The people in our community

- Financial balance, Carbon footprint and Health inequalities

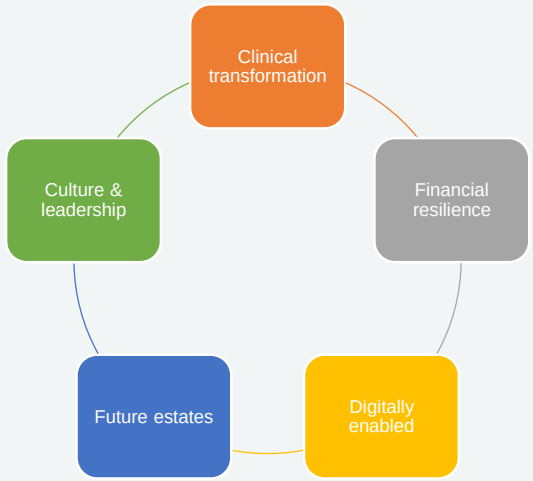
Breakthrough Goals

Discrimination
% of staff reporting they have experienced discrimination at work from colleagues

A&E waiting times
To ensure 76% of patients attending the emergency department are seen within 4 hours

Elective productivity
See and treat 9% more patients for planned care to help reduce waiting times

Strategic Initiatives



Mission Critical Projects

Basics matter
Cultural transformation programme

Patient safety programme
Patient flow and elective and Cancer recovery programmes
Patient experience; real-time feedback

Financial improvement programme
Health inequalities programme
Carbon net zero
Care closer to home

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 care for

The RUH, where you matter

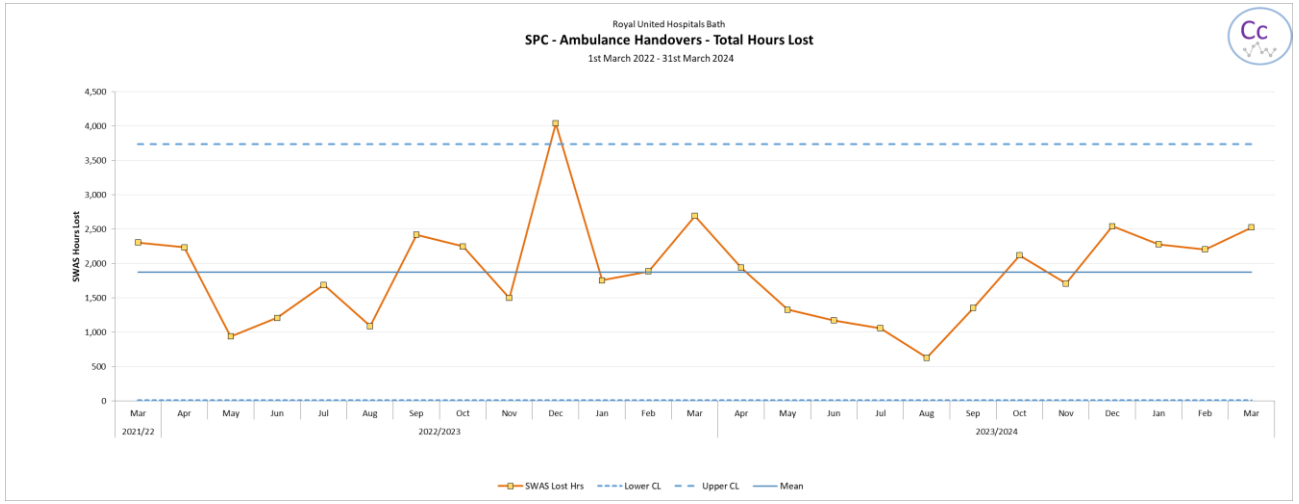
Strategic Goal		Performance Indicator	Target		2023/24						Trend	Movement From Previous Month
			Performing	Under Performing	Oct	Nov	Dec	Jan	Feb	Mar		
Trust Goals	People in our Community	Ambulance Handover Delays	>=39	<39	760	684	822	810	887	995		
Breakthrough Objectives	People We Care For	4 Hour Performance (Total RUH Footprint, including MIU & Booked)	>=76%	<76%	66.4%	69.2%	67.7%	66.4%	68.7%	69.8%		
	People in our Community	Non Criteria to Reside	<=62	>62	93	89	83	82	80.7	86.2		
Key Standards	People We Care For	RTT - Incomplete Pathways in 18 weeks	>=92%	<92%	59.1%	60.1%	60.2%	60.4%	62.3%	63.6%		
		Combined 31 Day Cancer Targets	>=96%	<96%	93.1%	94.8%	92.2%	90.7%	94.3%	(LAG 1)		
		Combined 62 Day Cancer Targets	>=75%	<75%	64.9%	71.1%	71.8%	66.5%	66.3%	(LAG 1)		
		Diagnostic tests maximum wait of 6 weeks	<=1%	>1%	42.0%	36.9%	32.7%	26.8%	19.6%	18.5%		

Measure	Change	Executive Summary
Ambulance Handover	↓	In March, the Trust lost a total of **2,524** hours in ambulance handovers, an increase from the previous month. The percentage of Ambulances handed over within 30 minutes also declined for March (**40.5%**). The RUH is continuing to experience discrepancies regarding ambulance handover data in March, which, following validation, totalled **317** hours (Highest since validation began); SWAST have now confirmed that manual validation of XCAD will no longer be possible however the RUH continue to validate ambulance arrivals over 6 hours. Ambulance improvement plan is being revised and submitted to BSW, linked to 4-hour recovery and discharge improvements.
4 Hour Performance	↓	RUH 4-hour performance in March was **69.8%** and **62.2%** on the RUH footprint. This is an improved position from February however did not meet the revised H2 trajectory submitted to NHS England of **76.0%** for March. Attendances during March increased further than the previous month to **9,246** (February **7961 a**nd March 2023 **7830**). Improvements included; Senior operational and nursing staff linking with the site team in place 08:00 – 22:00 to drive performance and planning at 2 hours from patients' arrival, including UTC performance improvement to 80% (ambition to sustain 85%), non-admitted performance improvement with clinical specialty response as part of the Trust-wide response and clinical division review of breach analysis to direct improvement focus.
Non Criteria to Reside (NC2R)	↑	During March the Trust had an average of 86.2 patients waiting who had no criteria to reside, which is 5.5 higher than the previous month. BaNES continue to see an increase of 3.4 patients this month due to a surge in referrals post doctor strike, Wiltshire continues to be below target of 30 averaging 29.8 patients this month, and out of area averaged 12.8 patients. Somerset have seen a reduction in their system target but remain above the target levels.
Referral to Treatment	↓	In March the Trust had 0 patients waiting over 78 weeks and 39 patients waiting over 65 weeks against a trajectory of 98 breaches. The longest waiters are in Gastroenterology, Trauma & Orthopaedics and General Surgery. RTT performance was 63.6% in March, an increase of 1.3%
Cancer 62 Days	↓	In February 62 Day performance was 67.6%. Urology recorded the most breaches, the majority of whom were patients with prostate cancer. Breaches were due to a combination of longer waiting times for MRI, biopsy and surgery. The December/January junior doctor strike also led to delays in first diagnostics for some patients. Colorectal remained the specialty with the most challenged performance with breaches due to outpatient and diagnostic waiting times as well as for Oncology appointments. Skin performance was impacted by delays to excisions and an increased number of patients undergoing biopsies before primary treatment, leading to extended pathways. The 62 day backlog position recovered during February and March, ensuring the Trust overachieved against the end of year fair shares target.
Diagnostics	↓	March >6-week performance was **18.47%,** which represents a decrease in total breaches from previous month (**-1.09%**). Improvement in performance in most modalities with USS, CT and neurophysiology being the top contributors for improvement.DM01 performance did not hit forecasted trajectory (**15.85%**). Performance has been affected by the ongoing increase in demand for cancer diagnostics and prioritisation of the cancer standards. Overall, the percentage of patients accessing a diagnostic test within 6 weeks is increasing, the actual number of patients breaching is reducing and the total activity for diagnostics performed per month is also increasing (now exceeding 10k tests per month).

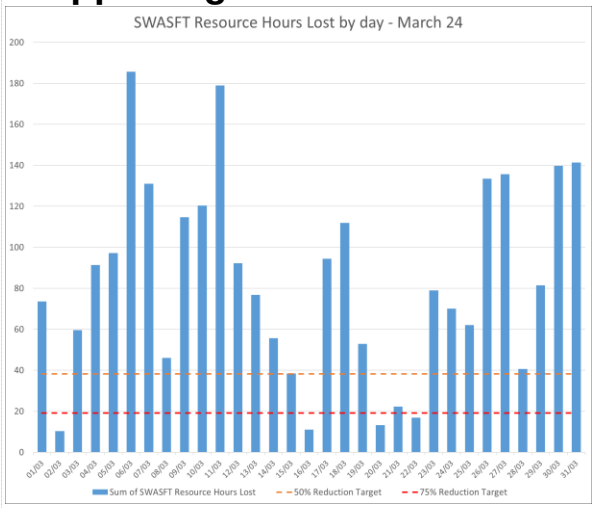
Trust Goal | Ambulance handover delays

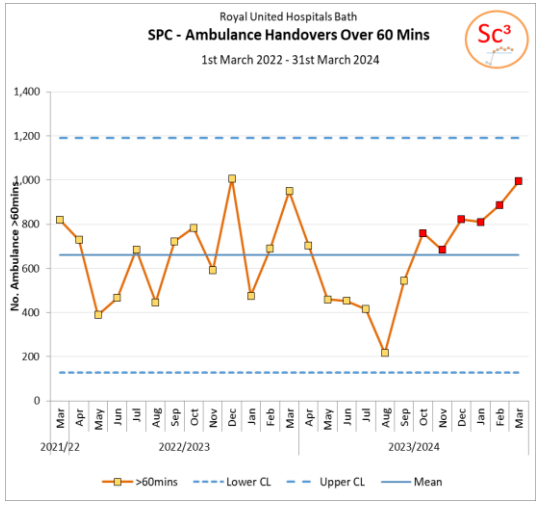
Performance target: lose no more than 500 hours per month

Historic Data: Hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

In March, the Trust lost a total of 2,524 hours in ambulance handovers, an increase from the previous month. The percentage of Ambulances handed over within 30 minutes also declined for March (40.5%). The RUH is continuing to experience discrepancies regarding ambulance handover data in March, which, following validation, totalled 317 hours (highest since validation began); SWAST have confirmed that manual updates to X-CAD will no longer be possible, however the RUH continue to validate ambulance arrivals over 6 hours. Ambulance improvement plan is being revised and submitted to BSW, linked to 4-hour recovery and discharge improvements, is in place.

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

The Trust did not improve the number of hours lost, or percentage of handovers completed within 30 minutes in March. The beginning of the month saw significant flow pressure and high bed occupancy (98.50% medical beds), increase in ED attendances and also an increase in ambulance conveyances (339 additional compared to February 2024) which led to periods of not offloading, as demonstrated by the middle graph which shows the days of not offloading. The overall performance was also contributed by:

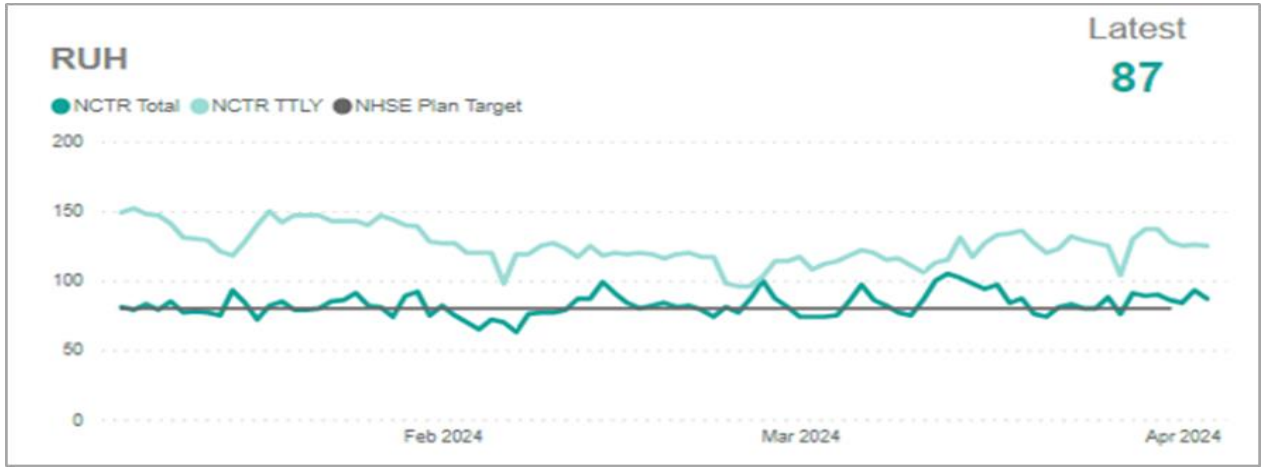
- X-CAD only utilised in ED which is leading to data errors particularly when cohorting patients
- Challenges with validating ambulance handover delays when a patient is placed into a Cohort Area. Daily validation is ongoing but manual validation will not override X-CAD recorded time
- Days when SDEC Units full so expected patients arrive in ED & UC contributing to overcrowding

Countermeasures / Actions	Owner	Due Date
Continue to complete daily validation of ambulance handover delays in excess of 6 hours	E. Tate	Ongoing
Review RAT process in ED to ensure this does not delay ambulance handovers	M. Price and C. Forsyth	15.04.2024
Ensure internal escalation process is followed by ED staff to ask for support from Site team to decompress ED – commenced in March, to further embed during April	ED Triumvirate	30.04.2024
Ambulance improvement plan to be reviewed as part of the trust UEC refresh	S Hudson	19.04.2024

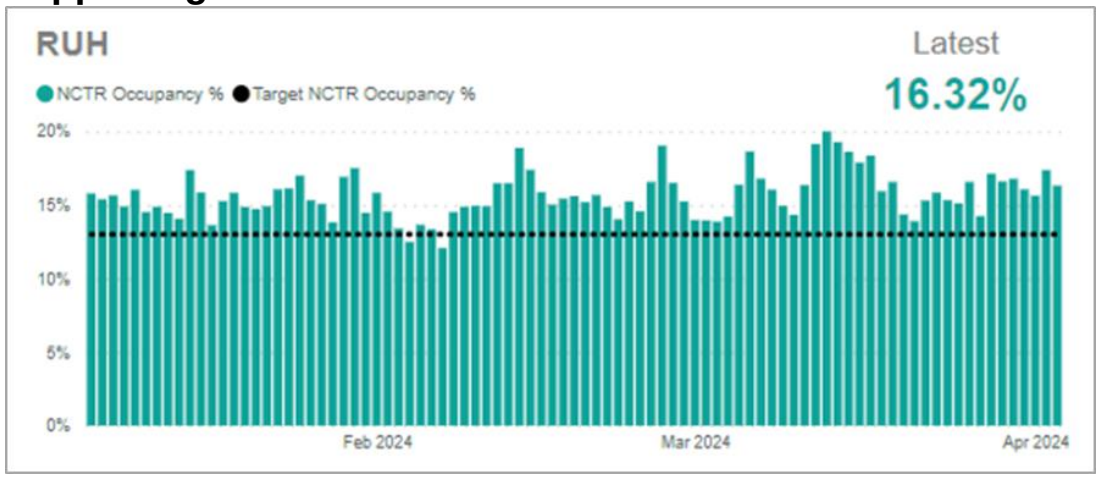
Breakthrough Goal | Non criteria to reside

Performance target; agreed with commissioners for no more than 55 patients waiting who don't have criteria to reside

Historic Data: as of 04/04/24



Supporting data



Is the standard being delivered?

During March the Trust had an average of 86.2 patients waiting who had no criteria to reside, which is 5.5 higher than previous month. This remains above the system refreshed target of 55.

Wiltshire have seen a 75% reduction in their Pathway 1 waits due to the funding implemented in December. Continued funding decision pending and therefore remains a significant risk to current progress if not supported

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

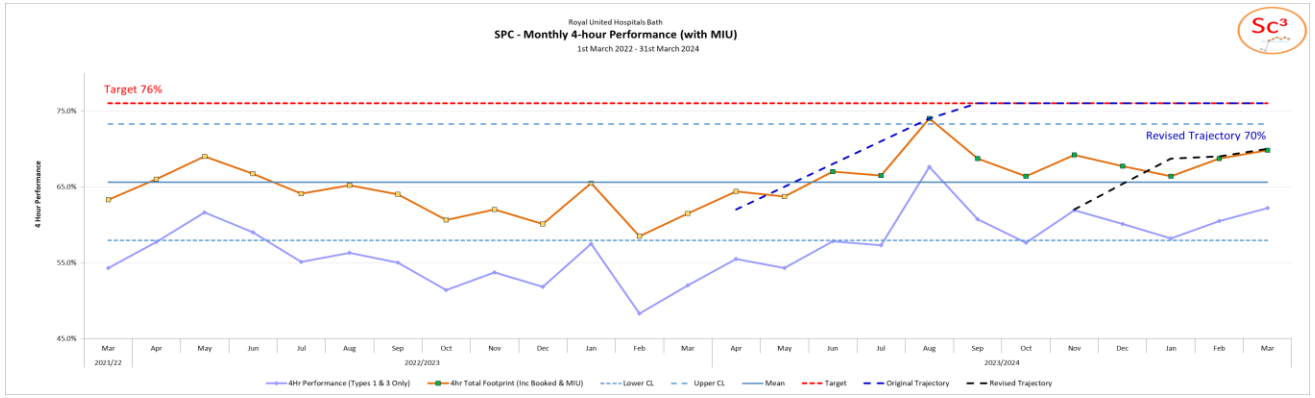
- Top right graph shows the daily percentage of beds occupied at the RUH by NC2R patients
- During February BaNES had an average 34.3 against a target of 20 – this is an increase of 3.4 patients in comparrison to last month - recovery plan being implemented. Reopenning of 5 community beds due to estates work in April.
- Wiltshire had an average of 29.8 against a target of 30. Funding for continuation of p1 imp[rovement work still to be agreed at system level
- Somerset was at 12.8 against a target of 5. A reduction of 1.2 compared to February. New escalation actions bteween RUH and Somerset teams being trialled
- We continue to see a reduction in LOS post NCTR due to the introduction of the Complex Case Discharge Manager Role

Countermeasures / Actions	Owner	Due Date
Recovery plan and measures in place to support Wiltshire system	Goddard	On going
Ongoing work to increase system utilisation of virtual wards	Hopkins/ Scott	Q4 23/24
Wiltshire system remodelling out of hospital care model and balance of capacity across different pathways	Govender	Q4 23/24
Confirmation of continuing Wiltshire funding for P1 past March 2024	Goddard	April 2024
Recovery Plan for BaNES NCTR to be actioned	Goddard	March 2024

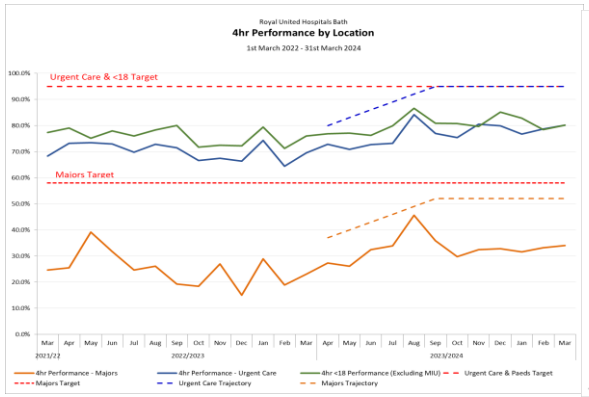
Key Standards | 4 hour Emergency Standard

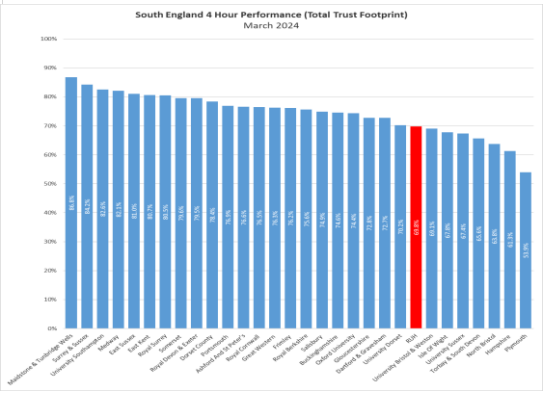
Performance target; 76% of patients discharged or admitted from ED within 4 hours

Historic Data



Supporting data





Is the standard being delivered?

There has been an increase in performance in March (69.8%) compared to the previous month (68.7%). The revised H2 trajectory submitted to NHS England stated a performance of 76.0% was required for the month of March.

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

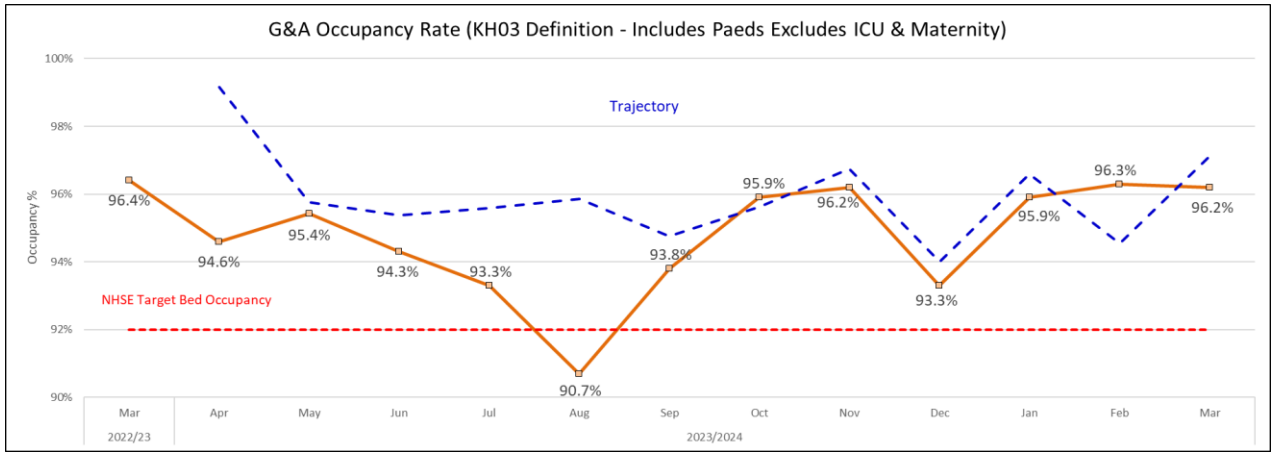
- Attendances during March increased further on the previous month to 9,246 (January 8,434 and February 7,961) which was above the upper control limit and the highest number of attendances the RUH has seen in one month
- Increase in ambulance conveyed patients (2,392) compared to previous months (February 2,082 and January 2,309)
- Urgent Care saw an improved 4-hour performance in March, achieving 80.2%, however Majors saw a small reduction compared to the month
- High bed occupancy at 98.5% across the medicine bed-base
- Increase in the number of patients discharged by midday (22.7% trust-wide), although still below target of 33%
- Ongoing challenges with GP/specialty expected patients going to ED and Urgent Care
- Ongoing long waits for mental health patients to be seen by Mental Health Liaison / AWP, particularly overnight, and in addition long waits for MH beds
- Ongoing IPC impact with patients in ED requiring side rooms. Ward closures reduced medicine bed base (Covid, Flu and Norovirus)
- Extra validation undertaken added a 3.72% improvement to the 4hr performance for March
- Enhanced Progress chaser and training for appointed progress chasers ongoing

Countermeasures / Actions	Owner	Due Date
Senior validation after initial admin validation to support 4 hour performance position – to continue into April 2024	E. Tate and C. Croxton	30.04.24
Refine internal escalation process to ensure standardised communications with the site team – to reduce unnecessary delays and reduce 4 hour breach occurrence, especially within 30 minutes of breach time. In place – moving to sustain in April 2024	C. Irwin-Porter	30.04.24
Reduce non-admitted majors breaches and escalate individual patients through the ED daily huddles and senior progress chase roles – embed during April 2024	ED huddles	30.04.24
Agree process for admin adding Surgically expected patients to Aramis	E. Tate	15.04.24
Clinical Divisions to provide capacity 24/7 for expected patients to prevent ED attendance – improvement seen in March – progress further in April 2024	S. Hudson	30.04.24

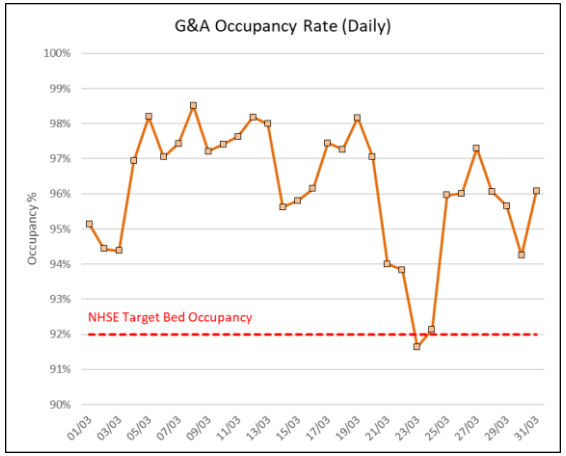
Key Standards | Bed Occupancy

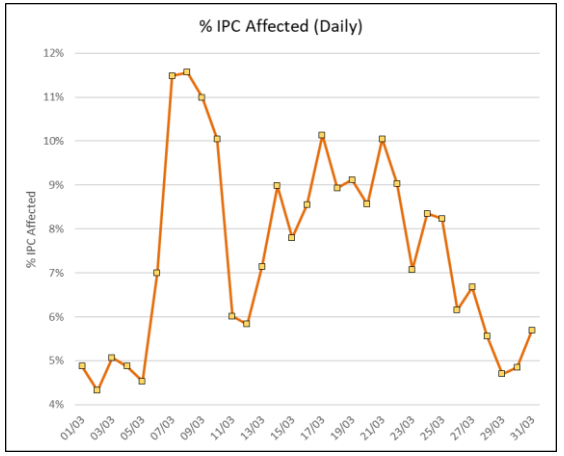
Performance target; Bed occupancy should be no greater than 92%

Historic Data



Supporting data





Is the standard being delivered?

NHS England target as described in the Urgent and Emergency Care Recovery Plan indicates that bed occupancy should be 92%. For March the Trust's bed occupancy was 96.2%.

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

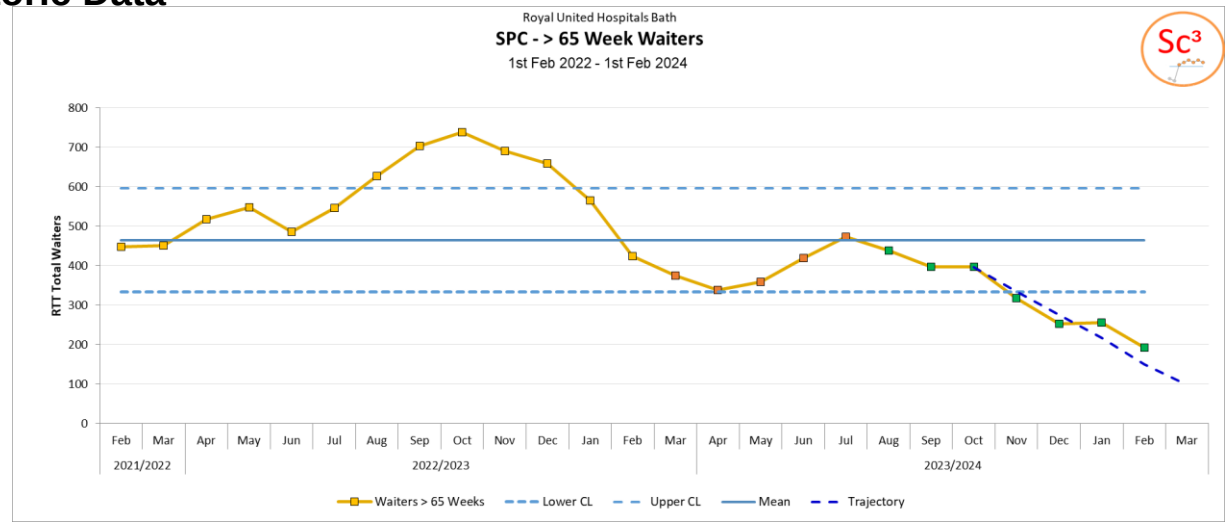
- Reduction in IPC affected beds throughout March with notable reduction in Covid numbers. Norovirus contributing to most ward issues for IPC closures during March
- SDEC continues with high usage of 36%
- Non-elective LOS increased to 4.3 (0.4)
- Pre midday discharges saw an increase to 24.4% of all discharges
- 20.4% of discharges utilised the discharge lounge in March – divisional engagement work in progress to improve

Countermeasures / Actions	Owner	Due Date
Recruiting to agreed business case expanding SDEC to support reaching 40% same day discharge	Medicine	Q3 23/24
Improvement work on pre-midday discharges and utilisation of discharge lounge	Divisions	April 2024
Launching review of board rounds and comparing against the Royal College of Physicians guide on modern ward rounds	Medicine	March 2024
Implementation of LLOS reviews by Ward managers, Matrons, DDoN and Deputy chief nurse	Nursing	March 2024

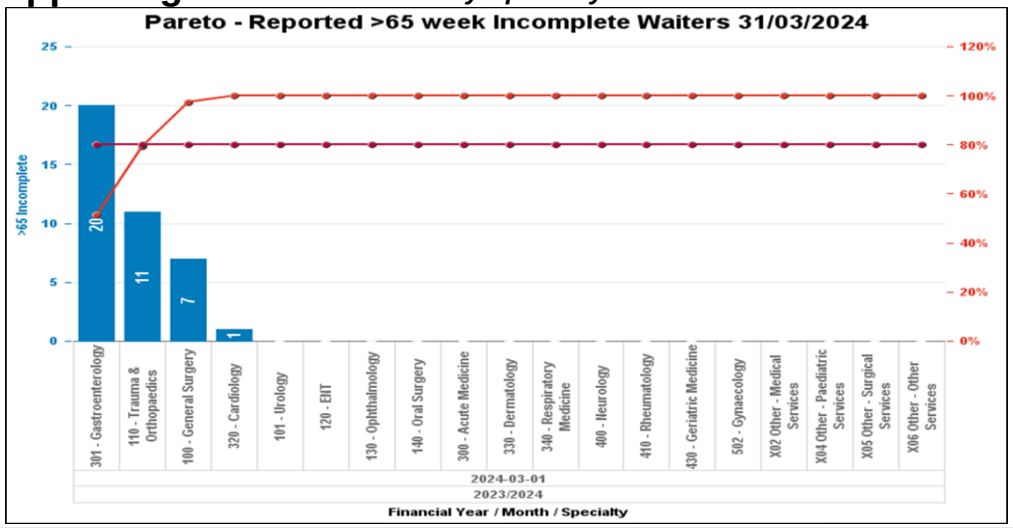
Key Standards | Referral to Treatment

Performance target; No patients waiting greater than 52 weeks by March 25

Historic Data



Supporting data - *Pareto 65+ by Specialty*



Is the standard being delivered?

- In March 24 the Trust had 39 patients waiting > 65 weeks, a decrease from 193 patients in February.
- 0 patients waiting over 78 weeks.
- RTT performance was 63.6% in March.
- For waiters over 65 weeks, the largest group remains Gastroenterology. Gastro had 20 patients over 65 weeks at the end of March, a decrease from 70 at the end of February.
- General Surgery have consistently halved their number of patients waiting over 65 weeks each month: 47 patients in Dec; 24 patients in Jan; 15 patients in Feb; 7 patients in Mar.
- As part of the H2 planning submission the Trust was forecasting a backlog of 98 by March 24, which has been achieved and surpassed.

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

- Weight management have cleared their longest waiting patients and are working on a sustainable plan.
- T&O continue to be challenged with long waiting spinal and paediatric patients. Joint working with Sulis to support the longest waiting spinal patients continues
- Despite notable improvements Gastroenterology remain the biggest contributor to over 65 weeks

Countermeasures / Actions	Owner	Due Date
Development of robust pathways for routine patients in pressured specialties e.g spine and ENT, being developed with Sulis to provide additional capacity to support performance	Roberts	Q1 24/25
Continue 3 x weekly long waiter PTLs for "challenged" specialties to meet 65 weeks by end of June 24 – currently Gastro, T&O, Gen Surg, ENT	Dando	End of Q1 24/25
Continued focus on utilising BSW system wide capacity to support focused effort on reducing waiting list	Roberts/ Hudson	Ongoing
Validation "deep dive" into challenged specialties to obtain learning for specialties and drive process improvements	Dando	Ongoing

Key Standards | Elective Recovery

Performance target; Deliver 109% of elective activity compared to 2019/20

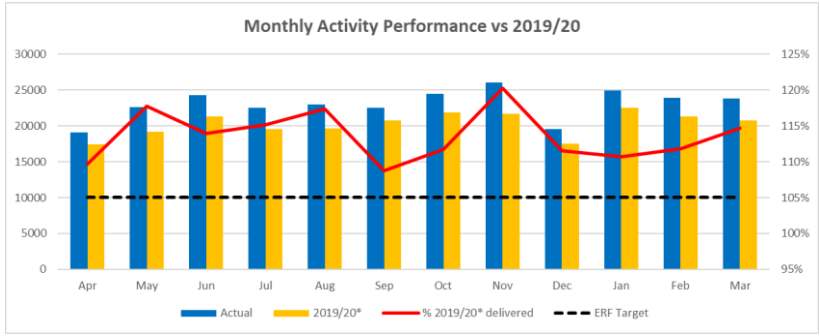
ERF Performance

	vs 19/20												
Division	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	**YTD**
FASS	102%	122%	133%	120%	152%	138%	120%	134%	119%	124%	131%	119%	126%
Medicine	119%	131%	143%	120%	130%	133%	122%	140%	125%	119%	129%	123%	129%
Surgery	83%	98%	109%	90%	114%	102%	107%	114%	101%	113%	118%	102%	104%
RUH	**94%**	**111%**	**122%**	**104%**	**126%**	**117%**	**114%**	**123%**	**111%**	**116%**	**123%**	**111%**	**115%**

	vs 23/24												
Division	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	**YTD**
FASS	87%	94%	106%	98%	106%	109%	99%	111%	100%	124%	121%	105%	105%
Medicine	103%	113%	121%	115%	106%	115%	107%	118%	100%	119%	114%	104%	110%
Surgery	92%	103%	115%	98%	100%	102%	108%	116%	95%	113%	129%	107%	107%
RUH	**96%**	**104%**	**115%**	**103%**	**103%**	**107%**	**106%**	**116%**	**97%**	**117%**	**123%**	**106%**	**108%**

Supporting data

ERF Activity Delivery



Is the standard being delivered?

March showed another positive position with value of activity against 19/.20 of 111% and against 23/24 plan of 106%. The positive financial position was reflected in our activity figures with 109% of 19/20 and 102% of 23/24 plan

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

The biggest contributors to this performance in month over 2019/20 in each Division are as follows:

Surgery

- ENT income increased by £85k compared to £32k over last month; this is driven by case mix change (inc inpatients) and a higher volume of OP attendance;
- Ophthalmology also saw an overall increase income through additional outpatient procedures
- T&O saw a decrease in overall income, with a drop in inpatient and day case compared to M11
- General Surgery also saw a reduction in income from M11 of £90k, largely due to drop in inpatient higher tariff cases v day cases and drop in outpatients seen.

Medicine

- Gastro increased slightly on income earned with the total rising by £83k to £235k in month
- Dermatology in-month position is £91k mostly day cases and includes some backdated activity
- Acute Medicine saw a small reduction in income from M11 of £26k

FASS

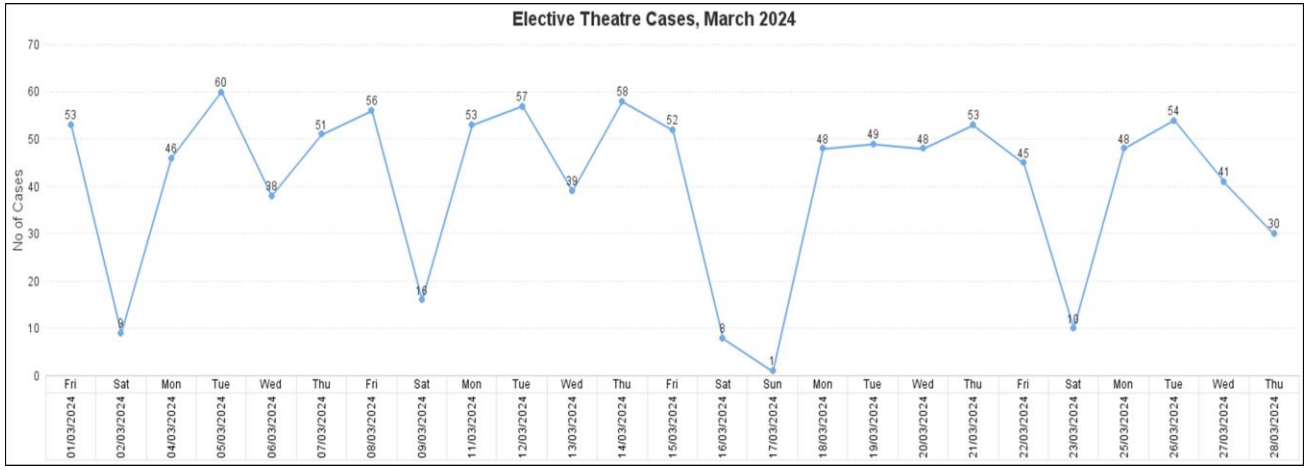
- Oncology was driving the small increase in month, with income up £15k from February
- Paediatric Income earned remains at February levels of £93k

Whilst un-coded activity remains high due to the coding team focusing on the retrospective coding, an estimated tariff based on the previous quarter has been applied

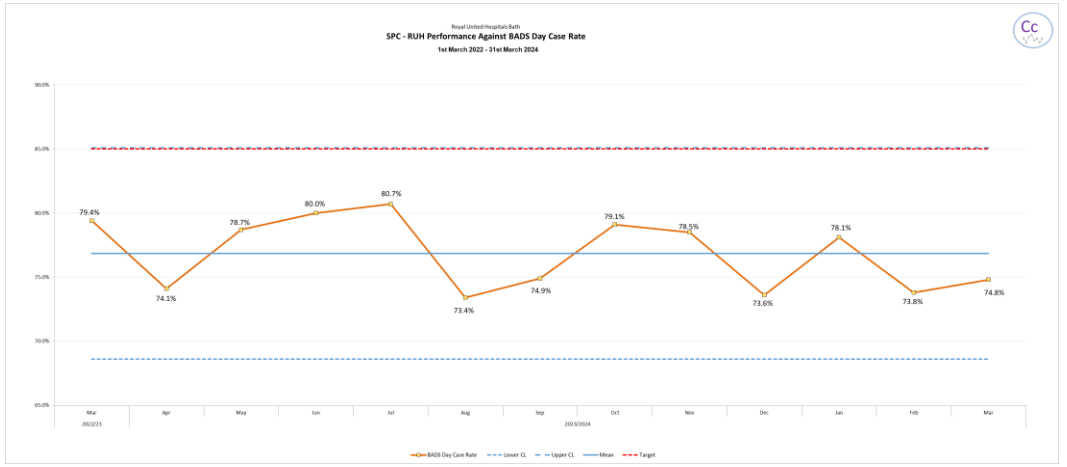
Countermeasures / Actions	Owner	Due Date
Transformation workstreams focused on supporting increased activity within Theatres and Outpatients. Extending to endoscopy/ cath labs	Divisions	Through Q4 23/24
Identifying additional follow up appointments that can be converted into new appointments	Divisions	Through Q4 23/24
Reviewing M11 Non-elective activity to ensure all appropriately coded	Wisher-Davies	March/Apr 24

Key Standards | Productivity

Historic Data:



Supporting data



Is the standard being delivered?

- The RUH aims to book to 85% list available minutes (to allow for turnaround time), in March theatres were booked to 79.2% a slight improvement from Feb; the capped utilisation was 76.3% (target 85%) again another small improvement from 74% in Feb
- The Trust identified a target of 85% of procedures which are deemed suitable for Day Case to be undertaken as a day case. In March the Trust performance fell very slightly to 82.7%. (YTD 83.45%)
- Only 39 cases failed as day cases in March, the lowest number since Nov 23 (only 4.7% conversion; this was on average 18% in 2022).

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

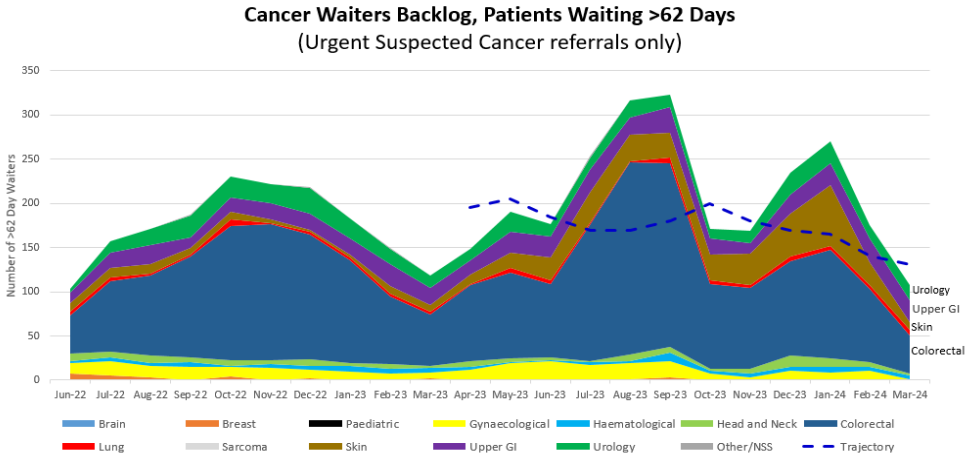
- March delivered a day case performance of % of 19/20 in Surgery (majority of activity through theatres). This high % shows a case mix with less electives (86% of 19/20)
- Over 100% of available theatre lists were utilised.; including an increase in weekend lists in month at 11 all day theatre lists across the month.
- Main challenges for BADS in Breast, plus validation of DC conversions in OMFS, Urology
- The cancellation on the day were 24, the lowest since Oct 23. However, this still represents an opportunity to reduce further.
- The Improvement Team continue to support theatre efficiency projects with focus on bookings

Countermeasures / Actions	Owner	Due Date
Theatre productivity workstream has been re-launched – additional cases by specialty agreed for 24/25. Monitored through monthly divisional ERF review.	S Roberts	Q1-Q4 24/25
BADs day case recovery action plan been implemented and will continue through 24/25 focusing on reaching 90%	R Edwards	February 24
Review/refresh of booking and procedure times to ensure lists booked more accurately .	D Robinson	Q4 23/24
Development of speciality specific productivity dashboard to become breakthrough objective for each speciality	S Williams	Q1 24/25

Key Standards | Cancer 62 days

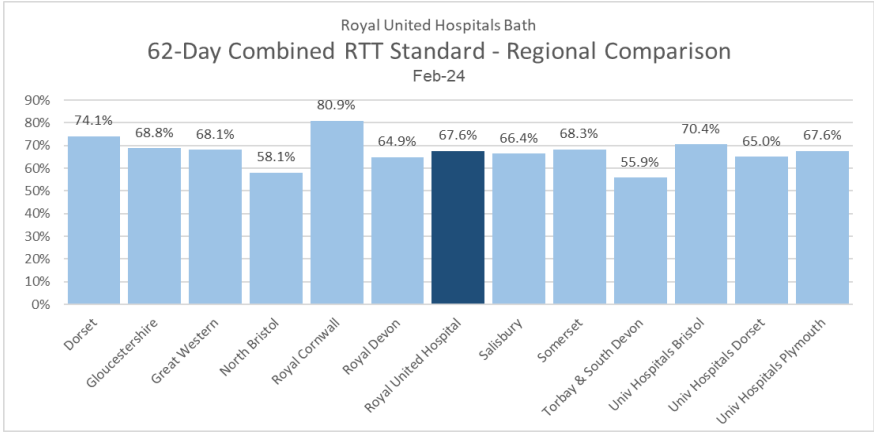
Performance target; 85% of patients treated within 62 days of referral on a cancer pathway

Historic Data



Supporting data

Regional 62 Day Combined RTT Comparison



Is the standard being delivered?

February performance was 67.6% (January 68.7%). March saw a continued reduction in the backlog, which was 108 patients at the end of March following a recent high of 270 in January.

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

62 Day Treated:

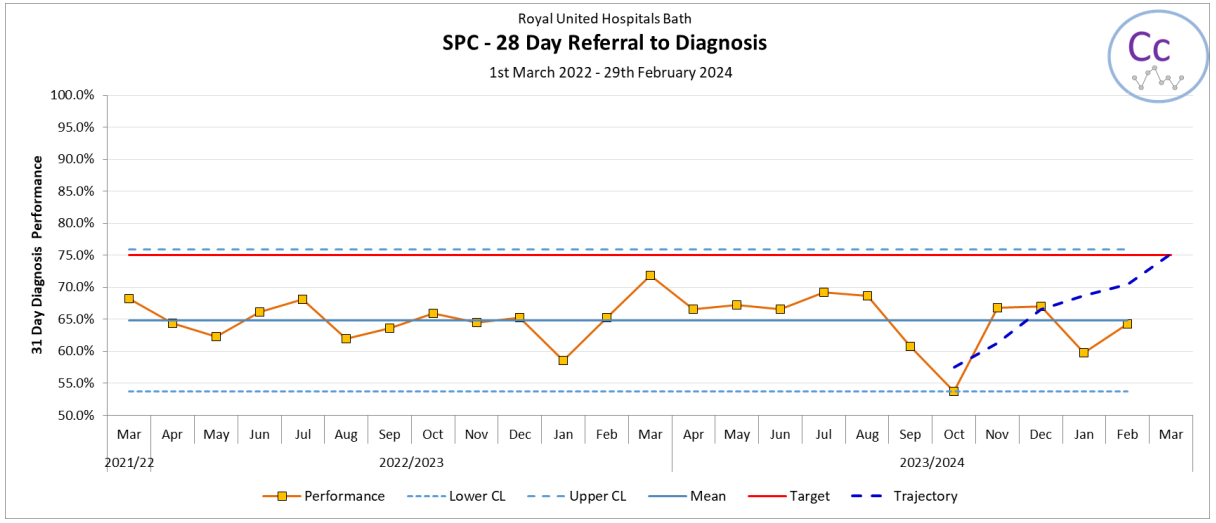
- Urology saw a slight deterioration in performance. Most breaches remained for patients with prostate cancer, due to longer waiting times for MRI, biopsy and surgery.
- Non-prostate pathways saw delays in initial outpatient and diagnostics as a result of cancelled capacity due to the junior doctor strikes in December and January.
- Colorectal had very challenged performance with breaches due to outpatient and diagnostic waiting times as well as for Oncology appointments.
- Endoscopy recovery space works delayed by 2-3 months.
- Skin performance was impacted by delays to excisions and an increased number of patients undergoing biopsies before primary treatment, leading to extended pathways.
- Lung breaches remained high with delays at UHBW for surgical outpatients and treatment. Some reduction in waiting time noted but long delays remain.
- **62 Day Waiters (backlog)**
- The 62 day backlog position recovered during February and March, ensuring the Trust overachieved against the end of year fair shares target.

Countermeasures / Actions	Owner	Due Date
Trust-wide – Bids submitted to Cancer Alliance for funding for capacity increase and service development programmes	E Nicolle	May 2024
Endoscopy – Increased recovery space – works delayed, completion expected in June	R Weston	June 2024
Skin – Recruitment to locum consultant and specialty doctor roles – interviews in April	G Lewis	April 2024
Skin – Insourcing for minor ops – to cover capacity gap March/April onwards	G Lewis	April 2024
Urology – Improve robotic prostatectomy efficiency – two cases per session	J McFarlane	March 2024
Lung – Surgical waiting time discussions with UHBW	V Masani	April 2024

Key Standards | Cancer 28 days

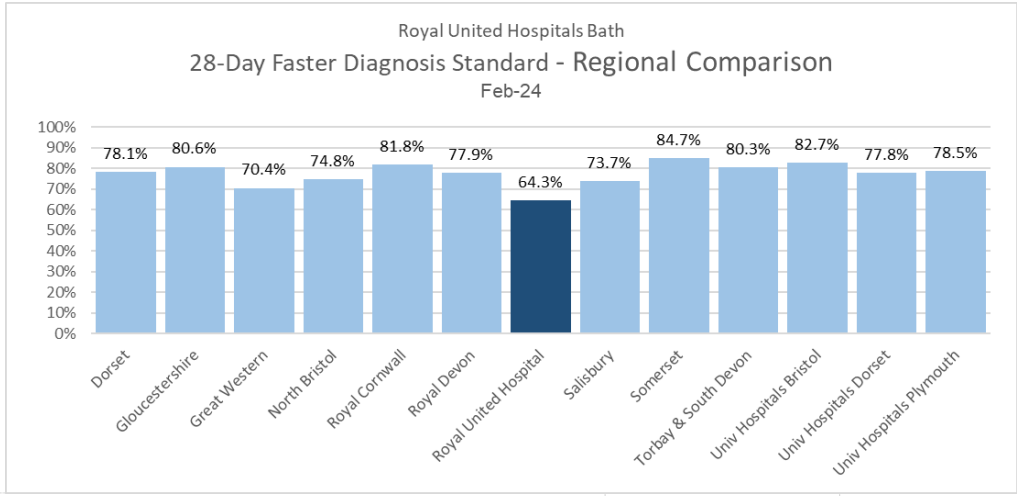
Performance target; 70% of patients given their diagnosis within 28 days of referral

Historic Data



Supporting data

28 Day FDS Regional Comparison



Is the standard being delivered?

In February performance was 64.3%, an improvement from 63.1% in January.

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

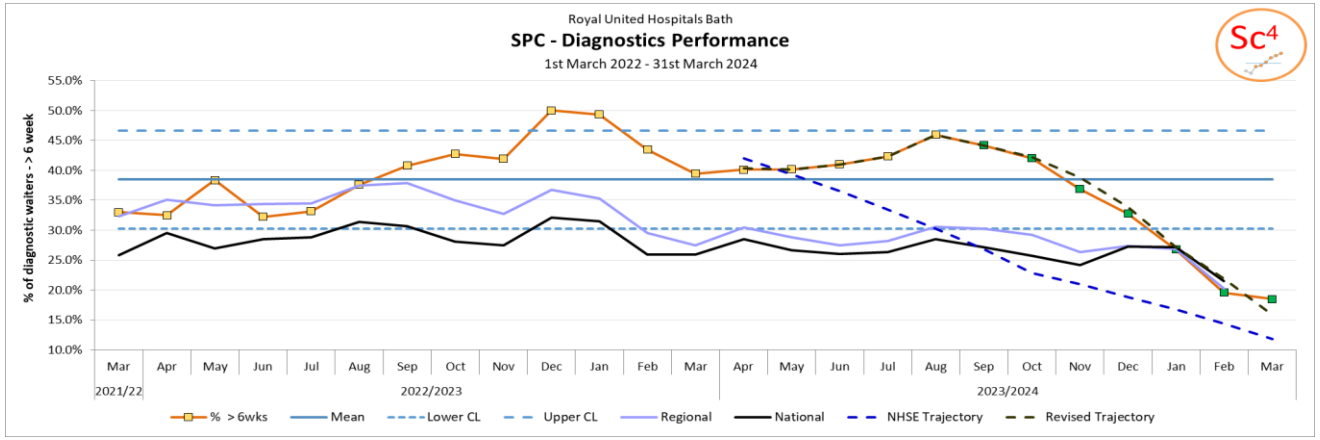
- Colorectal performance remained very challenged with large numbers of breaches and performance of 21.5%.
- Waiting time for diagnostics remains one of the key drivers for performance.
- Cancellations/DNAs of endoscopy and imaging appointments remained a top contributor to the capacity challenges.
- Performance in Upper GI was impacted by the same diagnostic challenges with longer waiting times for OGD as colonoscopy capacity was increased to support Colorectal
- Urology performance was below target but did improve in February as the backlog of patients awaiting haematuria diagnostics was cleared.
- Skin and Gynae both improved following diagnostic capacity increases and pathway changes.
- During February the focus across a number of specialties remained on reducing the 62 day backlog with priority for capacity given to the longest waiting patients, the consequence of which was increased 28 day breaches as backlogs reduced through February and March.

Countermeasures / Actions	Owner	Due Date
Endoscopy – Increased insourcing capacity – additional 15 colonoscopies per week – Works delayed until June	R Weston	June 2024
Endoscopy – Establish pre-assessment service – jobs advertised	R Weston	June 2024
Endoscopy – Visibility of 28 day breach dates through PTL – improved BIU reporting	J Edwards	April 2024
Radiology – CTC patients to receive 2nd confirmation of appointment call to manage cancellation/DNA numbers.	N Aguiar	April 2024
Breast – Full one-stop clinic following staff training and recruitment	H Wheeler	September 2024

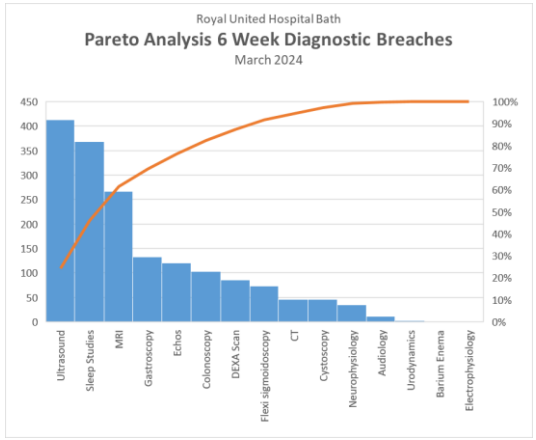
Key Standards | Diagnostics 6 weeks

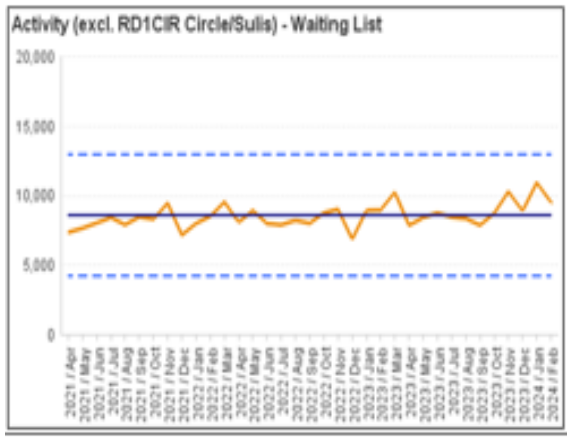
Performance target; No more than 15% of patients waiting over 6 weeks for their diagnostic test

Historic Data



Supporting data





Is the standard being delivered?

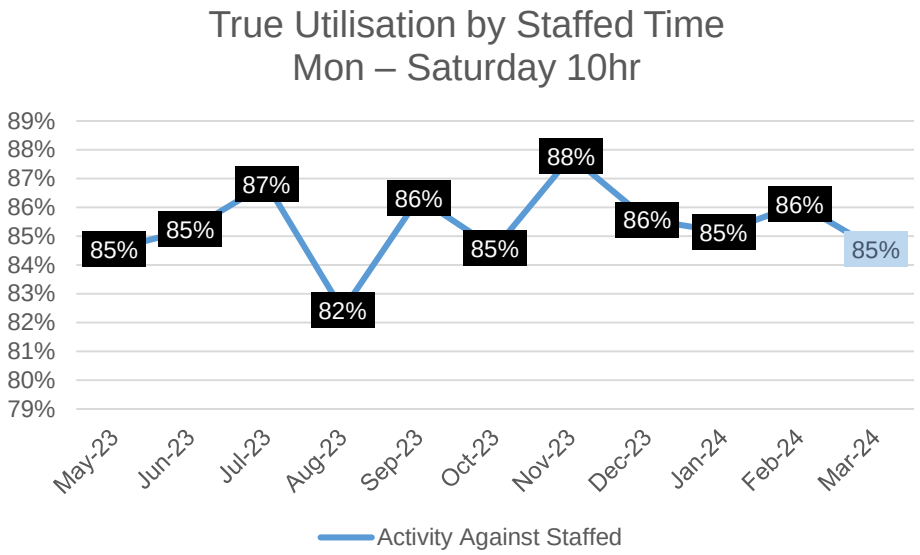
March 2024 >6-week performance was **18.47%**, which represents a decrease in total breaches from previous month (**-1.08%**). USS, CT and Neurophysiology were the top contributors for improvement. DM01 performance did not hit forecasted trajectory (15.85%). To achieve the trajectory would require a further 350 diagnostic test to be delivered. Performance has been affected by the ongoing increase in demand for cancer diagnostics and prioritisation of the cancer standards. Overall, the percentage of patients accessing a diagnostic test within 6 weeks is increasing, the actual number of patients breaching is reducing and the total activity for diagnostics performed per month is increasing (now exceeding **10k** tests per month).

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

- Top contributors: Ultrasound, Sleep Studies and MRI.
- Improvement in performance in CT, USS, Neurophysiology and Audiology.
- Decline in performance in-month for Echo, Sleep Studies, MRI, Endoscopy and Cystoscopy.
- High demand for clinically urgent (2WW) and long RTT waiter requests continue to impact of overall capacity for routine investigations, especially with the increased focus on colorectal recovery.

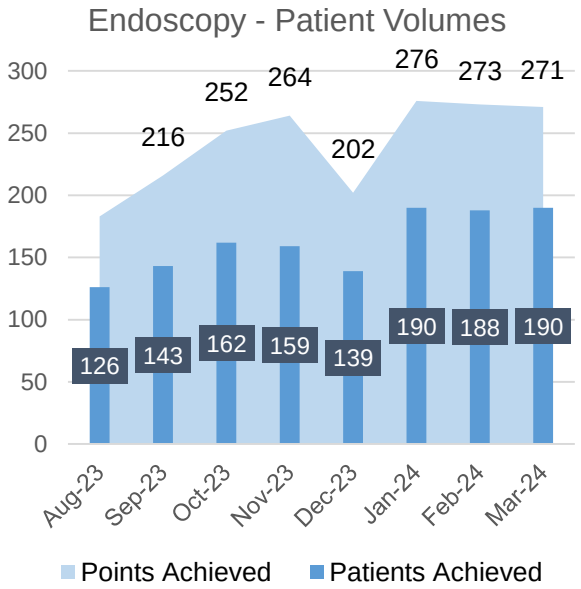
Countermeasures / Actions	Owner	Due Date
Increased Radiology activity at Sulis CDC (CT, MRI and USS). Increased capacity available from April 2024.	NA / TB / MC	April-24
Establishment of electronic process for referral transfer to Sulis CDC – enable real-time monitoring of status of referrals.	RW / MC	April-24
Update new DM01 trajectories and revised action plans (on Team channel)	All modalities	April-24
Transfer of Sleep Studies service to Sulis CDC	MHW	May-24
Increased Endoscopy capacity at Sulis.	RW / JE	April-24
Review and early action: • > 13 weeks breaches review and booking	JA/NA	Ongoing

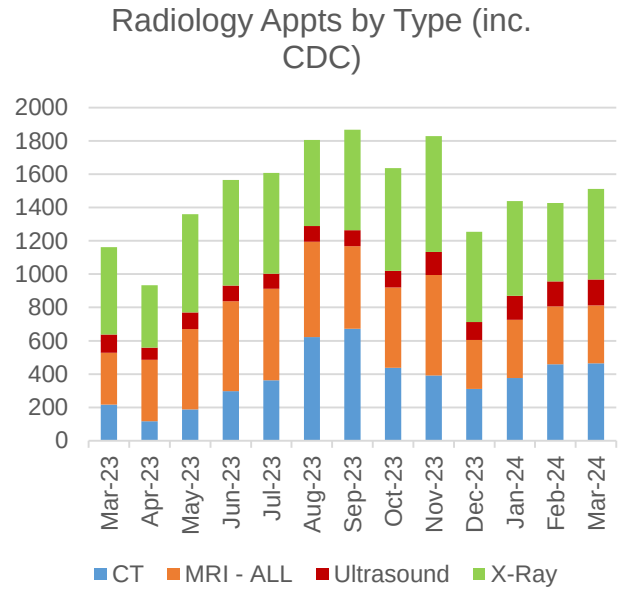
Key Standards | Sulis Hospital



RTT: **74% - ↓4%**

Weeks	PT QTY
78+	0
65+	11
31-65	404
19-30	747
0-18	2219





Is the standard being delivered?

- Theatre uptake was improved and was 93%.
- 85% activity utilisation 10 hour metric
- Endoscopy session slightly down to 72%. Activity levels maintained through better list utilisation. Activity volume of JAG points 271 (190patients) - (75% utilisation against staffed time).
- Radiology volumes increased 6% MoM. Radiology volumes through outside of CDC Programme are down, with a private payor group in decline.
- Ultrasound capacity improved with 14% increased for CDC activity.
- Sulis RTT position currently at 74% compliance overall – Improvements required in validation. Long waits reported from Spinal Pathway, subject to process review.

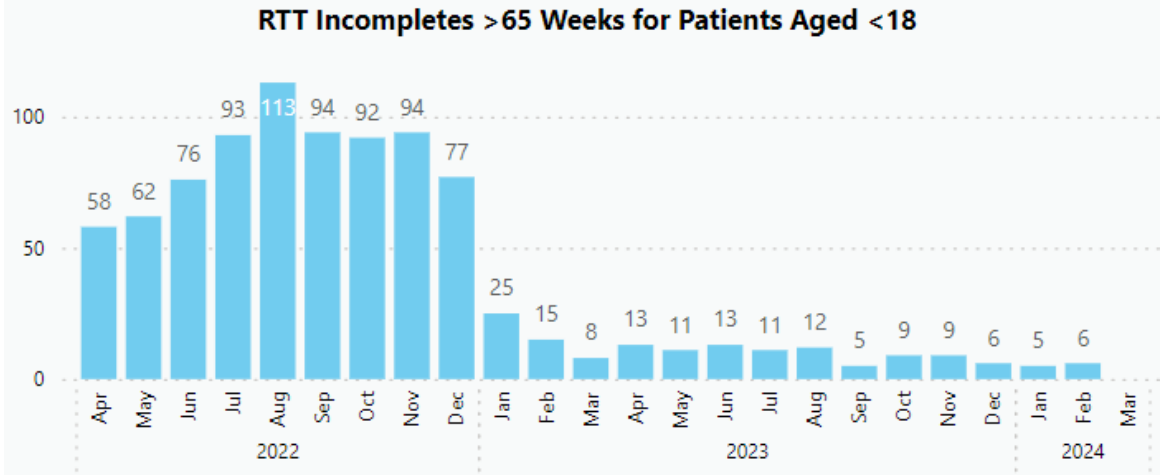
What's the top contributor for under/over achievement?

- Main highlights are Theatre utilisation and uptake being maintained.
- Radiology CDC project hitting planned targets.
- Endoscopy volumes maintained despite slightly fewer staffed sessions – better activity utilisation.
- IPT programme being reviewed with RUH – specifically how RTT is reported..
- Cardiology utilisation needs to be improved with more capacity now available.

Countermeasures / Actions	Owner	Due Date
Improved IPT pathways with RUH – Specifically around supporting surgery division with ENT and Spinal non-admitted pathways. .	Milner	April 24
Need to establish service transfer/ Service development for Sleep Service and transnasal endoscopy (TNE) service	Milner	May 2024
Improve direct access for CDC activity – Radiology, Cardiology, Endoscopy	Milner	Ongoing
Explore direct to scope pathway from community/ RUH to Colonoscopy (Endoscopy)	Milner	May 24

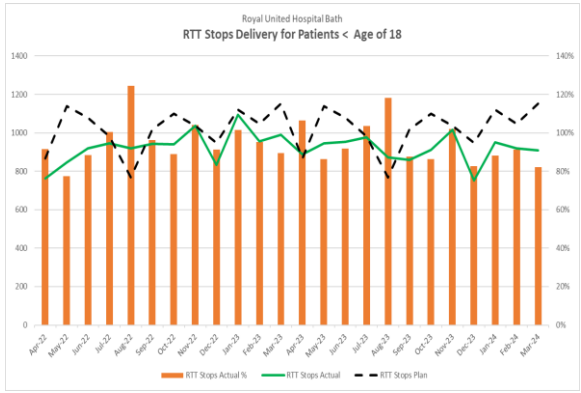
Key Standards | Paediatrics

Historic Data

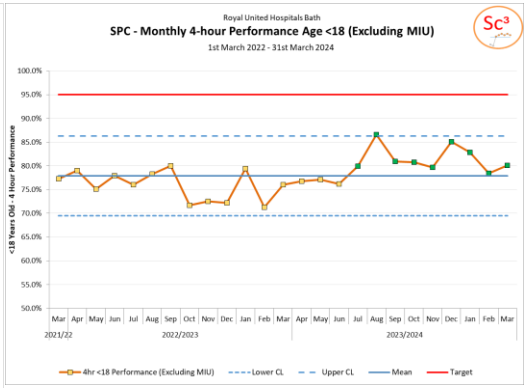


Supporting data

Stops v Plan



4 hr performance



Is the standard being delivered?

- RTT non-compliant – In March we reported 0 patients <age of 18 waiting >78 weeks and 0 patients waiting over 65 weeks.

- Cancer 28 Day Diagnosis compliant – 77.7% in February (9 patients - x2 breaches). One patient waited longer for breast imaging following an outpatient appointment. One patient breached due to the waiting time for communication of results to the patient following treatment. Both patients were confirmed non-cancer.

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

Increasing paediatric surgical capacity via adult footprint. The new paeds area in day surgery has opened, unlocking additional capacity.
Paediatric Orthopaedic capacity remains challenged

Countermeasures / Actions	Owner	Due Date
Paediatric Surgical (Day case) working group set up to optimise performance – increased dental booking to 8 cases per list	Goodwin	Completed.
ED paediatric team and PAU working closer together to improve pathways and processes. FirstNet screen to be brought online in PAU by 22/4/24.	Gilby / Potter	In progress
Paediatric Surgical working group working to further optimise paediatric day-case capacity from the current 26 cases/week to 48 cases/week	Goodwin	Completed

Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

April 2024 – (March 2024 Data)

The RUH, where you matter

Executive Summary I

				National Survey	
	Performance Indicator	Performing	Outside Tolerance	2022	2023
Trust Goal	Staff Recommend Trust as Place To Work	>=65.0%	<60.0%	62.49%	68.10%
Breakthrough Goal	Experienced Discrimination from Manager/Colleague	<=5.0%	>5.75%	8.1%	8.2%

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Key Standard	Trust Vacancy WTE (Unit 4)	<=212.8	>239.4	319.7	359.5	339.6	330.9	252.5	225.0	133.9	176.8	104.5	91.8	56.2	80.4
Contextual Information	Trust Establishment WTE (Unit 4)			5586.4	5633.6	5642.7	5645.5	5659.5	5694.5	5671.4	5693.8	5689.9	5690.5	5700.2	5699.4
Contextual Information	Substantive WTE (Unit 4)			5266.6	5274.1	5303.2	5314.6	5407.0	5469.4	5537.5	5517.0	5585.4	5598.7	5643.9	5619.0
Key Standard	Vacancy Rate	<=4.0%	>4.5%	5.72%	6.38%	6.02%	5.86%	4.46%	3.95%	2.36%	3.11%	1.84%	1.61%	0.99%	1.41%
Key Standard	In Month Turnover	<=0.92%	>1.00%	0.99%	0.63%	0.80%	0.55%	1.01%	0.94%	0.63%	0.52%	0.49%	0.53%	0.51%	0.72%
Key Standard	Rolling 12 Month Turnover	<=11.0%	>12.0%	11.72%	11.34%	11.07%	10.48%	10.21%	9.94%	9.35%	9.24%	8.98%	8.78%	8.52%	8.33%
Contextual Information	Leavers Inside 1st Year WTE (Permanent Contract Held, All Reasons)			10.5	7.0	7.2	3.2	11.3	6.9	4.8	4.9	3.2	3.3	3.6	6.0
Contextual Information	Bank Use (Staffing Solutions Data)			312.6	336.7	311.8	222.2	219.9	234.4	255.0	241.2	196.2	204.5	193.6	183.3
Contextual Information	Agency Use (Staffing Solutions Data)			75.1	87.0	87.0	82.7	84.3	77.6	63.3	43.7	28.5	20.8	18.8	20.8
Key Standard	Agency Spend as Proportion of Total Pay Bill	<=2.5%	>4.0%	3.30%	3.65%	3.70%	3.81%	2.27%	3.27%	2.14%	2.47%	2.13%	0.33%	2.22%	1.12%
Contextual Information	Agency Spend			£855k	£1000k	£976k	£981k	£636k	£874k	£590k	£683k	£588k	£87k	£600k	£446k
Contextual Information	% of agency usage that are off framework			30.93%	26.56%	25.38%	24.49%	13.63%	Not Avail	16.86%	2.88%	1.13%	1.58%	0.54%	3.62%
Contextual Information	% agency shifts that are above price cap			43.09%	49.01%	49.93%	55.69%	83.70%	Not Avail	73.74%	94.51%	81.9%	76.9%	81.4%	82.9%
Key Standard	Nurse Agency Spend as Proportion of Registered Nursing Pay Bill	<=3.0%	>4.0%	4.28%	4.50%	4.80%	4.45%	2.76%	4.81%	3.73%	3.73%	3.62%	0.85%	2.16%	1.57%
Key Standard	In Month Sickness Rate (Actual) - Reported 1 month behind	<=5.1%	>5.6%	4.24%	4.28%	4.26%	4.70%	4.24%	3.93%	4.53%	4.40%	4.66%	4.90%	4.76%	
Contextual Information	In Month Sickness - Estimated Cost (£m)			£667k	£718k	£679k	£780k	£691k	£655k	£794k	£736k	£807k	£860k	£804k	
Key Standard	Rolling 12 Month Sickness Rate - Reported 1 month behind	<=4.3%	>4.8%	4.95%	4.92%	4.82%	4.68%	4.66%	4.63%	4.59%	4.56%	4.46%	4.45%	4.47%	
Tracker	Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.05%	1.05%	1.08%	1.13%	1.14%	1.15%	1.18%	1.22%	1.22%	1.19%	1.19%	
Contextual Information	In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.06%	1.09%	1.19%	1.31%	1.18%	1.08%	1.24%	1.30%	1.22%	1.11%	1.20%	

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

** Vacancy figures does not include reserves or QIPP

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Sickness Absence	The 12-month rolling sickness absence rate remains above target at 4.47%, with Anxiety, Stress and Depression sickness increasing slightly in month during Feb 24.	Sickness reduction project being developed in April 24 to reduce absence in 2024/25 by 1%. RCA of MSK sickness has taken place – countermeasures being reviewed.

Executive Summary II

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Tracker	Global Majority likelihood of being appointed from shortlisting - comparative ratio to 1 White (WRES 2) - Rolling 3 months	0.8 - 1.25	<0.8 or > 1.25	0.68	0.69	0.73	0.67	0.62	0.58	0.62	0.64	0.70	0.67	0.64	0.56
Contextual Information	% of Band 6/7 who are from Global Majority Background (WTE)			13.24%	13.10%	13.13%	13.11%	13.63%	14.08%	14.48%	14.81%	14.81%	15.14%	15.02%	15.17%
Contextual Information	% of Band8A+ who are from Global Majority Background (WTE)			5.10%	5.37%	5.89%	5.51%	5.44%	5.36%	5.03%	5.83%	6.16%	6.11%	6.10%	6.49%

				Last 12 Months											
	Performance Indicator	Latest Month Target	Outside Tolerance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Key Standard	Appraisal Compliance Rate	>=90.0%	<85.0%	77.15%	75.00%	74.93%	75.03%	73.41%	71.94%	71.44%	72.67%	74.84%	75.82%	77.05%	77.07%
Contextual Information	Global Majority Appraisal Compliance Rate	>=90.0%	<85.0%	76.16%	74.73%	74.73%	75.83%	72.73%	69.63%	67.63%	69.76%	71.82%	73.02%	75.67%	76.77%
Key Standard	Mandatory Training Compliance (exc Bank)	>=85.0%	<80.0%	86.59%	86.49%	87.60%	88.54%	89.54%	89.01%	89.37%	89.37%	89.82%	90.29%	90.84%	90.40%
Key Standard	IG Training Compliance (exc Bank)	>=95.0%	<90.0%	81.27%	81.88%	82.94%	84.23%	86.05%	86.20%	85.72%	86.18%	86.79%	87.62%	88.40%	87.70%
Key Standard	Safeguarding Adults Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	86.34%	86.56%	88.85%	90.88%	92.08%	91.41%	91.81%	91.62%	92.10%	92.44%	92.81%	92.42%
Key Standard	Safeguarding Adults Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	86.98%	87.20%	89.86%	90.75%	91.69%	90.74%	90.99%	90.68%	91.31%	91.02%	91.84%	91.35%
Key Standard	Safeguarding Adults Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	71.68%	81.74%	81.42%	88.29%	92.92%	93.58%	92.59%	96.26%	94.55%	93.75%	89.47%	93.21%
Key Standard	Safeguarding Children Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	87.70%	87.74%	88.79%	90.74%	91.93%	91.44%	91.81%	91.82%	92.23%	92.64%	92.86%	92.19%
Key Standard	Safeguarding Children Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	89.40%	89.48%	90.30%	91.23%	91.96%	91.26%	91.14%	90.97%	91.61%	91.74%	92.46%	91.58%
Key Standard	Safeguarding Children Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	85.79%	86.55%	87.43%	90.36%	89.85%	91.26%	90.88%	91.48%	91.24%	91.97%	90.95%	91.20%

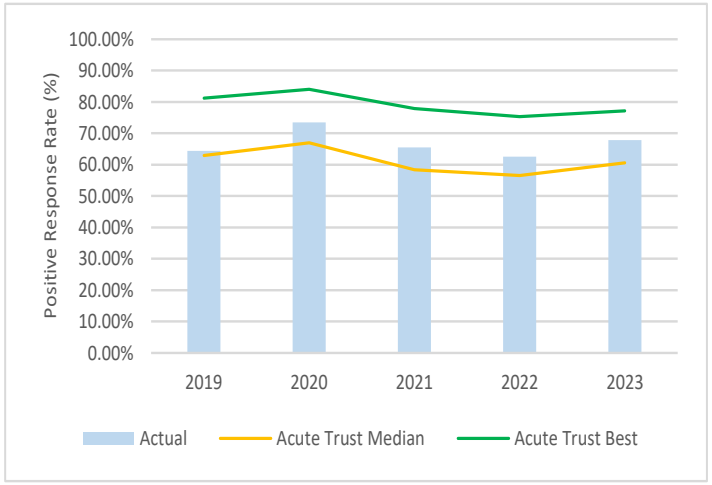
** Training data based on Learning Together from Jun-23; Appraisal and Training information re-stated due to new reporting methodology

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Appraisal	Appraisal compliance remains at 77%. To achieve the 90% target a further 640 appraisals are required to be completed.	Strong focus from Divisions on individuals whose appraisals have expired and will expire in the next 3 months.

Trust Goal | Staff Recommend the Trust as a Place to Work

National Survey Results



Latest Survey	67.9%

Is standard being delivered?

When weighted, 67.86% recommended the Trust as a place to work in the 2023 National Staff Survey. This places the Trust in the top quartile for its benchmark group, ranking 18th overall nationally.

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

Estates and Facilities had the lowest positive response rate at 57.6%.

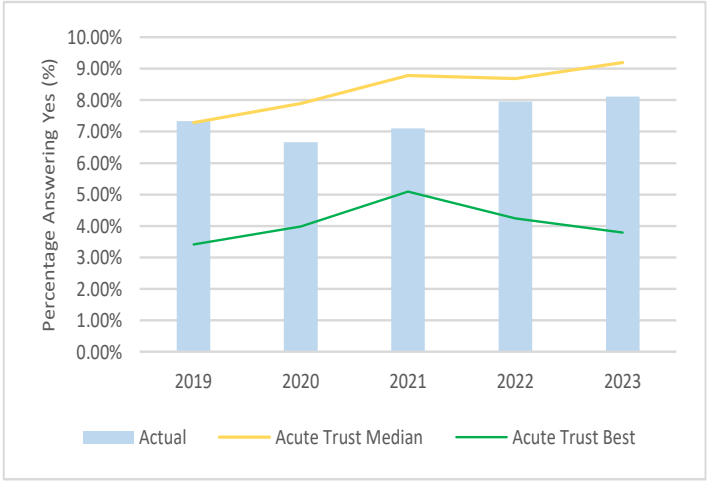
Countermeasure Summary

Countermeasure/Action	Owner
Divisional action plans for staff survey under development. Medicine priorities: Discrimination as per driver measure, ED action plan, Dermatology action plan. Specialty plans under development for each area. E&F Board prioritising lowest scoring themes and focusing efforts to drive across areas. All department managers contacted by HR to discuss results and plan strategy.	Divisional People Partners
Central workstreams continue to prioritise this measure, with projects including; • IHI Framework for Joy in Work • Exploring new, easy to use team development options for struggling areas • EDI projects to increase engagement and provide safe, inclusive working environments. • Change team interventions	People Team for Culture

Breakthrough Goal |

Reduce Proportion of Staff Reporting Experiencing Discrimination from Line Managers/ Colleagues

National Survey Results



Latest Survey	8.11%

Is standard being delivered?

When weighted, 8.11% of respondents stated they experienced discrimination from a manager or colleague. Although this is an increase on the previous year, the Trust is still ranked 39th amongst its benchmark group, placing in the third quartile.

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

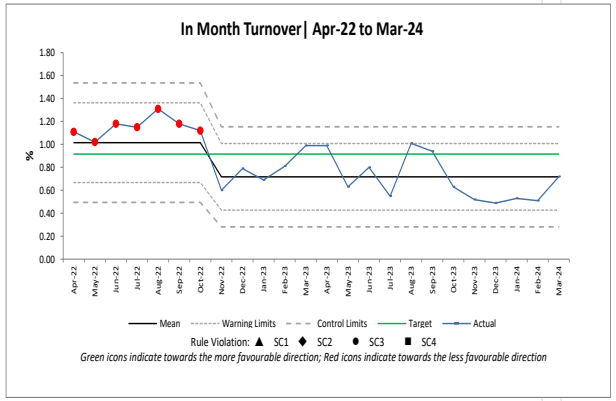
Emergency Medicine had the lowest proportion of staff reporting that they had not experienced discrimination from a manager or colleague at 85.9%.

Countermeasure Summary

Countermeasure/Action	Owner
• Targeted team development interventions (in collaboration with HR) to address identified issues, including emergency medicine. • Introduction of Report and Support in May 2024, to be linked with RUH People Hub – therefore better, swifter support to areas most affected by discrimination. • Launch / embedding of Dignity in Work Programme.	People Hub / DPPs People Team for Culture Programme Lead for DaW

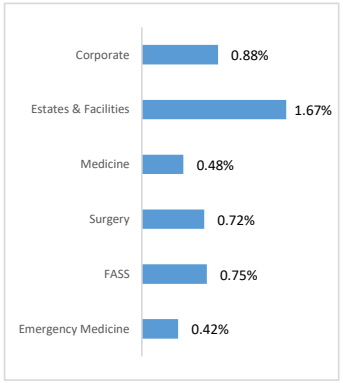
Key Standard| Turnover Rate

In Month Turnover - Trust

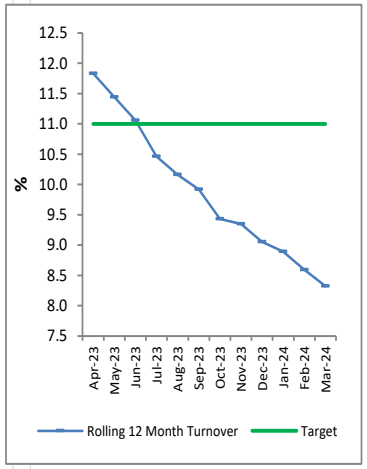


Turnover Rate	0.72%

In Month Divisional Turnover



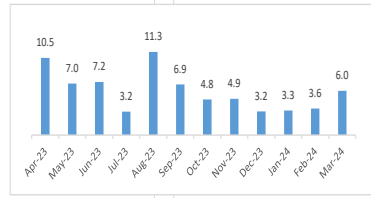
Rolling 12 Months Turnover - Trust



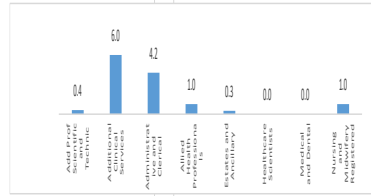
Turnover Rate	8.33%

Leavers Inside 1st Year (Permanent Contract)

Trust Trend



Staff Group - Last 3 Months



Is standard being delivered?

- As it stands in month turnover for March was again low at 0.72%. This is a slight increase on recent months but nonetheless remains below the target of 0.92%.
- 12-month rolling turnover again has marginally decreased to 8.33%.

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

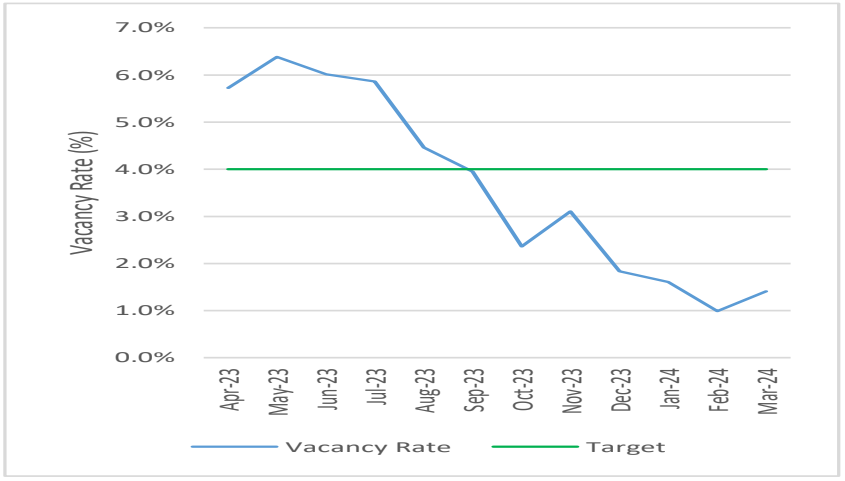
- Estates and Facilities (1.67%) is the only Division to have an in month turnover rate above target, but currently this would not be cause for concern.
- No main Division has a rolling 12 month turnover rate above 10%.
- Compared to recent months, there was a slight upturn in retirements which is not uncommon in March.

Countermeasure Summary

Countermeasure/Action	Owner
Medicine –Work to reduce the Therapies T/O rate has resulted in a reduction from 20% to 12% over the past 12 months. E&F- HR and recruitment working with line managers to improve working conditions for new and existing staff to help improve retention, most recently in Waste portering.	DPP Medicine

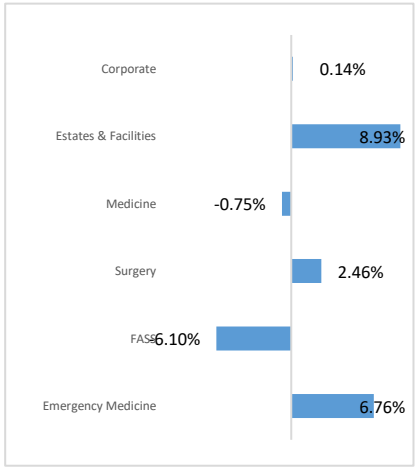
Key Standard| Vacancy Rate

Vacancy Rate - Trust

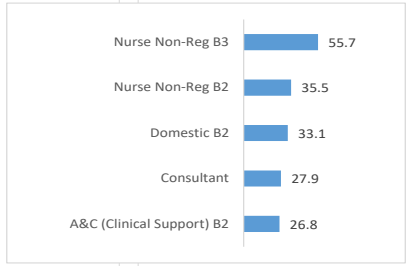


Vacancy Rate	1.41%

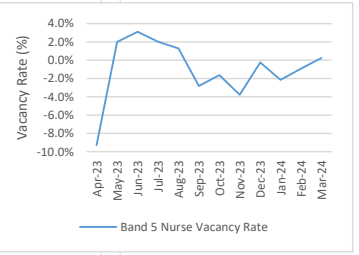
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

The new Financial year may see revised budgets which could impact vacancy rates - As we commence 24/25 the current vacancy rate is 1.41% which is equivalent to 80.4WTE.
April vacancy rate has increased slightly from our year end position as March recorded 0.99% or 56.2WTE.

We continue with the positive position of remaining below our target position of 4% and have done for over 6months.

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

At a Divisional level; Estates and Facilities have the highest vacancy rate at 8.93% which primarily is cleaning vacancies.

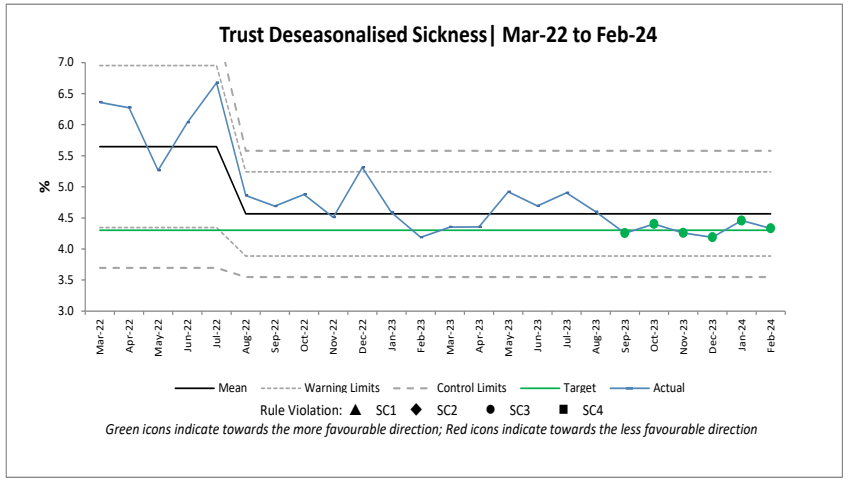
Medicine is showing as being over-established by 0.75% with Older People's Unit, Radiology and Gastroenterology being key contributors

Countermeasure Summary

Countermeasure/Action	Owner
Our Employee Value Proposition launches in May to support our vision of being one of the top 3 Trusts that staff recommend a place to work – work underway to ensure recruitment collateral has the new look and feel	AD for Capacity & Head of Comms
Immigration legislation is changing so we're supporting Recruitment to attend a BSW collaborative training workshop to upskill their knowledge	Recruitment Team
To support our new Talent Acquisition ways of working – We've secured a partnership with Wiltshire College to promote our opportunities and support our local community to apply for posts commencing in April	Recruitment Team
Trust led Vacancy Control and Agency Reductional Panel continues to supports having the right people, in the right posts against our workforce plans. The new controls and scrutiny are supporting the Trust financial recovery plans.	Executive Team

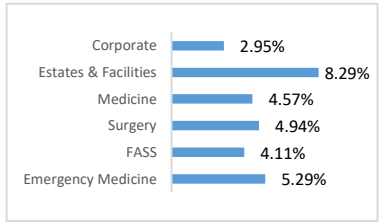
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

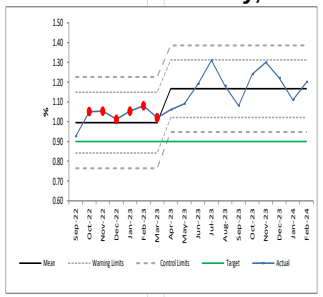


In Month Actual	In Month Deseasonalised	Rolling 12 Months
4.76%	4.33%	4.47%

In Month Divisional Sickness Rates



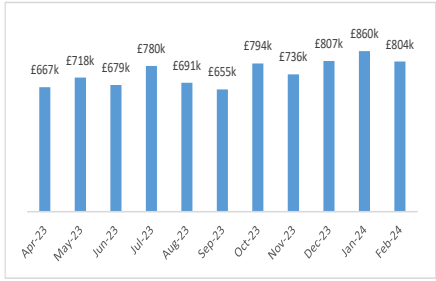
Anxiety, Stress & Depression - Trust



1.20%

Absence Rate

Estimated Absence Cost



RIDDOR Reporting - Employees

	2022/23				2023/24			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Dangerous Occurrence –release or escape of biological agents	-	-	-	-	-	-	-	-
Exposed to harmful substance/ Work acquired Infection	2	2	-	1	-	-	-	-
Lifting and handling injuries	3	1	1	1	-	1	3	-
Physical assault	1	1	1	2	1	-	-	-
Slip, trip, fall same level	3	2	1	1	-	1	3	1
Struck against	-	-	1	-	-	-	-	-
Struck by object	1	-	-	-	1	-	-	1
Fell from height	-	-	-	-	2	-	1	-
Another kind of accident	-	-	1	-	-	1	1	2

Is standard being delivered?

• In month sickness in February was 4.76%, which was below the seasonally adjusted monthly target.

• Rolling 12-month sickness continues to exceed the targeted position of 4.3%, currently standing at 4.47%.

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

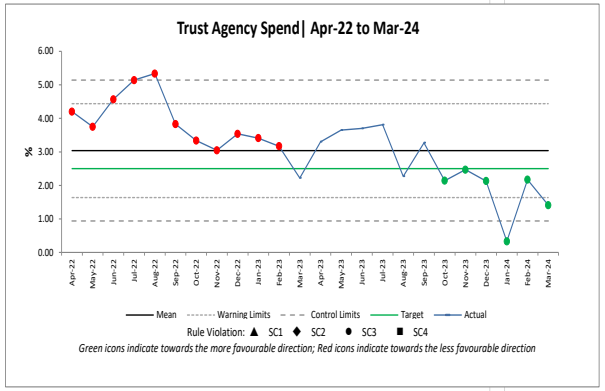
• Anxiety, Stress and Depression continues to be on a sustained run above target, in-month rate for February =1.20%.

Countermeasure Summary

Countermeasure/Action	Owner
E&F continue to focus efforts on driving down sickness rate. Dropped slightly in month. Problem areas remain catering and cleaning- HR leading bespoke Sickness Absence training to E&F teams. E&F board challenging departmental managers to produce action plans to tackle high percentages. Medicine: Top 50 sickness cases reviewed on a monthly basis. Support provided to departmental managers at 1:1's and training on sickness management delivered in hot spot areas.	Divisional People Partners
RCA of MSK sickness has taken place, countermeasures being developed, costed and ROI identified.	H&WB lead

Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

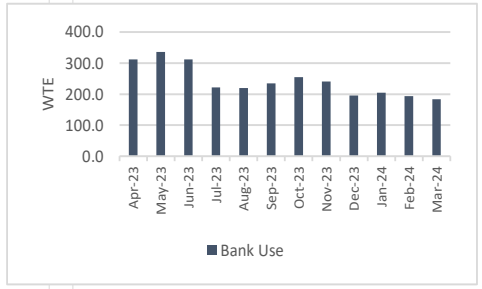


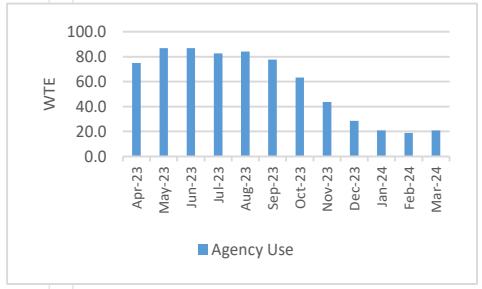
Proportion	1.12%

Agency Spend Breakdown

	In Month	FYTD
Consultants	£224,351	£2,652,815
Junior Medical Staff	-£1,091	£76,611
Non Medical - Non-Clinical Staff	£76,692	£1,535,803
Registered Nurses & Midwives	£134,468	£3,501,495
ST&T - Allied Health Professionals	£11,931	£545,757
ST&T - Health Care Scientists	£0	£1,438
ST&T - Other	£0	£4,556

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

Agency spend figures are provisional, whilst accounts are being finalised. As it stands, our in month agency spend was 1.12% or 20.8WTE in March continuing the general downward trend in agency use across the Trust..

The Agency Reduction plan continues to support the Trust to be within or below our internal target position for the last 8months. The work supports Managers to develop exit plans for agency workers by recruiting substantively, if required or moving high cost workers onto the Bank, moving to framework suppliers to secure price caps which all supports financial savings and increased compliance.

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

Surgery is the top contributor for agency spend, with Theatre workers and Cellular Pathology being the two highest spending departments across the Trust. Work is underway to support the division in reducing their reliance on high cost agency workers. For example, We have reduced the agency rate card for Band 5 theatre workers as part of our South West Regional Agency rate card reduction without impacting on cover.

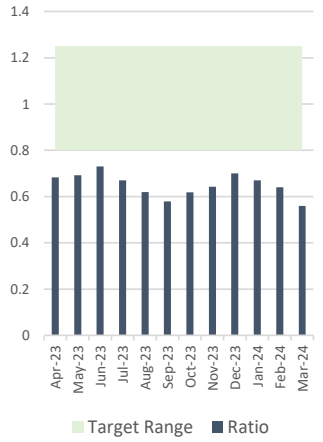
Consultants remain the staff group with the highest agency spend this quarter - Work is progressing with the PAN South West region to reduce our agency rate card for medical workers.

Countermeasure Summary

Countermeasure/Action	Owner
Divisional workforce data tracked prospectively (and retrospectively) and shared with divisional teams to support management of spend	Head of Workforce Planning
South West Regional Agency Rate card for Nursing going live in April with a further planned stepped reduction in July to reach NHS price cap	Associate Director for Capacity
South West Regional rate card for Medical workers being developed – Go live date to be confirmed. The proposed rate card is not aligned to price cap given Trusts across the region are some way off therefore approach more likely to be longer lead time with planned incremental drops to reach price cap	Associate Director for Capacity
Procurement in the process of awarding contracts to suppliers to operate a 'Preferred suppliers list' for Nursing. Supplier Day being designed for May to support implementation.	Associate Director for Capacity
Bank rate review underway to ensure we operate a fair and transparent approach to our rates which demonstrates value for money and competitive within labour market	Associate Director for Capacity

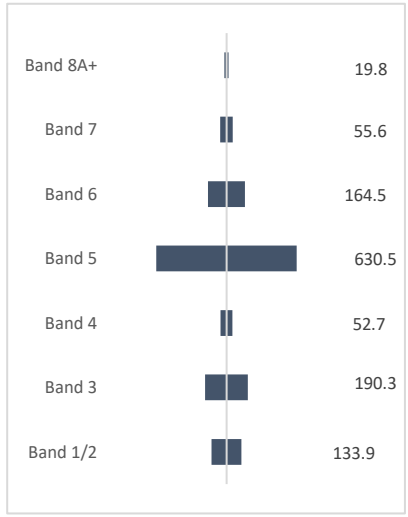
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

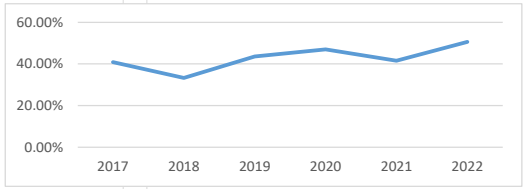


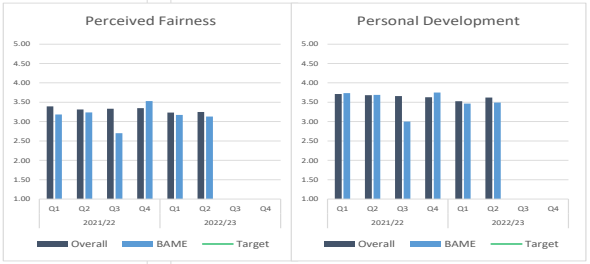
Proportion	0.56

Agency Spend Breakdown



Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

Based on Trac data, the ratio of the likelihood of appointment from shortlisting comparing Global Majority to White candidates has fallen to 0.56. This is moving away from the targeted two-fifths range(0.8-1.25).

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

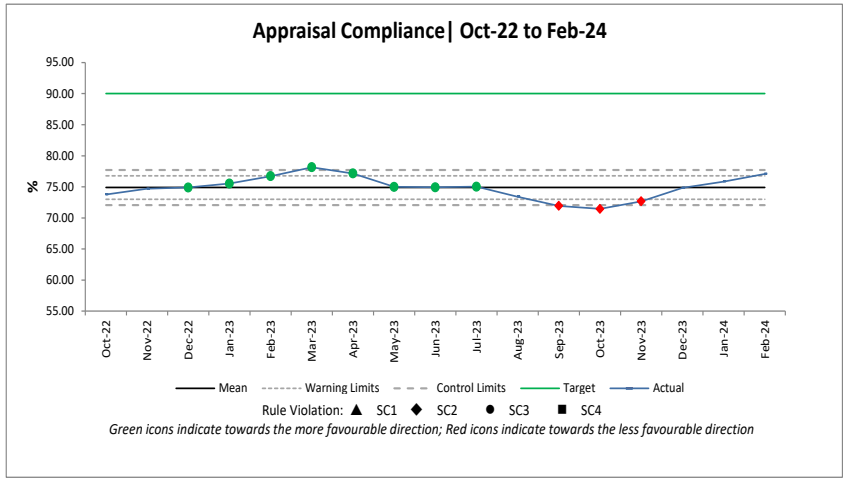
Candidate distribution across vacancies is masked by the aggregation and this has a significant impact in determining the overall figure.

Countermeasure Summary

Countermeasure/Action	Owner
Ongoing workstreams related to People Plan Programme 4, with support from DPPs and People Hub include: • Positive Action Programme • Review of coaching and internal recruitment processes to improve equity. • Staff networks developed further to 'hear' real-time experiences for people, and better support for network chairs to communicate themes for action • Review of DISGro to ensure action-focussed work and clearer reporting to People Committee.	People Team for Culture People Hub DPPs.

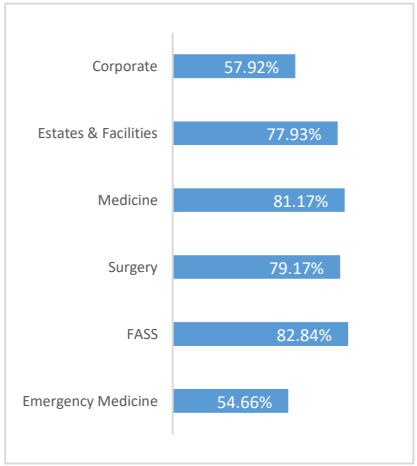
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	77.1%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff	77.1%
M&D Staff	77.2%
Consultants	83.6%
White	77.2%
BME	76.8%

Is standard being delivered?

• Appraisal compliance remains broadly static at 77.07% - almost 13 percentage points below target.

• Based on March's position, over 640 more appraisals would have had to have been completed to achieve the 90% target.

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

• No Division has achieved the 90% target, with only FASS and Medicine above 80%.

• Emergency Medicine and Corporate continue to have the lowest compliance rates and are both below 60%..

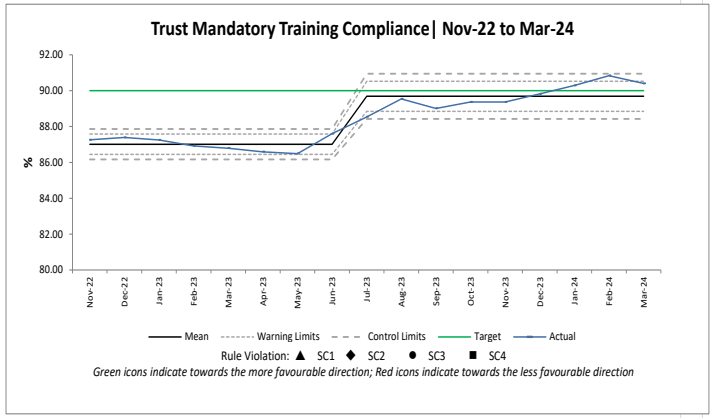
• Based on March's parameters, Corporate, Medicine and Surgery all require well over 100 further appraisals to be conducted to achieve 90%.

Countermeasure Summary

Countermeasure/Action	Owner
E&F Board reviewing obstacles preventing line managers completing appraisals and collating the feedback. HoE and HR partnering to tackle outstanding appraisals across E&F. HR to look at bespoke Appraisal training with Line managers to increase compliance and understand importance of appraisals. Medicine: Trajectory set to improve to 90% compliance over next 6 months. Appraisal review at Specialty review meetings and trajectory reviewed on a specialty basis. Surgery: Sisters and leads all familiarised with dashboard, continued focus on staff who are out of date or due in next 3 months.	Divisional People Partners

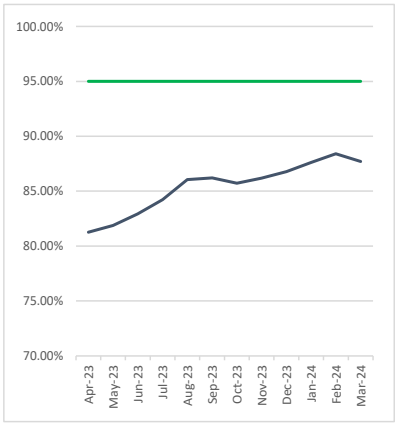
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



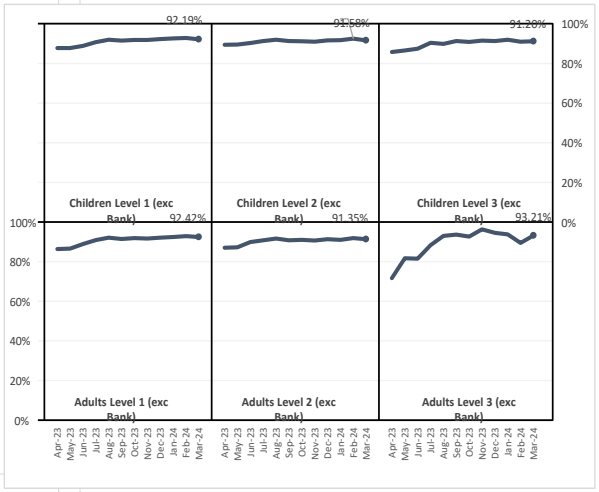
Compliance Rate	90.4%

Information Governance Training Compliance Rate - Trust



Compliance Rate	87.7%

Safeguarding Training Compliance Rates - Trust



Is standard being delivered?

For the first time since the introduction of Learn Together, Mandatory Training compliance has fallen. However, at 90.4%, it remains above the 85% target.

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

Emergency Medicine (81.32%) and Estates and Facilities (82.65%) are the only main Division with a mandatory training compliance below the targeted 85%.

Countermeasure Summary

Countermeasure/Action	Owner
E&F in process of recruiting Training Manager for Cleaning which will support the increased compliance. Looking to review and potentially pilot across all of Facilities in the next 12 months. Medicine: Continued focus on resus subjects, reviewed monthly at specialty review meetings.	Divisional People Partners
Review of Resuscitation delivery frequency and model	Head of Resus
Compliance data monitoring, due to one month decrease.	

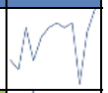
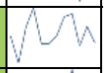
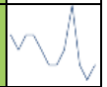
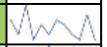
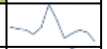
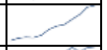
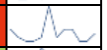
NHS
Royal United Hospitals Bath
NHS Foundation Trust

Quality Report

April 2024 (February 2024 data)

The RUH, where you matter

Executive Summary | Quality

Strategic Goal		Performance Indicator	Description	Target		2022/2023													Trend
				Performing	Under Performing	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Trust Goals	People we care for	Connecting with you - helping you feel safe, understood and always welcome	Reported Patient Safety incidents resulting in significant harm (moderate to catastrophic), excl. rejected			11	18	16	25	18	23	25	26	25	26	13	24	29	
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	51	51	47	53	56	50	50	51	54	55	49	53	50	
		Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	5	4	3	4	4	3	2	2	3	6	2	1	2	
		Number of falls resulting in significant harm (Moderate to Catastrophic)		<=1	>=3	1	4	1	7	0	3	1	4	3	1	0	5	0	
		ED time to triage	Percentage of ED attendances triaged within 15 minutes			57.1%	55.5%	54.6%	54.1%	52.1%	55.6%	65.9%	58.8%	50.3%	52.6%	54.1%	53.1%	48.8%	
		Falls per 1000 bed days	Includes all falls			6.6	7.3	6.2	6.5	6.6	6.5	7.2	6.6	7.1	8.4	7.4	7.1	7.0	
		Medication Incidents per 1000 bed days	All Incidents			6.8	8.5	6.9	7.3	6.2	7.6	7.2	7.8	8.5	9.0	6.5	7.4	7.4	
		Number of Patients given medication by scanning device				20.2%	21.4%	22.7%	23.3%	22.9%	24.2%	27.5%	29.4%	30.1%	33.0%	35.7%	39.5%	40.6%	
		Early Identification of Deteriorating Patient				23.6%	21.2%	20.7%	20.5%	19.7%	18.0%	20.2%	20.3%	22.2%	25.6%	22.9%	25.3%	26.0%	
		Hospital acquired infections				15	20	24	22	16	24	16	11	13	15	15	22	29	
		Number of COVID nosocomial infections				43	26	39	26	8	14	7	20	52	13	15	44	22	
		Number of Hospital Acquired Pressure Ulcers Category 2	Includes Medical Device Related	<=2	>2	1	5	1	1	3	1	4	4	4	2	2	5	4	
		Number of Hospital Acquired Pressure Ulcers Category 3 & 4	Includes Medical Device Related	<=0	>0	1	3	1	0	0	1	9	1	3	3	0	0	2	
		Never events		0	>=1	0	1	0	0	0	2	1	0	0	0	0	0	0	
		Mixed Sex Accomodation Breaches				15	16	113	172	118	57	67	31	94	70	97	163	170	

Notable practice

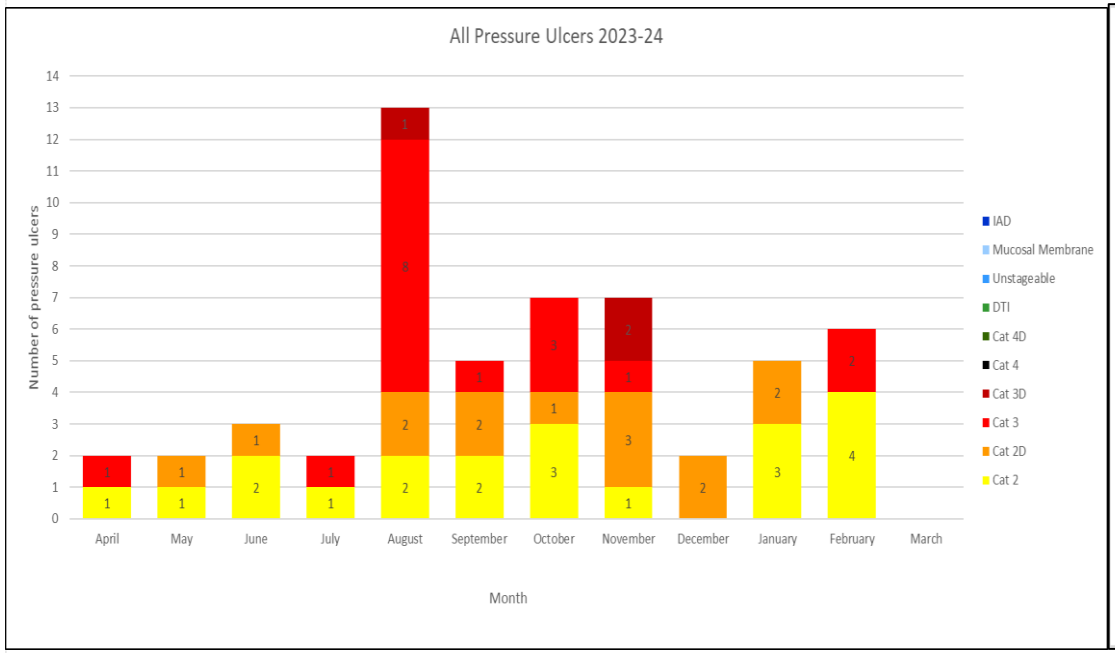
Measure	Executive Summary
Serious Incidents with overdue actions	There are two Serious Incidents with overdue actions in February 2024.
Number of falls resulting in significant harm	There were no falls resulting in significant harm.

Measures requiring focus and a countermeasure summary this month are:

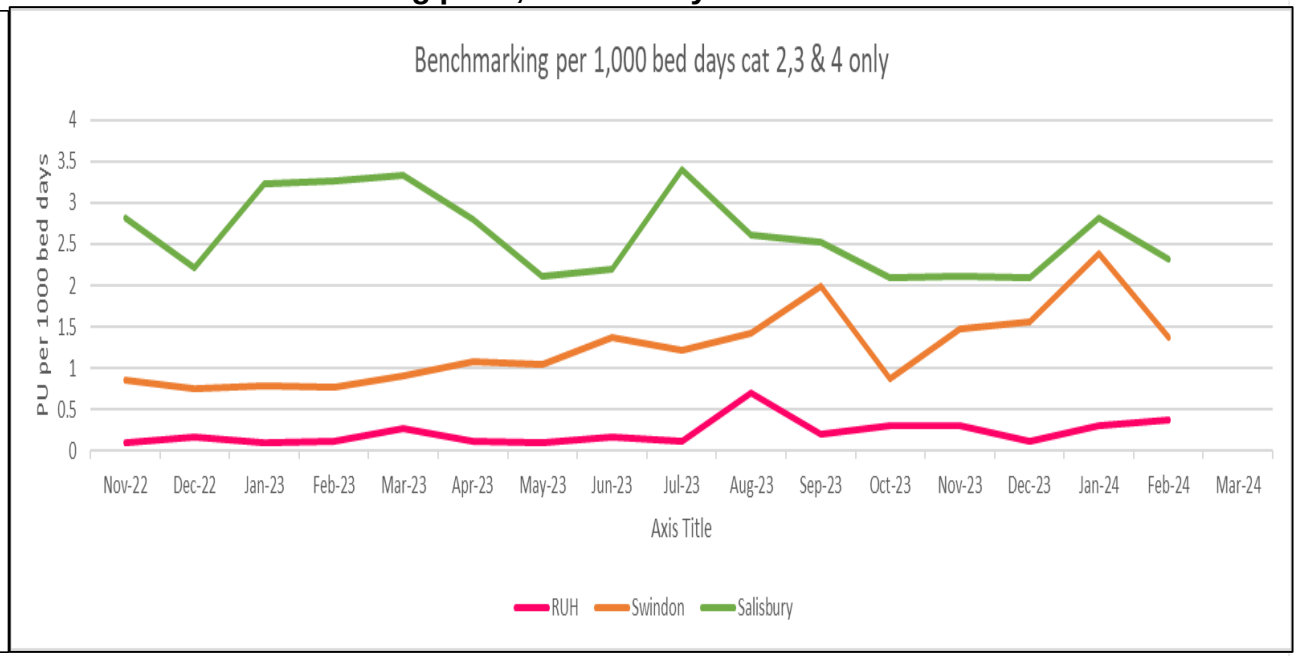
Measure	Executive Summary
Number of Hospital acquired pressure ulcers cat 2	In February the Trust reported four category 2 hospital acquired pressure ulcers. The Trust remains above the threshold with 20 reported up to February 2024 against a threshold of 9. However, local benchmarking shows that the Trust reports fewer pressure ulcers per 1,000 bed days than Trusts across the Acute Hospital Alliance.
Number of Hospital acquired pressure ulcers cat 3 & 4	In February the Trust reported two category 3 hospital acquired pressure ulcers with 17 reported from April 2023 to February 2024. However, local benchmarking shows that the Trust reports fewer pressure ulcers per 1,000 bed days than Trusts across the Acute Hospital Alliance.

Tracker Measures | Pressure Ulcers

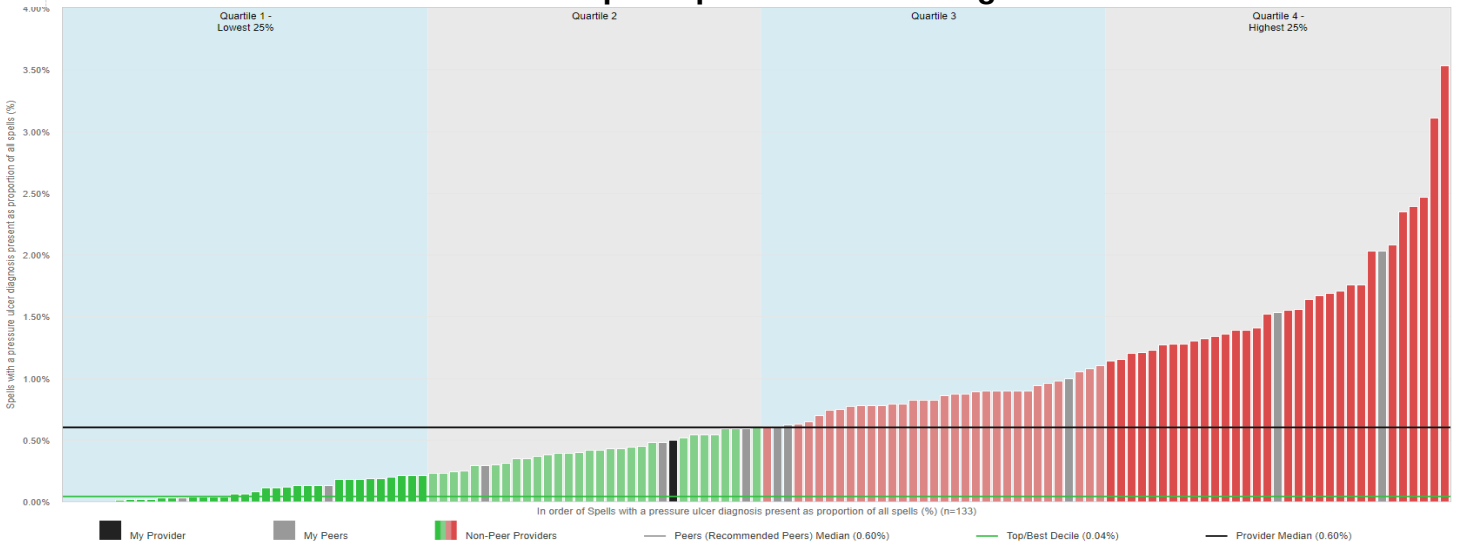
Trust Performance



ICB Benchmarking per 1,000 bed days



How do we benchmark? Model Hospital spells with a PU diagnosis



There were four category 2 pressure ulcers and 2 category 3 pressure ulcers in February 2024. Local benchmarking per 1,000 bed days shows the RUH continues to be a leader in the ICB

Model Hospital Update:

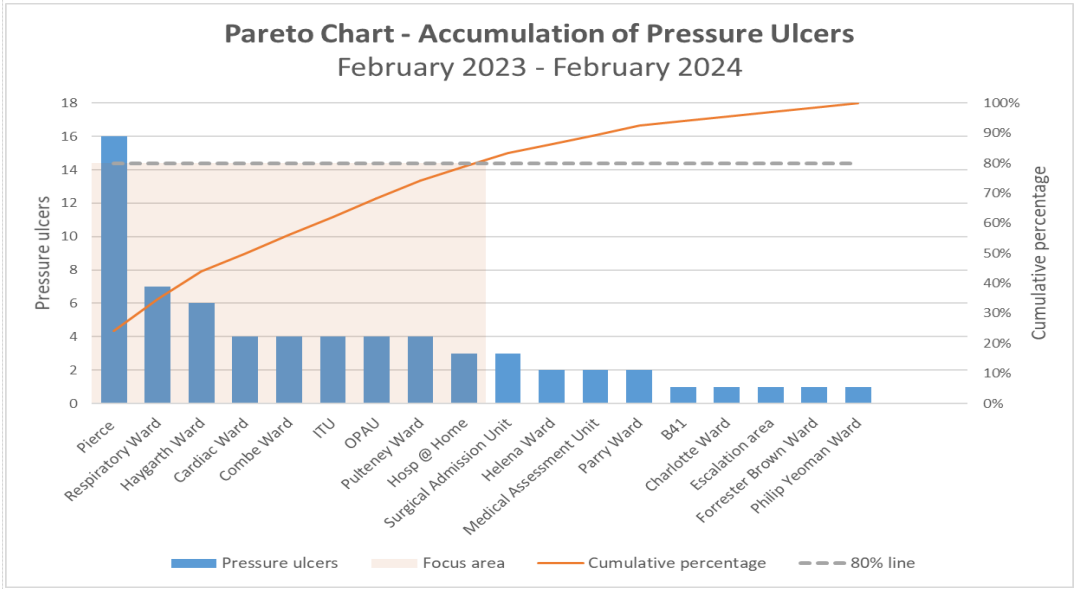
For the period to January 2024, the Model Hospital data shows the Trust has improved and is in quartile 2 - Low for spells with a pressure ulcer diagnosis present as a proportion of all spells. This is an improvement on last month.

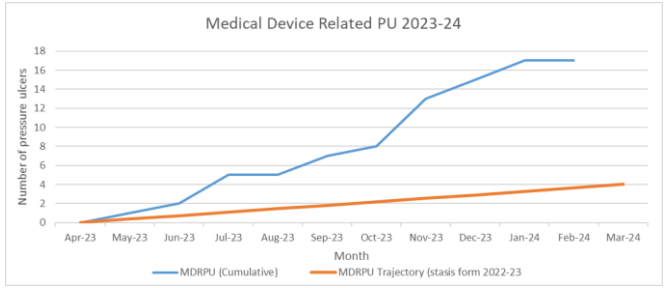
N.B. The data for the local ICB does not correlate with the local benchmarking above. There is no update due to MH lag. The RUH data is collected from coding and through working together improvements have been made.

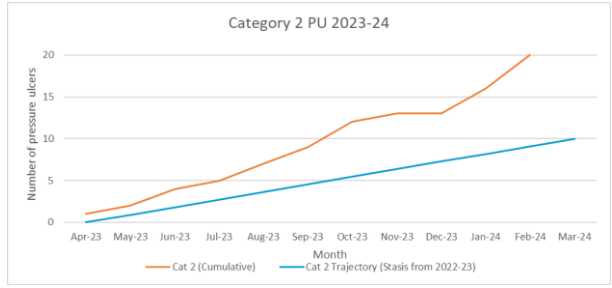
Tracker Measures | Pressure Ulcers

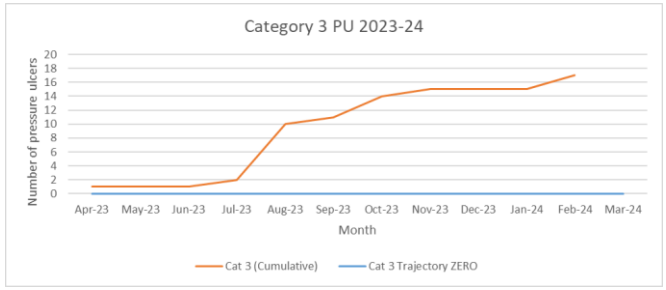
Is there a live A3 / Improvement project addressing this Trust Goal? Yes: Reduce the incidence of medical device related PU by 50% There is a CQUIN to achieve 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.

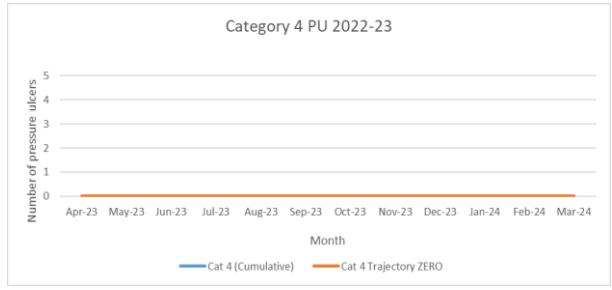
Insights











Pierce ward has now been pressure ulcer free since October 2023. The data collected for the pressure ulcer CQUIN shows improvement for initial risk assessment (Braden) completed within 6 hours of admission (46.2%) and within 24 hours (83.9%).

What are the top 3 contributors for under achievement? What are the top 3 actions for each countermeasure?

Contributor	Countermeasure	Action	Expected Completion Date	Expected Outcome
Skin Assessment – variances across wards under medical devices	Process – for skin assessment to be standardised	Patient experience team to aid with collecting feedback	April 2024	Understand the challenges in particular with skin assessment and skin care
Patient on trolleys for prolonged periods	Expedite the transfer of frail older people from DAA to a ward bed	Senior Sister to meet with site team to discuss a more robust process	April 2024	No frail elderly in DAA over 6 hours
Enhancing knowledge and understanding	Knowledge – training theory to practice gap	TVN to create a QR code for staff responses to test knowledge. This is an additional actions to those already completed	April 2024	Understand the gap and focus on how to increase knowledge and understanding

REGISTERED NURSING & HEALTH CARE SUPPORT WORKER DASHBOARD February 2024

Vacancy rate: Improvement in Surgery as undergoing a budget re-set to match ESR/H.Roster & review of theatres. A reduced trend in Medicine due to ward B41 - 20 escalation beds are staffed but unfunded, 19 WTE RN are required to staff the beds, plus ward B36 – 12 escalation beds which are unfunded 3.75WTE RN are required to staff the beds. FaSS continues to recruit to the safe-staffing establishment and has vacancies. Medicine & Surgery are over-established in February due to IEN recruitment – IEN programme has now stopped. **Turnover rate**: Significant achievement in month, minimal increase observed. **Sickness Absence**: Improvement in Surgery & Medicine for RN, FaSS has significant sickness in William-Budd. HCSW sickness is a key focus. **Healthcare Support worker % roster fill rate**: Improvement of fill-rate across all Divisions in the day, owing to roster reconciliation and division roster reviews. Worsened trend overnight. **Registered Nurse % roster fill rate:** Decreasing trend resulting from high levels of short term sickness.

Red Flag Type	Total
Delay of 30 minutes or omission of Medication	4
Delay of 30 minutes or omission of Pain Relief	2
Less than 2 RNs on shift	4
Omission of comfort rounds	8
Shortfall of 25% of RN time	12
Vital signs delayed or omitted	7
Grand Total	**37**

Vacancy Rate RN Division

January	February
Emergency Medicine 7.20%	**Emergency Medicine** 9.92%
Family and Specialist Service 2.61%	**Family and Specialist Service** 3.22%
Medical -7.17%	**Medical** -7.30%
Surgical -5.45%	**Surgical** -1.72%

Sickness Absence HCSW

Division	January HCSW % Sickness	February HCSW % Sickness
Medicine	6.95%	6.14%
Surgery	10.0%	10.06%
FaSS	6.03%	8.80%
ED	12.09%	14.78%

Division	January HCSW % fill rate - Day	February HCSW % fill rate - Day	January HCSW % fill rate – Night	February HCSW % fill rate – Night
Medicine	77.75%	79.0%	157.12%	150.53%
Surgery	66.27%	69.23%	171.43%	163.65%
FaSS	77.83%	80.04%	234.32%	245.94%
ED	74.17%	76.24%	176.15%	171.17%

Turnover Rate RN (in month)

January	February
Emergency Medicine 0%	**Emergency Medicine** 0%
Family and Specialist Service 0.76%	**Family and Specialist Service** 0.42%
Medical 0.30%	**Medical** 0.48%
Surgical 0.38%	**Surgical** 0.46%

Sickness Absence RN

January	February
Emergency Medicine 6.16%	**Emergency Medicine** 7.91%
Family and Specialist Service 7.22%	**Family and Specialist Service** 7.71%
Medical 6.73%	**Medical** 6.14%
Surgical 8.08%	**Surgical** 7.09%

Division	Jan. RN % fill rate - Day	Feb. RN % fill rate – Day	Jan. RN % fill rate – Night	Feb. RN % fill rate - Night
Medicine	83.39%	78.65%	85.01%	90.43%
Surgery	75.39%	68.61%	78.53%	83.84%
FaSS	79.75%	76.66%	54.57%	51.88
ED	85.00%	85.00%	93.00%	93.00%

Executive Summary

Trust Integrated Balanced Scorecard - February 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

Strategic Goal		Performance Indicator	Description	Target		2022/2023												Trend
				Performing	Under Performing	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Tracker Measures	People we care for	% of Complaints responded to within target	35 working days'	>=90%	<90%	55.6%	74.4%	69.2%	76.5%	88.2%	63.2%	71.4%	87.5%	60.9%	80.0%	93.3%	82.6%	90.9%	
		Number of formal complaints		<30	>=30	35	29	14	31	22	19	20	20	19	31	28	19	37	
		Number of re-opened complaints		<=3	>3	4	1	2	4	4	1	4	2	0	3	1	3	5	
		PALS Response Time	Performance against 48hr standard resolution timeframe	>90%	<90%	64.0%	69.0%	59.0%	61.0%	57.0%	54.0%	59.0%	59.0%	54.0%	54.0%	53.0%	40.0%	53.0%	

Measures requiring focus and a countermeasure summary this month are;

Measure	Executive Summary
PALS response time	The numbers of PSCT contacts in February was 333, this was a decrease from January contacts (367). PSCT contacts are increasingly complex as patients and families are given a choice about the method of resolution for their concerns and this is supported by the NHS Complaints Standards approach to early resolution. We aim to achieve early resolution by providing a response to the more complex cases within 14 working days. All PSCT contacts are acknowledged within 2 working days but it has not been possible to accurately measure this. As of April 2024 this can now be measured and will be the measure for PSCT cases.

Tracker Measures | PSCT response time

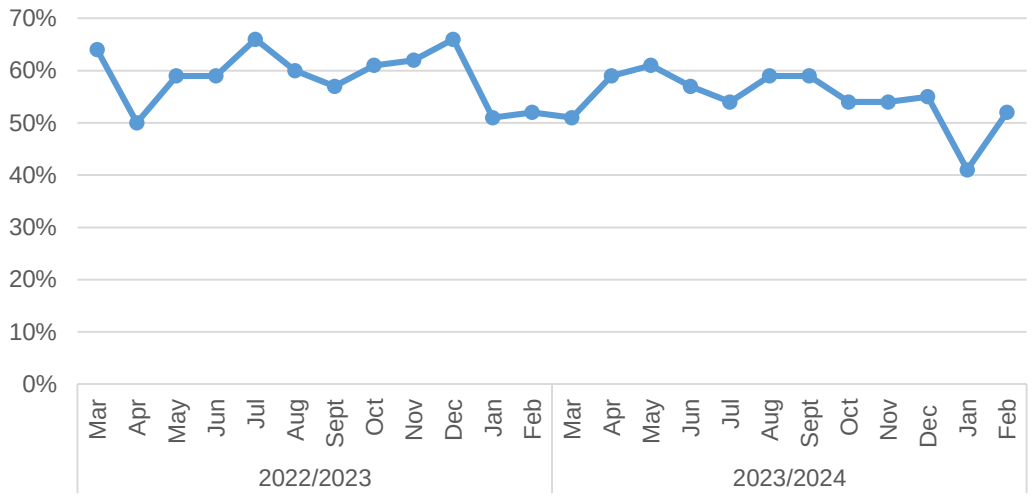
Trust Performance

There were 333 logged contacts with PSCT in February 2024. PSCT received a further 134 contacts that were general enquiries. All PCST contacts are acknowledged within 2 working days whether they are received by phone, email or in person.

52% of cases were resolved in 48 hours or less; a further 11% were resolved in 5 days and 16% between 6-14 days. 21% of the complex cases took more than 14 days.

The introduction of the single point of access for complaints and concerns has meant that there has been an increase in complex concerns raised as people are choosing earlier informal resolution rather that following the formal complaint process.

Trajectory



How do we benchmark?

There is no central data available to benchmark against and no NHS standard for resolving PSCT.

A review of concern response/resolution target times for other Trusts has indicated that no Trust has a specific timeframe for a concern to be addressed and closed. All Trusts have a target for acknowledgement of concern and these range between 1 to 3 working days. At RUH all concerns are acknowledged within 2 working days and most within 1 working day, depending on the urgency of the concern.

Tracker Measures | PSCT response time

Is there a live A3 / Improvement project addressing this Trust Goal? No

Insights

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

Appointments (n=70). The highest number of enquiries related to the length of time patients were waiting for new and follow up appointments (n=36) 51%. Hotspot areas are General Surgery (6), Gastroenterology (5), Cardiology (5), Oral & Maxillofacial Surgery (4) and Audiology (4).

Communication and information (n=58). The highest number of contacts were telephone issues (phone not answered) (n=12) 21%. Hotspot area is Ophthalmology (4). A further 21% (n=12) were concerns. These contacts vary in subject matter and are specific to the individual patient.

Clinical care and concerns (n=32). The highest number of contacts were general enquiries (n=9) 28%. A further 16% concerned inappropriate care and treatment (n=5). There were no hotspot areas identified.

What are the top contributors for under achievement? What are the top actions for each countermeasure?

Contributor	Countermeasure	Action	Expected Completion Date	Expected Outcome
The top contributors above are reflected in the Q3 Patient Experience report. Gastroenterology is a top contributor for issues concerning appointments and communication & information.	Extra clinics are being put on and suitable patients are being offered to go to an alternative provider. The specialty are focussing on the whole pathway wait. Patients on the 'surveillance' list (1, 3 & 5 years) were not seen during the pandemic. The department have recruited additional clinicians to help address the backlog.	There is additional funding in place to expand the recovery department so that more patients can be treated. Better use is being made of clinic slots and calling patients prior to their endoscopy appointment has helped to reduce the 'Did not attend (DNA) rate.	Ongoing	Continued pressure on the Gastro service means that the hospital is likely to see continued contact with the PSCT team as the wait to be seen for first referrals (outside the 2 week wait pathway) is more than a year. (72 weeks)

Royal United Hospitals Bath
NHS Foundation Trust

Perinatal Quality Surveillance

RUH Maternity

The RUH, where you matter

Safe – Maternity& Neonatal Workforce

	Target	Threshold G	Threshold A	Threshold R	Dec 23	Jan 24	Feb 24	SPC	Comment
Midwife to birth ratio	1:24	<1:24		>1:26	1:26	1:26	1:27		The midwife to birth ratio changes dependent on the acuity of the women/birthing people seen in the month. The threshold is <1:24 which is not achieved with substantive staff, it is achieved with the use of bank staff.
Midwife to birth ratio (including bank)	1:24	<1:24		>1:26	1:23	1:23	1:24		
Consultant presence on BBC (hours/week)	98	>97			98	98	98		Meeting RCOG recommendation from Jan 23
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0		
Daily multidisciplinary team ward round	90%	>90%		<80%	82%	82%	45%		Data capture issue recognised in response to digital transition.
Band 5/6 Midwifery Vacancy rate (inclusive of Maternity leave) WTEs	7.0	≤7.0		>10	9.5	7.6	8.5		New starters in SN period currently
Neonatal Nurse QIS rate	70%	≥70%		≤60%	63%	63%	63%		
Neonatal staffing meeting BAPM standards	100%	>90			98%	97%	100%		
Maternity Turnover rate	≤5%	≤5%		≥7%	5.4%	5.0%	4.5		
Percentage of TC shifts with staff dedicated to TC care only		>90%		<80%	90%	97%	100%		

Table 1.

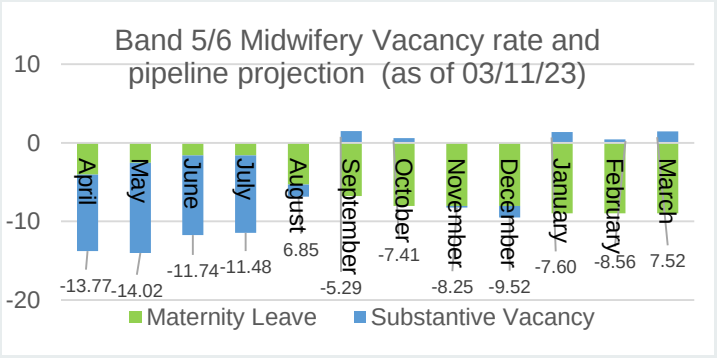
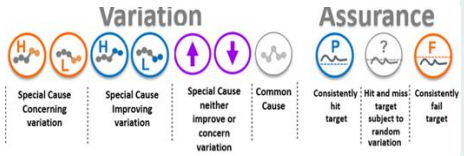


Table 2. Band 5/6 Midwifery Vacancy rate and staffing pipeline projections

Average Shift Fill Rates

		Dec 23	Jan 24	Feb 24
Midwives	Day	84%	89%	88%
	Night	89%	93%	89%
MCA/MSWs	Day	53%	54%	52%
	Night	46%	52%	37%



Countermeasure /Action (completed last month)	Owner
Birthrate+ investment YR1 in budget, recruitment in progress. Specialist roles, Infant feeding and fetal monitoring lead recruitment plan and recruitment in Q4.	DOM
Vacancies out to advert for increased establishment to obstetric workforce following funding securement outlined within maternity business case- interviews anticipated 12/3/2024.	Clinical Director Maternity

Countermeasure /Action (planned this month)	Owner
Continuing work to establish workforce plan for acute/community sites, continuity of carer and on call model.	DOM
Continued work with HR and finance to ensure pipeline position is accurate and externally funded posts are visible and clear narrative to explain ESR variation related to administrative lags	Acute Maternity Services Matron
Data capture problem identified since transition to digital audit tool for MDT ward round. Aim to move towards exception reporting however not optimal timing in view of current data capture issues. Bath Birthing Centre lead midwives keen to pursue transition to digital capture, additional process put in place to support digital solution.	Quality and Patient Safety lead/ Clinical Audit Midwife

Maternity Support workers (MSW) - Shift fill rate deep dive

Average Shift Fill Rates

		Dec 23	Jan 24	Feb 24
Midwives	Day	84%	89%	88%
	Night	89%	93%	89%
MCA/MSWs	Day	53%	54%	52%
	Night	46%	52%	37%

Reporting error identified for MSW shift fill - not representative of clinical shift cover

- MSWs for acute and community are captured on a single roster therefore representing multiple clinical areas/services
- Large number of optional shift tiles on roster for allocation to community, acute and specialist shifts if required
- These additional tiles influence 'required totals' which shift fill percentages are calculated
- Optional tiles influencing shift fill rates need to be removed
- Historic community tiles no longer required due to transformation of community services include: night shifts, continuity of carer teams, historic community roles now undertaken by bespoke services, optional tiles to meet service needs and adjust clinics at short notice.

Actions	Owner
Review and removal of all historic 'optional' tiles on Maternity Support Worker Roster for all clinical areas	Matron Team
Separation of Maternity Clinical Support Worker roster to reflect separate clinical areas. This will make requirement in each area clearer including impact of vacancy rates.	Matron Team Health Roster Lead
Active recruitment into MSW acute vacancy	Matron Team Recruitment Lead

Acute Shift fill

(extracted from MSW roster)

Month	Clinical WTE Required	Clinical WTE Assigned	Acute Shift Fill %	Acute vacancy WTE
Dec	**19.84**	14.96	**75%**	9.51
Jan	**19.84**	18.55	**93%**	9.91

Calculated by filtering roster by clinical area and using known clinical need requirements based on establishment

The RUH, where you matter

Safe – Maternity& Neonatal Acuity

	Target	Threshold G	Threshold A	Threshold R	Dec 23	Jan 24	Feb 24	SPC	Comment
Percentage of 'staff meets Acuity' BBC (intrapartum care)	100%	>90%		<70%	87%	87%	62%		Deep dive of safety metrics to understand reduction in intrapartum acuity
Percentage of 'staff meets Acuity' Mary Ward (inpatient care)	100%	>90%		<70%	New metric awaiting return of BR+A summaries function				
Confidence factor in BirthRate+ recording BBC	60%	>60%		<50%	82.26	87.63	81.61		Percentage of possible episodes for which data was recorded
Confidence factor in BirthRate+ recording Mary Ward	60%	>60%		<50%	New metric awaiting return of BR+A summaries function				
Maternity Absence rate	4.5%	<4%		>5%	5.2%	5.2%	lag		
1:1 care not provided in labour	0	0		>1	0	0	0		
Labour ward coordinator not supernumerary episodes	0	0		>1	2	0	0		
Number of red flags on Birth Rate +	0				52	33	142		Review of Red flag events in progress
Birth outside of BAPM L2 place of birth standards	0	0		1	0	0	1		
Number of days in LNU outside of BAPM guidance	0	0		>2	1	2	0		

Table 1.

BirthRate + Acuity tool was re-activated following a national update in January of 2024. We are awaiting the return of the 'summaries' function to present Acuity by RAG (percentage) for Mary Ward in this space

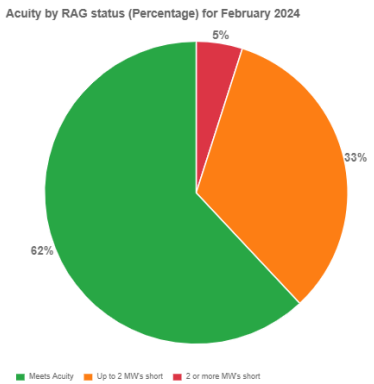


Table 2. Acuity by RAG for BBC February 2024

Countermeasure /Action (completed last month)	Owner
Commencement of recruitment into increased midwifery establishment as outlined within the Maternity Business case aligned to the Birth Rate + report of 2023	DOM

Countermeasure /Action (planned this month)	Owner
Re-commencement of the Mary Ward 'summaries' function of BirthRate + Acuity tool to present holistic view of acute services. Deep dive into Intrapartum safety metrics, deployment of acute and community staff as per Maternity Escalation Policy to mitigate risk	Inpatient Matron
Recruitment to current vacancies out to advert in the LNU	Neonatal Nurse Lead Consultant
Review of current 'Red Flag' Birth Rate + Acuity triggers to ensure system wide, regional and national alignment.	Quality and Patient Safety Lead

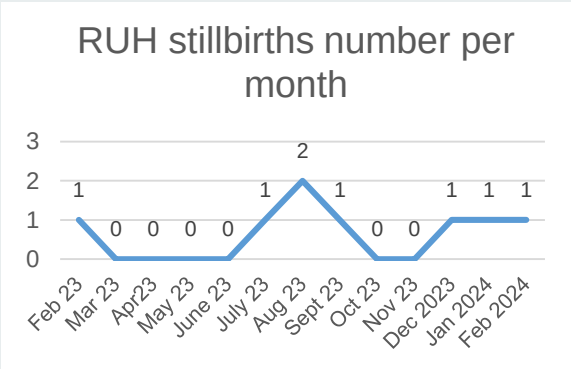
Is the standard of care being delivered?

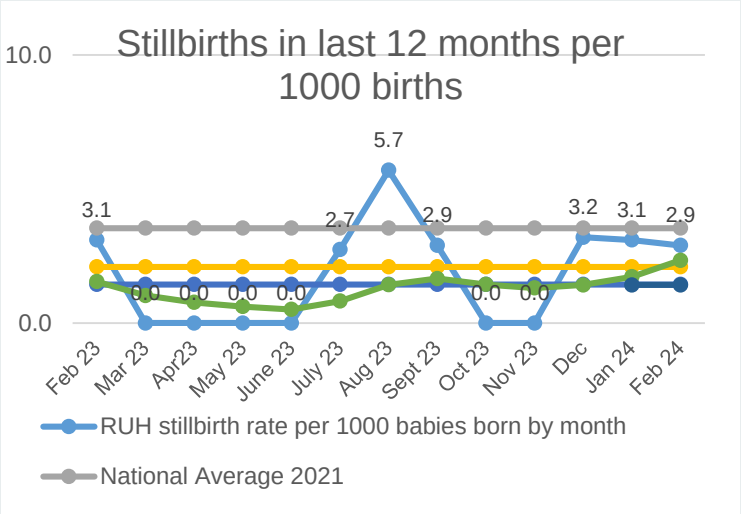
- 1 to 1 care in labour maintained on all occasions
- No episodes of supernumerary Labour Ward coordinator status
- The Midwife to birth ratio met BRA+ 23 recommendations

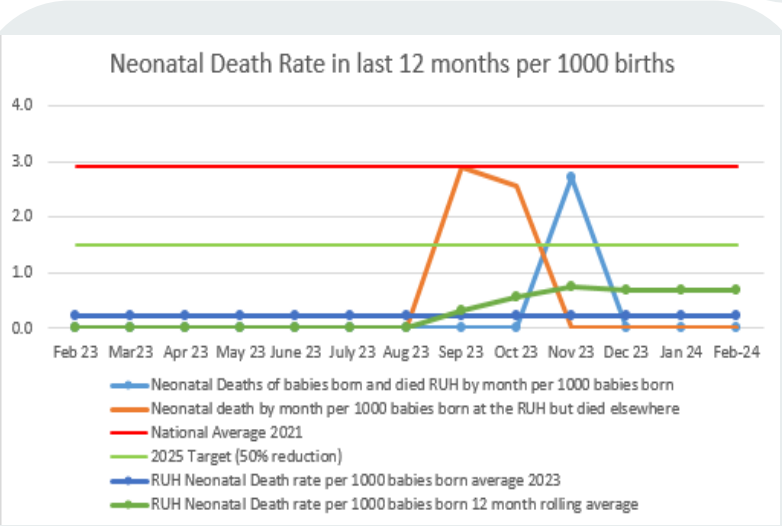
What are the top contributors for under/over-achievement?

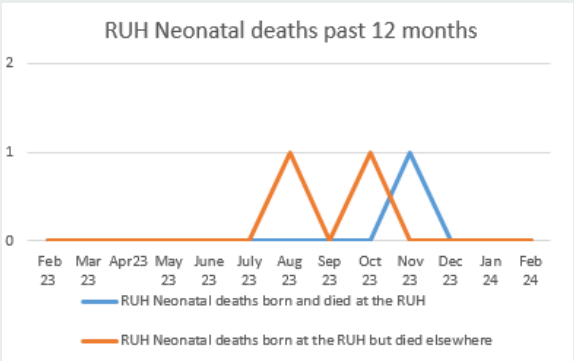
Recruitment commenced in response to BRA+ report recommendations 2023
Reduced number of births in comparison to average in December 23 and January 24.

Safe- Perinatal Mortality Review Tool (PMRT)









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.

Postmortems were resumed routine service from 12 weeks in November 22 (except specific clinical indications).

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.

Still birth, and neonatal death rates is presented as ‘rate per 1000 births’ for national benchmarking, therefore the numbers per month are presented on separate graphs.

From January of 2023 the internally reported neonatal death rate is representative of those babies who were born at the RUH but died elsewhere, this is with the aim to accurately reflect MBRRACE perinatal mortality rates for the trust ahead of the reported stabilised and adjusted figures. Therefore the overall neonatal death rate for the RUH appears greater than previously reported rates , this is an anticipated position due to a change in internal reporting criteria as above.

In February there was 1 still birth at 38+2 days of pregnancy. This will receive a full PMRT review. No immediate concerns have been raised at MDT review.

The still birth at the RUH for 2023 has been calculated as 1.42 per 1000 births this is a minor reduction from the 2022 reported rate of 1.44 and remains below the national reported rate in 2021 of 4.2 per 1000 births.

Incidents

New Cases for February 24

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	SI? Reference
126176	February	Moderate	Missed placental biopsy from stillbirth	DOC commenced – to be reviewed within PMRT		
126649	February	Moderate	4th degree tear	Awaiting MDT review (planned 06/03/24) DOC commenced		
126172	February	Moderate	Intrauterine Death	DOC commenced will receive PMRT review		

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	SI? Reference
121264	09/23	Moderate	Transfer to Tertiary neonatal unit for active therapeutic cooling. MRI normal post cooling.	Ongoing MNSI review at family request	**MI-034606**	
122028	10/23	moderate	Baby transferred to tertiary unit for active therapeutic cooling. MRI normal post cooling.	Ongoing MNSI review at family request	**MI-035529**	
123053	11/23	Unavoidable death	Birth of 22+0 baby with no signs of life	PMRT review		
124381	2/23	Unavoidable death	Stillbirth of 38+3 week pregnancy	PMRT review		
125436	25/1/2024	Unavoidable death	Intrapartum stillbirth of baby on-route to hospital	MDT review – no immediate concerns identified Will receive full PMRT review, Case referred to MNSI – case confirmed	**MI-**	
124902	/2024	Moderate Harm	Placental abruption – Neonatal transfer to tertiary NICU for therapeutic cooling. Normal MRI post cooling	MDT initial learning regarding escalation to Obstetrics of a difficulty in auscultating a fetal heartrate in a previously well recorded normal CTG Case referred to MNSI no family consent/request- awaiting family response to local enquiry of care	**MI-036728- no family consent**	

Closed Cases February 24

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
121463	0/23	Unavoidable death	Neonatal death	Internal SI/PSII		

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

Responsive

MNVP Service User Feedback collected in Jan 24

Key points raised:

- A desire for more information on postnatal care including recovery from caesarean birth and the importance of rest and recovery > establishment of routine
- Lack of awareness of 'hello baby' classes available both in persona and online content
- Health care professionals taking the time to explain medical terminology was appreciated

Next steps/ service user feedback for service suggestions:

- Would prefer forward facing wheelchairs
- A desire for more continuity in antenatal community midwifery appointments

Safety Champions Staff Feedback

Safety Champion 'Walk around' 13th Feb 24
Safety Champion Listening Event 15th of Feb 24

Key points raised:

- Challenges in recruitment to the community birth team
- No safety concerns raised
- Clinical spaces remain a challenge in the central Bath area
- Staff feedback that 'meet the midwife' sessions are going well
- Safety Champions are keen to attend community midwifery units

Next steps:

- Community birth lead midwife to commence external recruitment campaign
- Director of Midwifery and community Matron to follow up exploration of community hub in Bath with Bath City council.

Compliments & Complaints

Compliments	**9**	**PALS Contacts**	**10**
Online Compliments	**--**	**Formal Complaints**	**1**

Pals contacts in February 24:
9 Compliments made to the service and 1 complaint regarding postnatal care.

Friends & Family Survey

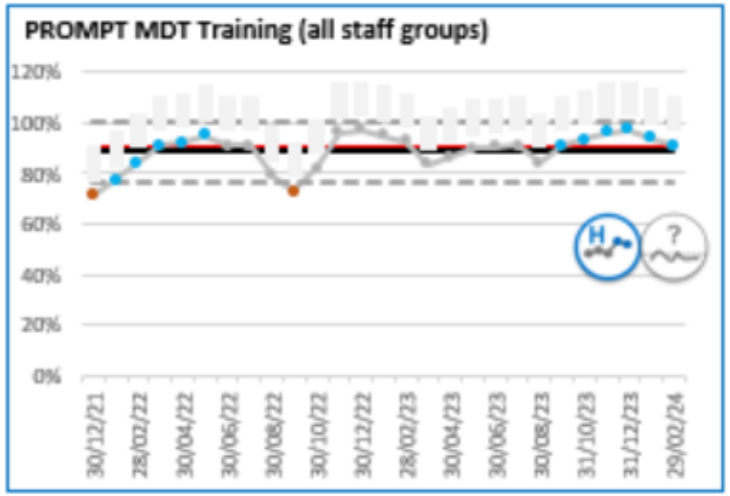
Key Achievements:
Formal publication of CQC survey published in February 2024. The Trust received a 57% response rate of 196 respondents; small reduction from the 2022 response rate of 63%. All actions from 2022 survey saw an increase in responses.

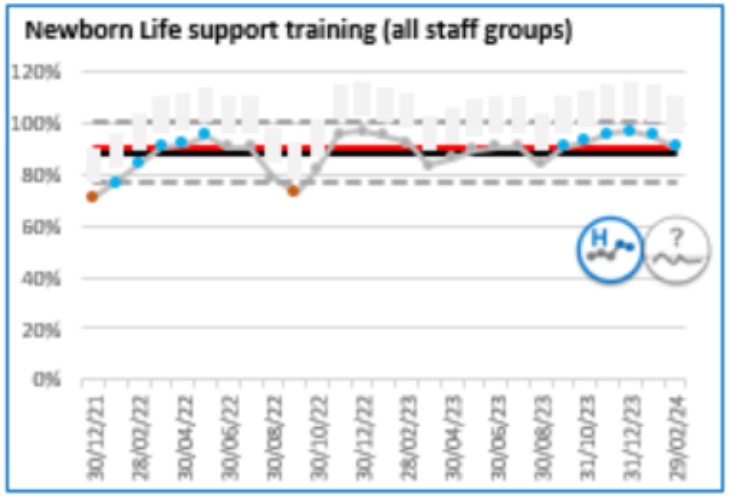
No areas of care identified as 'somewhat worse' 'worse' or 'much worse'.

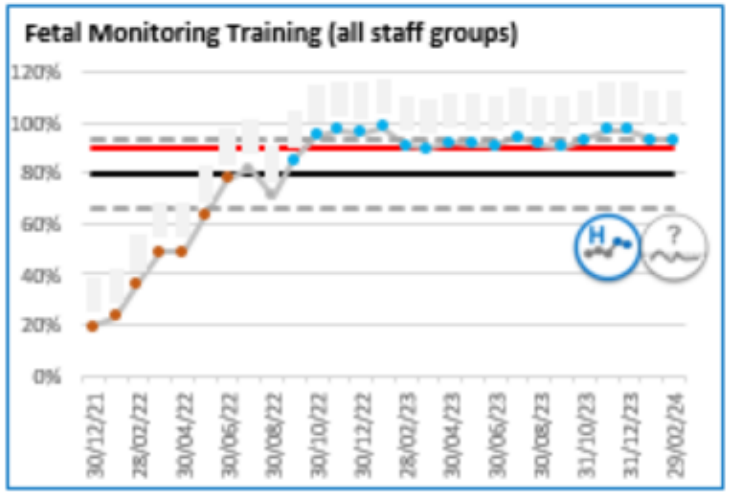
'Much better than expected' in families 'involved in decision to induce'.
'Better than expected' in Advice at the start of labour, Kind and understanding care.
'Somewhat better than expected' in Partner length of stay.

Identified Areas of Improvements: One area with a statistically significant decrease from 2022 survey, related to women and birthing people being offered a choice about where to have their baby. This result may have been impacted by the community birth suspension which was in place in February 2022.

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/action:
- Bespoke refresher skills sessions available for community staff: Skills drills and newborn life support with dates booked for the next year. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs).
- Additional skills sessions available to newly qualified staff and senior students facilitated by the Retention and Education team.
- Risk assessment for the risk register completed for mandatory training room bookings.
- PROMPT Faculty proposal in progress for options

Risks:
- 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.
- Influx of new MDT staff in September October November 23 impacting upon compliance.
- Booking of training rooms availability – currently provided with rooms however 11/15 on a Friday presenting a risk to flexible availability to staff. Risk 2681 (9).
- MSW Prompt compliance projections .
- Maternity staff compliance with K2 (supplementary assessment for Fetal monitoring training) in person training compliance 95.1% K2 89.3%.
- PROMPT Faculty arrangements.

Compliance to National Guidance

	Maternity Incentive Scheme - Safety Action Detail	Submitted position for MIS year 5
1	Are you using the National PMRT to review perinatal deaths to the required standard?	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	
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?	
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?	

Maternity Incentive Scheme (CNST) Year 5

- **Key Achievements:**
- KPMG external audit of MIS evidence submission completed evidencing compliance in all elements – Element 6 excluded
- LMNS assurance provided to confirm target of >70% compliance for SBLv3 implementation achieved – Element 6 confirmed
- Declaration to Board made in January for full compliance of MIS year 5.

Next Steps for Progressions:

- Continued work towards full implantation of SBLv3 (currently 73%) (6)
- Continued development and progression of SBL assurance data, collaboration with digital lead midwife as part of preparatory work for procurement of a new EPR to ensure new service can meet data capture demands.(6)
- Anticipated release of MIS year 6 April 24.

Ockenden 2022	
IEA	% of Compliance
1- Workforce Planning and sustainability	70.6
2- Safe Staffing	66.7
3- Escalation and Accountability	71.4
4- Clinical Governance Leadership	81.3
5- Incident investigation and complaints	77.8
6- Learning from maternal deaths	100.0
7- Multidisciplinary Training	58.8
8- Complex Antenatal Care	83.3
9- Pre-term Birth	60.0
10- Labour and Birth	63.6
11- Obstetric Anaesthesia	50.0
12- Postnatal Care	25.0
13- Bereavement Care	88.9
14- Neonatal Care	77.8
15- Supporting Families	75.0
Total	73.8

Ockenden Report

Key Achievements:

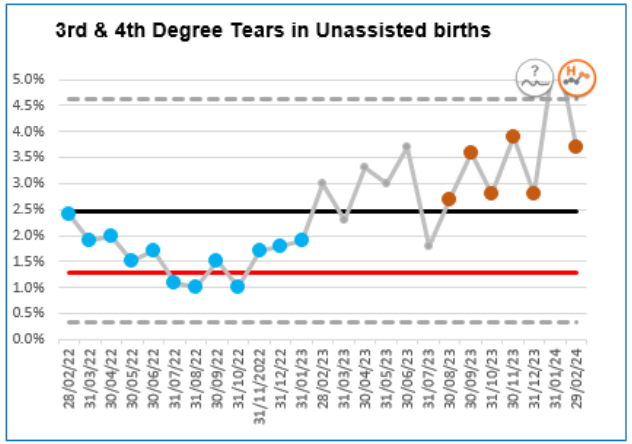
- Provisional agreement of business case to fund consultant staffing establishment
- SBL v3 work increasing compliance across IEAs
- Current job advert out for obstetric consultant lead for postnatal care

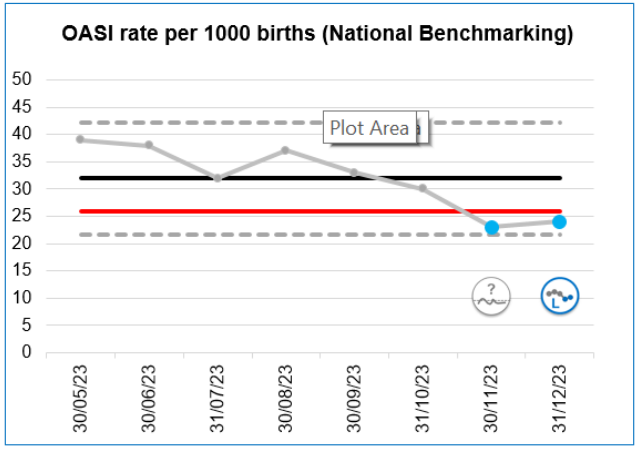
Next Steps for Progressions:

Plan in place for development of an RUH Maternity Improvement plan collating local and National improvement drivers together for a cohesive presentation of Quality Improvement progress within Maternity and Neonates.

IEA 12 BirthRate+ ward acuity tool re-instated November 2023 awaiting re-instatement of 'summaries' function.

Themes from Service Insights





Theme - Increased rate of % of women sustaining 3rd and 4th degree tears in unassisted births seen during 2023 on 2022.

When presented as a rate per 1000 births declining trend noted potential link to a reduction in birth rate in December 23. Unclear cause at this point. Case cohort review undertaken by perinatal pelvic health team in 2023 action plan in place.

Next steps for progression:

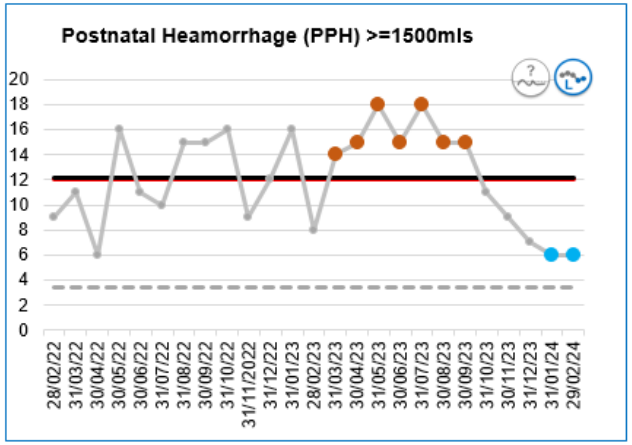
- Perinatal pelvic health team exploration work on-going.
- Data validation evaluation underway supported/undertaken by the QIPS team clinical audit midwife.
- Work in collaboration with Business intelligence to present data on RUH dashboard as a rate per 1000 births for contemporaneous national benchmarking.

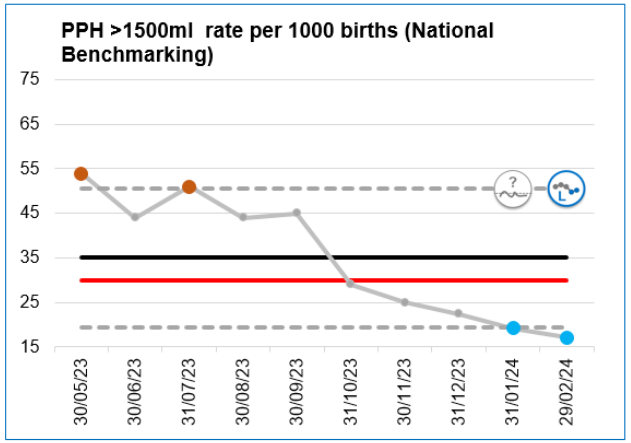
Theme –

Previously identified Post Partum Haemorrhage rate above the national average

Key achievements:

continued declining trajectory seen for a period of 6 months, Following case cohort review. With a sustained below national average rate for the past 4 months.





NHS
Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 12

The people in our community

The RUH, where you matter

Summary

Overall Position

- The NHS is required to achieve a break even position this financial year. The BSW ICS have been working on a plan to achieve breakeven however the impact of Industrial Action since December 23 has resulted in a deficit of £7.9 million; this includes a deficit of £3.49 million for the RUH. This is an improvement of £4.1 million from the previous month. This was predominantly achieved through increased delivery through Elective Recovery and the full delivery of QIPP schemes.

Operational Pressures impacting on our costs

- The number of non-criteria to reside patients has remained broadly constant an average of 64 which is 26 below the planned level. Non-elective activity remains significantly high at 122% of plan in the month.
- Agency usage has remained below the 3% target at 1.6% in month.
- In order to reduce our waiting times for elective activity, additional capacity has been created. The M12 activity delivered was 111% of the plan and is 106% of planned elective activity levels year to date. The out turn income was 115% of 2019/20 values and 108% of plan.

Financial Variances

- A total of £23.5 million of QIPP savings have been delivered year to date. £13.1 million has been made on a recurrent basis.
- The £4.1 million in month surplus in month related to:
    - Technical Adjustments £2.6 million.
    - Elective Recovery Funding £1 million.
    - Run Rate Improvements £0.5 million.
- Total capital expenditure is £38.1 million at year end, which is delivered in line with forecast outturn.
- The closing cash balance for the Group was £34.5 million which is 12.8% lower than the plan.

Executive Scorecard

	Performance Indicator	Description	Target: Performing	Target: Under Performing	Baseline	Actual 2023/24: Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Sustainability Tracker Metrics	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	£0	(£0.989m)	(£2.389m)	(£1.125m)	(£1.559m)	(£3.037m)	(£3.71m)	(£5.19m)	(£3.17m)	(£5.03m)	(£5.03m)	(£6.70m)	(£3.49m)
	Forecast delivery of Group financial plan	Forecast variance from year to date plan	<=0	>0	£0	£0	£0	£0	£0	£0	£0	£0	£0	(£5.8m)	(£5.8m)	(£3.5m)	(£3.49m)
	Group delivery of breakeven	Total year to date financial performance	<=0	>0	£0	(£2.390m)	(£5.389m)	(£5.625m)	(£7.045m)	(£9.804m)	(£11.655m)	(£13.844m)	(£9.860m)	(£9.821m)	(£9.334m)	(£7.487m)	(£3.49m)
	Delivery of QIPP	Total QIPP delivery	N/A	N/A	N/A	£0.216m	£0.345m	£0.663m	£2.757m	£3.504m	£4.985m	£5.787m	£7.498m	£11.311m	£14.707m	£16.940m	£23.5m
	Delivery of QIPP against plan	Performance against plan	<=100%	>100%	48.0%	76.0%	61.0%	113.0%	190.4%	170.9%	182.5%	168.0%	100.0%	98.5%	94.8%	86.8%	100.0%
	Reduction in agency expenditure	Agency costs as a % of total pay costs	<= 3%	> 3%	3.0%	3.3%	3.6%	4.5%	3.8%	2.5%	3.3%	2.1%	2.5%	2.2%	0.4%	2.2%	1.6%
	Sickness against plan	Actual levels of sickness against average pre-pandemic levels	<= 4.1%	> 4.1%	7.7%	3.3%	3.2%	3.2%	3.5%	3.3%	3.5%	3.9%	4.5%	4.3%	4.7%	4.9%	4.8%
	Reducing no criteria to reside patients	No criteria to reside to reduce by 40% from December 2021	<= 90	> 90	149	117	108	108	92	70	65	62	68	62	64	66	64
	No COVID admissions	Average number of beds occupied by COVID patients	<=30	>30	64	29	12	5	3	7	3	2	3	6	22	4	3
	Reducing staff vacancies	Total contracted vacancies reported each month	<=7.4%	>7.4%	7.4%	5.1%	6.2%	6.3%	6.5%	5.0%	5.5%	3.5%	3.1%	1.8%	1.6%	1.0%	1.4%
	Net impact of high cost drugs and devices	Total expenditure and income against plan for high cost drugs and devices	<=0	>0	£0	£0	£0	£0	£0	£0	£0	-£500k	-£500k	-£500k	-£500k	-£500k	£0
	Increase productivity	Implied productivity based on financial and operational performance (Quarterly)	>=3%	3%	-20%	-22%	-22%	-22%	-24%	-24%	-23%	-23%	-23%	-23%	-23%	-23%	-23%
	Elective recovery	In Month Performance against planned levels of activity (Value based)	>= 100%	< 100%	n/a	93%	102%	114%	101%	102%	106%	105%	115%	97%	117%	123%	106%
	Non elective activity	In Month Performance against planned levels of activity (Value Based)	<= 102%	> 102%	n/a	101%	107%	106%	105%	113%	109%	112%	126%	134%	133%	138%	122%
	Delivery of capital programme	Variance from year to date planned capital expenditure (Internally Funded Schemes)	-5%	<5%	n/a	15.3%	79.4%	35.8%	-15.7%	-54.7%	-69.0%	-68.4%	-68.2%	-67.0%	-57.9%	-33.1%	-0.5%
	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+ or - 5%	><5%	n/a	0	0	0	0	0	0	0	0	0	0	0	-0.5%
	Delivery of planned cash balance	Variance from year to date planned cash balance	- 10%	<10%	n/a	11.6%	10.20%	64.90%	45.9%	50.4%	31.0%	24.1%	13.4%	14.0%	-5.1%	-8.6%	-12.8%

True North | Breakeven position

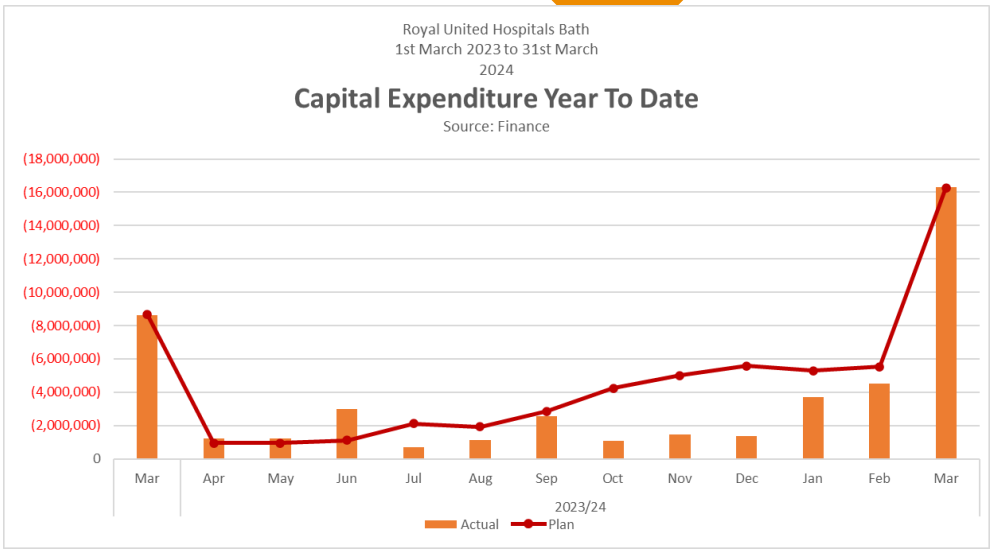
Statement of Comprehensive Income Period to 202312	Total Group Position					
	202312			YTD		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Other Operating Income	8,150	8,785	635	51,989	53,104	1,115
Unallocated	0	0	0	0	0	0
Income Total	47,397	67,623	20,226	522,112	559,191	37,079
Pay	(26,410)	(44,770)	(18,359)	(330,465)	(363,226)	(32,761)
Non Pay	(13,647)	(17,180)	(3,534)	(154,772)	(170,795)	(16,024)
Depreciation	(1,824)	(1,241)	583	(21,806)	(19,372)	2,434
Impairment	(6,519)	(2,162)	4,357	(6,519)	(2,498)	4,021
Expenditure Total	(48,400)	(65,353)	(16,953)	(513,562)	(555,892)	(42,330)
Operating Surplus/(Deficit)	(1,003)	2,270	3,273	8,550	3,299	(5,251)
Other Finance Charges	(857)	406	1,262	(10,300)	(5,905)	4,394
Other Gains/Losses	2	1	(1)	29	92	63
Share of loss in joint ventures					(56)	(56)
Finance Charges	(855)	407	1,261	(10,271)	(5,869)	4,401
Surplus/(Deficit)	(1,857)	2,677	4,534	(1,720)	(2,570)	(850)

Adjusted Financial Performance						
Add back all I&E impairments/ (reversals)	6,519	2,162	(4,357)	6,519	2,497	(4,022)
Retain impact of DEL I&E (impairments)/ reversals	0	0	0	0	(336)	(336)
Remove capital donations/grants I&E impact	(3,879)	(936)	2,943	(4,799)	(3,229)	1,570
Remove net impact of consumables donated from other DHSC bodies	0	148	148	0	148	148
Adjusted financial performance surplus/(deficit)	**783**	**4,050**	**3,268**	**(0)**	**(3,490)**	**(3,490)**

Tracker Measure | Sustainability – Capital (RUH and SULIS)

Capital Programme

Capital Position as at 31st March 2024	Annual Plan	Forecast @ M11	Year to Date		
			Plan	Actuals	Variance
	£000s	£000s	£000s	£000s	£000s
Internally Funded schemes	(13,878)	(13,216)	(13,216)	(13,191)	25
IFRS 16 Lease Schemes	(7,555)	(4,011)	(7,555)	(4,130)	3,425
Disposals - NBV write off - Internally Funded				52	52
Disposals - NBV write off-Lease			0	141	141
External Funded (PDC & Donated):					
Cancer Centre PDC	(6,650)	(6,650)	(6,650)	(6,650)	(0)
SEOC PDC	(10,090)	(4,739)	(10,090)	(4,739)	5,351
BSW EPR PDC	(3,360)	(1,212)	(3,360)	(808)	2,552
Digital Diagnostic PDC	(299)	(453)	(299)	(453)	(154)
Community Diagnostic Centre PDC	(2,923)	(2,923)	(2,923)	(2,923)	(0)
Endoscopy Recovery PDC	(1,278)	(1,278)	(1,278)	(1,278)	(0)
Cyber Security PDC	(93)	(93)	(93)	(93)	0
Donated	(5,697)	(5,029)	(5,398)	(3,993)	1,405
Total	**(51,823)**	**(39,604)**	**(50,862)**	**(38,066)**	**12,796**



Is standard being delivered? Yes
What is the top contributor for under/over-achievement?

Trust funded programme has delivered in line with forecast outturn with the full capital allocation for the Group delivered. The variance against the annual plan is due to the plan including a 5% overprogramming.

IFRS 16 also delivered in line with forecast outturn.

External funded schemes all delivered against the forecast outturn and full funding spent in line with agreements.
The only exception to this was the BSW EPR project which has delivered in line with revised agreements across the System.
The forecast for a number of schemes is less than the original plan for the year however in line with national agreements.

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

	31/03/2024 Plan £'000	31/03/2024 Actual £'000	Variance £'000
Non current assets			
Intangible assets	11,112	7,105	(4,007)
Property, Plant & Equipment	301,097	301,391	294
Right of use assets - leased assets for lesse	53,922	51,037	(2,885)
Investments in associates and joint ventures	56	0	(56)
Trade and other receivables	1,997	1,861	(136)
Non current assets total	**368,184**	**361,394**	**(6,790)**
Current Assets			
Inventories	5,539	8,284	2,745
Trade and other receivables	15,072	26,815	11,743
Cash and cash equivalents	39,598	34,531	(5,067)
Current Assets total	**60,209**	**69,630**	**9,421**
Current Liabilities			
Trade and other payables	(44,907)	(48,142)	(3,235)
Other liabilities	(5,502)	(16,439)	(10,937)
Provisions	(263)	(475)	(212)
Borrowings	(2,155)	(3,070)	(915)
Current Liabilities total	**(52,827)**	**(68,126)**	**(15,299)**
Total assets less current liabilities	**375,566**	**362,897**	**(12,669)**
Non current liabilities			
Provisions	(1,525)	(1,370)	155
Borrowings	(59,145)	(54,128)	5,017
TOTAL ASSETS EMPLOYED	**314,896**	**307,400**	**(7,497)**
Financed by:			
Public Dividend Capital	256,585	253,534	(3,051)
Income and Expenditure Reserve	11,665	12,304	638
Revaluation reserve	46,646	41,562	(5,084)
Total Equity	**314,896**	**307,400**	**(7,497)**

The Group Balance Sheet (RUH and Sulis)

Month 12 against plan:

- Non current assets have decreased against the plan. This relates to audit adjustments, and a decrease in depreciation as a result of amending the life of some plant property and equipment.
- Trust inventories have increased against plan assumptions, and have decreased in month.
- Trust receivables continue to remain above the plan, the key drivers are prepayments for expenses paid in advance of use, and income earned which have not yet been paid.
- Trust payables continue to remain above plan. This is net of movement of capital creditors, Public Dividend Capital dividend, and increases in expenditure.
- Trust other liabilities are above plan and have increased due to the full year effect of ERF that remains outstanding.
- The group cash position is £5.0 million lower than planned. The variance against plan is driven by non pay expenditure, and capital expenditure.

QIPP | Financial Progress

	Year to Date Plan £,000	Year to Date Actual £,000	Variance £,000
Total Divisional QIPP	**£ 6,023**	**£ 3,811**	**-£ 2,212**
Improvement Programme Schemes			
Productivity and Efficiency	£ 4,250	£ 4,164	-£ 86
Workforce	£ 4,802	£ 1,070	-£ 3,732
Cost and Control Management	£ 1,842	£ 466	-£ 1,376
Estates and Facilities	£ 1,025	£ 11	-£ 1,014
Income Commercial	£ 1,179	£ 355	-£ 824
Income Clinical	£ 4,380	£ 4,794	£ 414
Central		£ 8,830	£ 8,830
Total Improvement Programme Schemes	**£ 17,478**	**£ 19,690**	**£ 2,212**
Total QIPP	**£ 23,501**	**£ 23,501**	**£ 0**

Summary

The full plan of QIPP was £23.5 million target.

This included £10.4m non recurrent savings or additional income.

The success of the programme included £2.5m of procurement savings, £1.6m income from improved coding, £1m savings from agency costs, and £5m of additional income from productivity and other initiatives.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item No:**	**11**
Date of Meeting:	**1 May 2024**		

Title of Report:	**Maternity and Neonatal Safety Report Quarter 3**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Author(s):	**Zita Martinez, Director of Midwifery** **Jodie Clement, Quality Improvement and Patient Safety Lead Midwife**
Appendices	**Appendix 1: Transitional and ATAIN Audit report** **Appendix 2: Still birth and perinatal mortality report Quarter 3**

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) and Board of Directors of present and/or emerging safety concerns.

This report identifies a Royal United Hospitals Bath NHS Foundation Trust (RUH) calendar year average stillbirth rate for 2023 of 1.42 per 1000 births; this is below the reported national average of 4.2 per 1000 births (2021), and a minor reduction on internal reported rate of 1.44 per 1000 births in 2022.

The RUH Neonatal mortality rate for 2023 is 0.71 per 1000 births. This is an anticipated greater value than the internal reported RUH rate from 2022 of 0.23 per 1000 births. The increased rate is in response to 2023 figures, which account for babies born at the RUH but subsequently die elsewhere. This aligns to the stabilised and adjusted rates received via Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) national reporting. The internal only death rate was unchanged in 2023, when compared to 2022 at 0.23 per 1000 births.

During Q3, the service made 2 referrals to the Maternity and Neonatal Safety Investigations (MNSI) team hosted by the Care Quality Commission. One referral has been confirmed, as an ongoing investigation at the family's request, 1 has not progressed following MNSI triage process. One new internal Serious Incident was declared in Q3.

The report outlines the key points of progression towards the 15 Immediate and Essential Actions outlined within Ockenden 2022. Plans are in place for Q4 to align all national and local improvement drivers into a singular RUH Maternity Improvement plan, encompassing Ockenden 2022, the 3 year single delivery plan 2023, Saving Babies Lives v3 and locally identified safety priorities.

This report outlines the Trust's progress towards Year 5 full compliance of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), submitted in February 2024. During Q3 KPMG completed an internal audit of submitted evidence and supported compliance with 9 out of the 10 Safety Actions. Safety Action 6 was excluded from the scope of KPMGs audit due to oversight and assurance being provided by the Local Maternity and Neonatal System (LMNS). This report identifies the Trust projection and progression target towards meeting the 70% for 'implementation of the Saving Babies Lives care bundle of 2023', and therefore full compliance with all 10 Safety Actions for year 5 in February 2024.

The Avoiding Term Admissions into Neonatal Units (ATAIN) and Transitional Care (TC) reporting is included in this report. The ATAIN rate for Q3 remains stable, below the national target of 5%. An increase in the number of avoidable term admissions in Q3, and outlines the plan for an annual trend and theme analysis in Q4. The report outlines the leading cause for admission into the RUH

Neonatal Unit remains respiratory distress, and details a new practice development project; 'The COSEI project' to reduce admissions of babies with the need for transient respiratory support by providing bedside respiratory support within the birth environment for a specified period of time.

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

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.)

In Q3 Maternity and Neonatal, services presented six new risk assessments, which was approved for the risk register:

2649	Delays to commencement of induction of labour	12
2679	Service provision of digital blood pressure monitors validated for use in pregnancy and pre-eclampsia	5
2660	Tertiary level neonatal cot capacity in the region	8
2648	Family Origin Questionnaire processing for screening of Haemoglobinopathies	9
2681	Room bookings for mandatory training programme as outlined in the maternity TNA –section 6.	9
2664	Ligature risk	5

Current Open Risks in Maternity and Neonates Q3 23/24:

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1948	Obstetric ultra sound scan capacity	12
2359	Maternity Information System IT support/capacity	8
2417	Maternity triage	12
2467	Maternity workforce	12
2481	Staff Entonox exposure in birthing environments	4
2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	6
2522	The Provision of maternity care to birthing people who do not identify as a female gender	8
2483	Expiration of Maternity and Neonatal staff resources and guidelines	8
2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millennium	12
2581	There is a risk that we will be unable to meet the service demand for obstetric medical staging with the current unsecured establishment of Obstetric Consultant.	12
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from the neonatal Operational Delivery Network.	9
2649	Delays to commencement of induction of labour	12

	2679	Service provision of digital blood pressure monitors validated for use in pregnancy and pre-eclampsia	5
	2660	Tertiary level neonatal cot capacity in the region	8

5.	Resources Implications (Financial / staffing)
Compliance with the Maternity Incentive Scheme for Trusts, 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
Maternity and Neonatal 2023 Q3 report, Quality Governance Committee – March 2024 Previous monthly Perinatal Quality Surveillance reporting (Integrated Performance Reports) Maternity and Neonatal Safety Report Q2 – October 2023 Safer Staffing Report – August 2023. CNST Maternity Incentive Scheme – Year 4 declaration of compliance - December 2022.	

8.	Publication
Public.	

MATERNITY AND NEONATAL Q2 23/24 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 MNSI	✓ see report	✓ see report	✓ see report
Report on: 2a. The number of incidents logged graded as moderate or above and actions	✓ see report	✓ see report	✓ see report
2b. Training compliance for all staff groups in maternity related to the core competency framework v2 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	✓	✓	✓
5.MNSI/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	✗ New MIS standards released 30 May 23	✗ New MIS standards released 30 May 23	✓ On Target, not yet fully compliant See report
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 - 65% Treatment - 75% Staff Survey 2022
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)

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 concerns within Maternity and Neonatal services. The information within the report reflects actions and progress in line with Ockenden 2022 and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

1. PERINATAL MORTALITY RATE

The following graphs demonstrate RUH performance against the national ambition to reduce stillbirth in the UK by 50%, and the local ambition for continual progression in reducing perinatal mortality at the RUH.

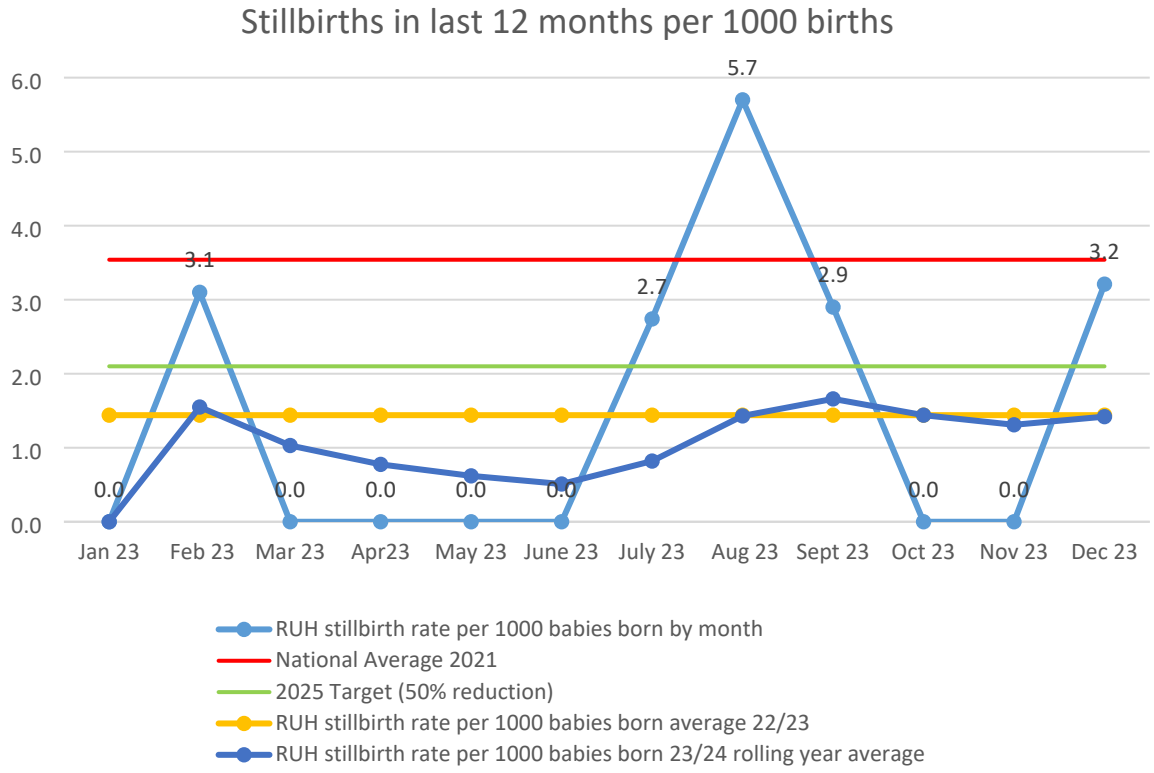


Figure 1. RUH NHS Trust stillbirth rate per 1000 births over last 12 months

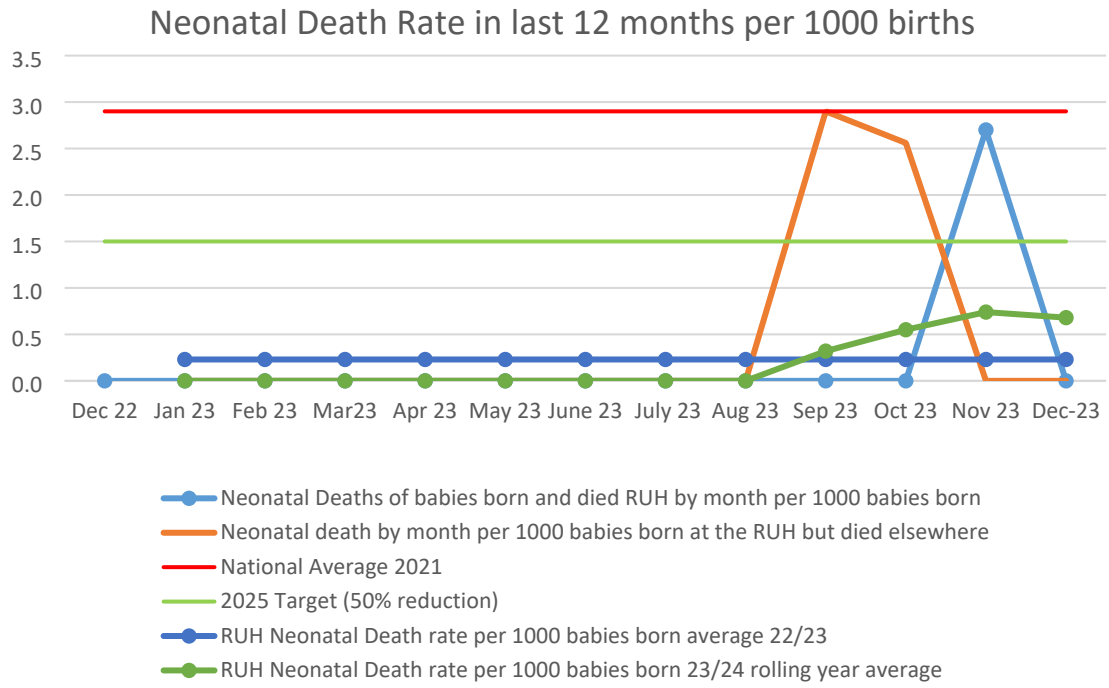


Figure 2. RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

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 at the RUH. Births between 22-24 weeks are pulled manually and added to the data set submitted to MBRRACE-UK as in figure 1. Perinatal deaths are defined from birth after 22 weeks gestation and include neonatal deaths at any gestation where the baby is born with signs of life, but stillbirths are defined from 24 weeks at diagnosis of death. The rate of stillbirth and perinatal death may therefore be different.

Trusts are provided with initial MBRRACE perinatal mortality rate per 1000 births, results are subsequently stabilised and adjusted to include deaths of babies who were born with Providers but subsequently died elsewhere. This report has therefore separated these values to ensure alignment of internal mortality data figures ahead of reported and adjusted MBRRACE figures, see Figure 1 and Figure 2.

Three perinatal deaths (excluding Medical Termination of Pregnancies (MTOP)) were reported in Q3. There was 1 stillbirth, and 1 neonatal death; of pre-viability pregnancy birth where the baby was born with signs of life at the RUH. We were informed of one neonatal death of a premature baby born at the RUH and subsequently transferred to a tertiary Neonatal Intensive Care Unit (NICU).

2023/24 (excluding terminations for abnormalities)	Q3 23/24	Annual total 23/24	Annual total 2023 (calendar year)
Stillbirths (>37 weeks)	1	2	2

Stillbirths(>24weeks-36+6weeks)	0	3	4
Late miscarriage (22+weeks-23+6weeks)	0	1	2
Neonatal death at the RUH	1	1	1
Neonatal death elsewhere following birth at the RUH	1	2	2
Total	**3**	**9**	**11**

Table 1. Perinatal Mortality summary by number of cases, quarter 3 2023/24

MBRRACE report mortality figures annually per calendar year therefore the mortality rates for 2023 are as follows;

- RUH stillbirth rate 1.42 per 1000 births (n=6), this is a minor reduction on the 2022 reported rate of 1.44 per 1000 births, and remains below the nationally reported rate in 2021 of 4.2 per 1000 births.
- RUH Neonatal mortality rate 0.71 per 1000 births (n=3). This is greater than the reported RUH rate from 2022 of 0.23 per 1000 births; however, this is an anticipated increased rate in response to 2023 figures accounting for those babies born at the RUH but subsequently died elsewhere. The internal death rate; babies who were born at the RUH and died at the RUH, was unchanged in 2023 at 0.23 per 1000 births (n=1).

Following the publication of the 2021 MBRRACE statistics in September 2023, a thematic review of all Perinatal Mortality Review Tool (PMRT) reviews following stillbirth (n=13) and neonatal deaths (n=4) in the year of 2021 was completed. This report identifies key priorities for improvement and progression continues towards completion (Appendix 2). The review did not identify any concerning or causal trends or themes within the cases reviewed.

The report has considered all care issues identified via PMRT in 2021 irrespective of impact upon outcome. This report identifies 3 key areas of improvement in 2021:

- Plotting of Symphysis Fundal Height measurements (n=4)
- Use of Partogram in the care of Intra-Uterine Death intrapartum care episodes (n=2)
- Provision of written information about reduced fetal movements (n=2).

Actions towards improvement undertaken at the time, and current progression/compliance in response, are outlined within the report.

2. PERINATAL MORTALITY REVIEW TOOL (PMRT)

All perinatal deaths that occur within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is a requirement of Safety Standard 1 of the NHS-R Maternity Incentive Scheme year 5. All Q3 cases have been reported to MBRRACE via PMRT.

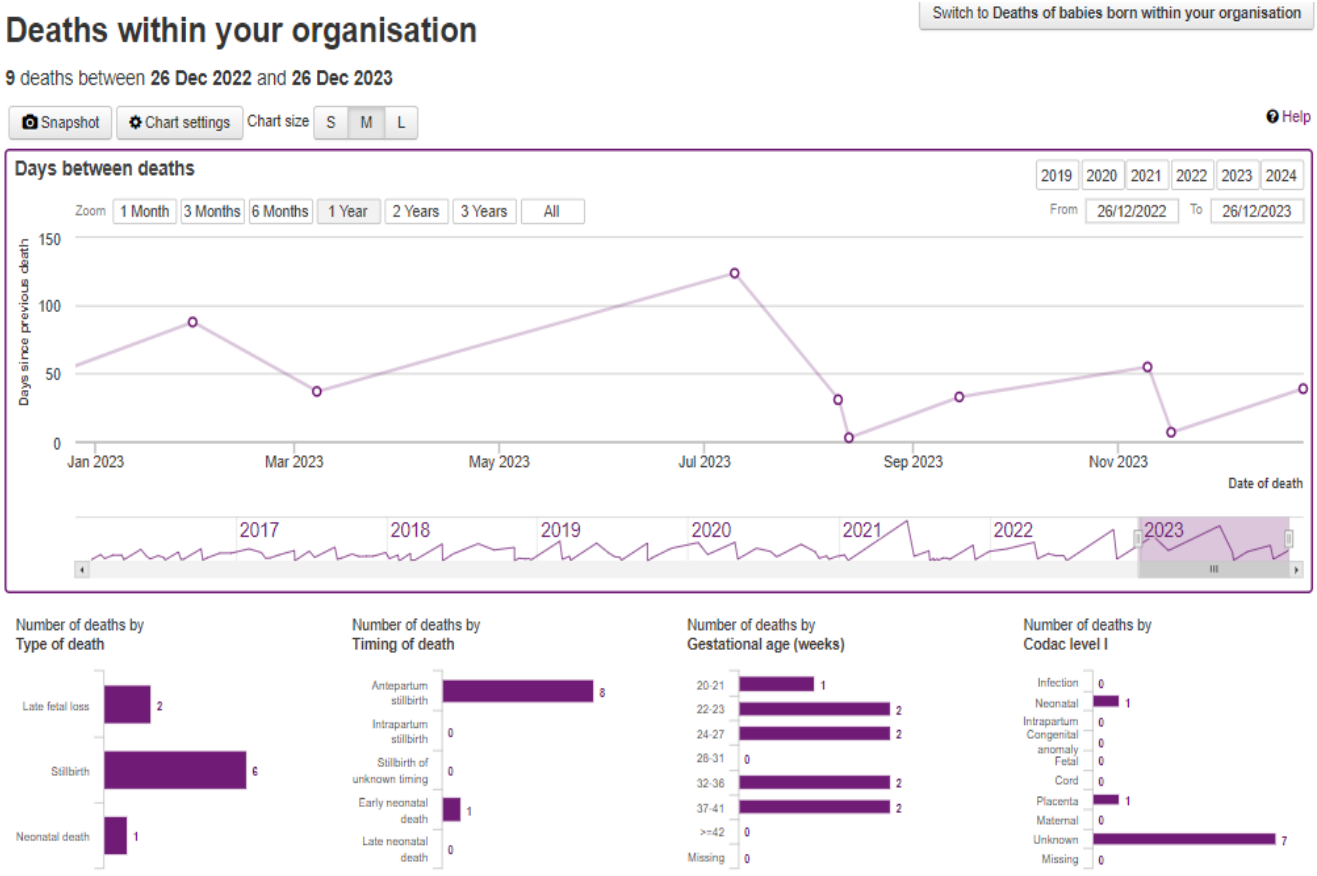


Figure 3. Reporting of RUH NHS Trust Deaths within Organisation.

2.1 LEARNING FROM PMRT REVIEWS

No PMRT reviews reached completion in Q3 of 2023.

3. MATERNITY AND NEONATAL SAFETY INVESTIGATIONS (FORMERLY THE HEALTHCARE SAFETY INVESTIGATION BRANCH) AND MATERNITY SERIOUS INCIDENTS

3.1 BACKGROUND

MNSI 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 INVESTIGATION PROGRESS UPDATE

Two new referrals were made in Q3 to MNSI, one was rejected by MNSI following internal triaging, and one progressed at the family request.

Table 2 identifies ongoing MNSI reviews into Q3. The findings and recommendations of these reviews, and the actions taken in response, will feature in future reports.

Ref	Details of Event	confirmed Investigation	External Notifications and Other Investigations
Completed in Q3			
MI-026685	Neonatal resuscitation following home birth	May 2023	N/A
Ongoing			
MI-030349	Neonatal transfer to Tertiary Neonatal unit for ongoing care and active therapeutic cooling, Normal MRI post active therapeutic cooling progressing at family request	Sept 2023	N/A
MI-034656	Transfer to Tertiary neonatal unit for active therapeutic cooling following resuscitation at birth, Normal MRI post active therapeutic cooling progressing at family request	Oct 2023	N/A
New Referrals			
MI-036039	Baby admitted on day 2 of life transferred to Tertiary Neonatal Unit for ongoing care	MNSI reject due to diagnosis of metabolic disorder	N/A
MI-035529	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling	Normal MRI post active therapeutic cooling, progressing at family request.	N/A

Table 2. MNSI referrals and ongoing investigations Q3 2023/24

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY SERIOUS INCIDENTS

One patient safety review was completed in Q3, the findings and recommendations have been actioned as per paragraph 3.5. There was 1 new Serious Incident identified during Q3. See Table 3.

Ref	Details of Event	Review Response	External Notifications and Other

			Investigations
Completed reviews			
118499	Mother birthing outside of guidance. Shoulder dystocia, baby born in poor condition requiring resuscitation at birth Transferred to Bath Birthing Centre (BBC) no blood gas analysis performed	learning identified at Multi-disciplinary Team (MDT) regarding current care provision for women who choose to birth outside of guidance Neonate's deviation from care pathway missed opportunity for blood gas on admission and potential Cerebral Function Monitoring	STEIS 2023/15926 Downgraded from STEIS
New reviews			
121463	Neonatal death at 27 weeks gestation following a difficult caesarean section birth.	Ongoing review declared as SI in Q3.	

Table 3. Maternity and Neonatal Serious Incident reviews Q3

There were 7 moderate harm events reported during Q3, of which 2 were duplicated reports, all have received a local review, the multidisciplinary review team (MDT) which did not identify any acts or omissions in care casual to the event.

3.5 LEARNING AND IMPROVEMENT

One completed MNSI review and 1 completed local patient safety review were received in Q3 2023. The reports outlined co-incidental findings and safety recommendations, which have been assessed for future learning and improvement; action plans have been derived, and will be monitored via Maternity and Neonatal Specialty Governance for progress towards ensured completion.

A theme related to intermittent auscultation has emerged in Q3 from these reports and local clinical audit findings. A Quality Improvement project has been initiated, inclusive of ensuring alignment to national improvements outlined within Saving Babies Lives version 3. The development and continued progression of this project will be monitored within the Maternity and Neonatal QI Hub reporting into Maternity and Neonatal Specialty Governance.

Learning and Improvement drivers from these events are fed back in a variety of formats including: maternity newsletter, staff e-mails, staff safety briefings, patient safety 'Safety Catch' newsletter, Microsoft Teams RUH Maternity Team, case review QR code posters to full reports and quality and safety whiteboards displayed in clinical areas with a 'Safety Hot Spot' of the month. Safety Hotspots are identified through service insights such as themes of low and no harm incidents, audit and, or family feedback.

4. OCKENDEN UPDATE

4.1 OCKENDEN FINAL REPORT UPDATE – Q2 2023-2024

The Trust is not required to submit evidence of compliance with the 15 Immediate and Essential Actions outlined within the Ockenden report of 2022. Monitoring of compliance and improvement towards compliance is monitored via Specialty Governance, Maternity and

Neonatal safety champions via the Internal Performance Review (IPR) presentation every month.

Plans are in place during Q4 to align all national and local improvement drivers into a singular RUH Maternity Improvement plan, encompassing Ockenden 2022, the 3 year single delivery plan 2023, Saving Babies Lives v3 and locally identified safety priorities.

Key Achievements in progression during Q3:

- Completion of the second bespoke in-house multidisciplinary High Dependency Unit (HDU) training for senior midwives in November 23, increasing compliance across senior midwifery team.
- Agreement of Maternity investment case to fund consultant staffing establishment, recruitment process in place, interviews scheduled for Q4 of 23/24.
- BirthRate+ inpatient ward acuity tool re-instated November 2023 following period of unavailability for national updates.

Next Steps for Progressions:

- Continued work towards compliance with 10 safety actions for MIS, and SBLv3
- Collation and alignment of the national improvement drivers; Ockenden IEAs of 2022, the Three-year delivery plan of 2023, Saving Babies Lives v3 of 2023 into a single RUH Maternity Improvement plan to ensure cohesive tracking of progress.

Key Risks to Full Compliance:

- There are currently individual action plans in place in response to each national driver; the risk is that these are not cohesively integrated to accurately represent contemporaneous compliances.

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

5.1 SITUATION REPORT

Compliance with fetal monitoring, neonatal resuscitation and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) across all staffing groups is required to be above 90% across all staff groups to fulfil the requirements set out within the CNST MIS and Saving Babies Lives Care Bundle v3. The reporting deadline for mandatory training compliances for CNST MIS and SBLv3 was met in Q3 with the RUH declaring >90% compliance across all staffing groups in Maternity services. See figure 4.

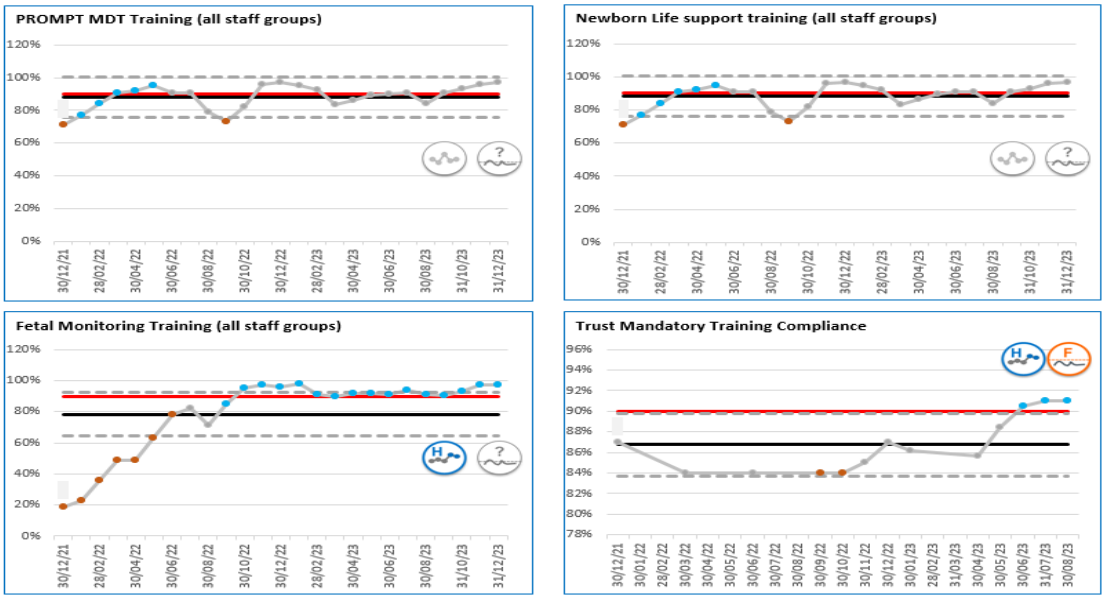


Figure 4. Maternity Training Statistical Process Charts as of 31/12/2023

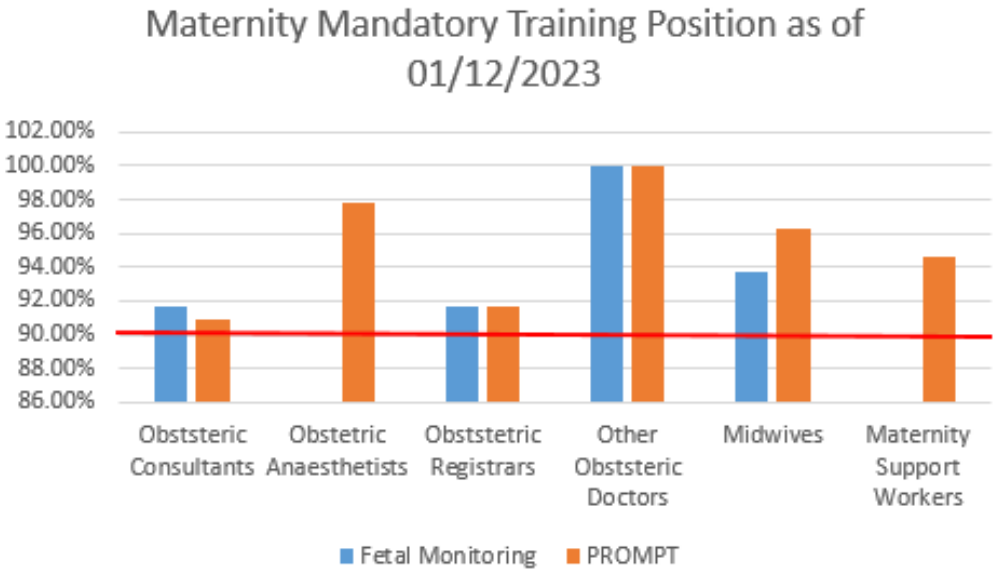
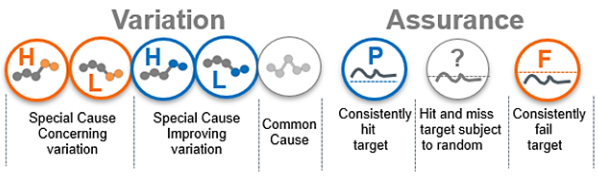


Figure 5. Prompt and fetal monitoring Training Compliance (%) by staff group as of 01/12/2023 (CNST MIS position of declaration).



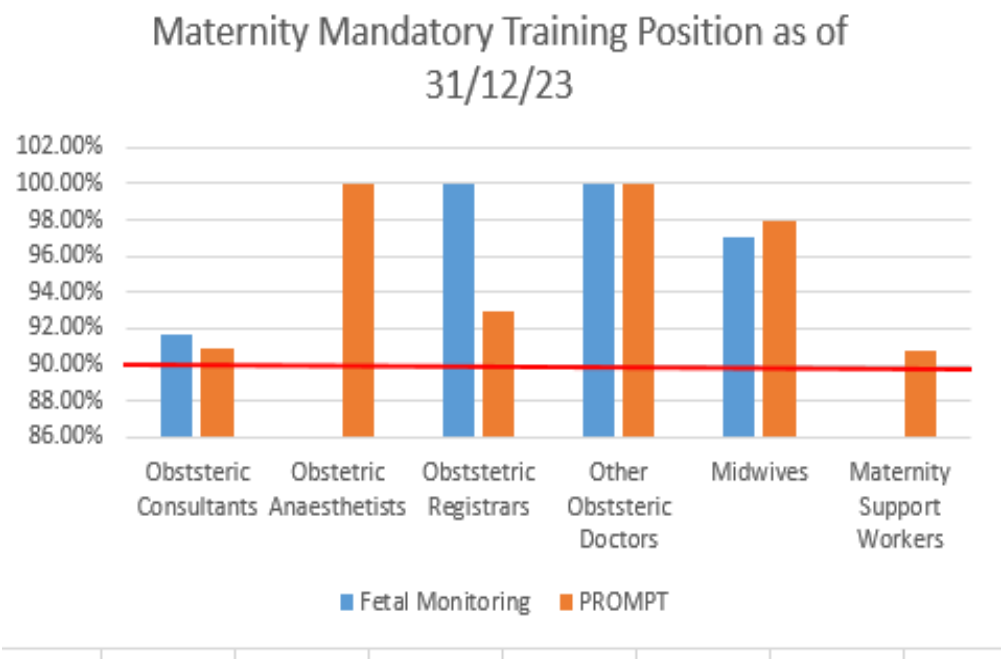


Figure 6. Prompt and fetal monitoring Training Compliance (%) by staff group Q3 2023/2024

6. BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions are active in their role to listen to the staff voice in maternity services. All staff are invited to attend monthly 'listening event' meetings and interact with safety champions during walkabouts with the Chief Nursing Officer, the Non-Executive Director for Maternity and Neonatal services, and the Obstetric, Neonatal and Maternity Safety champions.

Members of the maternity and neonatal team attended the listening event meetings in Q3 from a range of areas, including neonatal services, community midwifery and specialist midwives.

Themes raised during Q3 were:

- Designated areas for breast feeding staff to express
- The movement of staff from substantive to bank contracts of employment to facilitate flexibility in shift allocations.
- Challenges with the current digital Electronic Patient Record system and data capture capabilities.

Current work is ongoing within the specialty to address the concerns raised:

- The Trust are aware of the current lack of private designated expressing areas and is part of the Trust-wide agenda and Baby Friendly Initiative (BFI) strategy group
- The Retention Midwife has begun exploring flexible rostering with the maternity Matrons
- Maternity digital system - ongoing business planning is in place to secure funding for the new system– risk register entry 2467

Themes, commonalities and actions from this feedback is monitored via the Maternity and Neonatal Safety Champions meetings and is triangulated with further service insights in the Maternity and Neonatal Bi-annual 'Insights' report to drive our continuous improvement work.

7. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q2 2023/24

The Clinical Negligence Scheme for Trusts released their Safety Standards for Year 5 on 30 May 2023 including a new Saving Babies Lives Version 3. Updates on progress and monitoring towards achievement of the 10 safety actions outlined is completed and shared within Maternity and Neonatal Speciality Governance meeting and Board Level Safety Champions.

The current position and projection for submission in January 2024 is detailed in table 4. Of note, the Trust has had confirmation of compliance with MIS Year 5 and the Board of Directors has signed off compliance which was submitted in February 2024.

	Maternity Incentive Scheme - Safety Action Detail	RAG (Dec 2023)	Projected Submission RAG
1	Are you using the National PMRT to review perinatal deaths to the required standard?		
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?		
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?		
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		
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?		
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?		

Table 4. Progress and projection for compliance with MIS Year 5.

This year KPMG undertook an audit of the evidence submitted from Maternity and Neonatal services to demonstrate compliance with MIS. Safety Action 6 of MIS has been excluded from the audit as this element of MIS is being over-seen by the Local Maternity and Neonatal System (LMNS).

The audit commenced in October of 2023 with a finalised report received in December of 2023 outlining compliance in all 9 of their assessed standards upon completion of 3 tasks, which fell outside of the time scale of their review.

Finding/Action	Completion
Safety Action 4 – Sharing of the anonymous staff survey regarding obstetric workforce compensatory rest shared with Trust Board	**Completed** please see Maternity and Neonatal Quality report for Q2 23/24
Safety Action 8- Sharing of the Maternity Training Needs Analysis 23/24 with the Trust Board and LMNS	**Completed** please see Maternity and Neonatal Quality report for Q2 23/24, discussed with LMNS on 21/11/2023
Safety Action 9- for the Board Level Maternity Safety Champions to complete the NHS E Perinatal Culture and Leadership Programme.	**Ongoing** Training commenced in November of 2023.
Safety Action 9- for the Perinatal 'Quad' leadership team to meet with the board level safety champions on a quarterly basis (2 within the reporting period)	**Completed** at the time of the report completion 1 meeting had taken place the second took place in January 2024

Table 5. Progress of outstanding actions upon completion of KPMG audit Dec 2023

8. SAFETY ACTION 6 OF MIS SAVING BABIES LIVES CARE BUNDLE V3.

Saving Babies Lives Version 3 implementation was assessed externally by the LMNS using the national implementation tool on NHS futures platform. The RUHs evidenced position in Q3 is reported in table 6.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	80%	Partially implemented	60%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	78%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	86%	Partially implemented	73%	CNST Met

Table 6. RUH Maternity Current position for implementation of Saving Babies Lives v3.

Ongoing work continued towards full implementation of all elements of Saving Babies Lives Version 3. CNST MIS compliance required 70% implementation compliancy by submission in February 2023 encompassing of a minimum of 50% compliancy in each of the elements. The position in Q3, projection was for >70% of compliance by submission in February, fulfilling the MIS standards requirement

Key areas of focus are:

- Element 2 - Capacity of Obstetric Ultrasound (USS) department to facilitate alignment to the national USS pathways, whilst fulfilling next working day targets for unscheduled USS in response to reduced fetal movements. Significant systems and practice changes required in response. Risk Register entry 1948. Ongoing audit plan in place; to closely monitor service change impacts.
- Element 2 - Digital Blood Pressure (BP) monitors are not currently validated for use in pregnancy and pre-eclampsia. National procurement issue in response to Saving Babies Live v3. Risk register Entry 2679.
- Element 5 - Current national shortage of evidence-based best practice Point of Care Bedside Biomarker for the assessment of Threatened Pre-Term Labour Risk currently under assessment for the risk register.

9. SAFE MATERNITY STAFFING

9.1 MIDWIFERY STAFFING

As of 15 of January 2024, the band 5/6 Midwifery Vacancy rate was 1.38 whole time equivalents (WTE), however 8.29 WTE are on maternity leave giving an overall 'gap' of 9.52 WTE.

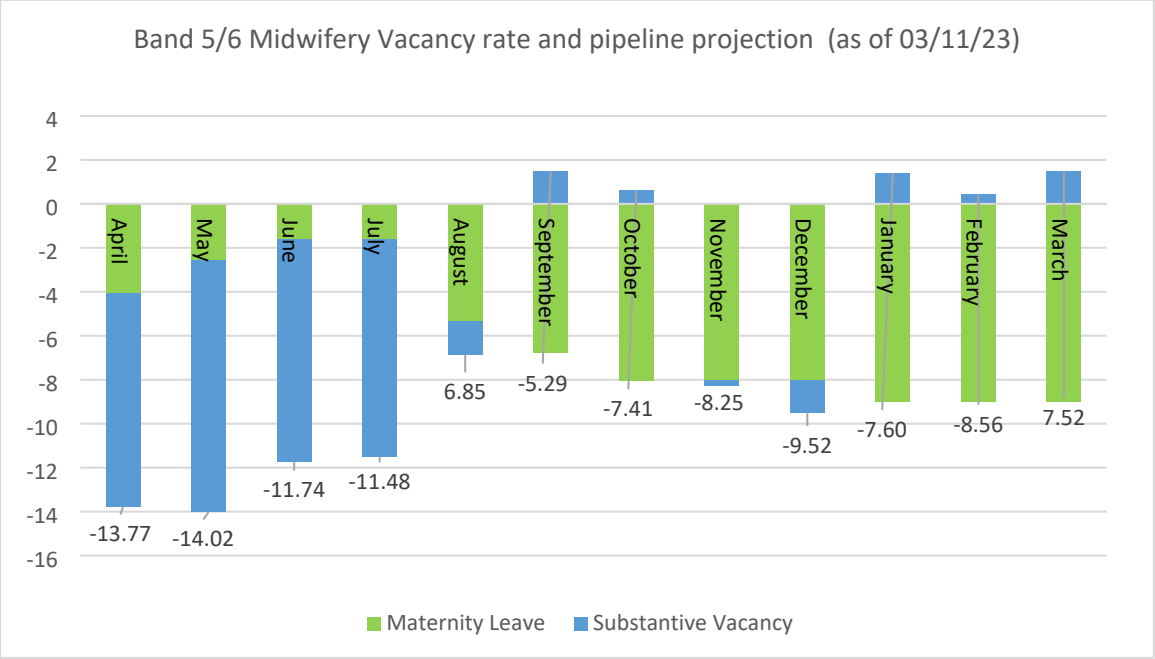


Figure 7. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness)

Measure	Aim	October	November	December
Midwife to birth ratio	1:24	32	30	26
Midwife to birth ratio including bank	1:24	29	27	23
Episodes of inability to maintain Supernumerary labour ward coordinator status	0	5	2	0
1:1 care not provided	0	1	0	0
Confidence factor in Birth-rate+ recording	60%	85.5%	82.78%	82.28%

Table 7. Midwifery staffing safety measures

9.2 OBSTETRIC STAFFING

Measure	Aim	October	November	December
Consultant presence on BBC (hours/week)	≥90 hours	98	98	98
Consultant non-attendance (in line with RCOG guidance)	0	0	0	0
Twice daily MDT ward round	90%	87%	50%	82%

Table 8. Obstetric staffing safety measures

MDT ward round has been negatively impacted by a change in data capture from a paper based system to digital reporting. In Q3, the decision has been agreed to revert to a paper based system to provide assurance of true 'work as done'. Following receipt of assurance of a stable position; achieving consistence of ≥90% compliance, the service intends to move towards an exception reporting model.

During the month of October 2023, a noted increased birth rate and acuity was identified with the number of births exceeding the normal average rate of approximately 340 babies born. The number of babies born in the month of October was 390. This was identified as an impacting factor on the midwifery staffing metrics.

An Obstetric workforce review has been completed and has identified a risk within the current established funding of Obstetric Consultant posts, Risk 2581. The maternity investment case has supported an increase of 2.0 WTE consultants, the posts are currently out to advert with interviews scheduled in 2024, once recruited this risk will be re-assessed with potential for closure.

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

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

	October	November	December
Number of formal compliments	5	4	5
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	8	5	10
Complaints	3	0	0

Table 9. Complaints and compliments Q3 23/24

During Q3, the service received 3 complaints, of which there were no commonalities noted; ranging between postnatal care, neonatal care and antenatal translation/interpretation during first trimester screening. Two of the complaints have been closed with responses shared with the families in December of 2023, one complaint remains open. PALS contacts varied in Q3 from parking fines received during care episodes to breastfeeding support, no clear themes were identified within the contacts made.

During Q3, the service established a triangulation of feedback 'Insights group' to review the range of feedback the service receives on a monthly basis. The aim will be to assess new 'insights' identifying any areas of emerging concern and provide information for the cumulative oversight of trends and themes. This working group will support the information presented in

the Bi-Annual Maternity and Neonatal 'Insights' report aiming to identify the speciality's Safety Priorities informing future improvement work. The reporting will be shared wider within the LMNS for collaboration and regional system-wide improvement.

Compliments to the service were received across all areas of Maternity and Neonatal care including Bath Birthing Centre, Anaesthesia and Mary Ward. A continued theme amongst compliments to the service is the kindness and compassion showed to birthing people and their families from members of staff providing care. We are currently exploring a more robust method of capturing compliments received to the service as often these are received via informal routes, and kind gestures from families such as cards.

Example:
'*Massive thank you to all of the staff in the birthing centre and maternity ward. I recently gave birth and the care I received was just brilliant, everyone we came into contact with were just so caring and kind, they were all amazing. Thank you for making such a huge moment of becoming a mother and giving birth a positive one'.*

10.2 MATERNITY AND NEONATAL VOICES PARTNERSHIP PLUS (MVPP)

The Maternity and Neonatal Voices Partnership Plus (MNVPP) will hold a key stakeholder membership in the 'Insights' group and have been providing feedback into the meetings since their commencement in October 23.

The NHSE Maternity and Neonatal Programme have published the Maternity and Neonatal Voices Partnership Guidance in November 2023; a gap analysis will be undertaken with the RUH MNVP lead in Q4.

MNVP hours have been increased and agreed via the LMNS Programme Board to support the work plan across the BSW system. This will support delivery of the key priorities;

- Listen to Women & Families from all backgrounds & ethnicities
- Support improvement of Antenatal and Postnatal care
- Support development of perinatal specialist services
- Improve digital systems and process for our families
- Improvement of intrapartum care – Induction of Labour (IOL) flow, supporting birth choices and consent
- Improved involvement in governance and communication to support delivery of the 3 year Maternity and Neonatal delivery plan and transformation

11. AVOIDING ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE

During Q3, the Transitional care service was facilitated 100% of the time with >50% of neonatal care provision within a Transitional Care Pathway (TCP), providing neonatal care at the mother's bedside.

Q3 saw the launch of the new TCP guidance increasing the scope to encompass clinically well babies born ≥34+0 (previously 35+0), and all babies born <2nd centile for birth weight. This will further reduce separation of mothers and babies for those families requiring increased clinical care and support.

A new named link midwife role for TCP was established to ensure effective communication and collaborative service planning across the service. The service looks towards establishing a core TCP working group consisting of clinicians across the Multidisciplinary team to continue the assessment and evaluation of the service's effectiveness and improvements/developments.

The Avoiding Term Admissions into the Neonatal unit (ATAIN) working group identified 7 avoidable admissions into the Local Neonatal Unit (LNU) in Q3. There were no clear commonalities seen within the modifiable factors in care resulting in admission. Immediate learning was identified in one case regarding escalation of Fetal Heartrate concerns from the outset of CardioTocoGraph (CTG) monitoring. This has been addressed via the monthly 'safety catch' vignette news flash, and added to the safety briefing within the antenatal/intrapartum care settings.

The Q4 ATAIN report will provide an annual review for themes and trends to feed into improvement work streams and wider correlation for thematic assessment via the Maternity and Neonatal 'Insights' report.

The leading cause for admission into the neonatal unit both locally and nationally remains respiratory distress. The RUH remains committed to reducing separation of mothers and babies, by avoiding term admissions into the neonatal unit (ATAIN) therefore will be embarking upon a practice development project called the 'COSEI project' . The COSEI project aims to deliver nasal continuous positive airway pressure (NCPAP) within the birth room via a ventilator whilst babies are skin to skin with a parent. It is designed for babies that develop transient respiratory distress around the time of birth, which can resolve following additional support via NCPAP. Simulation training is in progress with an anticipated launch date during Q4 23/24.

12. RISK REGISTER

In Q3 Maternity and Neonatal, services presented six new risk assessments, which were approved for the risk register:

2649	Delays to commencement of induction of labour	12
2679	Service provision of digital blood pressure monitors validated for use in pregnancy and pre-eclampsia	5
2660	Tertiary level neonatal cot capacity in the region	8
2648	Family Origin Questionnaire processing for screening of Haemoglobinopathies	9
2681	Room bookings for mandatory training programme as outlined in the maternity TNA –section 6.	9
2664	Ligature risk	5

Table 10. New Risks for the Maternity and Neonatal risk register Q3 2023

During Q3 one risk was closed, following installation of Emergency Bells in all Obstetric Theatres in October of 2023

2396	Obstetric theatre emergency call bells	12

Table 11. Closed Risks for the Maternity and Neonatal risk register Q2 2023

A full summary of the Maternity risk register is detailed in table 14. Actions towards closing the

gaps identified within the individual risk assessments on datix, and continued mitigation of risk, will be monitored through Specialty and Divisional governance with Trust Management Executive, oversight to ensure appropriate actions are taken in accordance with the Trust risk framework.

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1948	Obstetric ultra sound scan capacity	12
2359	Maternity Information System IT support/capacity	8
2417	Maternity triage	12
2467	Maternity workforce	12
2481	Staff Entonox exposure in birthing environments	4
2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	6
2522	The Provision of maternity care to birthing people who do not identify as a female gender	8
2483	Expiration of Maternity and Neonatal staff resources and guidelines	8
2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millennium	12
2581	There is a risk that we will be unable to meet the service demand for obstetric medical staging with the current unsecured establishment of Obstetric Consultant.	12
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from the neonatal Operational Delivery Network.	9
2649	Delays to commencement of induction of labour	12
2679	Service provision of digital blood pressure monitors validated for use in pregnancy and pre-eclampsia	5
2660	Tertiary level neonatal cot capacity in the region	8
2648	Family Origin Questionnaire processing for screening of Haemoglobinopathies	9

Table 12. Maternity and Neonatal Risk Register December 2023

13. MATERNITY CQC INSPECTION

The CQC undertook an announced inspection of Maternity services in November 2023 as part of the national maternity inspection programme. As detailed in the Chief Executive Report, Maternity services on the Combe Park site were rated overall as ‘outstanding’. Chippenham and Frome Birth Centres were inspected for the first time, they were both rated as ‘good’. The finalised report was published in March 2024 and will feature in the Q4 report.

14. RECOMMENDATION

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

Appendix 1 TC and ATAIN report Q3 23/24

Appendix 2 2021 MBRRACE stillbirth and neonatal death thematic analysis report

Appendix 1

Clinical Audit Report

Transitional Care Pathway and Avoiding Term Admissions Into Neonatal (ATAIN) Audit Q3 2023/2024

Speciality: Local Neonatal Unit

Division: Family & Specialist Services Division

Project team				
Kirstie Flood	Title/grade:	Lead Nurse	Data period:	Q3 October 2023 – December 2023
Sarah Goodwin	Title/grade:	Quality and Education Neonatal Sister	Report completion:	January 2024

Transitional Care Pathway and ATAIN Audit Q3 2023/2024

Contents

Executive Summary

1. Background

Avoiding Term Admissions Into Neonatal (ATAIN) Services and Transitional Care services at the RUH, strives to reduce the separation of mothers and babies, by providing services and staffing models that keep mother and baby together. This is pivotal in reducing the harm caused by separation.

The continued monitoring of admission data and modifiable factors enable RUH Maternity and Neonatal services to continuously evaluate current systematic care provision and seeks to identify key areas of improvement.

Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising the separation of mothers and babies (Neo-056). Neonatal teams are involved in decision making and planning care for all babies in transitional care.
The pathway of care into transitional care has been fully implemented and is audited on a quarterly basis. Findings are shared with the Neonatal Safety Champion, Local Maternity and Neonatal System (LMNS), and Integrated Care System (ICS) quality surveillance meeting every quarter.

This audit report is demonstrative of the upward reporting from the ATAIN working group's Terms Of Reference (TOR) supporting the continued improvement of services and supplementary evidence of the Maternity Incentive Scheme - year five, Safety Action 3*.

**Safety Action 3: To 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 (ATAIN) into Local Neonatal Units (LNU) programme.*

2. Objectives

- To evaluate the number of admissions into the neonatal unit that would have met transitional care (TC) admission criteria but were admitted to the neonatal unit (NNU) due to capacity or staffing issues.
- To evaluate 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
- To provide a data record of existing transitional care activity, (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.) The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery, nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered
- Analysis of staff/parent data, captured via a questionnaire relating to satisfaction, quality and safety of care
- Outline the key findings and improvements identified by the ATAIN working group's activity on a quarterly basis for sharing within Maternity and Neonatal Governance structures and the Board Level Safety Champions

- To provide evidence and assurance of sharing with the Neonatal and Maternity Safety Champions, and Board Level Safety Champions, LMNS and ICS quality surveillance meeting each quarter
- To provide an audit trail of evidence that reviews all term babies transferred or admitted to the LNU, irrespective of their length of stay.

The ATAIN working group is responsible for completing a thematic review of the primary reasons for all admissions, with a focus on the leading cause/reason(s) for admission through a deep dive to determine relevant areas of improvement to be addressed. This is in line with the working group's TOR.

Table 1 details the key findings from the audit

Standard	Compliance October 2023	Compliance November 2023	Compliance December 2023	Quarter 3 23/24 Totals
Audit findings shared with neonatal safety champion	**Complete**	**Complete**	**Complete**	**Complete**
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	**0**	**0**	**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	**5**	**6**	**3**	**14**
% of shifts TCP nurse provided as per TCP staffing model	**100%**	**97%**	**90%**	**95.6%**
TCP open	**100%**	**100%**	**100%**	**100%**
Number of babies readmitted to neonatal unit from TCP	**0**	**0**	**1**	**1**
Of the cases reviewed, the number of avoidable term admissions 37+0 weeks gestation and	**1**	**4**	**2**	**7**

above admitted to the neonatal unit				
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	**2**	**1**	**3**	**6**

Table 1: Key findings from the audit

3. Clinical Audit Report

Project title

Transitional Care and ATAIN Audit Q3 2023/2024 October - December 2023

Division

Family & Specialist Services Division

Specialty

Local Neonatal Unit

Disciplines involved

Neonatal Nurse Consultant, Neonatal Senior Sister

Obstetric Consultant, Patient Safety Midwives

ATAIN working group

Project leads

Kirstie Flood Lead Nurse

Sarah Goodwin Quality and Education Neonatal Sister

Standards

Maternity Incentive Scheme - year five. Safety Action 3.

Sample

All admissions to LNU and TCP from 01/10/2023-31/12/2023 to determine if the correct location of care was achieved.

All babies born at 37+0 weeks gestation and above from 01/10/2023-31/12/2023 who were admitted to the LNU.

Data source

Badger Net, NNU and TCP admission book and individual medical notes.

Audit type

Retrospective and live data collection.

3.1 Transitional Care Audit Findings

3.1.1 In Q3, 57% of the total number of admissions to the Local Neonatal Unit (LNU) (102 babies) were cared for on the transitional care pathway for some or part of their admission. Out of this, 35% (62 babies) spent the entirety of their admission on the TCP.

3.1.2 One baby was identified as a potential missed opportunity to have facilitated non-separation of mother and baby via the TCP. The baby was admitted from home with hypothermia but their temperature very quickly normalised, therefore at review it was assessed that they could have been admitted with their mum on the TCP.

3.1.3 Compliance with the staffing model outlined in the Maternity Safety Standards for staffing of the TCP was 100% of shifts for October, 97% November and 90% for December. The decrease in compliance in December was attributable to the neonatal unit being over capacity with high acuity, vacancies in B6 and B5 posts, higher than average study leave (due to supporting staff to complete their Qualified in Speciality course) and 4.4% sickness. Some shifts showed the TCP nurse looking after more than the four recommended babies. Due to the workload on the neonatal unit, staff could not be redeployed from LNU to assist on TCP. Other shifts showed staff looking after babies on TCP and babies in LNU.

3.2 ATAIN Audit Findings

3.2.1 The ATAIN working group identified seven avoidable admissions during Q3. Two babies were identified as avoidable in response to modifiable factors within their maternity care, which may have changed the neonatal care pathway. The other five were in response to modifiable factors in their neonatal care, which may have avoided their subsequent admission.

3.2.2 October admissions - Baby 1 was admitted from home with a skin abrasion in their groin. The care was reviewed and it was declared an avoidable admission to the LNU, this baby could have been admitted either into the Children's ward or under the TCP.

3.2.3 November Admissions - Baby 2 had a pathological cardio-tocograph (CTG) in labour, which if escalated sooner; the subsequent birth may have been expedited. This may have improved the baby's condition at birth and avoided the baby's admission to the LNU. Babies 3 and 4 were twins who were admitted to the LNU with hypothermia and hypoglycaemia. Following review of their care, it was recognised that the mother had been on labetalol in pregnancy, the recommended postnatal care for this was for the babies to receive blood glucose monitoring. This monitoring did not occur as per guidance, subsequently it was identified that the babies had low temperatures and were hypoglycaemic.

Baby 5 was a baby admitted to the LNU with poor adaptation, the review highlighted that due to the poor recording of the fetal heart rate during re-siting of an epidural, there was a potential opportunity for fetal concerns to have been noted earlier and a decision to deliver could have been expedited.

3.2.4 December Admissions - Baby 6 was a known to be subject to safeguarding plan, this outlined that mother was not to be unsupervised with her baby. Children's social care did not provide cover for overnight and the maternity service was unable to provide 1:1 care due to service acuity, therefore the baby had to be admitted to the LNU as a place of safety. Baby 7 was admitted from home with poor feeding; upon review it was deemed he TCP would have been a more appropriate location than the LNU. The cases have highlighted learning that is cascaded to the teams. Learning has been highlighted on the Safety Catches, shift Safety Briefs, Local Newsletters, Quality Board displays and is shared at the Maternity Neonatal Governance meeting. In line with the Standard 3, neonatal unit transfers or admissions regardless of their length of stay, of all term babies transferred or admitted to the neonatal unit from other areas within the RUH, are reviewed. This includes, Emergency Department and the Children's ward. In Q3 23/24 there were 3 babies that were admitted, a decrease on the previous quarter, admissions are assessed against current admission guidance seeking to ascertain if the LNU was the appropriate care setting. In all cases, the admission to the LNU was considered appropriate.

4. Quality Improvement Projects

The Newborn Early Warning Trigger and Track (NEWTT2) charts and toolkit has been implemented for all TC babies in Q3, 2023-2024. The NEWTT2 chart and framework encompass parental concern into escalation scoring, in acknowledgement of the importance of the family voice as part of holistic care reviews.

This extended framework provides an escalation tool and a standardised response and review too using the PIER principles of 'Prevention, Identification, Escalation, and Response' adopted by the National Patient Safety Improvement Programme. NEWTT2 outlines a standardised escalation response including who is responsible, time scale of

review target, and support information for further escalation. This tool is designed to support recognition and escalation of the deteriorating Newborn under the care of TCP. Audit results for the use of NEWTT2 charts identify full completion, an audit of 10 sets of notes from Q3 identified 2 occasions where there was a lack of documented escalation in line with the framework. This was communicated to the team via e-mail correspondence and information in the newsletter to remind staff to follow the correct escalation pathway as per instructed on the charts.

- Fund-raising continues to covert clinical room G into a 4 bedded nursery with beds alongside each cot for a parent to sleep
- New named link midwife role for TCP to improve communication and collaborative working amongst the clinical team
- TCP MDT working group in the process of being established, aiming to work together to implement change and improve and progress TCP service.

5. COSEI Project

The leading cause for admission into the LNU at the RUH is respiratory distress (appendix 1) The project, 'continuous positive airway pressure on skin to skin early intervention' (COSEI), aims to reduce admissions with transient respiratory distress. The COSEI Project is a practice development project that aims to deliver nasal continuous positive airway pressure (NCPAP) in Bath Birth Centre via the ventilator while babies are skin to skin on a parent. It is designed to reduce maternal separation rates for babies that develop transient respiratory distress around the time of birth that fit a certain criteria. Simulations are in progress, with launch date anticipated in Q4 to ensure staff training has been facilitated.

The project aims to:

- Reduce parental-infant separation, avoiding unnecessary admission to the Neonatal Unit
- Reduction of parental-infant stress levels
- Promote bonding and increased breastfeeding rates
- Improve long-term family outcomes
- Reduce of term admissions to the Neonatal Unit

6. Conclusion

RUH Maternity and Neonatal services remain committed to ensuring progression towards a reduction in preventable or avoidable separation of mothers and babies wherever possible. The progression of quality improvement and learning initiatives within this report will be monitored through Maternity and Neonatal governance with progress updates, and clinical outcome measures within future reporting.

Appendix 1: Detailed analysis of babies requiring TCP

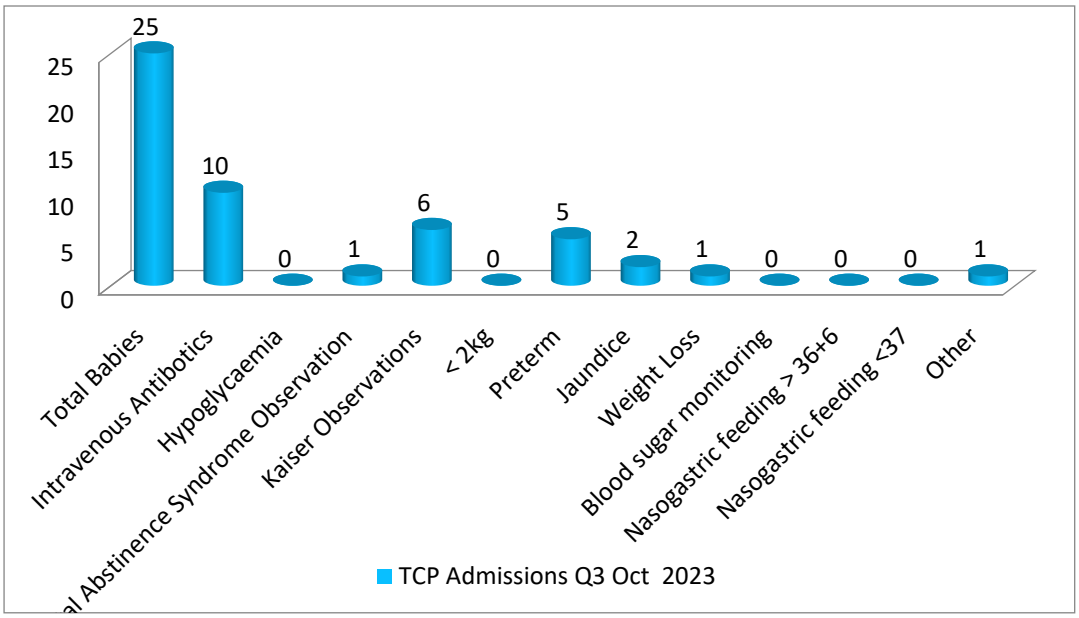


Figure 1: The reason for admission to Transitional Care for October 2023

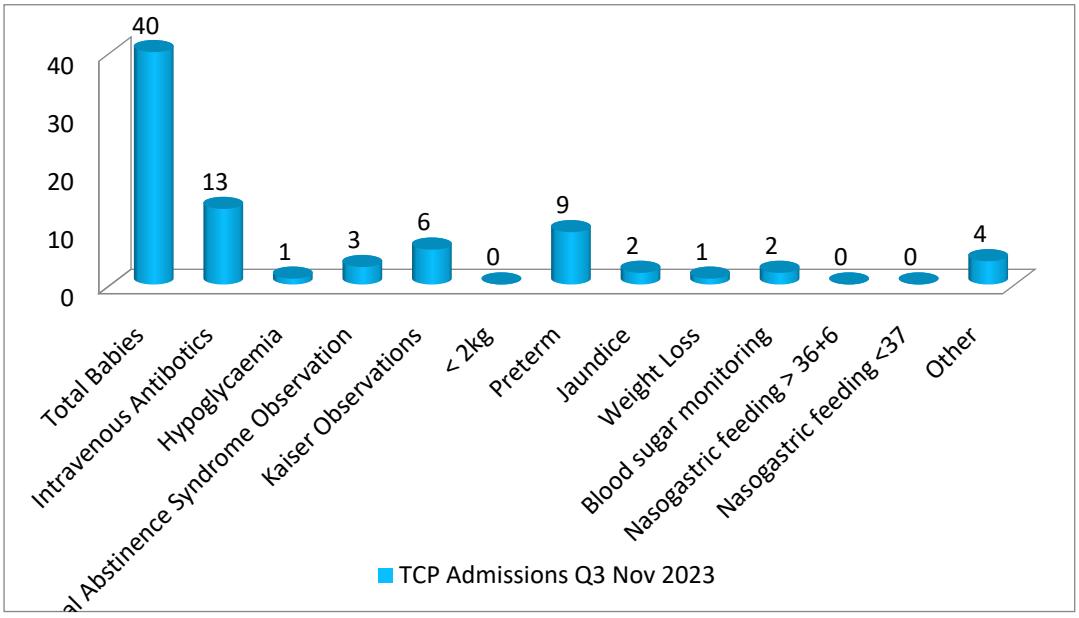


Figure 2: The reason for admission to Transitional Care for November 2023

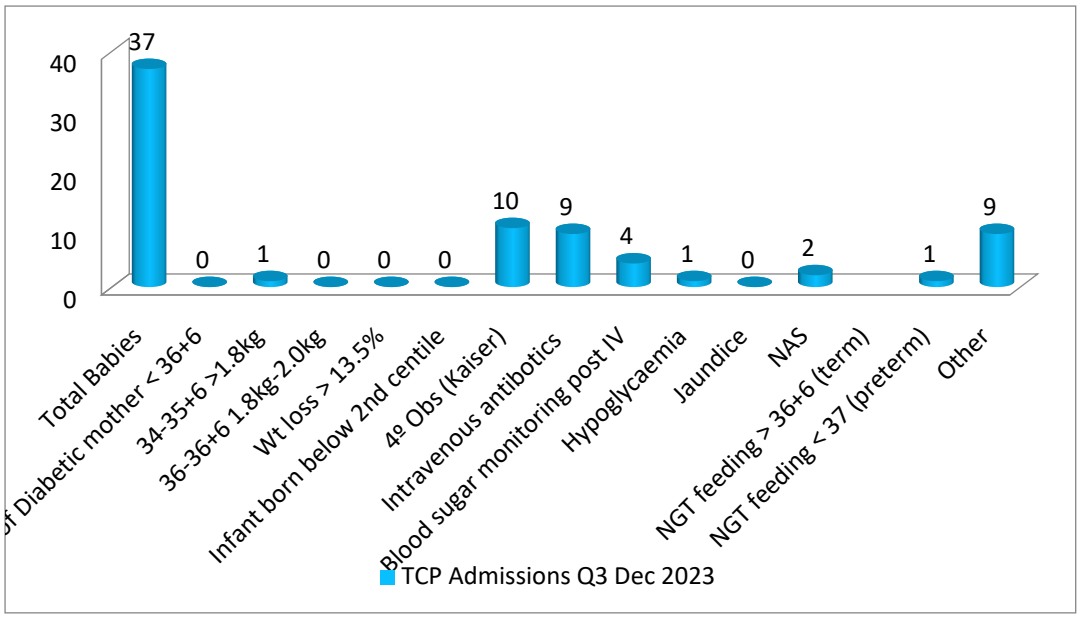


Figure 3: The reason for admission to Transitional Care for December 2023

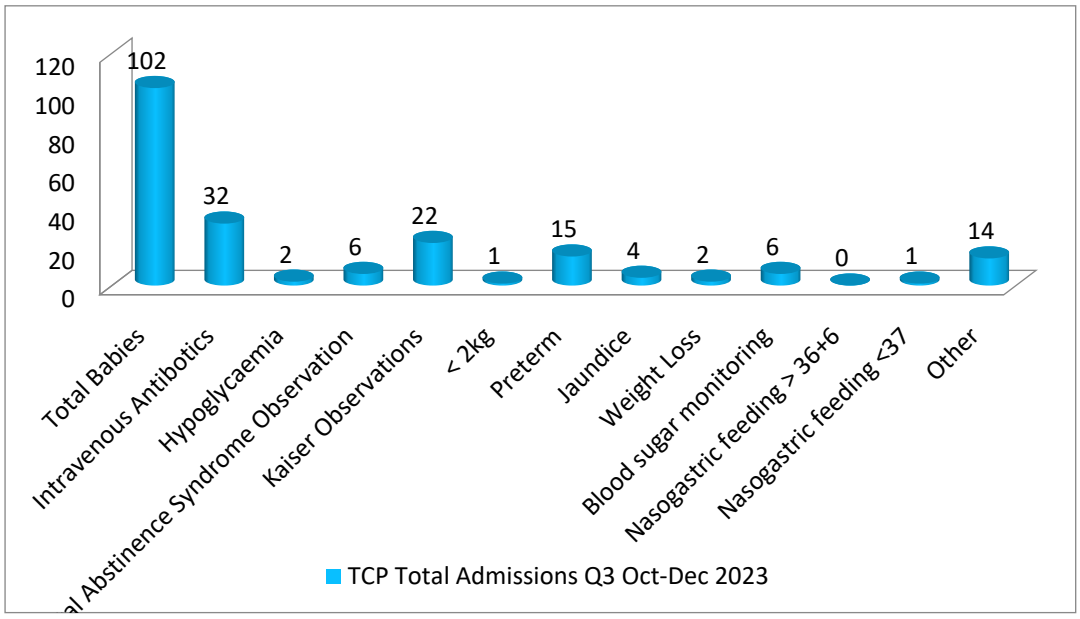


Figure 4: Reasons admissions to Transitional Care for Q3

Appendix 2: Detailed analysis of Term admissions to NNU

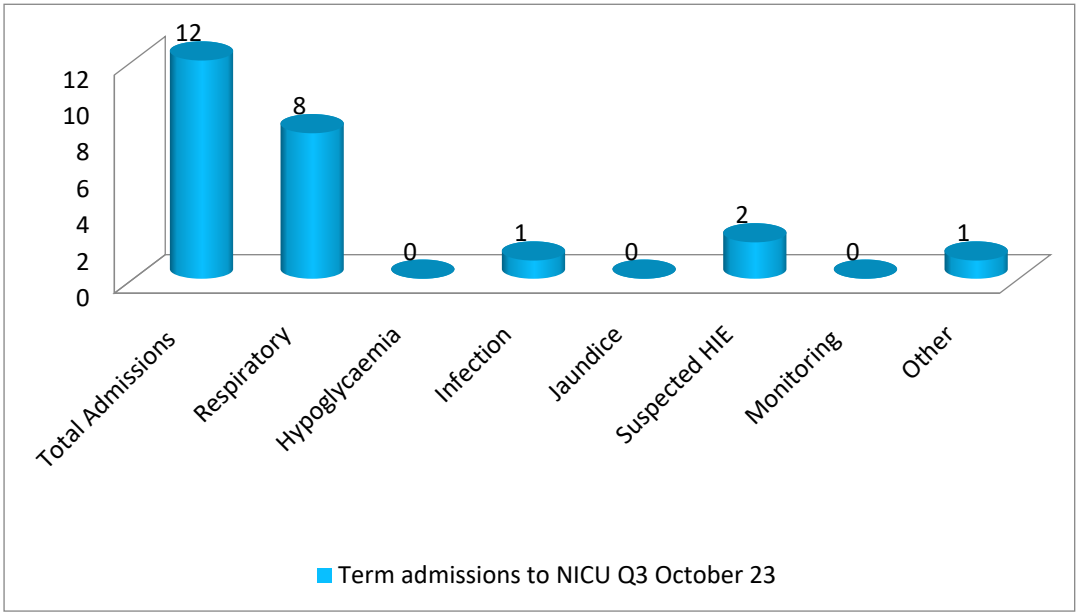


Figure 5: Reason for term admissions to NNU in October 2023

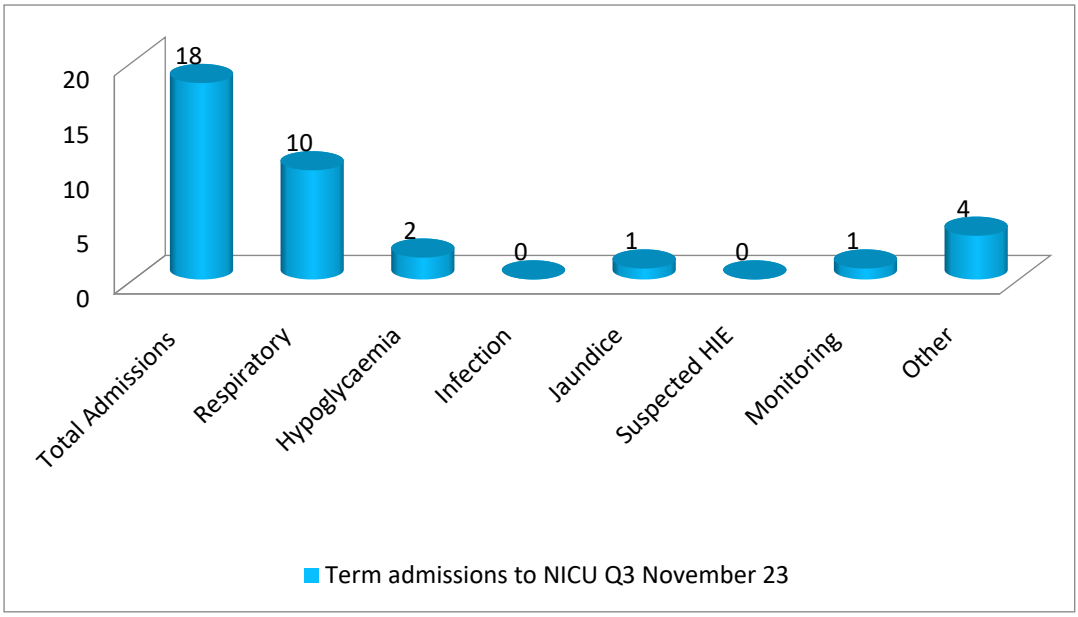


Figure 6: Reason for term admissions to NNU in November 2023

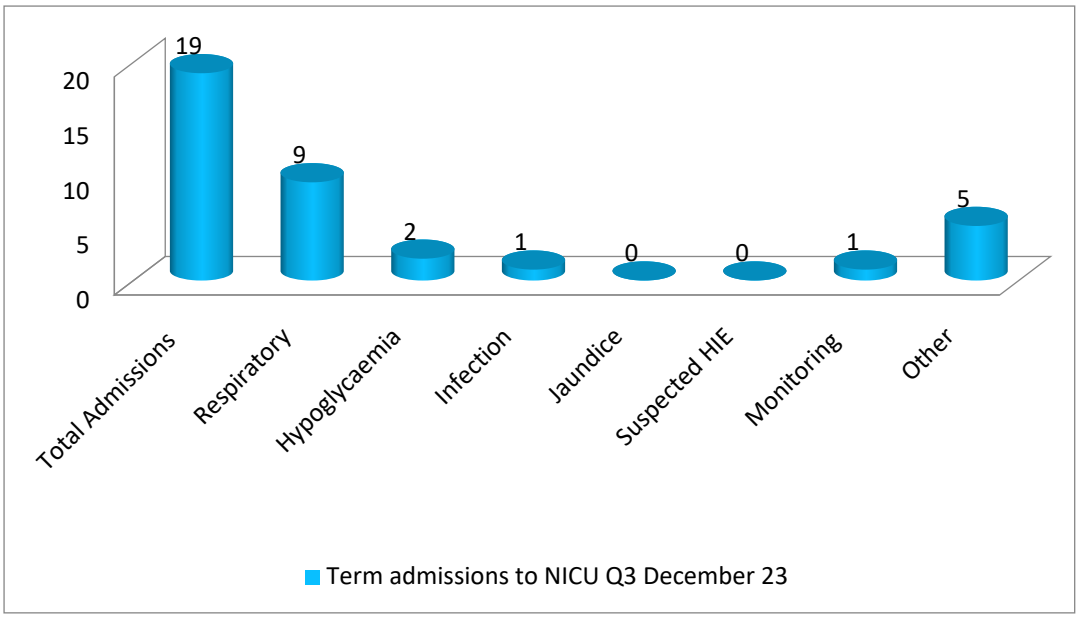


Figure 6: Reason for term admissions to NNU for December 2023

Appendix 2

Stillbirth and Neonatal Mortality review of 2021 cases for learning and improvement in Royal United Hospitals (RUH) Bath Maternity and Neonatal Services.

October 2023
Bex Walsh Bereavement Midwife

1. Report Terms of Reference, Background and Context.

Following the publication in September 2023 of the National Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE) Perinatal Mortality Surveillance report of births during 2021, this report aims to review and analyse the learning and improvement findings, recommendations, and actions, in response to Stillbirth and Neonatal Mortality across the RUH Maternity and Neonatal service in 2021. The national ambition through the Maternity Safety Strategy comprises of evidence based initiatives to implement best clinical practice through a culture of continuous learning and improvement.

The MBRRACE report identified that in 2021, the RUH Maternity and Neonatal services rate of stillbirth was 3.24 per 1000 births (2.89 per 1000 births when excluding death due to congenital abnormalities). This data set has been analysed by MBRRACE to account for factors such as maternal age, deprivation, baby's gender, ethnicity, multiplicity and gestation at birth. This stabilised and adjusted rate, according to MBRRACE is around the average for similar Trusts and Health boards, producing an amber classification (Table 1).

When reviewing Neonatal Mortality, MBBRACE identified a rate of 1.1 per 1000 births (0.89 per 1000 when excluding deaths due to congenital abnormalities). This data set has been stabilised and adjusted as above and according to MBRRACE is in line with the average for similar Trusts and Health Boards, producing an amber classification.

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	13	2.89	3.24	(2.54 to 4.21)	Up to 5% higher or up to 5% lower
Neonatal	4	0.89	1.10	(0.69 to 1.73)	Up to 5% higher or up to 5% lower
Extended perinatal	17	3.77	4.33	(3.62 to 5.58)	Up to 5% higher or up to 5% lower

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	13	2.89	2.98	(2.38 to 3.81)	Up to 5% higher or up to 5% lower
Neonatal	3	0.67	0.83	(0.53 to 1.33)	Up to 5% higher or up to 5% lower
Extended perinatal	16	3.55	3.80	(3.22 to 4.87)	Up to 5% higher or up to 5% lower

Table 1 – RUH Bath Perinatal Mortality statistics MBRRACE report 2021 available at: RUH MBRRACE report 2021-rep.pdf

2. MBRRACE recommendations

The stabilised and adjusted mortality rates for RUH were similar to, or lower than, those seen across similar Trusts and Health Boards (table 1). However, the aspiration is to seek rates comparable with the best performing countries, for example those in Scandinavia. MBRRACE stipulates that all trusts ensure a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths.

The scope of this report is to undertake a review of the RUH PMRT response at the time of all stillbirths and neonatal deaths. This report will analyse the issues, actions or themes identified across the cases.

3. Stillbirths

In 2021, the RUH Maternity and Neonatal services reported 13 stillbirths and 2 neonatal deaths (MBRRACE referrals). Two further Neonatal deaths were reported, these babies had been transferred for higher neonatal care needs.

Two cases were investigated by the maternity branch of the Healthcare Safety Investigation Branch as intrapartum stillbirths, all other cases were reviewed within the PMRT framework. All cases reviewed within the PMRT framework received a Multi -Disciplinary Team (MDT) review with external representation from a clinical professional outside of the RUH services.

4. Neonatal Deaths

In the 2 cases of Neonatal deaths at the RUH, PMRT has been completed.

One baby was known to have congenital anomalies which were incompatible with life, this case was identified in the antenatal period and managed jointly between the bereavement midwife, screening, obstetric and neonatal teams to facilitate the care pathway chosen by the family.

In 1 case the mother was known to be COVID-19 positive prior to the birth and the baby tested positive for COVID 19 three days following birth.

In the 2 cases where the babies were transferred due to requiring a higher level of neonatal care, the hospital where the death occurred become the reporting hospital. Learning is included below and both cases were scrutinised by an MDT.

5. Findings and Recommendations

5.1 Plotting of symphysis fundal height measurements

In 4 cases, the symphysis fundal height (SFH) measurements were not always plotted. The review process identified that the current charts do not allow for pregnancies beyond their due date, standardised charts have now been added to the notes. Training on measuring and

plotting symphysis fundal measurements has also been provided and is mandatory for all midwifery and obstetric staff. Current processes require the measurement of SFH (Q1 audit compliance 100%) to be re-plotted onto the SFH chart two pages subsequent, this presents an inherent risk to the process of error. Current compliance of plotting the subsequent plotting in Q1 23 was 75%. This forms part of an ongoing audit programme in maternity and as part of the quality improvement trajectory within Saving Babies Lives. Digital transformation and procurement of a new Electronic Patient Record will facilitate automated plotted of SFH following data input of measurement.

5.2 Use of partograms

In 2 cases, the PMRT process identified that partograms had not been fully completed during labour. Partograms aid the identification of the normal progress in labour, safe uterine activity and early identification of the deteriorating mother. The use of partograms has been added to the stillbirth care pathway and included in the new mandatory perinatal bereavement study day launched in 2023.

5.3 Written information about Reduced Fetal Movements (RFM)

In 2 cases, the PMRT process identified that written information about what to do if RFM is experienced during pregnancy was not given. The 'Tommy's' pregnancy charity RFM leaflet should be given and discussed during antenatal appointments; in both cases RFM information was discussed however, there was no evidence that the Tommy's leaflet had been given. The Maternity Service has subsequently changed practice, the Tommy's leaflet is provided electronically via a QR code within the mother's handheld maternity record, this will also facilitate the provision of the leaflet in the mothers preferred language via the Tommy's leaflet.

5.4 Other learning -The following was identified in singular cases

- Need for clear documented plans for repeat CardioTocography (CTG)s
- Fresh eyes implemented in routine midwifery care to ensure referrals, pathways and additional tests are conducted robustly
- Safeguarding team audited enquires about domestic abuse
- Antenatal referral process updated to include the type of appointment
- Information was disseminated to detailing availability of services for those with a learning disability
- Feedback was given to the clinical team regarding maintaining a baby's temperature during resuscitation
- Start and finish group reviewed how to support transfers to hospice/home in the future.

5.5 Percentage of ethnicity and deprivation on perinatal mortality

Within this data set, 3 (17.6%) of the 17 mothers were of non-white British ethnicities. Data collected for the number of women who birthed at the RUH from 2021-2022 and 2023, thus far, identifies that approximately 90.5% and 90.94% of birthing people respectively, were from white group as detailed in tables 2 and 3.

		2021/2022	
		Total	
Measure	Ethnic Group	Total	%
Women who have birthed by Ethnicity	White (A,B &C)	3,989	90.5%
	Mixed (D,E,F & G)	48	1.1%
	Asian or Asian British (H,J,K &L)	80	1.8%
	Black or Black British (M,N & P)	34	0.8%
	Any other Ethnic Group (R &S)	67	1.5%
	Not Stated/ Not Known (Z, 99)	185	4.2%
	Blank Data	3	0.1%
	Total	4,406	

Table 2 – Births by ethnicity 21/22

		2022/2023															
		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov	
Measure	Ethnic Group	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Women who have birthed by Ethnicity	White (A,B &C)	293	86.94%	312	88.64%	308	91.12%	312	91.76%	334	89.78%	339	93.13%	340	93.92%	311	90.94%
	Mixed (D,E,F & G)	9	2.7%	4	1.1%	7	2.1%	6	1.8%	8	2.2%	9	2.5%	5	1.4%	8	2.3%
	Asian or Asian British (H,J,K &L)	9	2.7%	14	4.0%	10	3.0%	10	2.9%	10	2.7%	3	0.8%	4	1.1%	11	3.2%
	Black or Black British (M,N & P)	4	1.2%	3	0.9%	2	0.6%	2	0.6%	6	1.6%	4	1.1%	5	1.4%	2	0.6%
	Any other Ethnic Group (R &S)	6	1.8%	9	2.6%	1	0.3%	3	0.9%	4	1.1%	7	1.9%	3	0.8%	4	1.2%
	Not Stated/ Not Known (Z, 99)	9	2.7%	4	1.1%	7	2.1%	6	1.8%	10	2.7%	2	0.5%	5	1.4%	6	1.8%
	Blank Data	7	2.1%	6	1.7%	3	0.9%	1	0.3%	0	0%	0	0%	0	0%	0	0%
	Total	337		352		338		340		372		364		362		342	

Table 3 – Births by ethnicity 22/23

This indicates a proportionate representation of ethnicity within the stillbirth and Neonatal death data set and the number of birthing people at the RUH.

5.6 Index of Multiple Deprivation (IMD) deciles

This report could find no clear trends, or correlations between the proportion of birthing people within the RUH per decile of IMD, and the proportion of stillbirth cases encountered per decile of IMD.

Measure	IMD	2021/2022 Total No.	2021/2022 Total %
Women who Birthed by IMD	1	49	1.1%
	2	149	3.4%
	3	203	4.6%
	4	379	8.6%
	5	478	10.8%
	6	650	14.8%
	7	448	10.2%
	8	687	15.6%
	9	626	14.2%
	10	667	15.1%
	No IMD	70	1.6%

Number of Women who have had a Stillbirth	1	0%
	2	0%
	3	0.5%
	4	0.8%
	5	0.4%
	6	0%
	7	0.7%
	8	0.6%
	9	0%
	10	0.3%

Table 4 – Births by IMD 21/22

Number of Women who have had a Stillbirth	1	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%		
	2	0	0%	0	0%	0	0%	1	8.3%	0	0%	0	0%	0	0%	0	0%		
	3	0	0%	0	0%	1	8.3%	0	0%	0	0%	0	0%	0	0%	0	0%		
	4	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%		
	5	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%		
	6	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%		
	7	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%		
	8	0	0%	0	0%	0	0%	0	0%	1	1.6%	0	0%	0	0%	1	1.8%		
	9	0	0%	0	0%	0	0%	1	1.8%	0	0%	0	0%	1	1.6%	0	0%		
	10	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%		

Table 5 – Births by IMD 22/23

The IMD decile for cases of Neonatal death is not a routine data set collected at the RUH, the provision of this data set is being explored with the Business Intelligence Unit (BIU). On reviewing the IMD deciles for the 4 Neonatal deaths within this data set, no clear trend was identified and numbers are in keeping with the data above.

5.7 Social circumstances and lifestyle factors.

From this data set, 5 people never smoked, 7 people ceased smoking prior to the pregnancy, 2 people ceased smoking in pregnancy and 3 continued to smoke.

In 2021, the actions undertaken in response to the 2020 MBRRACE cases have remained in place. Routine fetal growth surveillance for all smoking birthing people/mothers and the introduction of a fetal growth Ultrasound (USS) for all smoking mothers at 38-39 weeks of gestation. The service recognises that at the time of writing this report (October 23) the USS pathways in place at the RUH were not fully aligned to the national USS pathway as outline within Saving Babies Lives v3 due to Obstetric USS capacity; this is recognised as a high risk on the risk register. Work is ongoing towards implementation of the SBL V3 national pathway the implementation is planned in a two phased approach aiming for phase one to be rolled out in Q4 of 2023/24, with projected compliance in Q4 of 23/24 supported by the securement of funding for a further 2 trainee midwife sonographers in Jan 2024. Phase 2 will encompass uterine artery Doppler for all pregnancies at the 20 week USS from Q2 of 24/25.

6. Summary

This report has reviewed the cases of neonatal death and stillbirth reported to MBRRACE in 2021 and has been unable to identify any clear, concerning, or causal trends within the findings and recommendations. Areas for learning and improvement within our services have been identified within the implementation of Saving Babies Lives Version 3, the continued improvement journey is imperative to the safe provision of maternity care and outstanding actions will be monitored monthly via the Maternity and Neonatal Specialty Governance meeting, Family and Specialist Services Divisional Governance and Maternity and Safety Champions.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	12
Date of Meeting:	1 May 2024		

Title of Report:	Quality Account 2023/24
Status:	For noting and approval
Board Sponsor:	Antonia Lynch, Chief Nursing Officer
Author:	Jason Lugg, Deputy Chief Nursing Officer
Appendices	None

1. Report

All NHS providers are required by law under the National Health Service (Quality Accounts) Regulations 2010 to produce a Quality Account annually. NHS England no longer publishes guidance for the preparation of the Quality Account and the production of the document has been based on the most recent template (2019/20) as well as the content of the Regulations, with the focus placed on reporting progress against the Trust's Quality Account priorities.

The Regulations state that Quality Accounts must be published by June 30 each year following the end of the reporting period. By publishing our Quality Account on our website and forwarding the link to NHS England, we fulfil our statutory obligation to submit the Quality Accounts to the Secretary of State.

Work is underway, coordinated by a small task and finish group to produce this year's Quality Account. The working deadline for the first draft of the document is the end of April 2024. As part of the process, the draft Quality Account will then need to be shared with Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board (ICB), the BaNES and Wiltshire branches of Healthwatch, and BaNES and Wiltshire Councils' Health Scrutiny Committees.

The proposed timescales for completion and approval of the document are as follows:

- Review and approval at Quality Governance Committee (10/06/24)
- Presented retrospectively to Board of Directors (3/07/24)

The Board of Directors is asked to delegate the final approval of the publishing of the Quality Accounts 2023/24 to the Quality Governance Committee.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors asked to note the content of the paper and delegate the approval of the publishing of the Quality Accounts 2023/24 to the Quality Governance Committee.

3. Legal / Regulatory Implications

The Trust is required to produce an annual quality account by virtue of the National Health Service (Quality Accounts) Regulations 2010.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
None identified.	

5.	Resources Implications (Financial / staffing)
Preparation of the quality account is a joint responsibility between the Corporate and Quality Governance teams.	

6.	Equality and Diversity
There are no identified impact on equality and diversity in this paper.	

7.	References to previous reports
N/A	

8.	Freedom of Information
Private – subject to future publication.	

9.	Sustainability
N/A.	

10.	Digital
N/A.	

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**13**
Date of Meeting:	**1 May 2024**		
Title of Report:	**Alert, Advise and Assure Report from the Quality Governance Committee**		
Status:	**For discussion**		
Author:	**Ian Orpen, Non-Executive Director and Chair of the Quality Governance Committee**		

Key Discussion Points and Matters to be escalated from the meetings held on 13 March 2024.

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- None

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

March

- The Deputy Chief Nursing Officer advised the Committee that work would be taking place around the complaints timescales to ensure that they were realistic, and a proposal would be presented at a future meeting.
- The Committee received an update on the Quality Governance Project and were informed that there was a delay in finalising the proposed quality metrics due to wider system work to develop a Quality Dashboard. Further assurance would be provided at a future meeting.
- The Committee had a robust discussion around infection prevention and control (IPC) and were informed that the team's key concerns related to the Trust's ability to keep the site clean and management of C. diff rates. They acknowledged the significant progress that had been made during the year and oversight of progress against IPC as one of the 5 patient safety priorities would be maintained through the IPC Report going forward.
- The Committee received the Draft Maternity CQC Inspection Report and noted that this was under review to confirm its factual accuracy. A more formal updated would be presented at a future meeting.
- Concerns were raised around care of, and communication with end of life patients and the Committee recognised that further learning was required. The Deputy Chief Nursing Officer had discussed development opportunities with the new End of Life Care Lead and agreed to work with the Deputy Chief Medical Officer to progress this.
- The Committee noted that whilst there had been a slight decline in positive responses to the Friends and Family Test (FFT), the digital offer had resulted in a significant increase in uptake which provided a more realistic perspective. The Deputy Chief Nursing Officer agreed to present the new Patient Experience Strategy to the Committee at a future meeting to enable a better understanding of FFT data.

- A KPMG internal audit of complaints had found no evidence of non-compliance and the Trust had been awarded partial assurance with some improvement required.
- The Committee queried whether the Trust's consent processes met the required standards, whether there were opportunities to embed a more consistent approach and recommended that an internal audit was undertaken and presented to the Audit and Risk Committee.
- The Deputy Chief Nursing Officer reported that he and the Deputy Chief Medical Officer had been working together to draft a new governance process for the Committee which would revert to meeting bi-monthly in due course. This would be presented to the Chief Medical and Chief Nursing Officers in due course.

April

- **Clinical Audit** – the Committee noted that good progress had been made, but further work needed to be done to align to Trust priorities.
- **VPAC** – the Committee noted the change in level 3 compliance and the need for the Mental Capacity Act Assessor.
- **Sulis Governance** – the Committee recognised that this needed to be worked through and that the Chief Medical Officer would arrange a meeting to discuss this further.

ASSURE: Inform the board where positive assurance has been achieved

March

- The Committee discussed the measles outbreak and the potential risk to staff and received assurance that the Trust was working closely with Public Health. The Occupational Health Team were also targeting staff working in front door areas of the Trust and the situation would continue to be closely monitored.
- The Committee were informed that the Estates and Facilities portfolio would be split between the Chief Operating and Chief Nursing Officers going forward and it was hoped that this would facilitate the resolution of some of the existing IPC issues, particularly in terms of the cleaning standards.

April

- **TQSG** – the Committee noted that it was good to see alignment with reporting.

RISK: Advise the board which risks where discussed and if any new risks were identified.

- There were no new risks identified.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding

March

- The 4 hour standard in the Emergency Department had improved from 51.88% to 62% since March 2023 and there had been a 28.5% reduction in diagnostic

breaches since October despite a 28% increase in demand. There had also been a 50% reduction in the number of patients waiting over the 6 week target. The Committee recognised that these achievements should be celebrated, particularly in light of ongoing interface issues within the system. • The Committee acknowledged the great work that was ongoing in maternity as demonstrated by the draft CQC report and recommended that learning was shared in terms of the way that the service approached patient safety.
APPROVALS: Decisions and Approvals made by the Committee
March • There were no approvals or decisions made by the Committee. April • **Quality Governance Meeting Structure** – the Committee agreed a proposed new quality meeting structure. The revised structure provides greater clarity and focus on the purpose of individual committees and groups. A circa 25% reduction in meetings has been achieved with no anticipated risk to quality and safety delivery. The proposals agreed also cover many of the recommendations from the 2023 AQUA report.

The Board is asked to NOTE the content of the report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**14**
Date of Meeting:	**1 May 2024**		
Title of Report:	**Alert, Advise and Assure Report – People Committee**		
Status:	**For discussion**		
Author:	**Paul Fairhurst, Chair of the People Committee**		

Key Discussion Points and Matters to be escalated from the meeting held on 31 January 2024

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- **Restorative, Just & Learning culture:** work that began following a 2021 review has stalled and there is limited evidence that RJLC is embedded. The team is now looking to reboot the programme (including through leadership training). Work is needed to upskill the Executive Team to drive the cultural shift needed. It is suggested that the NEDs need immersion to enable effective interrogation and assurance.
- **Dignity at Work:** whilst the Staff Survey reported a decline in incidents of violence from patients (to the lowest since 2020 and better than the national average) incidents of abuse from managers and colleague to colleague have increased. Due to a lack of confidence in reporting incidents, the true picture is likely worse. Key to improvement will be to ensure that line managers are trained to manage conflict in the workplace and to respond in a supportive and assertive way.
- **Workforce planning:** the Board is alert to work to finalise the 2024/25 workforce submission and to develop and deliver plans to achieve the targets.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- **Fit for Purpose (ongoing monitoring)**: the programme to improve functioning of People Directorate (including through feedback from a recent listening exercise and a review by AQUA) is being monitored.
- **Basics matter (ongoing monitoring):** The Staff Survey indicates focus areas for 2024/25, including IT/ digital resources and skills.
- **Clinical skills training (ongoing monitoring):** clinical skills training has historically been delivered at RUH by subject matter experts; some training materials are outdated; assessment processes and support lacks standardisation; and the Trust lacks a centralised record of clinical skills compliance. The Interim Head of Clinical Skills is working closely with the nursing workforce team to address these issues. Clinical skills will be recorded on Learn Together and will link to Healthroster to provide assurance on the clinical skills of staff on shift. The team will investigate inclusion of mental health training. Action: Deputy Chief Nursing Officer to report back to the Chief People Officer.
- **Recruitment (ongoing monitoring):**
    - Vacancy Control and Agency Reduction Panel: VCARP has delivered significant benefits in terms of bank and agency cost. Work in progress to mitigate the impact of lengthened recruitment pathways/ hiring timelines.
    - Reservist Scheme: the scheme is being revived. It was launched in March 2022 in response to the COVID19 pandemic. It is designed to build a cohort of people who could support the NHS during times of significant pressure. National benchmarking has been undertaken and plans are being developed to deliver the BSW Reservist Scheme in 2024/25.

- Volunteering strategy: work is underway to develop the 2024-27 strategy. It will be presented to the People Committee in July. Ongoing governance will sit with QGC, subject to further discussion to ensure that the people aspects are effectively governed as well as quality.

- **Appraisals (negative assurance):** this is the only indicator where trackers are not showing improvements. We remain some way off where we need to be. Action: a deep dive will be scheduled, with the Improving Together team invited to join.
- **Workforce Planning/ Transformation Plan (ongoing monitoring)**:
  - Finalisation of 2024/25 workforce submission; development of plans to deliver against those targets, including cultural and behavioural shifts and tools to support change (including Calderdale Framework and communications plans).
  - Focus will turn to equipping leaders with the change management skills and capabilities to lead through change.
  - Scott Harrison, Reporting Radiographer shared his perspectives on opportunities to better utilise the skills of the AHP Reporting Radiographer role and the potential for significant cost savings, activity/ income generation and service development with modest investment to protect time for reporting imaging investigations and expansion of the team. It was observed that, given the CMO had not previously been briefed on these opportunities, this might indicate ongoing issues with internal information flows. Action: Associate Directors for Capability & Planning and Programmes & People Partnering to consider Scott's insights as part of workforce planning/ transformation work.

ASSURE: Inform the board where positive assurance has been achieved

- **Basics matter:** considerable progress made against existing plans.
- **People Plan Governance**: programmes on a page have been developed for each of the 11 People Plan Programmes; The dashboard is continually being refined to clearly state project linkages to the People Plan and responsibilities for delivery and to enable clarity on individual responsibilities.
- **Workforce Planning**: we are currently projecting to deliver against the requirement that Whole Time Equivalent (WTE) position at month 12 2023/24 does not exceed our position at month 7 2023/24. This reflects the increased governance around workforce planning and improved cross-directorate working.

RISK: Advise the board which risks where discussed and if any new risks were identified.

None.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding

- **Dignity at Work:** excellent feedback shared with the Committee from a Cardiac Ward Sister regarding support she received from Will Smith, Dignity at Work Programme Lead and Interim Reservist Scheme Lead

APPROVALS: Decisions and Approvals made by the Committee

- None

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**24 April 2024**		

Title of Report:	**Research Strategy**
Status:	**For Approval**
Board Sponsor:	**Joss Foster, Chief Strategic Officer**
Author:	**Kelly Spencer, Head of Research Operations**
Appendices	**None**

1. Executive Summary of the Report

The final draft of the Trust Research Strategy is included. This has been revised and improved following presentation at Trust Management Executive in Feb 2024 and subsequently at Private Board of Directors on 6 March 24.

The strategy is aligned to the three people groups alongside three key themes of accessibility (for both patients and staff), impact, and collaboration.

It is our aim that this strategy will be the springboard to enable greater spread of research and adoption of evidence across the entire system.

A sunray chart roadmap will be developed subsequent to approval of the strategy.

2. Recommendations (Note, Approve, Discuss)

Board of Directors is asked to provide final Approval for the strategy.

3. Legal / Regulatory Implications

Research active organisations support evidence oriented and continuous improvement cultures which contribute to meeting legal and regulatory obligations.

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

The strategy supports better care, better staff experience and better collaboration – enabling mitigation of a range of risks.

5. Resources Implications (Financial / staffing)

All research activity that takes place at RUH is funded from external sources.

6. Equality and Diversity

Inclusion has been drawn through as a specific theme in the strategy

7. References to previous reports/Next steps

Revised and improved following discussion at Private Board of Directors on 6th March 2024

8. Freedom of Information

Public

9.	Sustainability
Research as an enabler for environmental sustainability has been included as a theme	

10.	Digital
The strategy aims to “Take full advantage of opportunities to use digital and data for research” and “To build upon current research strengths in machine learning and artificial intelligence”	

NHS
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Research Strategy

2024 to 2029

Contents

Foreword

Sherlock Holmes said, “It is a capital mistake to theorise before one has data” and it is these data that are a fundamental aspect of research and development. We have never had more data available to us than now – the digital explosion in healthcare delivery provides us with much data. What still remains hard work is determining insights that will allow us to improve health and social care. You will see from this research strategy that using evidence to support the Trust’s key strategic priorities is core business.

Hospitals that actively engage in research deliver better care to their patients and have better staff recruitment and retention. So, research needs to be at the heart of what the RUH does.

We are committed to offering every patient the opportunity to be involved in research and for that research to be inclusive and accessible. It is our ambition that research, and use of evidence, will expand throughout the entire organisation involving all departments and being available all staff groups. We will also ensure that the research we undertake has impact both at RUH and within our local community.

Collaboration is a key theme in our strategy: Today no major advances are produced alone. We are fortunate to have excellent relationships with our local Higher Education Institutions and Healthcare Providers, which are key to the delivery of our strategy, and we will build on these further going forward.

We are one of the most research active hospitals in the UK of our type. Whilst this is laudable, there is much more that we can do, and this is where this strategy will take us.

Professor Richard Graham
Director of Research and Innovation

Introduction to Research at Royal United Hospitals Bath Foundation Trust

Royal United Hospitals Bath Foundation Trust is a busy medium-sized provider of secondary care and specialised services. We have a good reputation for delivering national research programmes across many of our clinical services, with a particularly strong portfolio of research that is developed and led by RUH researchers and healthcare professionals.

What we do

The Research and Development Team (R&D) support a wide range of research. Ranging from participating in large national clinical trials, which test medicines and devices before approval for general use, through to simple questionnaires and surveys that give us vital data to better understand a range of health conditions.

We work collaboratively with universities, other healthcare providers and the Life Sciences Industry to develop new research or be part of research taking place in multiple hospitals.

How we do it

For our size, RUH has a highly active research portfolio, with approximately 200 active studies at any time recruiting 3000 patients into research studies annually, and a total research income of around £4 million per year.

We employ a multidisciplinary team of around 60 members of staff and will closely with clinical colleagues and support services to deliver our broad portfolio of research.

Working closely with local academic institutions, RUH has been highly successful in attracting substantial external research grant funding of around £1.5 to £2 million per year.

Our Research Vision and Strategy

An organisation where development and delivery of research, and use of evidence, is truly embedded in the provision of outstanding healthcare across the community in collaboration with, and for the benefit of, patients and the public.

To create a culture which embeds research and use of evidence

Demonstrate the positive impact of clinical research in improving patient care, outcomes and clinical practice

- Establish robust systems to capture the impact of research and use of evidence on patient outcomes, experiences, and clinical practice
- Collaborate with external partners, such as academic institutions and research networks, and internal colleagues, such library services and divisional leads, to facilitate the translation of research findings into clinical practice.
- Implement mechanisms to support knowledge sharing and collaboration among staff, such as regular research forums, journal clubs, and multidisciplinary team meetings.
- Develop and signpost to training programs and resources to enhance research literacy and skills among clinical staff, enabling them to critically appraise and apply research findings in their practice

Create an environment that enables clinical staff to engage with research in a supportive and efficient (straightforward) way

- Streamline administrative processes related to research, such as confirmation of capacity and capability, and funding applications, to minimize the burden on staff.
- Provide dedicated research support services, to assist staff in study design, gaining appropriate approvals, data collection and analysis.

Growth and sustainability of research income

- Maximise opportunities to attract external research funding, ensuring that multiple sources are targeting to improve stability and sustainability
- Develop partnerships with other NHS Trusts, research organisations, and industry stakeholders to share resources, expertise, and best practices in research development and delivery.

Enhance the ability of established areas of research excellence to expand and embed

Through targeted collaborations and resource allocation, we will amplify the impact and long-term sustainability of well-established areas of research excellence (Cardiology, Radiology, Respiratory, Rheumatology, Pre- and Re-habilitation and Oncology and Haematology)

Take full advantage of opportunities to use digital and data for research

- To maximise the potential of big data analytics in leveraging large-scale healthcare datasets for research purposes
- To build upon current research strengths in machine learning and artificial intelligence
- Embrace digital solutions for document management, communication, and data storage to minimize paper usage. Implement electronic data capture systems for research studies to reduce reliance on paper-based records

Use of research to support key Trust strategic priorities

Align research activities and utilise research partnerships to support and contribute to key strategic priorities of the Trust

Research as an enabler for environmental sustainability

Establish, and build upon, collaborative partnerships with external organisations, academic institutions, and industry partners to leverage expertise and resources in advancing environmental sustainability research

The people we care for

To ensure equitable access to research for all patients and integrate research participation seamlessly into patient care

The people we work with

To value, develop and create opportunities for our workforce to produce and deliver high quality research

The people in our community

To create productive and collaborative research partnerships with our community stakeholders

The people we care for

To ensure equitable access to research for all patients and integrate research participation seamlessly into patient care

Our Goals

All patients will have the opportunity to participate in research

- Develop and implement systems to ensure that research studies are accessible to all patients, regardless of location, demographics or characteristics.
- Implementing referral systems and pathways that seamlessly connect patients to appropriate research studies.
- Collaborate with community organisations and patient advocacy groups to identify barriers to access and develop targeted interventions for those patients underserved by research.
- Integrate research into digital platforms and telemedicine solutions to enhance access to research studies for patients receiving remote care.

Empowering patients to access research opportunities

- We will promote the rights of patients to engage in research, and for staff to understand their opportunities and responsibility to offer and support appropriate research.
- We will ensure that information about research is easily accessible and that patients are supported to engage with research

Provision of time, resources, facilities and equipment to enable research to take place

- Allocate, according to need, dedicated resources and funding to support research activities, including dedicated research staff, infrastructure, and equipment.
- Develop robust and transparent processes for assessing activity in areas where research funding has been allocated to ensure effective use of resources.

- Utilise capability and capacity building income to invest in people and projects to build research success

A streamlined and efficient research set-up and delivery service

- Simplifying administrative processes and reducing bureaucratic barriers to enable faster initiation of research studies.
- Ensuring that support is in place to allow research active staff to undertake research without undue administrative burden
- Utilising digital tools and platforms for streamlined communication, document sharing, and data management during the research process.

Measures of Success

- ✓ The profile of staff, patients and public involved in research will reflect our local community
- ✓ Patient satisfaction with accessibility of research opportunities
- ✓ Research infrastructure mapped to activity
- ✓ Reduced timelines for set-up of new research studies

The people we work with

To value, develop and create opportunities for our workforce to produce and deliver high quality research

Our Goals

To attract, develop and support a highly skilled and valued research workforce

- Promote the Trust's reputation as a research-active organisation to attract staff and researchers who value opportunities for research involvement.
- Provide ongoing training and mentorship programs to support the continuous development of research skills and knowledge among the workforce.
- Work with clinical and leadership teams to focus and embed research within clinical pathways and staff job plans, ensuring results are disseminated through departments and divisions in a timely manner.
- Ensure the time our staff invest in our research is recognised and appreciated, helping to raise awareness of the value and contribution research makes in clinical practice.
- To support access to a broad range of learning and development opportunities for research delivery and management staff
- Develop and signpost to career pathways, secondment schemes and shared posts that support all staff to engage in research activities.
- Collaborate with academic institutions to establish joint appointments and research fellowships, providing staff with dedicated time for research alongside their clinical responsibilities

Skilled support to develop grant applications, and to navigate regulatory and approval processes for delivery of research (R&D team)

- Strengthen the research and development (R&D) team by facilitating access to specific training and continuous improvement in research management, grant writing, ethics, and regulatory processes.

- Establish a streamlined support system that offers guidance and assistance to researchers in developing grant applications, obtaining necessary approvals, and ensuring compliance with regulatory requirements.

To provide opportunities for research and build capacity through research education for all staff groups

- Develop a comprehensive program that offers research opportunities to a wide range of healthcare professionals and those training to become healthcare professionals
- Provide, and signpost to, research training opportunities for healthcare professionals to enhance their ability to integrate research findings into clinical decision-making and patient care.
- Collaborate with academic institutions, and apply for national funding, to establish placement programs, internships, and fellowships that enable healthcare professionals to engage in research activities.

Measures of Success

- ✓ Increased proportion of RUH staff involved in research and with research training
- ✓ Improved research awareness amongst staff
- ✓ Positive feedback from researchers on all R&D processes

The people in our community

To create productive and collaborative research partnerships with our community stakeholders

Our Goals

Create partnerships that will deliver high quality peer-reviewed research to answer questions that serve the needs of our community

- Strengthen and increase collaborations with academic partners, research organisations and patient groups
- Develop a framework for engaging patients, carers, and the public in the research process, ensuring that their voices are heard and that research addresses their concerns.
- Facilitate multidisciplinary research teams, encouraging healthcare professionals, researchers, and clinicians to work together to address healthcare challenges

Be a key partner in the wider research community

- Strengthen collaborations with the National Institute for Health and Care Research (NIHR), Research Delivery Network (RDN), industry partners, charities, Health Innovation Network and other relevant stakeholders
- To strengthen collaborations with key partners, such as local HEI institutions (such University of Bath and University of West of England) and partners across our local system. Engage with and encourage partnerships across the BSW Acute Hospitals Alliance.
- Engage with research sponsors and industry partners to facilitate the delivery of robust, peer-reviewed research studies

Enhance Trust reputation as a centre for excellence in research

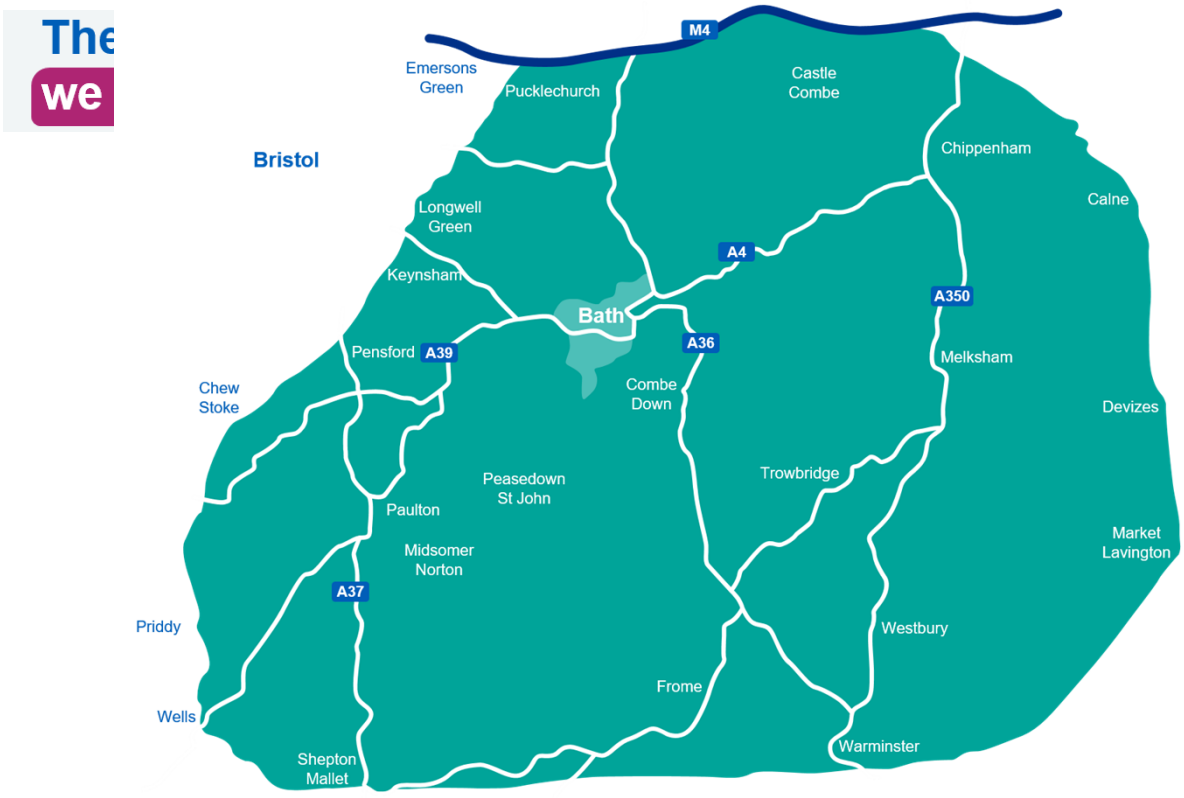
- Create a robust communications plan to promote research outputs and achievements, highlighting the impact on patient care and outcomes.
- Share research findings, best practice, and knowledge with the wider research community to contribute to evidence-based healthcare improvements

Maximise collaborations based on use of data for research

- Create research partnerships based on use of research and clinical data
- To be a key partner in the establishment of the South West Secure Data Environment (SDE) as a contributor and recipient of patient data for research

Measures of Success

- ✓ Increased research collaborations
- ✓ Grant application success rate
- ✓ Improved public awareness of research at RUH



Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**16**
Date of Meeting:	**1 May 2024**		

Title of Report:	**Year End Update 2023/24**
Status:	**For information**
Board Sponsor:	**Pippa Ross-Smith, Interim Deputy Chief Financial Officer**
Author:	**Pippa Ross-Smith, Interim Deputy Chief Financial Officer** **Tom Williams, Head of Financial Management**
Appendices	**None**

1. Executive Summary of the Report

Overview of financial performance

In 2023/24 the NHS has continued the drive to regain momentum delivering elective services and address waiting times, however industrial action during the year has impacted its ability to fully deliver this, alongside a continued high level of emergency and unplanned care. The impact of this was higher use of short-term staffing options to cover operational areas during industrial action.

At the RUH itself, 2023/24 started with high numbers of patients who although medically fit to be discharged remained in hospital due to a lack of suitable support for them in the community. This led to the need for escalation areas to be created and the loss of the use of elective wards which were needed to accommodate medically sick patients. Since August the Trust has managed to maintain this below an average of 70 patients per day.

Payments to the Trust for patient activity continued to operate on the same block basis introduced in 2021/22 covering the majority of the clinical activity undertaken in the organisation. The incentive funding stream made available to target increasing elective activity and create additional capacity to help reduce waiting lists and minimise very long waits for treatment, also continued into 2023/24.

The Elective Recovery Fund (ERF) allows Trusts to earn additional income for achieving nationally set targets of elective activity which included day case, inpatient and outpatient care. The RUH received £15.8 million through this scheme, of which £3.1m was paid to compensate lost activity incurred through industrial action. This income was used to cover the costs of providing extended services to treat patients. In 2023/24 variable income streams for outpatient diagnostics, chemotherapy and high-cost drugs and devices were introduced for activity and costs above 2022/23 outturn. This additional income helped off-set the higher costs incurred through providing these increases in activity.

£13.4 million of income has also been reported to off-set the NHS Pension liability the Trust is required to recognise in its accounts.

The ICB also made a variation payment of £20.5 million to reallocate the funds that they held in their capacity as Commissioner to each of the Providers as part of a risk share agreement.

Income flows from non-patient care services such as catering, car parking and non-clinical services have continued to increase over the course of the year. There have also been increased cost of sales, such as food prices, to deliver these non-patient services. Surpluses delivered from non-patient care activities are reinvested back within the Trust.

The financial performance of the Group (RUH and Sulis) varied over the period due to the pressures faced within the hospital, with escalation wards that were occupied by patients with no criteria to reside remaining open both before and after funding relating to winter pressures was received.

The Group closed the year with a deficit of £11.9 million. Following the required adjustments for national reporting, the BSW system reported an adjusted position for the Group of £3.5 million deficit. Within this Sulis closed the financial year with a £0.3 million surplus with increases in NHS and private activity.

	2023/24 £000	2022/23 £000
Group surplus for the period from continuing operations as per the Statement of Comprehensive Income	**-8,558**	**2,309**
Impairments	-4,684	-1,810
Revaluations	1,086	9,815
Other reserve movements	-1	-1
Movement in fair value of charitable funds	226	-345
Total comprehensive income for the period	**-11,931**	**9,968**

The Group has faced significant cost pressures over the last few years. These have resulted from insufficient inflation funding, the rising cost of high-cost drugs and other consumables and the increased operational costs to deliver pre-pandemic levels of activity, many of which reflect the national situation within the NHS. The cost of bringing waiting lists back down to pre-pandemic levels, while also managing increasing levels of emergency and urgent care, also remains significant. At the same time, income derived from non-patient care related services, such as car parking and catering, did not recover sufficiently enough to cover the Trust's overheads.

The recovery of elective activity is an area of significant focus across the Trust and the wider BSW system, with detailed plans being outlined for areas needing the most support to reduce waiting lists. National incentive schemes will continue into 2024/25 to support Trusts to deliver as much of this activity as possible.

Capital investment

The Group invested £34.1 million in infrastructure, equipment, information technology and projects during 2023/24, (£47.7 million in 2022/23). Separately, the Group also recognised capital assets of £4.0 million related to leases which are now capitalised in line with accounting standards. Therefore, total capital invested for 2023/24 was £38.1 million.

The total programme was funded through a combination of internally generated cash and I&E surpluses, charitable donations, and significant additional public dividend capital (PDC) from the Department of Health and Social Care.

PDC funding was provided for the Cancer Centre project. In addition, external support was also made available for projects to support additional elective capacity, community diagnostics and digital diagnostics. The Trust also received PDC funding for the System-wide electronic patient record system.

The capital programme has continued to seek to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk, and improving patient experience, within the context of significantly constrained capital funding and increased demand.

Significant in-year programmes included expenditure of:

- £6.2 million on various estates schemes including the single ITU project, day assessment unit works, works to support additional bed capacity and significant risks in critical infrastructure backlog expenditure.
- £6.6 million on the Cancer Centre, which includes the main Kier related works and enabling works.
- £7.6 million to support Community Diagnostics and the Sulis Orthopaedic Elective Centre (SEOC).
- £5.3 million on the digital programme, including additional investment in hardware to support changes in working practices, clinical systems, and infrastructure support as well as investment in cyber security. This included investment towards the BSW single electronic patient record system.
- £6.7 million on medical equipment, including Cath Lab replacement and theatre and diagnostic equipment. Within this, £3.8 million related to the purchase of a new robot and replacement Gamma Camera which were funded through charitable donations.
- £1.2 million for a ward project to support additional bed capacity and elective recovery.
- £0.5 million related to capital investment in Sulis Hospital which included X-ray equipment.
- £4.0 million which relates to right of use leases which are now required to be capitalised across the Group following changes in accounting standard.

These are capitalised costs only.

Capital Impairments

The Trust had capital impairments totalling £2.5 million of which £2.2 million related to an impairment on property valuation and £0.3 million capital asset impairments (£1.3 million in 2022/23).

Going Concern disclosure

After making enquiries, the Directors have a reasonable expectation that the services provided by the Group will continue to be provided by the public sector for the foreseeable future.

The definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual is "The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."
For this reason, the Directors have adopted the going concern basis in preparing the accounts.

2.	Recommendations (Note, Approve, Discuss)

It is recommended that the Finance and Performance Committee

- Note the delivery of the year end position for 2023/24.

3.	Legal / Regulatory Implications

Not achieving financial duties will impact on the ability for the Trust to secure the economy, efficiency and effectiveness in its use of resources.

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

In line with the Risk Assessment Framework:
The Trust fails to deliver its financial plan which leads to the Trust having a Single Oversight Framework rating of three or higher, representing a material level of financial risk. This results in a lack of confidence from the Trust's commissioners and the regulator and increases the level of scrutiny which utilises significant resources and can damage the reputation of the Trust.

5.	Resources Implications (Financial / staffing)

Not Applicable

6.	Equality and Diversity

It is important that delivery of a financial plan enables health inequalities to be addressed.

7.	References to previous reports

Monthly Finance Reports have been included in the Integrated Performance Reports throughout 2023/24.

8.	Freedom of Information

Public

9.	Sustainability

Further opportunities to improve sustainability should be pursued to contribute towards the Finance Improvement Programme

10.	Digital

Digital requirements are contained within the Income and Expenditure position and the Capital report for the year.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**1 May 2024**		
Title of Report:	**Alert, Advise and Assure Report – Non-Clinical Governance Committee**		
Status:	**For discussion**		
Author:	**Sumita Hutchison, Non-Executive Director and Chair of the Non-Clinical Governance Committee**		

Key Discussion Points and Matters to be escalated from the meeting

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

Environmental Sustainability in the RUH

Whilst there is a highly skilled team and small team (1.6 WTE) for sustainability and a clear strategy, that strategy is not able to be delivered in full due to the need for the board to give a clear direction of travel for this agenda (as a result of the increased requirements to do this/the work with the ICS/the evolving perception of this agenda within our workforce and communities). A new sustainability strategy is due for development. Furthermore, this agenda is yet to be fully embedded across the organisation and the benefits of this are yet to be realised.

The committee identified the following issues:

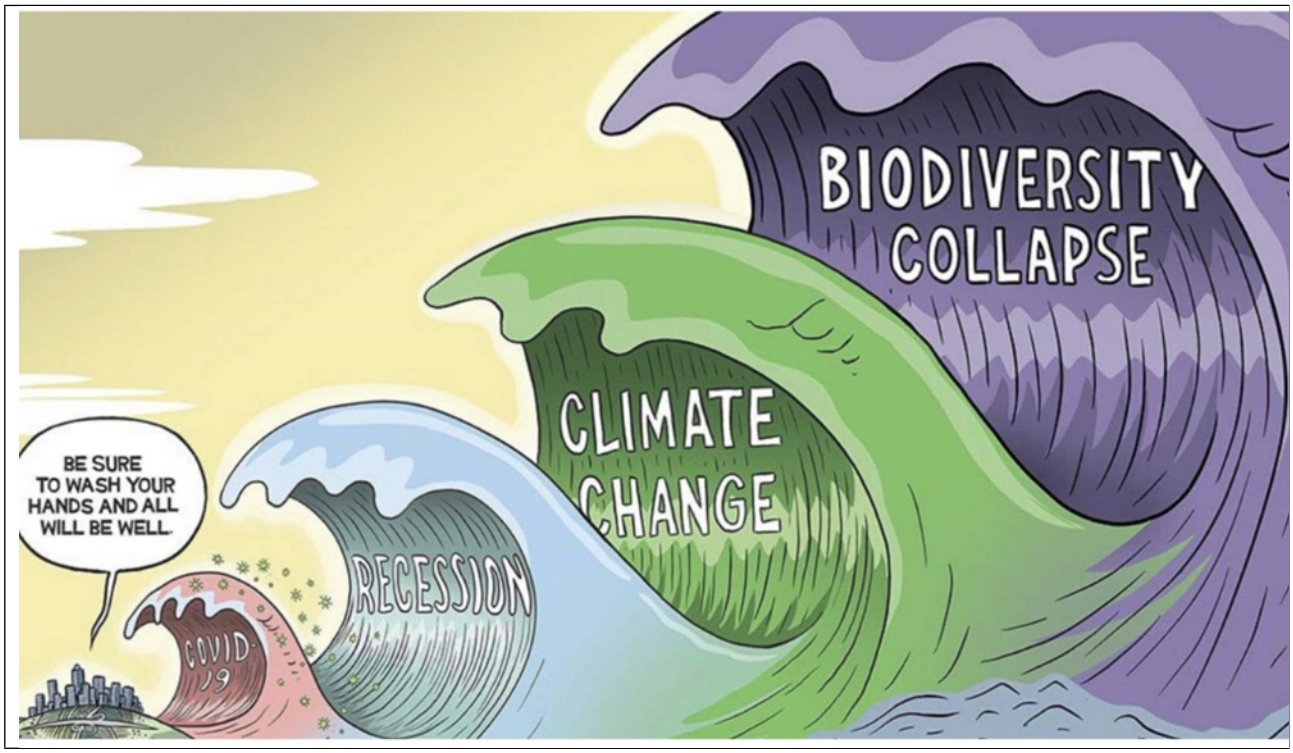
1. Development of a New Strategy: A new strategy to be developed in collaboration with the Board. However, there is uncertainty regarding whether the focus should solely be on achieving net zero or if a broader approach encompassing true and holistic sustainability is warranted.

2. Demonstrating Leadership and Clarity: There is a need for leadership to be demonstrated, accompanied by clear communication of roles, responsibilities, and messaging to all staff members.

3. Integration of Environmental Sustainability: Environmental sustainability could be seamlessly integrated into financial sustainability initiatives, cost-saving programmes, the clinical strategy, and various aspects of the people function.

4. Salix Contract Integration: The implications arising from the Salix contract to be integrated into our overarching strategy seamlessly.

5. Governance Beyond NCGC: Clarification is required on how governance for the sustainability agenda extends beyond the Non Clinical Governance Committee (NCGC).



The Board is asked to NOTE and Discuss the content of the report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**18**
Date of Meeting:	**1 May 2024**		
Title of Report:	**Alert, Advise and Assure Report – FPC Committee**		
Status:	**For information**		
Author:	**Antony Durbacz, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 23 April 2024

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- None

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Detailed operational performance will be considered by the board in the integrated performance papers. The committee noted the continuing challenges in non-elective care particularly impacting ambulance handovers and 4 hour performance. A detailed urgent care revised strategy is under development and will be presented at a future meeting.
- The committee discussed and recognised the underlying factors influencing improved performance in cancer 62 days, RTT and diagnostics. But noted that improvements were still needed to achieve the 24/25 targets. The operational metrics for 24/25 are now understood and the performance against these trajectories will be monitored by the committee moving forwards.
- The committee recognised the achievement of the trust to achieve its forecast financial benefits arising from the improvement programme. It noted the higher than anticipated non-recurring benefits and will consider at future meetings the implications on the longer-term financials.
- A revised governance structure for the improvement project was presented which addresses the need to assign limited resources more effectively to a large portfolio of opportunities. The proposal still needs some refinement around allocating accountability and will be reviewed again at a future meeting.
- A proposal seeking approval of contract award to a supplier following the Salix funding award was proposed. A recommendation for approval was deferred pending further information on the nature of the long-term support contract being offered.
- The challenges offered by the improvement plan for success in 24/25 are well understood. A governance strategy needs to be developed across the assurance committees to ensure effective assurance. This is of particular importance in the workforce objectives.

ASSURE: Inform the board where positive assurance has been achieved

- The Trust achieved its year end forecast deficit of £3.5m. The financial statements had only been finalised the day before, but nevertheless a clear

narrative was presented to provide assurance on the key elements of the financial result.

- Trust funded and externally funded capital was spent in line with the forecasts and in line with agreements.
- The Sulis/RUH team presented a review on the effectiveness of the partnership in managing the modular theatre. The committee commended the report which illustrated significant success.

RISK: Advise the board which risks where discussed and if any new risks were identified.

- Following the year end result, an assessment needs to be made on the impact of the final position on the 2024/25 plan. In particular we need to be clear on the QIPP and the run rate. A preliminary view was presented but this needs follow up at subsequent meetings

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding

- None

APPROVALS: Decisions and Approvals made by the Committee

- Following delegation from the board the committee recommended submission to the ICB of the 2024/25 business plan. It noted the following changes from the plan reviewed by the board. Operationally the targets for A&E 4hr performance,65-week waiters and 6-week diagnostic test targets were all increased. The Executives confirmed that these revised targets were achievable. The deficit in the plan was reduced to £15m following a reallocation of income from the ICB. This income would be dependent on achieving staged performance objectives that have yet to be agreed . The QIPP objectives in the plan were unchanged.

The Board is asked to NOTE the content of the report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**1 May 2024**		
Title of Report:	**Alert, Advise and Assure Report – Audit & Risk Committee**		
Status:	**For information**		
Author:	**Paul Fox, Non-Executive Director and Chair of the Audit and Risk Committee**		

Key Discussion Points and Matters to be escalated from the meeting held on 14 March 2024.

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- The Committee received a Draft Head of Internal Audit Option which based on the reviews completed to date is of only Partial Assurance. The Committee urged the Executive to urgently work with Internal Audit, focusing on the key reports on Risk, Data, and Budgetary Management to address the significant weaknesses identified, and to close and / or firm up the actions and timelines in respect of significant High priority actions arising from the eRostering, Infection Control and Patient Experience audits, such that the final opinion would be found to be Significant Assurance.
- Due to the timings of the Board of Directors, (5th June) and Audit & Risk Committee (20th June), the Audit & Risk Committee request that the Board of Directors delegate authority of the approval of the Annual Report and Accounts to the Audit & Risk Committee on 20th June.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- The Committee requested that the process of reporting individual internal audit reports to each of the Board's sub-committees be improved to enable the relevant committee to be informed by findings and to own agreed actions as an important part of their work programme.

ASSURE: Inform the board where positive assurance has been achieved

- The Committee received a high level of assurance that work on the 2023-24 final accounts audit was on track.

RISK: Advise the board which risks where discussed and if any new risks were identified.

- The Committee would like to see the BAF developed as a more forward looking tool, highlighting planned actions (with dates) which would mitigate risk and either bring it within the risk appetite (target) or else prompt a review of that risk appetite. KPMG offer to assist by reference to best practice elsewhere.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• None
APPROVALS: Decisions and Approvals made by the Committee
• The Committee recommended to the Board of Governors that Deloitte be re-appointed as External Auditors at the end of the current contract. • The Committee approved the 24/25 Internal Audit Plan and 24/25 Counter Fraud Plan • The Committee approved the Treasury Management Strategy noting the increased importance of cashflow forecasting.

The Board is asked to NOTE the content of the report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	20
Date of Meeting:	1 May 2024		

Title of Report:	Board Assurance Framework Summary 2024-25
Status:	Approval
Board Sponsor:	Cara Charles-Barks, Chief Executive
Author:	Christopher Brooks-Daw, Chief of Staff
Appendices	Appendix 1: BAF Risks Summary Sheet

1. Executive Summary of the Report

This report provides oversight of the RUH Board Assurance Framework (BAF) as at 25th April 2024 and provides a summary of the key risks which could impact on the ability of the Trust to achieve its strategic objectives and priorities.

BAF risks are routinely (no less than quarterly) reviewed through the Board sub-committee that is responsible for the corresponding subject area.

The Executive Team reviewed all risks on the BAF during a workshop on 16th April 2025. This resulted in some rewording of existing risks, as well as a rebalancing of ratings. The Executive Team will routinely, no less than quarterly, review the full BAF.

The full version of the BAF includes controls and mitigations for risks, as well as sources of assurance. It also reflects associated significant risks (rated ≥16) on the organisational risk register. Significant risks are overseen and reviewed through Trust Management Executive (TME) no less than quarterly.

The Board will receive the full BAF in July 2024.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to note and discuss the Board Assurance Framework.

3. Legal / Regulatory Implications

The Board of Directors is required to have a Board Assurance Framework in place as it one of the key sources of evidence to support for the preparation of the Annual Governance Statement.

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

The full version the BAF reflects specific significant risks for each BAF risk.

5. Resources Implications (Financial / staffing)

None

6. Equality and Diversity

No issues have been identified in this report.

7. References to previous reports/Next steps

Previously considered by all Board Committees through September and October 2023

8.	Freedom of Information
Public	

9.	Sustainability
None	

10.	Digital
None	

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Board Assurance Framework 2024 / 2025

BAF SUMMARY						
Strategic Priority 1 : People we Care For - Together we will support you, as and when you need us most **Objective: Consistently delivering the highest quality healthcare and outcomes**						
1.1	Chief Nurse Quality Governance Committee	**Description of Risk:** There is a risk that not meeting internally and externally set standards of quality and safety may result in harm to patients and/or experience below expected.	15	10	↓	QGC 8th Aoril 2024
1.2	Chief Operating Officer Finance and Performance Committee	**Description of Risk:** Increasing demand for both emergency and planned care is exceeding our capacity to treat patients promptly, leading to longer wait times for planned procedures. This could negatively impact patient outcomes and satisfaction.	16	12	↔	FPC 23rd April 2024
Strategic Priority 2: People we Work With - Together we will create the conditions to perform at our best **Objective: Demonstrating our shared values with kindness, civility and respect, all day, every day**						
2.1	Chief People Officer People Committee	**Description of Risk:** Failure to reduce levels and incidences of discrimination by managers against staff, based on race, ethnicity, religion, gender, sexuality or disability could affect the Trust's ability to recruit and retain staff, expose the Trust to unlimited damages following successful litigation and adversely affect the organisation's reputation	16	12	↓	People Committee March 2024
2.2	Chief People Officer People Committee	**Description of Risk:** The Trust could experience significant staffing risks as a result of the limited supply of healthcare professionals in the national NHS workforce market	16	8	↔	People Committee March 2024
2.3	Chief People Officer People Committee	**Description of Risk:** Failure to provide effective management and leadership development and succession planning could lead to a poor culture and/or to making cultural improvements unsustainable, which could lead to poor Staff Survey results, higher staff turnover and which could adversely affect patient care and outcomes, staff health and wellbeing and workforce expenditure (including agency cost).	20	16	↔	People Committee March 2024

Strategic Priority 3: People in our Community – Together we will create one of the healthiest places to live and work Objective: Working with partners to make the most of our shared resources and plan wisely for future needs						
3.1	Chief Finance Officer Finance and Performance Committee	**Description of Risk:** Failure to deliver a viable financial plan and create a culture of financial accountability across the organisation would impact on the Trust's ability to achieve financial recovery and sustainability, and could ultimately affect its ability to provide safe, appropriate and effective care to our patients.	16	12	⟷	Finance and Perf. Committee April 2024.
3.2	Chief Operating Officer Subsidiary Oversight Committee	**Description of Risk:** There is a risk that Sulis Hospital is unable to achieve its agreed financial and operational targets, and is therefore unable to support the Trust in providing the required additional elective and diagnostic capacity.	16	10	↓	SOC January 2024
3.3	Chief Medical Officer Quality Governance Committee	**Description of Risk:** Failure to target adequate resources to meet the health and care needs of those in the population we serve who are in greatest need will lead to worse outcomes for those communities, and further exacerbate current inequalities in outcomes.	16	12	⟷	Quality Governance Committee April 2024
3.4	Chief Operating Officer Non-Clinical Governance Committee	**Description of Risk:** Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, and a degraded experience for both patients and staff.	16	12	⟷	NCGC March 2024
3.5	Chief Operating Officer Non-Clinical Governance Committee	**Description of Risk:** Climate change and its accelerating consequences threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.	15	15	⟷	NCGC March 2024
3.6	Chief Finance Officer Non-Clinical Governance Committee	**Description of Risk:** There is a risk that due to a lack of funding the Trust fails to take advantage of opportunities to develop digital capabilities that could improve patient and staff experience while also improving efficiency and effectiveness.	16	12	⟷	NCGC March 2024
3.7	Chief Finance Officer Non-Clinical Governance Committee	**Description of Risk:** Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients.	16	12	⟷	NCGC March 2024