Bundle Public Board of Directors 22 July 2024

0 Agenda
- 0.0 - DRAFT Public BoD Agenda July 24 v2.5 - 19.07.24

1 Chair's Welcome and Apologies: Paran Govender, Antony Durbacz

2 Declarations and Conflicts of Interests

3 Written Questions from the Public

4 Minutes of the Board of Directors meeting held in Public on 1 May 2024
- 4.0 - DRAFT - Public BoD Minutes May - v1.2 - 02.05.24

5 Action Log
- 5.0 - DRAFT Public BoD Action List May 24 v1.2 - 16.07.2024

6 Governor Log of Assurance Questions and Responses
- 6.0 - Governor Log of Assurance Questions v1.1 - 15.07.24
- 6.1 - Appendix 1 - NED Assurance 2024 - 15.07.24

7 Items discussed at Private Board

8 Staff Story
- 8.0 - Staff Story cover sheet to Board of Directors 10.7.24_
- 8.1 - Staff story

9 CEO and Chair's Report
ICS Update
- 9.0 - CEO Public BoD Report 22.07.24

10 Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust
- 10.0 - AHA_CIC_220724_Collaboration_Leadership_Governance_Proposal_100724_ Top CopyV1.0
- 10.1 - AHA_CIC_220724_Appendix1_DRAFT AHA Joint Committee Terms of Reference_100724_V0.1

11 Integrated Performance Report
- 11.0 - BOD Integrated Performance Report - Cover Sheet - May performance_
- 11.1 - Integrated Performance Report May 2024
- 11.2 - Trust Scorecard May 24

12 Learning from Deaths Report Q3 & Q4
- 12.0 - Learning from Deaths Q3 & Q4 - Cover Sheet
- 12.1 - Quarterly Learning From Deaths Report Q4 23 24

13 MIS Combined Maternity and Neonates Quarterly Report Q4
- 13.0 - Matneo 2023-24 Q4 report V6 Final docx
- 13.1 - T C and ATAIN Q4 Jan 2024-March 2024 (002)
- 13.2 - Insights report 23-24 final V5_

14 Bi-Annual Staffing Report
- 14.0 - Bi-annual staffing paper July 23 (final)

15 Quality Assurance Committee Upward Report
- 15.0 - QAC Upward Report July 2024 v2
- 15.1 - 2024 07 QAC Upward Report to Board

16 People Committee Upward Report
- 16.0 - People Committee Upward Report

17 SIRO Annual Data Security and Protection Assurance Report
- 17.0 - SIRO DSPT Report July 2024 v2

18 Strategic Priorities Q1
- 18.0 - Q1 Quarterly Strategy Update Cover Sheet v3
- 18.1 - Q1 202425 review Final Draft V3.2

19 Non-Clinical Governance Committee Upward Report
- 19.0 - NCGC Report 22 July Board

20 Finance and Performance Committee Upward Report
- 20.0 - FPC Upward Report 25.06.24docx

21 Audit and Risk Committee Upward Report
- 21.0 - Upward Report Audit & Risk Ctte 200624

22 Charities Committee Upward Report
- 22.0 - Charities Committee Report 22 July Board

24 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
MONDAY 22 JULY 2024, 13:00 – 16:00
VENUE: WHARF ROOM, WIDCOMBE SOCIAL CLUB, WIDCOMBE HILL, BATH, BA2 6AA

Item	Item	Presenter	Enc.	For
OPENING BUSINESS				
1.	Chair's Welcome and Apologies: Paran Govender, Antony Durbacz, Ian Orpen	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 1 May 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.	Staff 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.	Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust	Cara Charles-Barks, Chief Executive / Alison Ryan, Chair	Enc.	A
11.	Integrated Performance Report	Alfredo Thompson, Chief People Officer	Enc.	I/D
The People We Care For				
12.	Learning from Deaths Report Q3 & Q4	Sarah Richards, Deputy Chief Medical Officer	Enc.	I/D
13.	MIS Combined Maternity and Neonates Quarterly Report Q4	Kerry Perkins, Maternity Matron	Enc.	I/D
14.	Bi-Annual Staffing Paper	Kerry Perkins, Maternity Matron	Enc	I/D
15.	Quality Assurance Committee Upward Report	Hannah Morley, Non-Executive Director	Enc.	I/D
The People We Work With				
16.	People Committee Upward Report	Paul Fairhurst, Non-Executive Director	Enc.	I/D
The People in Our Community				

17.	SIRO Annual Data Security and Protection Assurance Report	Spencer Thorn, Interim Chief Digital Information Officer	Enc.	I/D
18.	Strategic Priorities Q1	Joss Foster, Chief Strategic Officer	Enc.	I/D
19.	Non-Clinical Governance Committee Upward Report	Sumita Hutchison, Non-Executive Director	To Follow	I/D
20.	Finance and Performance Committee Upward Report	Paul Fairhurst, Non-Executive Director	Enc.	I/D
21.	Audit and Risk Committee Upward Report	Paul Fox, Non-Executive Director	Enc.	I/D
22.	Charities Committee Upward Report	Sumita Hutchison, Non-Executive Director	To Follow	I/D
Governance				
23.	No items this month			
CLOSING BUSINESS				
24.	Any Other Business	Alison Ryan, Chair	Verbal	-
Date of Next Meeting: Wednesday 4 September 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, 1 May 2024, 13:00 – 16:00
VENUE: PAVILION FUNCTION ROOM, KINGSWOOD SCHOOL UPPER PLAYING FIELDS, LANSDOWN ROAD, BATH, BA1 9BH

Present:

Members

Alison Ryan, Chair
Christopher Brooks-Daw, Director of Governance / Chief of Staff
Cara Charles-Barks, Chief Executive
Antony Durbacz, Non-Executive Director
Paul Fairhurst, Non-Executive Director
Jocelyn Foster, Chief Strategic Officer
Paul Fox, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Jon Lund, Interim Chief Finance Officer
Antonia Lynch, Chief Nursing Officer
Hannah Morley, Non-Executive Director
Ian Orpen, Non-Executive Director
Nigel Stevens, Non-Executive Director
Alfredo Thompson, Chief People Officer

In attendance

Elizabeth Bradbury, Aqua *(Observer via Teams)*
Public Governors
Sarah Hudson, Divisional Director of Operations, Medicine
Zita Martinez, Director of Midwifery (*agenda item 11)*
Roxy Milbourne, Interim Head of Corporate Governance
Charlotte Nicol, Lead Paediatric Nurse (*agenda item 8)*
Sarah Richards, Deputy Chief Medical Officer
Pippa Ross-Smith, Deputy Chief Finance Officer (*agenda item 16)*
Kelly Spencer, Head of Research Operations *(agenda item 15)*
Kathryn Kelly, Executive Assistant *(minute taker)*

Apologies

Para Govender, Chief Operating Officer
Andrew Hollowood, Chief Medical Officer and Deputy Chief Executive
Libby Walters, Chief Finance Officer

BD/24/05/01 Chair's Welcome and Apologies

The Chair welcomed everyone to the meeting, and confirmed that apologies had been received from Libby Walters (Chief Finance Officer), Andrew Hollowood (Chief Medical Officer) and Paran Govender (Chief Operating Officer).

The Chair introduced Jon Lund (new Interim Chief Finance Officer) and Pippa Ross-Smith (Deputy Chief Finance Officer) to the meeting and explained that Sarah Hudson (Divisional Director of Operations, Medicine) and Sarah Richards (Deputy Chief Medical Officer) were representing their Directors respectively.

BD/24/05/02 Declarations of Interest

The Interim Chief Finance Officer explained that he was currently on secondment from the BNSSG (Bristol, North Somerset and South Gloucestershire Integrated Care Board), who held a commissioning contract with the Trust.

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

BD/24/05/03 Written questions from the public

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

BD/24/05/04 Minutes of the Board of Directors meeting held in Public on 6 March 2024

The Chief Nursing Officer reported that she had requested an amendment to page 5 of the minutes and confirmed that the version of the minutes provided had been updated.

The minutes of the meeting held on 6 March 2024 were approved as a true and accurate record.

BD/24/05/05 Action List and Matters Arising

There were no actions to close on the action list.

BD/24/05/06 Governor Log of Assurance Questions and Responses

The Chair noted that the log of assurance questions was on the agenda for information.

BD/24/05/07 Item Discussed at Private Board of Directors meeting.

The Chair reported that the majority of the private meeting had been confidential, however there were a few items to note:

- Community services had been discussed and the challenge of resolving various conflicts had been acknowledged. The Trust was currently halfway through the bid process and this would end in July;
- The Trust was currently in critical incident level 2 and this was due to norovirus cases and problems with managing the estate during an infection. There was also a backlog of patients testing positive for COVID and emergency demand was extremely high, with over 300 attendances. The Chair reported that this was happening virtually every weekend and the Trust was focussing on flow and the reason for the high acuity;
- The Board had agreed to proceed with the Decarbonisation scheme.

BD/24/05/08 Patient Story

The Chair welcomed Charlotte Nicol, Lead Paediatric Nurse, to the meeting. The Chief Nursing Officer invited the Lead Paediatric Nurse to give a brief overview of the story contained in the video. The Lead Paediatric Nurse explained that the patient had been patient on the ward with her mother and had been admitted with an eating disorder and complex mental health issues.

The video highlighted the ward environment as not being very good and the mother explained how it would have been helpful to have somewhere for long-term patients to have access to. The Lead Paediatric Nurse explained that the aim was to divide the ward up to create an area for teenagers/young people experiencing mental health

disorders. The mother highlighted the lack of communication between the CAMHS team and the Trust and there had been a lack of understanding as to who was taking forward the child's care. The mother reported that his had now improved and closer links had been formed which would hopefully enable for less of a traumatic experience in future for patients.

The Lead Paediatric Nurse stated that the Trust was confident in the newly strengthened relationship with CAMHS and improved security on the ward. Bespoke training was also now in place and it was hoped that this would help build the confidence and expertise of staff.

The Chief Nursing Officer reported that the Trust was currently reviewing the paediatric nursing establishment and conversations were ongoing with Wiltshire College to see if they could assist in providing some education to children's and adults' nurses. The Chief Nursing Officer stated that providing an area where young people felt safe was very important. The Lead Paediatric Nurse stated that the Trust was not alone and these issues were being experienced across the country.

Sumita Hutchison posed a question regarding the position of the local Mental Health Trust and questioned as to how the Lead Paediatric Nurse felt about adjusting to the crisis. The Lead Paediatric Nurse stated that the position was challenging as the hospital was viewed as a place of safety.

Ian Orpen thanked the Lead Paediatric Nurse for all the work she was doing and acknowledged the challenges being faced. He questioned whether the Lead Paediatric Nurse was receiving the right amount of support. The Lead Paediatric Nurse stated that she felt well supported and felt happy with the progress being made. The Chief Executive acknowledged the changing face of paediatrics and stated that it was important to link in with training programmes to influence the spectrum of training to achieve a better balance.

Paul Fairhurst reflected on a discussion which had taken place at the last People Committee in relation to clinical skills training and incorporating mental health training. He stated that he would be interested to hear if the community services contract would present an opportunity for improvement. The Chief Strategic Officer agreed that this would be the case if within the area, but would not work with patients out of the area. The Chief Executive stated that this could be discussed within the mental health collaborative and recognised that this was a challenge.

Antony Durbacz questioned whether the Lead Paediatric Nurse was getting enough support to provide the new space. The Lead Paediatric Nurse stated that the team were taking the time to think about what would create the best service for patients and the Trust was supporting them in this.

In conclusion, the Chair agreed that she and the Chief Executive would look into the issues raised regarding mental health.

Action: Chair/Chief Executive

The Chair stated that the Chief Strategic Officer would further investigate the issues regarding community health.

Action: Chief Strategic Officer

The Chair thanked the Lead Paediatric Nurse for her presentation.

The Board of Directors noted the patient story.

BD/24/05/09 CEO and Chair's Report

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

The Trust had formally received the results from the staff survey and this had been the best response rate so far. The Chief Executive stated that it was fantastic for 69% of staff to recommend the Trust as a place to work, which put it in the top 20 in the country. The Chief Executive also highlighted that a greater number of staff from global majority backgrounds had responded to the survey.

The Chief Executive highlighted Maternity Services and how this was a real public concern at present. She praised the Maternity Team for retaining their outstanding rating from the CQC which put them in the top 3 nationally. The Chief Executive reported that this rating had been achieved by an incredible amount of hard work. She described the Director of Midwifery as being phenomenal, with a fantastic degree of positivity and energy, which was encouraging the staff to thrive. The Chief Executive explained that the local Birthing Centres had also improved and both had received good ratings.

The Chief Executive stated that the report from the unannounced CQC inspection in the Surgical Division would be received in due course.

The Chief Executive stated that the Dyson Cancer Centre had opened on 26th April 2024 and feedback so far had been phenomenal. The Trust was one of the largest providers in the South West and the ambition was to be the best in the country. Work had also commenced on ICU improvement works and a key strategic aim was for this to be consolidated to achieve a larger ICU which would be ready by Winter 2024.

The Chief Executive explained that there had also been refurbishment of staff and public areas, e.g. Lansdown Restaurant, and the menu had been refreshed. There was also now a Barista coffee van outside the Maternity Unit, further facilities planned for the Cancer Centre and the regular Food Fayres.

Sumita Hutchison highlighted the number of attendances in ED, especially in March, and questioned what sort of conversations were taking place to address this. The Chief Executive stated that the Trust continued to work with the Ambulance Trust and GP's to identify where the variation was and the interventions in place.

The Divisional Director of Operations, Medicine, acknowledged that March had been exceptional with paediatric attendances increasing steadily. Work was being done in urgent care and, whilst the pressures in primary care were understood, this was why high numbers were being seen at weekends. Pharmacy provision within Bath city was also not ideal out of hours and this was having a knock-on effect.

The Chair acknowledged that the current aspirations were being looked into in the community services bid and it was hoped that this would lead to a reduction in emergency demand.

Ian Orpen questioned whether patients were being seen in a timely manner in primary care. The Divisional Director of Operations, Medicine, acknowledged that access to primary care physicians could affect attendances and that work was ongoing to recognise health inequalities areas and how communities could be further supported.

The Board of Directors noted the report.

BD/24/05/10 Integrated Performance Report (IPR)

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

- Demand had affected the Trust's delivery and, despite unplanned care pressure, the Trust was reporting good performance in relation to patients reporting for planned care.
- The Trust had seen more category 2 pressure ulcers and there had been two category 3 ulcers in February.
- The Maternity CQC survey had reported a positive performance and the only area of concern had been offering a choice of birthing centres which had been the impact of community birthing centre services being suspended in February.
- The pleasing staff survey results which had been received and the approval of the People Plan programmes;
- The publication of the Trust's anti-racism statement in March;
- Focussing on the reduction of temporary staffing costs including a reduction in agency spend;
- The small increase in sickness absence which was being carefully monitored;
- The challenges of controlling spend and the work which was ongoing to make improvements on the trajectory.

Hannah Morley questioned Length of Stay and what the Trust's position was on this as an objective in the future. The Deputy Chief Medical Officer stated that, as the Trust moved to the electronic care data set, discussions were ongoing about how the Trust mitigated against this.

Paul Fairhurst highlighted the ward round compliance and the option of reverting back to a paper system. He questioned whether this was a backward step. The Chief Nursing Officer explained that the Trust did not currently have hand held devices for ward rounds but it would in the future when the transition from paper to digital would take place.

Sumita Hutchison questioned how the Trust was responding to the non-movement of figures relating to staff anxiety, stress and depression. The Chief People Officer acknowledged that the figures had remained persistent over time despite interventions. This required more analysis and review and lots of work was being dedicated to understanding short term sickness.

Sumita Hutchison questioned whether the pressure ulcer figures were the result of lapses in care and not having enough staff in place. The Chief Nursing Officer stated that pressure ulcers occurred for a number of reasons but acknowledged that inadequate staffing levels were one of the reasons for increased numbers. She explained that thee could often be delays in care and leadership, but that it was important to have well-run wards with the right level of knowledge and skills in place. The Chief Nursing Officer stated that any pressure ulcer obviously caused harm but the Trust's continued programme of improvement ensured that the pressure ulcer figures were much lower than other Trusts.

Antony Durbacz questioned whether there was a start date to the maternity EPR system. The Director of Midwifery confirmed that the start date would be 2025.

In response to a question from Nigel Stevens, the Chief Nursing Officer confirmed that the Patient Experience Strategy would be present to the Quality Governance Committee first and then to Board. The Chief Strategic Officer reported that the work relating to the Atrium was ongoing with a group of staff and volunteers looking at that the future experience should be like. This would be reported back at a future Board meeting and the most likely option was a phased approach which it was hoped would not cost a great deal of money.

In response to a question from Paul Fairhurst relating to the anti-racism statement and results from the staff survey, the Chief People Officer agreed to think about how results could be evaluated sooner.

Action: Chief People Officer

The Board noted the Integrated Performance Report.

BD/24/05/11 MIS Combined Maternity and Neonates Quarterly Report Q3

The Chair welcomed the Director of Midwifery to the meeting.

The Director of Midwifery highlighted that the Trust made two referrals to the Maternity and Neonatal Safety Investigations (MNSI) team hosted by the Care Quality Commission. One referral had been confirmed as an ongoing investigation at the family's request, one had not progressed following the MNSI triage process. The Director of Midwifery noted that one new internal Serious Incident was declared in Q3.

The Director of Midwifery reported that the Avoiding Term Admissions into Neonatal Units (ATAIN) rates had increased and a deep dive had been requested with thematic analysis. This would be reported to Board through future reports.

The Chief Executive posed a question to the Director of Midwifery regarding her learning over the past year. The Director of Midwifery stated that culture and leadership was the most important. She explained that she had found colleagues to be very welcoming, friendly and engaging and she encouraged her team to be kind, respectful and to lead with empowerment.

Nigel Stevens questioned whether any of the successes in Maternity could be replicated elsewhere in the Trust. The Director of Midwifery reported that the team had a lot of

engagement with its users and rhythmical governance systems and processes were important.

Ian Orpen congratulated the Director of Midwifery on enabling staff to feel listened to in a way they had not previously been and he stressed the importance of this.

The Chief of Staff questioned what had been the most challenging part of the Maternity Incentive Scheme. The Chief Nursing Officer explained that it had been difficult to hear midwives who had told her that services were not right and safe. She praised the Director of Midwifery for providing clarity and ensuring that the speciality was well connected. The Chief Nursing Officer stated that the only way to assure the Board was through truly understanding maternity services and that to have achieved the outstanding CQC rating was a cause for celebration but the level of focus must be maintained.

The Board thanked the Director of Midwifery for all her work.

The Board noted the report.

BD/24/05/12 Delegation of Authority to Sign Off Quality Accounts

The Chief Nursing Officer reported that the Quality Accounts must be published by 30th June 2024.

The Board agreed the delegation of authority to the Quality Governance Committee to sign off the Quality Accounts.

BD/24/05/13 Quality Governance Committee Upward Report

The Chief Nursing Officer stated that it was proposed to rename this Committee as the Quality Assurance Committee and to move to meeting bi-monthly once systems and processes were aligned.

The Board approved the renaming of the Committee.

The Board noted the report.

BD/24/05/14 People Committee Upward Report

Paul Fairhurst stated that most of the issues raised in the report had been covered in the CEO and Chair's Report and the Integrated Performance Report. He summarised that there were currently high levels of activity across all elements of the People Plan with good assurance and equity. Areas to watch were the Restorative Just and Learning Culture and challenges to address from the Staff Survey. In terms of culture and leadership development, Paul Fairhurst acknowledged that there was more work to be done in order to drive staff experience and patient care.

Antony Durbacz questioned the reservist scheme and how this had come to the fore. The Chief People Officer reported that this scheme had been in existence for approximately two years and had been a legacy of COVID.

The Chief of Staff stated that it would be interesting to see how the Restorative Just and Learning Culture would connect with PSIRF (Patient Safety Incident Response Framework). The Chief People Officer acknowledged that consistency would be key.

The Chief Nursing Officer stated that the Trust was working hard in its transition to PSIRF and trying to take away the punitive/blame approach which had been integral to the NHS. The Chief Nursing Officer described that the Trust was really focussed on this and it was a work in progress.

The Chief Strategic Officer stated that it was easy to miss some of the emerging risks. Paul Fairhurst stated that, in terms of workforce planning and reviewing risks, this was an issue for all the Committees. The Chair suggested that horizon scanning might be something which could be added to the template for upward reports. The Chief of Staff stated that he had been noting any rising risks and it would be more appropriate for these to be added to the Risk Register.

Nigel Stevens stated that the biggest risk to the Board was taking the time to think and not giving the appropriate amount of time and space to look at what was on the horizon.

The Board noted the upward report.

BD/24/05/15 Research and Development Strategy

The Chair welcomed the Head of Research Operations to the meeting.

The Head of Research Operations reported that the Trust stood out as a research organisation and it continued to deliver research strategies and developed areas of expertise. The Head of Research Operations stated that research was important for the entire organisation and the aim was to make research as accessible as possible. The Head of Research Operations explained that the team were good at reaching out to partners, funders and peers to use research to support the local community and the people the Trust served.

Nigel Stevens stated that he liked the clear and simple style of the strategy.

Paul Fairhurst expressed his gratitude for the clarity of the report and questioned whether the Trust was where it wanted to be in terms of incorporating this into other areas. The Head of Research Operations confirmed that there was still more work to be done.

The Chief People Officer raised the issue of consultants and the expectation of them carrying out research projects. The Deputy Chief Medical Officer reflected that the majority of medics wanted to do research and this was an untapped resource. The Head of Research Operations explained that the allocation of time for research was important and capacity was being looked at in job planning.

The Board approved the Research and Development Strategy.

BD/24/05/16 Year End Position

The Deputy Chief Financial Officer stated that the position had vastly improved and this had been despite the year of change which included periods of industrial action.

The Chief Strategic Officer stated that the final plan would be provided to Governors in June.

Paul Fox thanked the Finance team for all their hard work in arriving at this position.

The Board of Directors noted the report.

BD/24/05/17 Non-Clinical Governance Committee Upward Report

Sumita Hutchison shared her concern about the development of a new Sustainability Strategy and she requested clear direction from the Board as to how this could go forward. The Chief Executive acknowledged that this could be covered in a future Board Seminar session.

The Board of Directors noted the report.

BD/24/05/18 Finance and Performance Committee Upward Report

Antony Durbacz explained that the numbers had been changing as the FPC met and this had been unusual. He acknowledged that the Improvement Programme was important and it would be important to monitor how the structure was modified.

The Board of Directors noted the report.

BD/24/05/19 Audit and Risk Committee Upward Report

Paul Fox highlighted that the Internal Audit position had not been where it should be but he had raised this with the Chair and Chief Executive. As a result, the Chief of Staff had now intervened and a positive outcome had been achieved.

The Board approved the delegation of approval of the Annual Report and Accounts to the Audit Committee on 20th June 2024.

The Board of Directors noted the report.

BD/24/05/20 Board Assurance Framework Summary Report

The Chief of Staff requested that the Board take the paper as read and explained that the full BAF would return to the Board in July. The Chief of Staff reported that the BAF had recently been reviewed by the Executive Team and much tighter synergy was being brought to the risk register.

The Board of Directors noted the report.

BD/24/05/21 Any Other Business

The Chair expressed her thanks to Elizabeth Bradbury (Aqua), Governors, members of the public and to the Head of Communications for attending the meeting.

No other business was discussed.

The Meeting closed at 15.50 hours.

Royal United Hospitals Bath
NHS Foundation Trust

Agenda Item: 5

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY 1st May 2024

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB600	**Patient Story** Look into the issues raised in relation to Mental Health Services.	**BD/24/05/08**	**May 2024**	**July 2024**	Verbal Update to be given at the meeting. Open.	**Chair/Chief Executive**
PB601	**Patient Story** Further investigate the issues regarding community health services.	**BD/24/05/08**	**May 2024**	**July 2024**	Communications between paediatrics providers has been flagged as a theme for future focus at recent B&NES Health and Wellbeing Board development. Paediatric pathways have been reported to have improved significantly in the neighbouring Somerset system through their integration of community, mental and physical health provision. Whilst CAMHS is not included in the current scope of community services retendered in BSW, we will continue to seek opportunities from the community services contract as it develops going forwards. **To Close.**	**Chief Strategic Officer**
PB602	**Integrated Performance Report** Evaluate the results relating to the anti-racism statement	**BD/24/05/10**	**May 2024**	**July 2024**	Full response detailed at appendix 1. **To close**	**Chief People Officer**

Appendix 1: Update to PB602

We will not be evaluating the impact of the anti-racist statement as a stand-alone but will continue to measure the impact and effectiveness of our total EDI projects and workflows (People Plan Programme 4, reporting to the People Committee via the People Programme Board).

We will do this because all of our interventions focussing on race have only one real goal, and that is to provide safe and inclusive working environments/experiences for colleagues from the Global Majority, in which they can progress and thrive at work.

The metrics related to the ARS will be the same as all the other EDI metrics, so:

- **Improved experiential picture** described through the WRES/Staff Survey.
- **Increase in promotion** / progression of Global Majority colleagues to Band 7 and above posts.
- **Increased reporting** of racist behaviour / conduct – reports submitted by Global Majority colleagues, allies, managers etc.
- **Reducing frequency** of instances of discrimination, harassment, bullying etc towards colleagues from the Global Majority
- **Increase** in colleagues from the Global Majority accessing skills/career development programmes and training etc.

Frequency of review will follow the rhythm of existing EDI reporting (i.e. every two months via People Committee, and monthly through the IPR), but we will be conducting a qualitative review of the ARS and its impact 18 months after launch (therefore Autumn 2025).

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	6
Date of Meeting:	22 July 2024		

Title of Report:	Governor Log of Assurance Questions and Responses
Status:	For Information
Board Sponsor:	Alison Ryan, Chair
Author:	Roxy Milbourne, Interim Head of Corporate Governance
Appendices	Appendix 1: Governor Log of questions July 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.

Two new questions, APR24.1 and APR24.2, were raised since the last report was presented in May 2024. These related to the Trust Security Team and patient waiting lists and were closed by the Council of Governors at their meeting on 13 June 2024. The Council of Governors also closed the following outstanding questions at this meeting:

- MAR24.1
- MAR24.3
- MAR24.4
- MAR24.5
- MAR24.6

During the meeting on 13 June 2024, the Council of Governors reviewed questions MAR24.3 and MAR24.6 and agreed that they were not appropriate assurance questions and did not require a response.

All questions and responses since the last report in May 2024 are detailed in appendix 1.

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
May 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 of Assurance Questions

Date:	**23rd April 2024**
Source Channel	**Email Sent to the Membership Inbox following on from the March Quality Working Group**
Date Sent & Responder	Sent to ET and NEDs on the 23rd April 2024
Question and ID	**APR24.1** Can assurance be provided that the Trust Security Team has or will be reviewed to ensure a safe number of trained Security staff will be on shift to cover the entirety of the hospital, and that in a case of another lockdown a pool of Trained Security Officers would be available. Furthermore, entrances and exits will also need to be reviewed to ensure the ability to secure our site if needed.
Process / Action	Waiting for response
Answer	The Head of Facilities at Salisbury Foundation Trust has been asked to undertake an independent review the Security team and provide the Chief Nursing Officer of any recommendations. This is scheduled to take place in early July 2024. The outcomes will be reviewed in the Non-Clinical Governance Committee.
Closed?	Closed at the Council of Governors meeting on 13 June 2024.

Date:	**24th April 2024**
Source Channel	**Email Sent to the Membership Inbox**
Date Sent & Responder	Sent on 25th April 2024 to David Allison and Stephen Roberts.
Question and ID	**APR24.2** I am trying to get my head round waiting times. According to the 11 April 2024 press bulleting from the NHS, the following figures were recorded for February 2024: -7.5 million patients are currently waiting to start treatment -1,745,825 new referral to treatment (RTT) pathways were started -301,266 pathways were completed as a result of admitted treatment and 1,175,470 pathways were completed in other ways(non-admitted), a total of 1,476,736 This gives a capacity shortfall in February of 269,089 or ca. 15%. I have looked at a recent report to the governors quality working group and cannot find the equivalent numbers for the RUH. Are such numbers available? I have also thought about the meaning of waiting lists. If capacity equals or just exceeds demand, one might expect waiting lists of 4 to 6 weeks to accommodate fluctuations in supply and capacity. However, a waiting list in excess of 50 weeks means that at the 50 week point, sufficient patients have dropped off the waiting list for capacity to equal demand. Patients drop off for a number of reasons, overriding incapacities, death and going private being among the possibilities. I know people in our community who have been waiting two years for hip replacements. If you are unable to walk comfortably for a prolonged period, other things happen to the body, eventually leading to incapacity. My second question is this. Bearing in mind that every attempt to reduce waiting times by putting extra effort into supply results in an increasing mountain of demand (rising to 15% more if the system gets down to capacity equalling demand), is there any serious prospect of the RUH significantly reducing waiting times without making significant investment in capacity, beds and resources? My third question is ‘to what extent is theatre capacity limited by bed capacity.?
Process / Action	Sent on 25th April to David Allison and Stephen Roberts. Repsonse received on 15th May. Additional information needed and email sent to David Allison and Stephen Roberts on 16th May. Additional information received on 16th May.

Answer	In April we had -34,921patients are currently waiting to start treatment (Incomplete pathways) -10,630 new referral to treatment (RTT) pathways were started - 930 pathways were completed as a result of admitted treatment and 6862 pathways were completed in other ways(non-admitted), a total of 7,792 The figures in themselves are though misleading due to the nature of how RTT is reported and how it works operationally. A lot of stops come through validation and are therefore entered retrospectively. For example a patient is sent for a radiology scan, the result of which is that the patient no longer needs to be followed up. The patient gets a letter to this affect but a stop is not put on for that patient at the time, it is instead put on retrospectively the next month when the patient is validated. (Every patient should be validated every 12 weeks) Because RTT figures are submitted monthly and there is no resubmission process for previous months that stop doesn't get reported nationally. In addition there will be clock starts that happen that end up being excluded down the line as they are found to not be RTT reportable. I.e. patients that have been discharged but require a surveillance follow up. A new encounter is created which opens up an RTT pathway but they then get excluded rather than stopped when the outcome is entered. You can't therefore do what you would think you can logically do which is take the number of waiters add on the additions and remove the stops to get the net change. At a high level I think it is worth looking at the total number of incomplete waiters each month (the first figure) to see whether the waiting list is reducing. The total per month is as per below (I've gone back to the Pre COVID period so that you can see the long term trend. Options to reduce waiting lists that are not hugely costly is basically 'validation' of waiting patients; going through the waiting list at regular intervals to check if patients have had a definitive treatment (but not recorded correctly , or patient pathway not updated), still require an appointment/treatment (some patient issues simply settle or become manageable; have been referred elsewhere and been seen or gone privately). We have validators and specialty managers who regularly undertake this. We report nationally on the regularity of our validation, and how far down the waiting list we go (down to 12 weeks currently). We can invest in more validators at a relatively low cost, but in current climate (headcount/savings) this is a challenge. Very rarely. We run 16 theatres and the elective footprint (18 beds on Robin Smith a Day Surgery Unit, and some ICU requirement) copes 90% with the odd day case saying overnight that mat flex into non
Closed?	Closed at the Council of Governors meeting on 13 June 2024.

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?	Closed at the Council of Governors meeting on 13 June 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	The Council of Governors discussed the questions at their meeting on 13 June 2024 and agreed to close them as they were not appropriate assurance questions.
Closed?	Closed at the Council of Governors meeting on 13 June 2024.

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	The NEDs are assured that the Trust recognises the very serious risks of failure to develop an open, transparent and 'safe' culture: some staff could feel unable to raise concerns relating to patient care, staff safety and wellbeing; and that could lead to adverse effects on patient outcomes, staff welfare, the RUH reputation, and sustainability. The Board has captured that risk explicitly in the Board Assurance Framework (Risk 2.3). Other BAF risks also address the need to establish the right culture, specifically BAF Risk 2.4 which states that "failure to provide effective management and leadership development [...] could lead to inconsistencies in the way we lead people [which] could result in an adverse culture [and] could adversely affect patient care and outcomes, staff health and wellbeing, and workforce productivity and cost". The BAF risks (and the controls, assurances and actions to mitigate gaps) are reviewed regularly at People Committee and Board. The Trust provides several existing routes for staff to speak up, including to senior leaders, line managers, the Freedom to Speak Up Guardian and trade union representatives. There are some positive indicators as to the effectiveness of that framework: national indicators of speaking up culture show that the Trust performs in line, or just above, our NHS staff survey benchmark peers, and our Freedom to Speak Up Guardian case numbers have been similar to organisations of comparable size and function. However, whilst the Trust has a framework in place to encourage openness and transparency, our culture can be a barrier to effective delivery in practice. So too can our staff's perception of the culture: the perception amongst some being 'they say it is safe to speak up, but I don't believe it'. For that reason, the Trust has established a strategy and numerous workstreams and plans designed to move us ever-nearer to a culture in which all 8,000 staff feel safe to speak up. Some of those are: • Freedom To Speak Up review. ○ Last year the Trust commissioned The Guardians Service to carry out an independent review of our current FTSU processes, ways of working and culture.The Report was presented to the People Committee in November. It confirmed the Trust's assessment that there are opportunities to improve. Indeed, the report advised that if the Trust did not make changes now, our speaking up arrangements might deteriorate in the future. ○ Amongst its findings, the report identified issues with internal perceptions on the remit and role of the Guardian/ the FTSU service, specifically a perception that the Guardian was becoming a 'catch-all' for all speaking up matters, including those that could or should be more properly and effectively handled by others (specifically line-managers). ○ The report made eight core recommendations to improve the effectiveness of the FTSU Service and enable the Trust to deliver its aspiration to move from a 'good' to a 'gold standard' FTSU service. They include: ■ A full review of our People Policies to embed FTSU processes, especially around escalation policy and the inclusivity / accessibility of language used. ■ The creation of robust, visible processes for triage and escalation of concerns, including regular formal triangulation of FTSU with other data insights (e.g., patient incidents, WRES, WDES, NHS Survey data etc.) ■ A clearer demonstration of 'we say, we listen, we do' ethos, and continuation of workstreams to access hard-to-reach or hard-to-hear groups. ■ A communication campaign to clarify and educate around the FTSU Guardian role, alongside the wide range of other speaking up routes . ■ Continued need to role model curiosity and openness to 'hearing' and acting on feedback at the most senior organisation levels.

	• Culture Change: the Trust's newly-formed Culture Change Team, drawn from across the RUH and with a balanced demographic, is implementing plans to support openness in local Divisional, Directorate, Departmental, Service and Team level. • Restorative, Just and Learning Culture: a foundational element of the People Plan is the RJLC programme. The vision of that programme is to create an open, honest and supportive environment at work, which puts reflective practice and learning at the heart of what we do; to support people in being accountable and taking learning from incidents to provide better patient care; and to deliver 'People practices' that are fair, equal, agile, and, wherever possible, 'restorative'. • EDI Networks: our refreshed EDI Networks are being asked to consider ways to support openness in local Divisional, Directorate, Departmental, Service and Team level, particularly where the networks have a concern about culture. • Communications: work is in progress to ensure that the message to staff about safety to speak up is clear, consistent and frequent. That has been in evidence through Executive team communications to staff over recent months. • Policies: work is in progress to ensure that the Trust's values and behaviours (including that 'we will actively listen' and that 'we will share ideas and speak up') are woven throughout all relevant policies, together with clear messages about safety to speak up. • Leadership Development: the vision of the Leadership Development Programme is to develop the RUH leadership community to provide a compassionate, diverse, inclusive, effective, sustainable and safe work culture. The requirement to support and encourage a culture of speaking up is being emphasised within our development programmes for new and existing managers. • Induction: induction sessions for every new member of staff (now held every Monday) and the new induction programme for Medical Consultants both emphasise the duty to speak up and to support staff to feel safe to do so. • Job Descriptions: a project is in progress to update Job Descriptions and Person Specifications, including to capture either the requirement to facilitate speaking up (particularly for managers) or the duty to speak up for everyone. The NEDs are assured that the Trust Executive and leadership team are committed to an open and transparent culture where staff feel safe to speak up; that the cultural barriers to making that transformation are identified and understood; and that plans are in place and being implemented to deliver improvements. Specifically as regards the FTSU service, the NEDs are assured that plans are in place or under development to implement recommendations made by The Guardian Service and to improve its effectiveness. As regards the recent media reports, the Trust has consistently stated that it has never dismissed anyone for raising concerns and never will. Following detailed discussions with the Executives and the Trust's advisers in respect of that case, the NEDs are assured with regard to that statement.
Closed?	Closed at the Council of Governors meeting on 13 June 2024.

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	The Council of Governors discussed the question at their meeting on 13 June 2024 and agreed to close this as it was not an appropriate assurance question.
Closed?	Closed at the Council of Governors meeting on 13 June 2024.

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.

1.0 Overview

The purpose of this paper is to provide an update to RUH Governors regarding delays in ambulance handovers and to address concerns regarding the care provided to patients whilst they are waiting in ambulances. There are significant delays in RUH colleagues taking over the care of patients but there is no evidence that patients have not in the meantime had their care and dignity needs met by paramedics who remain with patients whilst waiting to handover to RUH colleagues.

There are three key metrics to objectively measure performance in this area:

1.1. The national standard for ambulance handover delivery is 90% of patients arriving by ambulance are handed over to the receiving hospital within 30 minutes of arrival. For February 2024, the RUH validated performance was 40.8% of patients handed over within 30 minutes.

1.2. The South West Ambulance Trust (SWAST) monitors how many hours are lost per day of ambulance crew time, when patients are not able to be handed over to Emergency Department staff and therefore patients are delayed in ambulances. For the period 26th February – 26th March 2024, the RUH had a daily average time lost of 57.8 hours per day. In comparison to the other Trusts within the South West, this the RUH is ranked 15th out of a total of 19 Trusts in terms of the number of hours delayed (appendix one).

1.3. During the same period, against the average handover time metric (average number of hours lost per ambulance attending the ED), the RUH was ranked 14th with a time of 1.2 hours.

2.0 Improvements to address ambulance delays

An improvement plan is in place to support the reduction in ambulance handover delays. This forms part of the Trust 4-hour recovery plan and key to improvement will be the ward discharge improvement as all contribute to the challenges of handing over patients from paramedics within 30 minutes.

The key actions, which are reviewed daily, weekly and reported monthly as part of the Medicine Division performance review meetings, are as follows:

• Site and Divisional Teams to support the ambulance handover performance:
  o Embed near real-time monitoring and early escalation when ambulances are on route and will be unable to offload their patient
  o Maximise our Ambulance Cohort Areas; both of which became functional towards the end of 2023. The RUH has made two Cohort Areas: available from 18:00 – 12:00 daily (18 hours a day). The RUH has an escalation process in place that reviews the use of Cohort Areas outside of these hours, if there is increased pressure on ambulance offloads
  o The X-CAD system does not support all ambulances that arrive at the Trust. Therefore, we are working with the other providers to ensure processes are fully embedded and accurate data is collected.
• The ED Consultant job plans are being reviewed to ensure Rapid Assessment and Treatment is rostered to ensure enhanced safety of ambulance arrivals, especially at times of non-offloading which occur during periods of high demand (early evening and weekends). Individual job planning within the Emergency Department has been completed, and the next step is departmental job planning, which is currently being undertaken with support from the Medical Division and Chief Medical Officer.

• Patients that arrive by ambulance are triaged via a process called Pitstop. There are specific actions that the Emergency Department team are undertaking to optimise Pitstop.
  o Adopt and standardise the role of an Ambulance Triage Nurse to enable rapid handover of crews at the hospital
  o Review of the ED Consultants' clinical time to support more allocation to Rapid Assessment and Triage (RAT) in Pitstop
  o Monitoring the process and adherence to the dual pin sign-off which is required to hand patients over
  o During the pitstop process there is a rapid assessment of the patient's condition and, if there is no cubicle available the patient's suitability to wait in an ambulance supported by paramedic crews.
• If a patient is waiting in an ambulance their clinical status is continually monitored by the paramedic crews who liaise with the RUH Emergency Team if there is a change in condition. In addition, there is usually during periods of high demand a paramedic based in the Emergency Department who undertakes a Hospital Ambulance Liaison Officer (HALO) role whose role is to support getting ambulances back out on the road, and reduce delays, and supporting patients' safety. All incidents relating to ambulance delays are recorded prospectively on Datix and investigated.
• Towards the end of 2023, a new IT system, called X-CAD, was implemented by SWAST to operate, and analyse ambulance data. There have been some issues across the whole of the South West with this implementation and the RUH continues to be part of a working group chaired by NHS England to identify improvements to the accuracy of data recording and standardise processes. Daily validation of the data provided by SWAST and exception report. The RUH are working with SWAST to ensure clear training is in place for all staff, as well as consistency in how the Hospital Ambulance Liaison Officer (HALO) role functions.

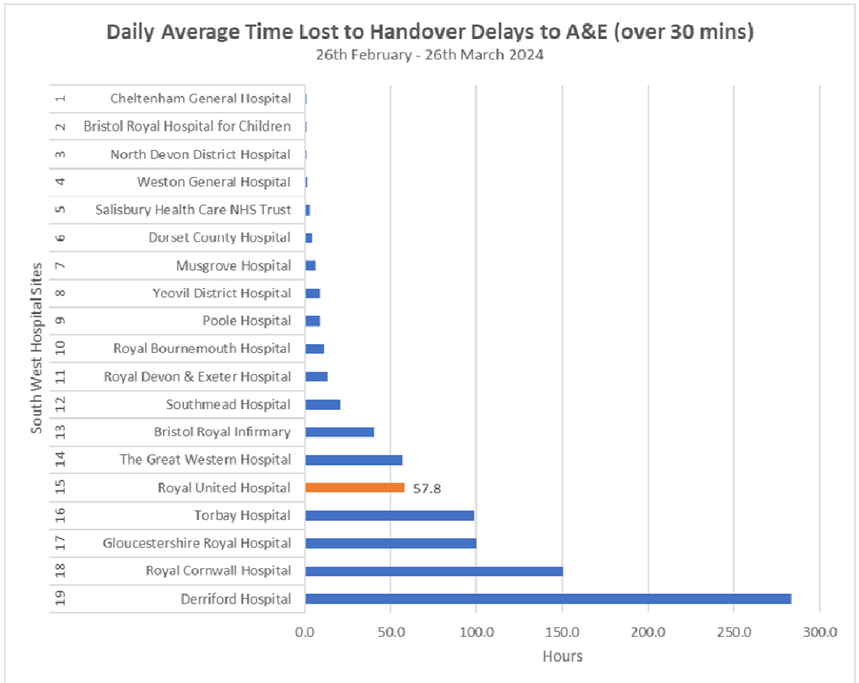
Answer

During periods of not being able to offload ambulances, all patients are clinically reviewed to ensure that they are safe to be transferred back into an ambulance. The paramedic crews always remain with the patient, and should the patient deteriorate, they are immediate transferred into the Emergency Department. All patients are recorded on the RUH IT system (FirstNet) so that the Nurse in Charge and Emergency Physician in Charge are aware, at all times, of the patients that remain in ambulances. Whilst patients are in ambulances, should it be required, then a patient is taken to the lavatory within the Emergency Department and should they not be mobile enough, then a bedpan will be used. Food and drink are given to patients who are not offloaded as well as, additional blankets and pillows sought.

The RUH also continues to work with colleagues from across the BSW system to minimise the delays in transferring patients from an ambulance to the emergency department, which during periods of high demand will involve collaboratively working to direct ambulances that are equidistant from two Emergency Departments to attend the one with the shortest waiting time. Work is also underway with system colleagues, supported by the RUH Deputy Chief Nurse to report on the effect of ambulance delays on patients' clinical outcomes.

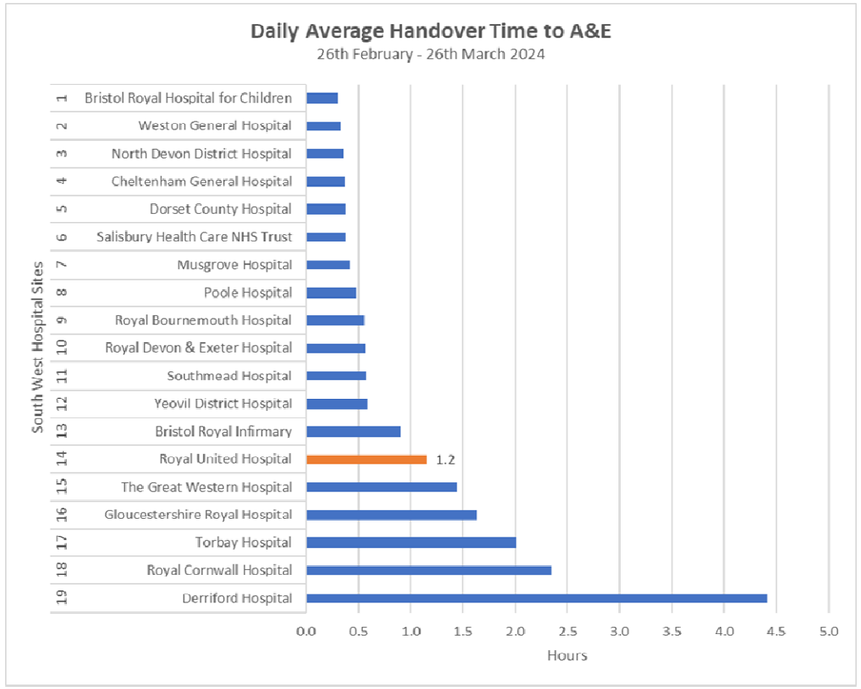
Appendix One: Ambulance delays

• 'Time Lost' is the time over 30 minutes that a patient is awaiting handover from the SWASFT ambulance to the Emergency Department (A&E). The clock starts when an ambulance arrives at A&E and ends when the patient moves into the A&E department.
• The figures in the graph below are displayed as a daily average for the last 30 days (26th February to 26th March 2024).
• The RUH is placed at 15th (of 19) in the South West, with an average of 57.8 hours per day 'lost'.
• This metric is affected by the volume of ambulances conveyed to each hospital site. Sites with a higher volume may have a higher amount of 'time lost', despite having a lower average handover time.



Average Handover Time

• This chart shows the average time that a patient waits for a handover, from the SWASFT ambulance arrival at hospital to being handed over to the Emergency Department (A&E).
• The figures are shown as a daily average for the last 30 days (26th February to 26th March 2024).
• The RUH is placed at 14th (of 19) in the South West, with an average of 1.2 hours per patient handover.



Date: 07/04/24
Key authors: Sarah Hudson, Jason Lugg, Shaun Lomax, Nasima Mamun and Paran Govender

Closed?	Closed at the Council of Governors meeting on 13 June 2024.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Board of Directors**	**Agenda item:**	**8**
Date of Meeting:	**22 July 2024**		

Title of Report:	**Staff Story**
Status:	**For discussion**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Mark Doblas, Lead Clinical Practice Facilitator**
Appendices	**Appendix 1: Staff Story Presentation**

1. Executive Summary of the Report

In the NHS, fostering leadership amongst Global Majority staff is pivotal for enhancing organisational efficiency, inclusivity, and patient care. The Global Majority workforce, bring a wealth of knowledge and experience to help improve the services we offer.

In the RUH, we are committed to investing in our people through celebrating each other's difference to make a difference. This resonates with our Trust values of 'e*veryone matters'* and our vision for '*the people we work with',* giving our staff equitable support to be at their best and make them feel valued and that we appreciate their contribution to the organisation.

A few of our staff have successfully completed the NHS England Southwest Regional Developing Aspirant Leaders Programme. Within the Trust, we have developed "Routes to Success" as part of our Positive Action Programme. Both programmes are aimed at supporting colleagues from the Global Majority to gain the confidence and the ability to move forward in their career.

Developing Aspirant Leader's Programme

This is aimed at supporting staff become a senior leader (Band 7s and above) in the Southwest region from the Global Majority and is run by NHS England following good results from its original pilot in the Midlands. On the first cohort, 5 out of the 15 participants in the region are RUH staff who successfully completed the course with a project aimed at improving the service in their respective expertise. This programme is on its 2nd cohort with 1 staff from the RUH currently completing the first half of the course.

Routes to Success

This programme supports RUH staff at the start of their leadership journey in Band 5 and Band 6 roles from the Global Majority across Nursing, Midwifery and Allied Health Professions. The programme was developed in collaboration with Yvonne Coghill CBE and Inspiring Hope in delivering the training to 21 RUH employees.

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

- Provide a personal and relatable perspective beyond the numbers and data of an organisation
- Underscore the importance of having a workforce that reflects a variety of perspectives and experiences and helps in the understanding of the challenges and opportunities faced by employees from different cultural backgrounds

enhancing cultural competence; diversity and inclusion; and drives engagement and retention.
- Highlights the impact of supporting staff and providing equitable support regardless of background, race or ethnicity and showing how policies, decisions, and programmes affect the development of employees that translates to better patient experience.
- Celebrating success and recognising the hard work and dedication employees, boosting morale and motivation.

Background and context

Our Workforce Race Equality Standards (WRES) data show that there is not an equal playing field for Global Majority staff in terms of career progression and likelihood of being appointed to a role following shortlisting, the Trust has a responsibility to address this.

Impact on the staff from the Global Majority

1. **Professional Development and Career Advancement**
   Access to networks, platforms and exposure where they can demonstrate their enhanced skills such as strategic thinking, decision-making, conflict resolution and effective communication opening opportunities for promotion.
2. **Individual Empowerment and Confidence**
   Boosts confidence and self-efficacy empowering them to take on leadership roles. Also, this creates leadership network connecting to other staff from various specialties, sponsors and senior leaders, and mentors and peers.
3. **Retention and Job Satisfaction**
   Through the Trust's commitment to their professional development, staff supported see clear paths to advancement and are more engaged and motivated leading to higher job satisfaction and retention.
4. **Organisational Impact**
   Leadership from diverse backgrounds creates a more inclusive decision-making fostering innovation, broader insights and creative problem-solving.

Actions and next steps

- Supporting more staff to gain access to national, regional or Trust wide leadership trainings.
- Create continuous support to Global Majority colleagues that is sustainable and accessible.
- Explore options at increasing likelihood of Global Majority staff being accelerated in the recruitment process after completion of leadership courses such as Developing Aspirant Leaders or Routes to Success.

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

3.	**Legal / Regulatory Implications**
Equality Act of 2010 to implement positive action measures to support underrepresented groups overcome disadvantages, access equitable support, and	

encourage participation where it is disproportionately low.

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

5.	Resources Implications (Financial / staffing)
To support the NHS Long Term Plan with its 50k programme, NHS England has provided funding for overseas recruitment to achieve this goal. In the Southwest, an exponential growth in terms of the number of global majority colleagues working in various healthcare professions in the region is evident in the past 4 years. This has an impact on the diversity of the workforce in the organisation and the need to support them thrive in their career to drive job satisfaction and employee retention.	

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

7.	References to previous reports
None.	

8.	Freedom of Information
Public.	

9.	Sustainability
n/a	

10.	Digital
n/a	

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Staff Story

Developing our nursing, midwifery & Allied Health colleagues

The RUH, where you matter

Routes to Success Course

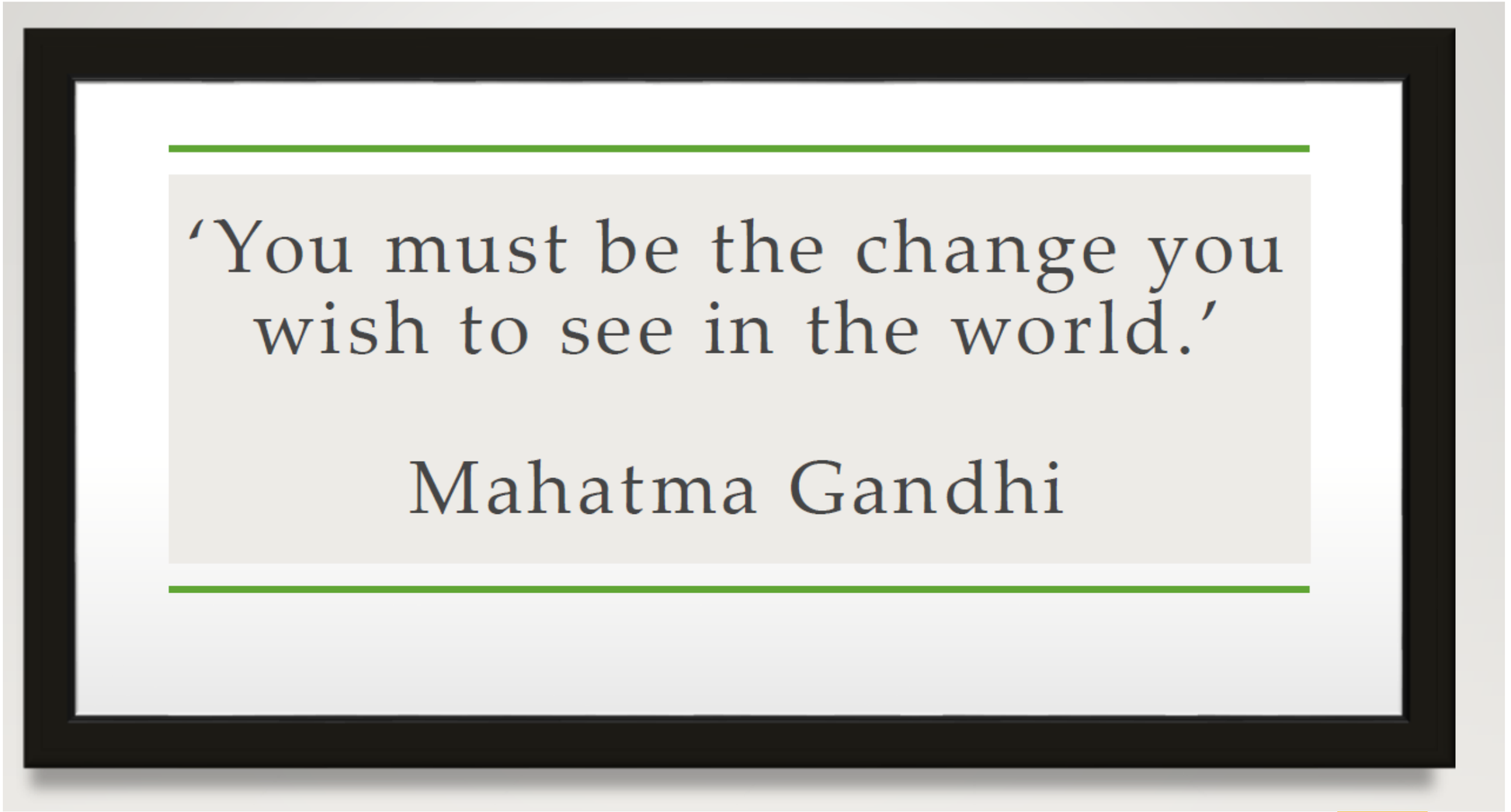
Kebalebile Galedibelwe
Staff Nurse, Biologics Units

The RUH, where you matter

Routes to Success

KEBALEBILE GALEDIBELWE

The RUH, where you matter


‘You must be the change you wish to see in the world.’
Mahatma Gandhi

Thank you

- RUH Board of Directors
- Routes to Success Facilitators
- Ward Managers and Teams

KEY LEARNING FROM ROUTES TO SUCCESS

- To know thyself- Authenticity.
- Developing confidence self.
- Directors' stories of their career journeys.
- Making a positive impact.
- Increased knowledge and understanding about the NHS.

IMPACT ON THE ORGARNISATION

EMPOWERED LEADERS

DELIVERING GOOD STANDARD CARE THAT MEETS CQC TARGETS

PROMOTING INCLUSIVITY AND DIVERSITY

BENEFITS OF ROUTES TO SUCCESS TO STAFF

- New leadership roles
- Increased confidence in applying for leadership roles
- Increased self confidence
- Self awareness of authentic self
- Resilience
- Motivating and supporting into leadership roles

Summary

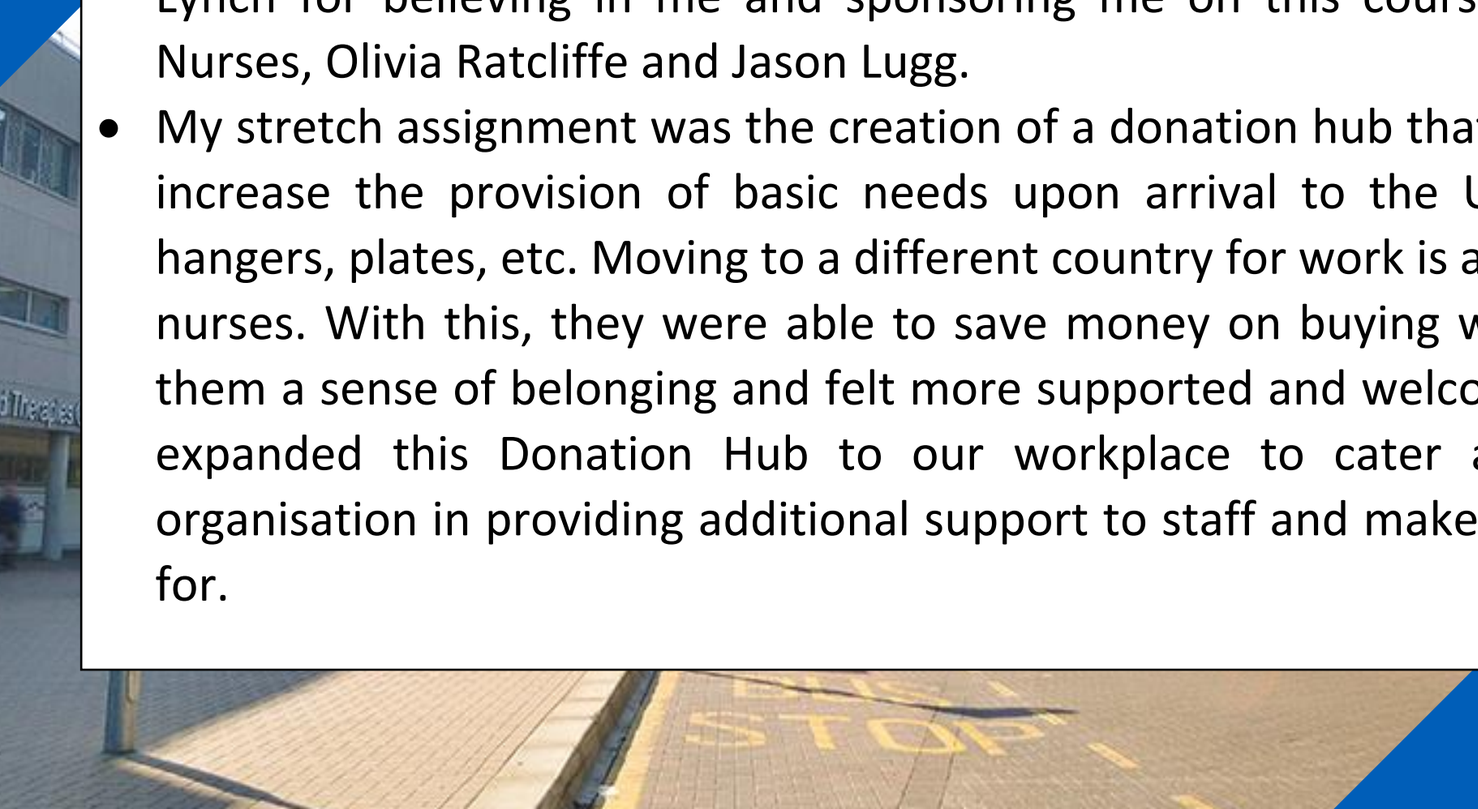
- The impact of Routes To Success has added to ongoing diversity in leadership and will continue to optimise personalised care to our diversified clientele.

Developing Aspirant Leadership Programme for Global Majority Nurses and Midwives

Ruel Donaire
Senior Clinical Practice Facilitator

THE IMPACT OF THE COURSE

- There are a lot of things that I learned all throughout the course. One is understanding the right leadership for me, discovering & exploring my strengths and weaknesses rather than comparing it with other leaders and enhancing that leadership style tailoring it to the need of my team. Lastly, is the growth of my confidence all throughout this course. As a global majority, I felt empowered and fully supported and I didn't even expect that progressing in my career in a span of 2 years is a possibility in a different country for which I am very thankful to the organisation, especially to Toni Lynch for believing in me and sponsoring me on this course and of course our Deputy Chief Nurses, Olivia Ratcliffe and Jason Lugg.
- My stretch assignment was the creation of a donation hub that helped our International nurses to increase the provision of basic needs upon arrival to the UK especially with coats, cutleries, hangers, plates, etc. Moving to a different country for work is a significant change for international nurses. With this, they were able to save money on buying winter clothes and cutleries. It gave them a sense of belonging and felt more supported and welcomed to the trust. Right now, I have expanded this Donation Hub to our workplace to cater all staff which will also help the organisation in providing additional support to staff and make a difference to the people we care for.



Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Board of Directors	Agenda item:	9.0
Date of Meeting:	22nd July 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
- Finance
- People
- NHS Oversight Framework Segmentation Review – Quarter 4 2023/24
- Junior Doctors Industrial Action
- Nurses Paid Breaks
- Annual Awards Ceremony
- The RUH celebrates 21,000 hours of volunteering
- RUH unveils expanded Maternity Outpatients Department
- Patients and Staff in Bath, Salisbury and Swindon to benefit from a new Shared Electronic Record
- Paediatric Team host 'teddy bear hospital' Event for Local Community
- RUH Membership
- Mendip (Somerset) By-Election
- 2024 Annual General Meeting
- 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 24/25 has started well with the strong position for M1 continuing into M2, despite unforeseen challenges such as the closure of the Modular Theatre for 10 days. We delivered 113% of 19/20 activity and 101% of our 24/25 M2 activity plan. This translates into a financial performance of 119% of 19/20 and 104% of our M2 24/25 plan. This has delivered a surplus of over £322k in-month and over £1m year-to-date, with Day Case and Outpatient new attendances being the significant contributors to this position.

In April, the 62 Day cancer performance was 74.8%, a further improvement above the 70% target set by NHSE in the 2024/25 Operational Planning Guidance. Urology recorded the most breaches with two thirds being for prostate patients, but performance remained above 70%. MRI scans were the most frequent contributing factor, although waiting times for joint clinic appointments post-MDT also led to breaches. Colorectal remained the most challenged pathway, although performance did improve to 46%. Diagnostic waiting times continued to be the common factors in breaches. We recognise that we are not yet achieving the standard required across each specialty, continuing to improve access to services remain a key priority. Lung performance also improved with surgical waiting times at UHBW continuing to reduce.

28 Day Cancer Faster Diagnosis Standard performance improved to 69.0% but remained below the 77% target, as a result of the performance the RUH is being placed into NHSE tiering. The top contributor to performance is Colorectal, with breaches due to outpatient and diagnostic waiting times. Histology waiting times are increasing for most tumour sites due to Consultant Pathologist vacancies and increasing demand. There is a further risk to performance from June due to increasing waiting times for first urgent suspected Cancer appointments in Skin and Urology, both impacting by increasing demand and consultant vacancies. An increase in Endoscopy capacity has been agreed through creation of additional recovery space in the department, and in Radiology with the use of extra mobile units supported by Cancer Alliance funding. An insourcing proposal for Skin first appointments is in the final stages of review, with plans in place to proceed rapidly within the month pending approval of the case. Recovery of the position in Skin is expected to be achieved by the end of August. A longer term plan is in development to ensure the position can be maintained beyond the end of the proposed insourcing contract. The Urology team have agreed additional capacity with Sulis, allowing the RUH team to increase ring-fenced capacity to reduce the waiting time for first appointments on the cancer pathway from August.

An action plan is in place and a trajectory for improvement at Trust-level is reviewed with NHSE.

The national operational standard for diagnostics is 95% to be delivered within 6 weeks (DMO1) by the end of March 2025. In May 2024, >6-week performance was 71.77%, a deterioration compared to 76.61% in April and not in line with the trajectory for May of 81.1%. The number of patients waiting more than 6 weeks has increased in month by 4.84% accounting for the deterioration in performance between April and May which is equivalent to an additional 872 patients breaching. Performance has been affected by an increase in demand for diagnostics (13% across all modalities since April 2024), with a noted increase in the suspected cancer referral cohort, which impacts directly on the

available capacity for the routine 6-week (DM01) activity. The diagnostic modalities of MRI, Sleep Studies and Ultrasound remain the top contributors to adverse performance. Additional capacity will be coming online from July 2024, with additional CT and MRI mobile capacity on the Combe Park site and increased capacity at Sulis. Year to date Sulis – Community Diagnostic Centre (CDC) has delivered 1957 diagnostic investigations and have a further 714 patients booked for June 2024. Focus for June is to recover the performance across all modalities in line with the revised performance trajectory, including additional activity provided by Sulis-CDC at the weekend for colonoscopy and CT/MRI and the option for a mobile endoscopy unit to support colonoscopy recovery from October 2024.

In May, the Trust lost a total of 2,296 hours in ambulance handovers, a reduction from the previous month. The percentage of ambulances handed over within 30 minutes also improved in May (42.7%). Through the BSW ambulance handover improvement group, there is an action to review the handover process with SWASFT to align across BSW aiming to streamline processes and improve quality standards, including patients seen within 15 minutes of arrival. The Urgent and Emergency Care (UEC) improvement plan will support flow out of the Emergency Department, which will increase the number of patients handed over within 30 minutes. The RUH is continuing to experience discrepancies regarding ambulance handover data in May, which, following validation, totalled 132 hours which would make our hours lost position for May 2,164 hours. Work continues with SWASFT as the hours lost relate to SWASFT processes which include leaving the Combe Park site freeing capacity for the next ambulance arrival. Ensuring that we are able to off load ambulances as quickly as possible is a key priority for us. We recognise that this causes stress and anxiety for our population but have in place a comprehensive recovery plan to enable us to sustainably improve our services.

RUH 4-hour performance in May was 68.6% and 60.0% on the RUH footprint (below the unmapped trajectory of 70.05%). This was the same position as April 2024. Attendances during May were 9,121, an increase from April and the second highest monthly attendances seen through the Emergency Department. The non-admitted 4-hour performance was adverse to plan due to an increase in the predicted number of attendances to the Urgent Treatment Centre, and the current staffing model not able to support this demand level to deliver within 4 hours. Admitted performance was affected by an increase in the occupancy of patients without a criteria to reside (92 patients), occupancy at 94% (target 92%) and ward discharges occurring after midday. Improvement in performance will be supported by the delivery of the UEC improvement plan, specifically the integrated front door workstream for non-admitted 4- hour performance and the In Hospital workstream which will support the 4-hour admitted pathway recovery.

2. Finance - RUH M2 Performance

The RUH Group (Trust & Sulis) I&E position is -£4.1m, which is £0.1m adverse to plan. Savings of £3.1m have been delivered to date (8.5% of the annual target). Both pay and income performed well, but non-pay is overspent by £0.5m predominately across supplier and services, which is being investigated.

The QIPP Programme was broadly on target at M2 reporting a slight adverse variance of £0.06m against a plan of £3.2m. Clinical productivity underperformed against plan (driven in part due to the modular theatre being out of action for 10 days) and there was a slight under-performance in non-pay, although both were largely offset by additional performance in pay.

A detailed forecasting exercise for both the I&E and QIPP positions is due to commence in M3 and will report regularly thereafter.

3. People

A key focus throughout 2024/25 will be the delivery of the programmes within the 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.

The immediate priorities within our People agenda will be to continue our work around pay efficiencies, improve how we manage sickness absence and achieve a 90% appraisal uptake.

Recently we introduced Wagestream, which is our toolkit of simple-to-use financial products and services. Wagestream offers colleagues flexible pay, a budgeting tool, the opportunity to build a pot (put money aside each month) and a benefits checker.

To date Wagestream has been used by 1052 colleagues, here are the key highlights:

- 305 colleagues used flexible pay in May 2024
- Since launch, £939,390 has been advanced with zero impact on organisational cash flow
- The top 3 reasons for using flexible pay: Bills (35%), Groceries (17%) and Shopping (17%)
- 111 colleagues checked their government benefits (76% of Wagestream users who complete the checker are entitled to £563)
- 787 colleagues use track, on average 11 times a month to support with budgeting and money management
- Colleagues have built up £40k in build pots

Whilst Wagestream has been a success, it is also a timely reminder of the financial challenges colleagues across our organisation face, which is why a key part of our People Plan focuses on well-being.

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

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

We continue to develop the People Hub, which is our 'one stop shop' in the people directorate for managing HR and medical workforce queries.

Following the procurement of the Halo HR portal, we are now working through our requirements for an employee relations case management system and the self-service portal. This work is being undertaken in partnership with IM&T colleagues who are also using the system. The Halo build is now underway with an expected launch of the case management system in July 2024 and the self-service portal in Q3. Later functionality in 2024 will be incorporating a chat bot, providing another method for colleagues to get support from the People function.

Starting in July 2024, we are rolling out Supporting Attendance training both face to face and virtually. Work is also beginning on new guidance for conducting investigations and flexible working requests.

<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 Anti-Racist statement launched in March 2024 and 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 early July 2024 (to coincide with launch of the Dignity at Work Policy), is linked with RUH People Hub and enables better, swifter support to areas most affected by discrimination. Report and Support enables anonymous reporting to help create psychological safety for those reporting. Other central support to the operational team's interventions include:

- A network of Inclusion Champions has now been launched
- The next cohort of Positive Action Programme (Routes to Success) in planned for the autumn
- The pre-recruitment stage for Independent Advisors (RCN Cultural Ambassadors)

<u>People Plan Programme 6 – Health and Well-being</u>
A new Employee Assistance Programme (EAP) was introduced in June 2024, this now includes the ability for managers to refer (with consent). This model will improve the targeting of well-being support to RUH colleagues.

<u>People Plan Programme 7 – Leadership</u>
Design of organisational leadership development offer/framework is underway with the Coach House and Strategy Team, and in collaboration with the Improvement Programme Lead. Focus is on change management and effective leadership in times of transformation. Uptake of leadership apprentices is increasing, and we continue to work with WHI Consulting for senior leadership development.

An Appraisal A3 has been developed with the Improving Together team to support increased compliance, which is currently falling short of our 90% target. Outcomes were presented to the People Committee and Trust Management Executive. In June, 360 feedback has been launched in Learn Together, which supports the drive to improve appraisal rates.

<u>People Plan Programme 9 – Talent Acquisition</u>
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.

<u>People Plan Programme 10 – Temporary Staffing</u>
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.

We continue to review our People Plan and the priorities within in it to ensure it continues to enable our organisational objectives.

4. NHS Oversight Framework Segmentation Review – Quarter 4 2023/24

Under the NHS Oversight Framework, NHS England is required to work with Integrated Care Boards to conduct a quarterly segmentation review of NHS Provider Trusts. The outcome of the RUH's review for Quarter 4, 2023/2024, took place in April 2024 and focussed on identifying areas of improvement and/or deterioration against previously flagged challenges. It also highlighted, by exception, any new areas requiring further consideration, and detailed any required exit criteria and/or support, to improve performance and quality of care outcomes for patients.

The segmentation review for the Trust identified a number of areas of challenge, following a meeting of the NHS England Regional Support Group, it was agreed that the Trust would remain in segment 3 for Quarter 4, 2023/24. This was based on the following Oversight Framework metrics:

- Cancer (62-day backlog)
- Finance (Efficiency, Stability and Agency Spend)

The Trust has a comprehensive improvement programme in place which we are monitoring through our Finance and Performance Committee.

During the review, the NHS England Regional Support Group recognised an improvement within Urgent and Emergency Care (Proportion of patients seen within four hours) and Elective (Diagnostics). Therefore, these areas are no longer within the above list.

Further information regarding the NHS Oversight Framework can be found via https://www.england.nhs.uk/publication/nhs-oversight-framework-22-23/

5. Junior Doctors Industrial Action

RUH Junior Doctors participated in further industrial action beginning at 7am on Thursday 27th June 2024 and ending at 7am on Tuesday 2nd July. In line with Great Western Hospital and Salisbury NHS Foundation Trusts, the Trust declared a Business Continuity Incident for the entirety of the strike period. The Trust, led by the Deputy Chief Medical Officer, Chief Operating Officer, Chief Nurse and Director for People and Culture put plans in place to respond.

As with previous strike activity, the Trust worked to prioritise resources to protect emergency treatment, critical care, neonatal care, maternity, and trauma, and maintain planned and routine care where safe to do so. Additionally, this strike fell on the weekend of Glastonbury Festival, which had the further pressure of an additional 200,000 people visiting the region. Our Emergency Preparedness Resilience and Response Team worked closely with the Glastonbury Health Information Centre to prepare for this and were commended for their hard work by the NHS South West.

At time of writing there has been no further notice of future planned industrial action.

6. Nurses Paid Breaks

In 2016 the Trust agreed to pay for a 30 minute break for Nurses, Midwives and Allied Health Professionals working greater than 12 hour shifts, this was in addition to their 30

minute unpaid break. Paid breaks were introduced at a time when the Trust had high vacancy levels which resulted in colleagues being unable to take their breaks.

Over the last 2.5 years the Trust has increased its workforce and significantly reduced its vacancies and therefore the Trust recently held a consultation to remove the 30 minute paid breaks from shifts greater than 12 hours, reverting back to the 60 minute unpaid break. The reasons for this are:

1. Nurses, Midwives and Allied Health Professionals do not receive a paid break as part of agenda for change agreement
2. Nurses, Midwives, Allied Health Professionals do not receive a paid break working other shift patterns i.e. 7.5 hour shifts, therefore the current system is inequitable
3. Benchmarking with other Trusts, identified that other NHS Trusts do not pay Nurses, Midwives and Allied Health Professionals for a paid break
4. The Trust, like all others in the NHS is being asked to be more financially efficient to meet the financial targets agreed with the Integrated Care System.

As part of the Consultation the Trust engaged widely with colleagues, working in collaboration with Staff Side. The outcome of the consultation was to implement the change from 2 September 2024, the decision outcome has generated a significant response from some of our colleagues as detailed in the recent coverage in local and national media. The Trust continues to be committed to ensuring that staff receive their break during their shift.

7. Annual Awards Ceremony

The Trust held the 2023/24 Annual You Matter Awards Ceremony on Friday, 17th May 2024 at Bath Pavilion where we celebrated the highest standards of care, compassion and innovation.

More awards than ever before were presented at the event, selected from over 130 nominations in 16 categories. Staff were thanked for their exceptional dedication to people they care for, the people they work with and people in the wider community.

Staff were also recognised for 25, 35 and 45 years of service.

Here is the full list of winners:

- Working Together Annual Award: Preceptorship team
- Making a Difference Annual Award: Dental Nurse Lorraine Forrester and Pharmacist David Skirrow
- Everyone Matters Annual Award: Talent Manager for Nursing Helen Slocombe
- Chief Executive's Outstanding Achievement Award: Director of Midwifery Zita Martinez
- Chair and Chief Executive's Outstanding Service Award: Senior Executive Assistant Helen Perkins
- Rising Star Award: Staff Nurse Vhari Macfadyen
- Leader of the Year: Consultant Oncoplastic Breast Surgeon and Clinical Lead Nicky Laurence
- Wellbeing at Work Award: Retention Lead Midwife Jess Murray
- Equality, Diversity and Inclusion Award: Estates Officer Nicky Bonner
- Kindness and Civility Award: Occupational Therapist Anna Hill
- Personal Achievement Award: Infection Control Nurse Dana Di.Iulio

- Patient Safety Award: Anaesthetist Ronan Hanratty
- Research and Innovation Award: Non-Invasive Parameters of Pulmonary Hypertension in Systemic Sclerosis project
- Working with our Community Award: Junior Charge Nurse Manny Mabulay
- Student of the Year: Clinical Research Practitioner Victoria Page
- Volunteer of the Year: Children's Therapies Volunteer Bob Gavin

8. The RUH celebrates 21,000 hours of volunteering

The RUH hosted a special party at the start of June to celebrate the invaluable contribution of volunteers to the hospital. The event kicked off National Volunteers' Week 2024, during which charities and organisations such as the RUH thank all those who give their time to help others.

In 2023, around 250 people volunteered with the RUH, ranging from 16-year-olds participating in the NHS Cadets programme, up to people in their 80s. Together, they gave 21,000 hours of time – with 71 individuals helping for more than 100 hours each. Receiving specialist training for their roles, the volunteers offer both practical and emotional support to those at all stages of a hospital journey, from the Welcome Volunteers in the Atrium who help visitors find their way around, to the Dorothy House Compassionate Companions who sit with end-of-life patients to ensure they are not alone.

9. RUH Unveils Expanded Maternity Outpatients Department

The Maternity Outpatients department has been redesigned to provide more capacity for women and pregnant people attending urgent and routine antenatal care.

It has been refurbished so that women and pregnant people attending pre-booked appointments at the maternity day assessment unit on the Combe Park site will be cared for in a new calming space on the first floor.

Urgent and non-routine care will now be facilitated in the new maternity triage area on the ground floor of the hospital's Princess Anne Wing, which consists of an extra five private consulting bays, providing a better experience.

10. Patients and Staff in Bath, Salisbury and Swindon to benefit from a new Shared Electronic Record

The three Trusts that form the Acute Hospital Alliance - Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust - have embarked on a new programme to implement a new shared Electronic Patient Record (EPR) across the three organisations

.

With backing from the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB), the significant investment over the 23/24 – 26/27 financial years will enable clinical staff within the region to digitally share patient information between Trusts.

The Shared EPR will ensure that staff have access to health-related information when and where it is needed, supporting them to deliver care efficiently, effectively and safely. In addition, it will help to reduce variations in care across the region and improve outcomes for patients.

11. Paediatric Team host 'teddy bear hospital' Event for Local Community

The RUH hosted a free event on 15th June 2024 to give primary school children the opportunity to experience a visit to the RUH in relaxed circumstances, and to give them lots of handy hints on looking after their own health at home.

Their visits replicated what it might be like to come to hospital: when they arrived, the children and their cuddly charges were first triaged at the nurses' station, before seeing a doctor to get their toy's legs, arms or tail plastered.

The day was organised and run by volunteers and children's ward staff.

12. Membership

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

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

13. Mendip (Somerset) By-Election

We recently held a by-election to elect a Public Governor within the Mendip (Somerset) constituency. The election was uncontested and our new Governor is Chris Norman. Mr Norman will begin his induction over the coming weeks, I would like to take this opportunity to welcome Chris to RUH and we look forward to working with him.

14. 2024 Annual General Meeting

This September the Trust will be holding it's Annual General Meeting combined with Annual Members Meeting on 17th September at the Apex City of Bath Hotel, James Street West, Bath, BA1 2DA.

Last year's AGM was a huge success and we welcomed 150 members to the event. We hope that this year will prover to be even more successful, so please save the date and share the details with friends and family.

More details regarding the AGM agenda will be shared over the coming weeks on our website and directly to members, but this will be your opportunity to hear about the work the Trust has been doing over the past year and there will be an opportunity to ask questions to the Board.

15. Consultant Appointments

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

Dr Sheila Jen, Clinical Fellow (Year 7 Specialty Trainee) at North Bristol NHS Trust was appointed as a Consultant Haematologist on 29th April 2024. Dr Jen will start at the Trust on the 30th September 2024.

Mr Paolo Scollo, Senior Clinical Fellow at John Radcliffe Oxford University Hospitals, was appointed at a Consultant ophthalmologist on 29th May 2024. Mr Scollo will commence his role at the Trust on 16th September 2024.

Dr Alison Montgomery, Year 7 Specialty Trainee at University Hospitals Bristol & Weston NHS Foundation Trust was appointed at a Consultant Gynaecological Oncologist on 12th June 2024. Dr Montgomery's start date with the RUH has not yet been confirmed.

Mr Andrew Brown, Year 7 Specialty Trainee at North Bristol NHS Trust was appointed as a Consultant in Urological Robotic Surgery on 18th June 2024. Mr Brown will commence his role at the Trust on 14th October 2024.

16. Chairs Update

In addition to the routine interviewing of consultants and completing appraisals of the Non Executive Board members, I chaired the Steering Group responsible for bidding for the BSW Community tender and the Members' Board of Wiltshire Health and Care, both responding to the challenges of managing demand through better community based services. With colleagues from BSW I have contributed to the development of our understanding of the potential benefits of closer Group working discussed on other papers at this meeting.

I was lucky enough to attend three delightful events – the Staff Awards Dinner, the MJ Church Race Day raising over £70000 for RUHX, and the Bath Cancer Unit Support Group's evening celebration of their extraordinary and long lived fundraising achievements. As a member of the BaNES Future Ambitions Board I was honoured to speak at the launching of the BaNES Future Ambition Civic Agreement committing the anchor organisations of BaNES – in particular the universities, the Council and ourselves – to ever greater cooperation for the benefit of the communities we live in and serve.

Meeting of Board of Directors

Report Summary Sheet

Report Title	Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust.					Agenda item		
Date of meeting	22nd July 2024							
Purpose	Note		Agree X		Inform		Assure	
Authors, contact for enquiries	• Ian Green, Chair SFT, Chair AHA Committees in Common • Liam Coleman, Chair GWH, Chair AHA EPR Joint Committee • Alison Ryan, Chair, RUH, Chair AHA-BSW Communities Together Programme • Lisa Thomas, Interim Chief Executive, SFT • Jon Westbrook, Interim Chief Executive, GWH • Cara Charles-Barks, Chief Executive, RUH, AHA SRO • Ben Irvine, Programme Director (ben.irvine@nhs.net)							
Appendices	• *Appendix 1: Draft Joint Committee Terms of Reference*							
This report was reviewed by	• AHA Committees in Common							
Executive summary	Our collective commitment in the NHS is to make a difference for the people we serve. We aim to improve quality and access for the people of BSW, while enhancing opportunities for our staff and responding to the unprecedented financial environment we now face. We know we need a different response to the changing needs of our communities, and we believe that working more closely together, sharing our combined talents and resources, is the best way to do that. We believe we need to be dynamic in response to current challenges and cannot assume significant change in the national NHS and public services economic position. In this context, our report sets out a joint proposal by the Chairs and Chief Executives of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust, to make some changes in the leadership & governance of the three Trusts. We are seeking to better connect our organisations, as simply as possible, to better support front line staff in their delivery of care.							

	Our three Trusts have been working increasingly closely since 2018. We have formalised our relationships with a Committee in Common (made up of CEOs and Chairs of our Trusts), an Electronic Patient Record Joint Committee of Boards, and our Executive teams also meet regularly through the year. However, our collective and individual Trust local performance, present a very challenging position. Increasingly, in relation to performance, we are reviewed and assessed by SW Region and NHSE as a system – e.g. for 4-hour delivery and financial balance and so, it is important that we have governance and management structures that reflect this. We believe it is the right time to accelerate and broaden our collaborative work, increasing our focus on fully realising the benefits of working at scale, reducing unwarranted variation, transforming services for the future, by delivering the opportunities described in the *Case for Collaboration* report, shared with Private Boards in May/June. With this shared ambition we intend to be proactive not reactive; in this paper we are signalling our strategic intent to establish a 'Group'. The report describes: • The case for collaboration and change • Proposed group leadership & governance, developments • Eight Recommendations The realisation of the significant benefits identified in the *Case for Collaboration* will require development in leadership and governance arrangements. Our proposed areas of change in the collaborative leadership, governance, and development of the Trusts are included in the recommendations set out below. • We recognise the importance of clear leadership to help set the vision for our effective collaboration, and the next step towards achieving this should be through our three organisations sharing leaders, identifying a Joint Chief Executive and Joint Chair for our Trusts. Each Foundation Trust will retain its own sovereign board, committed to an agreed roadmap for the Group; this change would not represent a merger of the Trusts. Each Trust will also have a Deputy Chief Executive to support the single CEO. • We will establish a Joint Committee, from September, to enable joint decision-making across GWH, RUH and SFT. This Joint Committee will oversee the plan for realising the case for collaboration, the subsequent delivery programme, and development of the proposed Group model. • In-year priorities and an associated concrete delivery plan will be agreed by executive teams in September, ensuring they enhance and

	align with the 2024/25 operational plan. The Joint Committee will hold Executives accountable for the delivery of this plan. What does this mean for our organisations? • These changes are designed to accelerate successful delivery of transformed sustainable excellent clinical services, in service of the BSW population. We believe that a joint leadership model will improve the delivery of care to local communities. • In establishing a Group, we will maintain three Trusts with their own Governors, Boards and Non-Executive Directors. Each of the hospitals will maintain their own identities reflecting the services they provide and the local population they serve. • GWH, RUH and SFT will provide the main interface with our patients and respond to the needs of our diverse population by ensuring equitable and high-quality safe care. • We are not recommending a merger or change in legal structure, as we do not think such a change would offer value for money or be in the best interests of our populations. The following timeline is proposed and will see vital involvement of Governors and Trust teams in helping shape our next steps: • July. Progress Initial recommendations. Remuneration Committees to convene to confirm process for appointment of Joint-Chief Executive. August-October. Establish Joint Committee to oversee Joint Development Phase. Engagement with Council of Governors regarding move to Joint Chair. Develop delivery plan for in-year priorities. • September-January. Joint Development Phase. Trusts develop target operating model, and strategic framework. Begin delivery of in-year priorities. Appointment of Joint-Chair. • January 25. Joint Committee and Three Boards consideration of proposed Operating Model and Strategic Framework • Q4 – Q1 Implementation of agreed Operating Model.
Equality Impact Assessment	An Equality Impact Assessment of proposed changes been completed.
Recommendation(s)	Boards are invited to approve the following eight recommendations: • *Recommendation 1.* We recognise the importance of clear leadership to help set the vision for our effective collaboration, and the next step towards achieving this should be through our three organisations sharing leaders, identifying a Joint Chief Executive and Joint Chair for our Trusts. Each Trust will retain its own board and this change would not represent a merger of the trusts. Each site will also have a Deputy Chief Executive to support the single CEO. We will progress with the appointment of a joint CEO immediately, convening Remuneration Committees to confirm process and

	timetable. We would like our Governors to come together over the next three months to scope the role of the shared chair, making a proposal to Boards in October, and then appointing to the role in the first quarter of 2025. • *Recommendation 2.* In July and August, the three Chairs will develop a Memorandum of Understanding (MOU) for how they support the Joint Chief Executive during the transition to a Joint Chair. • *Recommendation 3.* We believe that a joint leadership model will improve the delivery of care to local communities by simplifying decision-making, increasing integration, and improving quality. We will create a Joint Committee, from September, to oversee our work together. There will be a clear articulation of the topics overseen by the Joint Committee and those overseen locally; refer Appendix 1, initial Joint Committee Terms of Reference. • *Recommendation 4* We will identify a limited number of areas of work, that are priorities for 2024-25. These must include our *EPR Implementation, BSW Communities Together, stabilisation of the services we deliver and our financial position,* so in coming months we will bring executives and non-executives together to identify collective opportunities to work more efficiently and eliminate unnecessary duplication. An associated concrete delivery plan will be agreed by executive teams in September, ensuring they enhance and align with the 2024/25 operational plan. The Joint Committee will hold Executives accountable for the delivery of this plan. • *Recommendation 5.* Also in 2024-25, we will develop a Group Operating Model that allows us to focus on delivery of outstanding quality services, in a financially sustainable way, freeing-up teams to focus on what matters most to them; our Operating Model proposal will go to boards in January, mobilising in 2025-2026. Supported by a Group Development Team, our local leaders, our non-executives, and our governors will have an important role in shaping how we work, ensuring access, improvement & innovation, embracing standardisation, all in an effective and agile governance environment. • *Recommendation 6.* We will use our Improving Together approach to create our Strategic Planning Framework, using common tools and embedding shared behaviours and improvement culture. Using this framework, with *joint clinical strategy and associated workforce and digital strategies*, we will confirm our transformation programmes for clinical and corporate services. • *Recommendation 7.* We will work with *our partners in health, local government, and the voluntary sector to deliver the BSW Integrated Care Partnership Strategy*, identifying those areas where we work together most effectively at place or neighbourhood and those where partnership working across BSW delivers added benefits to the populations we serve. • *Recommendation 8.* We recognise that the changes of the scale we are proposing will be hard to achieve and that support will be essential as our leaders, teams, non-executives, and governors help

	shape our future together; Organisational Development support for coming years will be secured.							
Risk (associated with the proposal / recommendation)	High		Medium		Low x		N/A	
Key risks	The development of our BSW provider collaborative is in line with national policy and strategic direction on provider collaboration. The eight recommendations in this proposal are designed to address the following risks: • Quality of and access to planned and urgent care we deliver for BSW and local population. There is a risk that we fail to deliver the potential benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery. • Financial sustainability of our acute services. There is a risk that our Trusts fail to deliver the potential financial benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery. • Performance & oversight environment. There is a risk that if the case for collaboration benefits are not pursued as proposed, there will be a decrease in local control owing to deterioration in performance (financial and access to services), leading to great scrutiny, classification in SOF4 leading to mandated external support. • Capacity of Executives to engage in system working. The capacity of executives and senior managers in Trusts is constrained, with competing pressures from what can be irreconcilable internal and system-wide activities. Risk of proceeding with proposed recommendations: • Uncertainty for our staff. Changes may create uncertainty for some staff. *Mitigation and Management*: A comprehensive shared and well-resourced communications and engagement strategy and organisational development programme will be required. • Local ownership. There is a risk that local stakeholders perceive a loss of local ownership or influence at organisation or place level. *Mitigation:* Our communication and engagement plan will be clear that these changes offer the benefits of scale in service of local delivery.							
Impact on quality	The developments proposed are designed to enhance the quality and resilience of health services for the population in BSW.							
Resource implications	Establishment of a group will better enable GWH, RUH and SFT to deliver the benefits identified in the Case for Collaboration, thereby supporting the three							

	Trusts to improve the efficiency and value for money of our services. During the proposed *Joint Development Phase* - Q2 and Q3 2024-25 - a group operating model, with detailed resource implications will be developed by Trust leads, for consideration by Boards.
Conflicts of interest	None known.
This report supports the delivery of the following BSW Integrated Care Strategy Objectives:	☒ Focus on Prevention and Early Intervention ☒ Fairer Health and Wellbeing Outcomes ☒ Excellent Health and Care Services

Title: Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust:

1. Introduction and Context

Our collective commitment in the NHS is to make a difference for the people we serve. We aim to improve quality and access for the people of BSW, while enhancing opportunities for our staff and responding to the unprecedented financial environment we now face. We know we need a different response to the changing needs of our communities and we believe that working more closely together, sharing our combined talents and resources, is the best way to do that. We believe we need to be dynamic in response to current challenges and cannot assume significant change in the national NHS and public services economic position.

In this context, our report sets out a joint proposal by the Chairs and Chief Executives of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust, to make some changes in the leadership & governance of the three Trusts. We are seeking to better connect our organisations, as simply as possible, to better support front line staff in their delivery of care.

Our three Trusts have been working increasingly closely since 2018. We have formalised our relationships with a Committee in Common (made up of CEOs and Chairs of our Trusts), an Electronic Patient Record Joint Committee of Boards, and our Executive teams also meet regularly through the year. However, our collective and individual Trust local performance, present a very challenging position. Increasingly, in relation to performance, we are reviewed and assessed by SW Region and NHSE as a system – e.g. for 4-hour delivery and financial balance and so, it is important that we have governance and management structures that reflect this.

We believe it is the right time to accelerate and broaden our collaborative work, increasing our focus on fully realising the benefits of working at scale, reducing unwarranted variation, transforming services for the future, by delivering the opportunities described in the *Case for Collaboration* report, shared with Private Boards in May/June.

With this shared ambition we intend to be proactive not reactive; in this paper we are signalling our strategic intent to establish a 'Group' (refer sections 3-6 below). The report describes:

- The Case for Collaboration
- Proposed Group Leadership and Governance Developments
- Proposed Timeline, Risks and Eight Recommendations.

National Context

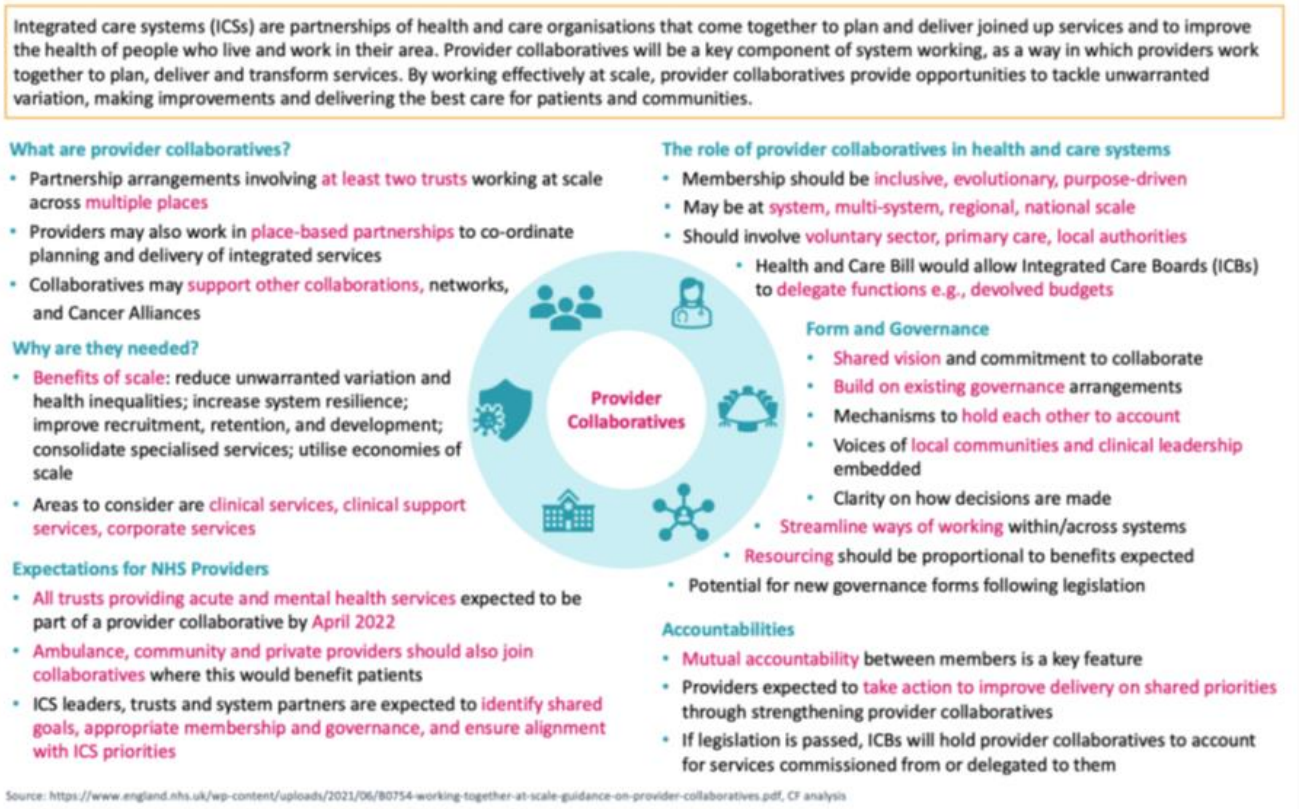
The Health and Care Act (2022)

The 2022 Health and Care Act created Integrated Care Boards (ICBs) as statutory bodies and established a new legislative framework to enable greater collaboration between health and care system partners, including NHS trusts. Provider collaboratives are core to the development of Integrated Care Systems (ICSs), particularly in terms of delivering the quadruple aim duties:

- Improve outcomes in population health and healthcare,
- Tackle inequalities in outcomes, experience, and access,
- Enhance productivity and value for money,
- Help the NHS support broader social and economic development.

Working Together at Scale: Guidance on Provider Collaboratives (2021)
Prior to the broader legislative framework coming into effect, guidance on provider collaboratives was published by NHS England in 2021. The guidance outlines the expectation of how providers should work together as provider collaboratives, principles to help support local decision-making, and function and form options that systems may consider in support of quadruple aim duties. NHS trusts were required to be part of at least one provider collaborative by April 2022. A high-level summary of the guidance is provided in Figure 1

Figure 1 Overview of NHS Provider Collaboratives



The developments we propose below are in the context of this increased drive for collaboration nationally.

2. The Case for Collaboration and Change to Support Delivery

We know that 2024-2025-2026 need to be years of action, delivered well and at pace with a focus on a small number of high impact changes. We are conscious of our system's financial position and must use collective opportunities to work more efficiently.

In this context a range of stakeholders from each of the three Trusts and wider system partners joined a series of corporate services and clinical services workshops designed to identify collaborative opportunities. These sessions led to ten areas for deeper collective work being identified as the *case for collaboration*; these are outlined in Figure 2. The areas identified can be broadly grouped as clinical and non-clinical opportunities, and centre on significantly improving quality and access for the people of BSW, achieving efficiencies and effectiveness in operations, and enhancing opportunities for staff.

Figure 2. Ten Areas: Our Case for Collaboration

Our *case for collaboration* report illustrates the challenges and potential impact across these ten opportunity areas, establishing a call to action to focus on clinical and operational performance to improve outcomes for people in BSW.

3. Proposed Provider Group Development

The realisation of the significant benefits identified in the *Case for Collaboration* will require development in our leadership and governance arrangements. Our review identified these areas as a critical requirement for success. Eight proposed developments are described here.

Recommendation 1. We recognise the importance of clear leadership to help set the vision for our effective collaboration, and the next step towards achieving this should be through our three organisations sharing leaders, identifying a Joint Chief Executive and Joint Chair for our Trusts. Each Foundation Trust will retain its own sovereign board, committed to an agreed roadmap for the Group; this change would not represent a merger of the Trusts. Each Trust will also have a Deputy Chief Executive to support the single CEO. We will progress with the appointment of a joint CEO immediately, convening Remuneration Committees to confirm process and timetable. We will ask our Governors to come together over the next three months to scope the role of the shared chair, making a proposal to Boards in October, and then appointing to the role in the first quarter 2025 [January-March].

Recommendation 2. In July and August, the three Chairs will develop a Memorandum of Understanding (MOU) for how they support the Joint Chief Executive during the transition to a Joint Chair.

Recommendation 3. We believe that a joint leadership model will improve the delivery of care to local communities by simplifying decision-making, increasing integration, and improving quality. We will create a Joint Committee, from September, to help oversee our work together. There will be a clear articulation of the topics overseen by the Joint Committee and those overseen locally; refer Appendix 1 initial Joint Committee Terms of Reference.

Recommendation 4 We will identify a limited number of areas of work, that are priorities for 2024-25. These must include our *EPR Implementation, BSW Communities Together, and stabilisation of the services we deliver and our financial position,* so in September we will bring executives and non-executives together to identify collective opportunities and clear plan to work more efficiently and eliminate unnecessary duplication. The Joint Committee will hold Executives accountable for the delivery of this plan.

Recommendation 5. Also in 2024-25, we will develop a Group Operating Model that allows us to focus on delivery of outstanding quality services, in a financially sustainable way, freeing-up teams to focus on what matters most to them; our Operating Model proposal will go to boards in January, mobilising in 2025-2026. Supported by a Group Development Team, our local leaders, our non-executives, and our governors will have an important role in shaping how we work, ensuring access, improvement, & innovation, embracing standardisation, all in an effective and agile governance environment.

Recommendation 6. We will use our Improving Together approach to create our Strategic Planning Framework, using common tools and embedding shared behaviours and improvement culture. Using this framework, with *joint clinical strategy and associated workforce and digital strategies*, we will confirm our transformation programmes for clinical and corporate services.

Recommendation 7. We will work with *our partners in health, local government, and the voluntary sector to deliver the BSW Integrated Care Partnership Strategy*, identifying those areas where we work together most effectively locally and those where partnership working across BSW delivers added benefits to the populations we serve.

Recommendation 8. Finally, and perhaps most importantly, we recognise that the changes of the scale we are proposing will be hard to achieve and that support will be essential as our leaders, teams, non-executives, and governors help shape our future together; Organisational Development support for coming years will be secured.

What do these proposed changes mean for our organisations?

- The *changes described are designed to accelerate successful delivery* of transformed sustainable, and excellent clinical services. They are a natural next step in the interests of the BSW population, patients, and our workforce. GWH, RUH and SFT will provide the main interface with our patients and respond to the needs of our diverse population by ensuring equitable and high-quality safe care.

- We are *not recommending a merger or change in legal structure*; it is considered that such a change would be highly disruptive and would not offer value for money for our system. In establishing a

Group, we will maintain three Trusts with their own Boards and NEDs. Each of the hospitals will maintain their own identities reflecting the services they provide and the local population they serve.

- *Subsidiarity*. Our agreed operating model will describe how the subsidiarity principle will be applied. Subsidiarity will see decisions being made at the lowest practical level, embedding local decision-making, and making decisions at group level only when it is considered beneficial to do so.
- *Long-term impact*. The anticipated impact over three+ years will be related to the ten clinical and corporate services areas set-out in the *case for collaboration*.
- *In the short-term*, change will be more limited. Staff and patients should not notice significant change in day-to-day operation and management of services. A joint-chief executive, with their team including the site deputy chief executives will lead an evolutionary process, developing an operating model, identifying priority areas for transformation. After these initial steps, the Joint Chief Executive with Deputy Chief Executives will support the Trusts to accelerate sharing of best practice, reduce duplication, enhancing resilience of our services while creating career structures and opportunities for many of our services that cannot currently benefit from working at scale. Again, in the short-term significant change in delivery and strategy is not anticipated, but teams will come together to develop and deliver collaborative plans, creating excellent sustainable services for our population.
- *Cost of new model*. Costs and return on investment will be defined in detail as part of the operating model proposal – due to be developed between August and December 2024, in readiness for Board review in January 2025.

4. Proposed Timeline

The timeline proposed is set out *in figure 3 below*. Learning from successful collaborative transformation schemes, other groups and collaboratives, we should not seek an off-the-shelf example or model. Rather, we should develop our BSW Providers model together. A three-phased approach is proposed, whereby an *initial phase* will be followed by a central *Joint Development Phase* leading to Board decision-making gateways before a *Joint Implementation Phase*.

- Progress Initial recommendations.
    - July. Remuneration Committees to convene to confirm process and timeline for appointment of Joint-Chief Executive.
    - August-October. Establish Joint Committee to oversee Joint Development Phase. Engagement with Council of Governors regarding Joint Chair. Develop delivery plan for in-year priorities.
- Joint Development Phase
    - September – January. Trusts develop target operating model, strategic framework. Begin delivery of in-year priorities.
    - January 25. Joint Committee and Three Boards consideration of proposed Operating Model and Strategic Framework

- Joint Implementation Phase. Q4 Onwards, 2025-2026-2027. Operating Model Implementation and delivery of Case for Collaboration.

Figure 3. Proposed Collaborative Development Timeline

5. Risks

The eight recommendations in this proposal will support us to address the following risks:

- Quality of and access to the planned and urgent care we deliver for BSW and local population. There is a risk that we fail to deliver the potential benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery. We will work within a clear framework that maintains responsiveness to the needs of the local populations and enables local innovation.
- Financial sustainability of our acute services. There is a risk that our Trusts fail to deliver the potential financial benefits identified in the case for collaboration. The recommendations are designed as a package to create conditions for successful delivery.
- Capacity of Executives to engage in system working. The capacity of executives and senior managers in Trusts is constrained, with competing pressures from what can be irreconcilable internal and system-wide activities *Mitigation*: We have begun, and in a group model should make standard practice, modelling different ways of deploying our senior leaders. Leading on behalf of others will become common, with local hospital leaders also having group-level leadership responsibilities – working in a matrix environment.
- Timeframes for Development. A drawn-out phased approach to development may create uncertainty. Staff need to be able to focus on local operational delivery. *Mitigation*: Our decision-making timetable should be pragmatic, but with sufficient pace to reduce uncertainty.
- Oversight. There is a risk that if the case for collaboration benefits are not pursued as proposed, there will be a decrease in local control owing to deterioration in performance (financial and access to services), leading to great scrutiny, classification in SOF4 leading to mandated external support.

Risk/s associated with pursuing this proposal:

- Local ownership. There is a risk that local stakeholders perceive a loss of local ownership or influence at organisation or place level. *Mitigation:* Our communication and engagement plan will be clear that these changes offer the benefits of scale in service of local delivery.
- Uncertainty for our staff. Changes may create uncertainty for some staff. *Mitigation and Management*: A comprehensive shared and well-resourced communications and engagement strategy and organisational development programme will be required. Additionally, the programme will see development of Group operating model over coming months - allowing for senior staff to be actively involved in development through co-creation.

6. Summary of Recommendations

Our recommendations are summarised in figure 4 below.

Figure 4. Our Eight Recommendations

1. We will identify a Joint Chief Executive and Joint Chair for our Trusts. Each site will also have a Deputy Chief Executive to support the single CEO. We will progress with the appointment of a joint CEO immediately, convening Remuneration Committees to confirm process and timetable. We will ask Governors to come together over the next three months to scope the role of the shared chair, making a proposal to Boards in October, and then appointing to the role January-March 2025.
2. In July and August, the three Chairs will develop a Memorandum of Understanding (MOU) for how they support the Joint Chief Executive during the transition to a Joint Chair.
3. We will create a Joint Committee, from September, to help oversee our work together. [Refer draft Terms of Reference in Appendix 1].
4. By the end of September, we will identify a limited number of areas of work, that are priorities for 2024-25. These must include our *EPR Implementation, BSW Communities Together, and stabilisation of the services we deliver and our financial position.*
5. We will develop a Group Operating Model, in 2024 that allows us to focus on delivery of outstanding quality services, in a financially sustainable way, freeing-up teams to focus on what matters most to them; our Operating Model proposal will go to boards in January 2025, mobilising in 2025-2026. Supported by a Group Development Team, our local leaders, our non-executives, and our governors will have an important role in shaping how we work.
6. We will use our Improving Together approach to create our Strategic Planning Framework, using common tools and embedding shared behaviours and improvement culture. Using this framework, with joint clinical strategy and associated workforce and digital strategies, we will confirm our transformation programmes for clinical and corporate services.
7. We will work with *our partners in health, local government, and the voluntary sector to deliver the BSW Integrated Care Partnership Strategy*.
8. We will invest in Organisational Development support to enable the scale of required change.

Close

Draft 1.0.

Ben Irvine. 10th July 2024 with IG, LC, AR, CCB, LT, JW.

Appendix 1. Joint Committee Terms of Reference [see accompanying document]

Development of Group Model by Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust & Salisbury NHS Foundation Trust.

Appendix 1: Draft Joint Committee Terms of Reference

DRAFT [BSW AHA Group [Name TBC]]

Joint Committee - Terms of Reference

1. **Status of the Committee**

1.1 Great Western Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust (the "**Trusts**") are parties to a long standing strategic collaboration known as the "**BSW AHA Group [NAME TBC]**", referred to hereinafter as "**the Group**".

1.2 To facilitate joint working across the Group's priorities and programmes, the Trusts have agreed to establish and constitute a joint committee pursuant to sections 65Z5 and 65Z6 of the National Health Service Act 2006 with these terms of reference (the "**Terms of Reference**"), to be known as the "**BSW AHA Group Joint Committee**" (the "**Committee**").

1.3 These Terms of Reference set out the membership, remit and delegation, responsibilities and reporting arrangements of the Committee.

1.4 The Committee is a committee of the boards of each of the Trusts and therefore its decisions are binding on each Trust. The Committee is authorised by the Trust boards to carry out the functions set out in these Terms of Reference to ensure the Committee can fulfil its purpose.

1.5 The Committee replaces the former Acute Hospitals Alliance/AHA committees-in-common arrangement.

1.6 Capitalised terms have the meanings given to them in these Terms of Reference or in the memorandum of understanding for the Group which the Trusts entered into on [insert x] ("**Group MoU**"). The Annex means the annex to these Terms of Reference.

2. **Purpose**

2.1 The purpose of the Committee is to ensure appropriate governance arrangements are in place to enable joint decision making in relation to the functions described in these Terms of Refence and the Annex which the Trusts have agreed to exercise jointly.

2.2 The Committee will be responsible for:

2.2.1 Oversight of the development and delivery of the Group Programme and the workstreams in accordance with the Principles of Collaboration; and

2.2.2 setting the overall strategic direction in order to deliver the Group Programme.

2.3 The Group Programme agreed by the Trusts for the years [insert financial years 2024-2028] includes:

2.3.1 the design and implementation of a group model for the Trusts (the **"Group Operating Model**");

2.3.2 the 10 agreed areas for collaboration ("**10 Areas for Collaboration"**), including annually agreed priorities for collaboration;

2.3.3 the response to the BSW integrated community health care services procurement exercise; and

2.3.4 oversight of governance over the joint EPR Programme,

all described in more detail in the Annex.

3. **General Responsibilities**

3.1 The general responsibilities of the Committee are to:

3.1.1 provide overall strategic oversight of and direction to the development of the Group Programme;

3.1.2 ensure the agreement of each of the Trusts to the vision and strategy underpinning the Group Programme;

3.1.3 formally recommend the final form of the Group Programme, including determining roles and responsibilities within the workstreams;

3.1.4 review and scrutinise the Group Programme key deliverables and ensure adherence to the required timescales;

3.1.5 obtain assurance that Group Programme workstreams have been subject to robust equality impact assessments;

3.1.6 review the risks associated with the performance of any of the Trusts in terms of the impact to the Group Programme and recommend remedial and mitigating actions across the system;

3.1.7 obtain assurance that risks associated with the Group Programme are being identified, managed and mitigated;

3.1.8 promote and encourage commitment to the Principles of Collaboration;

3.1.9 formulate, agree and implement strategies for delivery of the Group Programme;

3.1.10 determine or resolve any matter referred to it by the Group Programme Executive or any individual Trust and any dispute in accordance with the Group MoU;

3.1.11 approve the appointment, removal or replacement of Group Programme personnel;

3.1.12 review and approve the terms of reference of the Group Executive; and

3.1.13 agree the overall Group Programme budget, financial contribution and use of resources.

3.2 The Committee has the specific responsibilities set out in the Annex to these Terms of Reference.

4. **Membership**

4.1 The Committee will initially comprise the chair (representing the non-executive membership) of each of the Trusts, the Group Chief Executive and Deputy Chief Executive (representing the executive membership) of each of the Trusts. Once a chair is jointly appointed across all 3 Trusts, each of the Trusts shall nominate a non-executive director ("**NED**") to serve on the Committee. There will initially be 7

members on the Committee, 3 of whom are NEDs, and once a chair is jointly appointed there will be 8 individuals on the Committee, 4 of whom are NEDs. Each individual is hereinafter referred to as a **"Member"**.

4.2 Each Trust will nominate two deputy members (one from the non-executive membership of the Trust's board and one from the executive membership) (**"Nominated Deputy"**) to attend meetings of the Committee in the event that their Chair (or NED) and/or Chief Executive is unable to attend. The Nominated Deputy must be a voting board member of the respective Trust. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the Member is not personally present and do all the things which the appointing Member is entitled to do.

4.3 Each Member will have one vote.

4.4 At the first meeting of the Committee, the Committee will select a chair ("**Committee Chair**") from amongst the Members who are Trust chairs. Once a joint chair for the Trusts is appointed, he or she shall become the Committee Chair and the incumbent Committee Chair (if not the joint chair) shall immediately hand over.

4.5 In the absence of the Committee Chair at any meeting for reasons of conflict or otherwise, the Members present shall nominate one of the other NED Members to chair the meeting.

4.6 The Trusts will ensure that, except for urgent or unavoidable reasons, their respective Members (or their Nominated Deputy) attends and fully participates in the meetings of the Committee.

4.7 Meetings of the Committee will be regularly attended by the [Group Programme Director [and insert other regular attendees] on an advisory basis only. They will receive advance copies of the notice, agenda and papers for meetings. They may be invited, at the discretion of the Committee Chair, to ask questions and address the meeting but may not vote.

4.8 With the consent of the Committee Chair, other persons may be invited to attend and contribute to meetings of the Committee but not take part in making decisions.

5. Framework for Decision Making

5.1 The Committee (and each Member or Nominated Deputy) shall at all times act in accordance with these Terms of Reference and the internal governance arrangements of the individual Trusts including the Trusts' constitutions and standing orders insofar as these Terms of Reference do not provide otherwise. In the event of any inconsistency between the Trust's standing orders, the Committee Chair shall determine whose standing orders will prevail.

5.2 The following decisions may only be taken where the Members present and voting at a meeting vote unanimously in favour of it:

5.2.1 any decision relating to the design of the Group Operating Model – see the Annex;

5.2.2 [insert any other types of decisions which require unanimous approval].

5.3 Functions not delegated to the Committee in accordance with these Terms of Reference are retained by the Trust boards or other Trust committees. Matters specifically reserved to the Trusts, acting individually, include without limitation:

5.3.1 the approval of the design of the Group Operating Model;

5.3.2 a decision to enter into contracts following the Trusts' response to the BSW integrated community health care services procurement exercise;

5.3.3 [insert other matters reserved].

5.4 The Committee may not:

5.4.1 form sub-committees or delegate its functions to any individual Member;

5.4.2 pool budgets or establish any risk-gain share arrangements;

5.4.3 commit a Trust to any spend, loan or investment (including capital investment) or acquire or dispose of Trust property;

5.4.4 commit a Trust to enter into a contract, other than in relation to the Group Operating Model provided for in the Annex; or

5.4.5 carry out any function which is governed by a statutory process or reserved in law to a statutory committee of a Trust, including constitutional amendments and board appointments, or which may not be exercised jointly according to law or NHS England guidance.

5.5 In carrying out its functions, the Committee will abide by the Seven Principles of Public Life (Nolan Principles) and shall have regard to NHS England's statutory guidance for joint exercise of statutory functions and joint committees issued from time to time.

6. **Decision making**

6.1 The Committee must comply with the above framework for making decisions and have regard to the principles specified in paragraph 6.2.

6.2 When making decisions, the Members shall, recognising that some decisions may not be of obvious benefit to or impact directly upon all Trusts, nevertheless:

6.2.1 enable each Member to have an equal say in discussions;

6.2.2 work together in good faith and in an open, cooperative and collaborative manner for the benefit of one or more Trusts;

6.2.3 take collective responsibility for decisions whether impacting on one or more Trusts;

6.2.4 communicate openly about major concerns, issues or opportunities; and

6.2.5 share information, experience, skills and work collaboratively with each other to identify solutions, eliminate duplication of effort, mitigate risk and reduce costs.

6.3 The Committee will seek to make decisions on a consensus basis.

6.4 Any questions needing to be put to a vote at a meeting shall, save for the matters set out in paragraph 5.2 (matters requiring unanimous decision), be determined by a majority of the votes of the Members present and voting on the question and, in the case of the number of votes for and against a motion being equal, the chair of the meeting shall have a second or casting vote.

6.5 With the consent of the Committee Chair, urgent decisions or decisions required outside of scheduled meetings may be taken outside of a formal meeting by written resolution (including email). This is subject to the quorum of the Committee endorsing

the required decision. Any decisions taken in accordance with this section shall be reported to the next formal meeting.

7. **Proceedings of the Committee**

7.1 Subject to the provisions of this paragraph, the Committee may regulate its proceedings as it sees fit.

7.2 The Committee will meet [monthly], or more frequently if so required.

7.3 Meetings of the Committee are anticipated to take place in private as this is appropriate to facilitate discussion and decision making on matters deemed to be commercially sensitive or confidential.

7.4 For meetings to be quorate each of the Trusts must be represented by both its chair and chief executive, or their Nominated Deputies. No decision may be taken at any meeting unless a quorum is present.

7.5 No decision may be taken at a meeting unless a quorum is present.

7.6 Declarations and notifications of interests in relation to an item of scheduled or likely business must be made at the beginning of each meeting, and the provisions of the "Protocol for Managing Conflicts of Interest" (Schedule 4 of the Group MoU) applies.

7.7 Meetings may take place in person or remotely by telephone or video conference, or a hybrid, provided that each Member participating is able to speak to each of the others, and to be heard by each of the others simultaneously.

7.8 The Committee is authorised by the Trust boards to obtain independent legal or other professional advice and to secure the attendance of such persons with relevant experience or expertise at any meeting of the Committee.

8. **Administration of the Committee**

8.1 The administration of meetings, including the provision of governance advice, maintaining the register of interests and the preparation of minutes, will be provided by the Group Programme Office.

8.2 Agendas for meetings will be determined jointly by the Committee Chair and Group Chief Executive.

8.3 Papers for each meeting will be sent from the Group Programme Office to Members no later than five working days prior to the meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

8.4 The draft minutes of each meeting, together with a summary report from the [Group Chief Executive], will be circulated promptly to all Members as soon as reasonably practical after the date of the meeting to ensure their inclusion in the private agenda of each of the Trust's board meetings. The Committee Chair (or chair of the meeting) will be responsible for approving the first draft set of minutes for circulation to members. The Group Programme Director will provide a summary of the meeting for sharing in the public domain.

8.5 The Committee will prepare an annual report for the Trust boards on its performance against its annual work plan.

9. **Review**

9.1 It is anticipated that these Terms of Reference will be updated to reflect strategic developments in BSW. The Committee will review these Terms of Reference at least annually. Amendments to the Terms of Reference must be approved by the Trust boards.

Approved by the boards of:
Great Western Hospitals NHS Foundation Trust
Salisbury NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust

[date] 2024

ANNEX – Specific Responsibilities

1. The Committee will:

1.1 mobilise, oversee and assure successful delivery programmes in relation to the following Group Programme initiatives:

1.1.1 the design of the future Group Operating Model;

1.1.2 the "case for collaboration" as set out in [insert document which describes the case for collaboration] which identifies the 10 Areas for Collaboration (summarised in paragraph 2 below), including formulating and implementing key strategies for delivery, with a focus on improving quality and access for the people within the BSW integrated care system, achieving efficiencies and effectiveness in operations and enhancing opportunities for staff; and

1.1.3 the Trusts' response to the BSW integrated community health care services procurement exercise;

1.2 in respect of each of the areas in paragraph 1.1 above:

1.2.1 review and scrutinise key deliverables of such programmes and ensure adherence to the required timescales;

1.2.2 review significant risks to such programmes and obtain assurance that risks are being identified, managed and mitigated;

1.2.3 hold relevant teams to account for delivery of workstreams; and

1.2.4 agree communications strategies and stakeholder management strategies.

1.3 in relation to the design and/or implementation of the Group Operating Model, have authority to award contracts for consultancy and other services with individual values of up to [£1,000,000 (one million pounds sterling)] subject to procurement law and principles. When awarding contracts, the Committee shall also decide which Trust is to hold the contract and other related matters.

1.4 ensure that effective governance arrangements are in place for successful delivery of the EPR programme (overseen by a separate EPR joint committee).

2. The 10 Areas for Collaboration are:

Area 1	Tackling the challenges from chronic illness in the ageing population in the areas of the BSW integrated care system
Area 2	Aligning around transformation in Urgent and Emergency Care to better manage acute demand
Area 3	Delivering clinically sustainable services for the future
Area 4	Improving access, effectiveness and value for money of planned care
Area 5	Tackling increasing prevalence and performance challenges in cancer
Area 6	Aligning research and innovation to accelerate delivery of shared clinical priorities
Area 7	Developing a resilient workforce for the future, drawing on talents of the local population

Area 8	Creating efficiencies in the use of data and adoption of digital innovations
Area 9	Building resilience across finance
Area 10	Supporting corporate efficiency and cost reduction

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**11**
Date of Meeting:	**22 July 2024**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor:	**Paran Govender, Chief Operating Officer** **Jon Lund, Interim Chief Finance Officer** **Alfredo Thompson, Chief People Officer** **Toni Lynch, Chief Nursing Officer**		
Author:	**Tom Williams, Head of Financial Management** **Rob Eliot, Lead for Quality Assurance** **Matt Foxon, Associate Director for People**		
Appendices	**Appendix 1: Integrated Performance Report** **Appendix 2: Trust Scorecard**		

1. Executive Summary of the Report

The report provides an overview of the Trust Operational and Financial Performance for the period up to and covering May 2024, aligned to our True North Pillars and breakthrough objectives agreed for the year.

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

Performance

Elective Recovery Fund update

24/25 has started well with the strong position for M1 continuing into M2, despite unforeseen challenges such as the closure of the Modular Theatre for 10 days. We delivered 113% of 19/20 activity and 101% of our 24/25 M2 activity plan. This translates into a financial performance of 119% of 19/20 and 104% of our M2 24/25 plan. This has delivered a surplus of over £322k in-month and over £1mln year-to-date, with Day Case and Outpatient New attendances being the significant contributors to this position.

Cancer

In April 62 Day performance was 74.8%, a further improvement above the 70% target set by NHSE in the 2024/25 Operational Planning Guidance. Urology recorded the most breaches with two thirds of breach being for prostate patients, but performance remained above 70%. MRI scans were the most frequent contributing factor, although waiting times for joint clinic appointments post-MDT also led to breaches. Colorectal remained the most challenge pathway although performance did improve to 46%. Diagnostic waiting times continued to be the common factors in breaches. Lung performance also improved with surgical waiting times at UHBW continuing to reduce.

28 Day FDS performance improved to 69.0% but remained below the 77% target and as a result of the performance the RUH is being placed into NHSE tiering. The top contributor to performance is colorectal, with breaches due to outpatient and diagnostic waiting times. Histology waiting times are increasing for most tumour sites due to consultant pathologist vacancies and increasing demand. There is a further

risk to performance from June due to the increasing waiting times for first urgent suspected cancer appointments in Skin and Urology, both impacting by increasing demand and consultant vacancies.

Diagnostics

The national operational standard for diagnostics is 95% to be delivered within 6 weeks (DMO1) by the end of March 2025. In May 2024 >6-week performance was 71.77%, a deterioration compared to 76.61%in April and not in line with the trajectory for May of 81.1%. The number of patients waiting more than 6 weeks increased has increased in month by 4.84% accounting for the deterioration in performance between April and May that is equivalent to an additional 872 patients breaching. Performance has been affected by an increase in demand for diagnostics (13% across all modalities since April 2024), with a noted increased in the suspected cancer referral cohort, which impacts directly on the available capacity for the routine 6-week (DM01) activity. The diagnostic modalities of MRI, Sleep Studies and Ultrasound remain the top contributors to adverse performance. Year to date Sulis-CDC has delivered 1957 diagnostic investigations and have currently booked 714 patients for June 2024. Focus for June is to recover the performance across all modalities in line with the revised performance trajectory including additional activity provided by Sulis-CDC at the weekend for colonoscopy and CT/MRI and the option for a mobile endoscopy unit to support colonoscopy recovery from October 2024.

Urgent Care

In May, the Trust lost a total of 2,296 hours in ambulance handovers, a reduction from the previous month. The percentage of Ambulances handed over within 30 minutes also improved in May (42.7%). Through the BSW Ambulance handover improvement group, there is an action to review the handover process with SWASFT to align across BSW aiming to streamline processes and improve quality standards including patients seen within 15 minutes of arrival. The UEC improvement plan will support flow out of ED, which will increase the number of patients handed over within 30 minutes. The RUH is continuing to experience discrepancies regarding ambulance handover data in May, which, following validation, totalled 132 hours which would make our hours lost position for May 2,164 hours work continues with SWASFT as the hours lost relate to SWASFT processes which include leaving the Combe Park site freeing capacity for the next ambulance arrival.

RUH 4-hour performance

In May was 68.6% and 60.0% on the RUH footprint (below the unmapped trajectory of 70.05%). The same position as April 2024. Attendances during May were 9,121, an increase from April and the second highest monthly attendances seen through the department. The non-admitted 4-hour performance was adverse to plan due to an increase in the predicted number of attendances to UTC and current staffing model was not able to support this demand level to deliver within 4 hours. Admitted performance was affected by an increase in the occupancy of patients without a criteria to reside (92 patients), occupancy at 94% (target 92%) and ward discharges occurring after midday. Improvement in performance will be supported by the delivery of the UEC improvement plan, specifically the integrated front door workstream for non-admitted 4- hour performance and the In Hospital workstream which will support the 4-hour admitted pathway recovery.

Finance

BSW Integrated Care System

- The organisations in the BSW Integrated Care System must collaborate to develop Revenue and Capital Financial Plans with a view to achieving breakeven against allocations each year.
- The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to it's pre-pandemic levels.
- The BSW System has developed a financial plan with a £30.0m deficit for the year, of which the RUH is £5.3m deficit. There remains unidentified savings gaps within this System plan and system partners will be expected to deliver plans and seek to stretch these further.

RUH Group Financial Plan

- The RUH deficit plan of £5.3m is underpinned by £22.7m of non recurrent revenue financial support from commissioners and £6.3m of NHSE funding for revenue consequences of new capital investment
- The financial plan for the year requires full delivery of a £36.6m Savings Programme, which has been phased to show progressive reduction in costs and increases in productivity over the year
- Achieving the financial plan is an RUH Breakthrough Objective for 2024/25
- The organisation continues to operate under enhanced levels of Executive controls to ensure Savings plans are delivered and costs are controlled. Work continues to align Transformation & Improvement Planning activities and Divisional budgets are aligned and incentivised to the achieve this breakthrough objective using the Improving Together approach.

Revenue Financial Performance – Month 2

- At Month 2 the Group is at a deficit position of £4.06m, which is £0.1m worse than plan
- Savings of £3.1m have been delivered to date (8.5% of annual target in 16.7% of the financial year), including £1.6million of pay savings against budget, and the benefit of Elective Recovery Fund income and operating margin of 58%
- Non-Pay is overspent by £0.5m predominantly across supplies and services. This is being looked at, especially given the high level of activity in the month.
- This is being mitigated by higher than planned interest receivable.

Capital and Balance Sheet Position – Month 2

- Total capital expenditure is £1.6 million at Month 2, which is £6.4 million behind plan due to delays in both the SEOC and EPR programmes
- The closing cash balance for the Group was £27.6 million which is 25.6% higher than the plan due to the capital delays set out above

Risks and Issues

The Trust is managing a number of financial risks, of which,

- **Full delivery of the Savings programme** on a recurrent basis, including paybill reduction, is the most significant
- **Careful management of cash** through the middle of the year will be required

as the capital programme is in part front-loaded and the savings programme back-loaded

- **The Trust financial position is anchored on the wider Integrated Care System** and therefore contribution to RUH from working with other partners and the financial performance of other organisations could have a bearing on the financial position; which can be mitigated through collaborative working and problem solving

Workforce

- The RUH establishment in May 2024 (M2) was 5693 whole time equivalents (WTE), (reducing from 5888 WTE in April 2024).
- The staff-in-post remained at 5598 WTE.
- The M2 Vacancy rate (1.66%) has decreased compared to M1.
- Agency spend as a proportion of the total pay bill decreased slightly from 1.14% (M1) to 1.13% (M2) 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 pay bill increased slightly from 1.62% (M1) to 1.71% (M2).
- Staff turnover increased to 8.34% (from 8.09% in M12) a continued positive variance against a target of 11.00%.
- In month sickness absence has been on a decreasing trend since January 24, M1 4.47% compared to 4.58% in M12. Anxiety, stress, and depression remained the main causes of sickness absence at 1.20%.
- Based on Trac data, the ratio of the likelihood of appointment from shortlisting comparing Global Majority to White candidates is 0.63. This is moving away from the targeted two-fifths range (0.8-1.25).
- The target percentage figure for Appraisal completion is 90%; Appraisal has slipped slightly to 77.61%.
- Mandatory Training compliance continues to be narrowly above target at 90.04%. It is, however, down on the previous month but it should be noted that this in part due to a wider audience now having to complete Safeguarding Adults Level 3.

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 Programmes ensure the work is oriented to 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.

Following the procurement of the Halo HR portal, we are now working through our requirements for a case management system and the self-service portal. Halo build is now underway with an expected launch of the case management system in July 2024 and the self-service portal in Q3.

Starting next month, we are rolling out Supporting Attendance training both face to face and on TEAMS. Work is also beginning on new guidance for conducting investigations and flexible working requests.

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 early July 2024 (to coincide with launch of the Dignity at Work Policy), to be linked with RUH People Hub, therefore better, swifter support to areas most affected by discrimination. Report and support enabling anonymous reporting to help create psychological safety for those reporting.

Other central support to operational team's interventions include; Network of Inclusion Champions has now launched, next cohort of Positive Action Programme (Routes to Success) in planning for Autumn, and Independent Advisors (RCN Cultural Ambassadors) in pre-recruitment stage.

People Plan Programme 5 – 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. An Appraisal A3 has been developed with the Improving Together team to support increased compliance. Outcomes presented to the May 24 People Committee and TME. In June 24, 360 feedback has been launched in Learn Together, which supports the drive to improve appraisal rates.

People Plan Programme 7 – Learning and Development

National Statutory Mandatory training programme launched to align learning and develop centrally, we are now compliant to this programme. This will not impact hours required for training, our current training offering meets national standards and is shorted than the national programmes.

People Plan Programme 8 – Workforce Planning

Workforce whole time equivalent worked is below Month 1 plan and is underspent by £11k once cost premiums and skill-mix are taken into account. The organisation continues to operate under enhanced levels of Executive controls to ensure savings plans are delivered and costs are controlled.

People Plan Programme 6 – Health and Well-being

A new EAP programme rolled out in June 2024, this now includes the ability for managers to refer (with consent). This model will improve the targeting of well-being support to RUH colleagues.

People Plan Programme 9 – Talent Acquisition

The Trust led Vacancy Control and Agency Reduction Panel continues to support right-sizing our workforce with the controls supporting the Trusts financial recovery plans.

Employee Value Proposition visuals approved with work now underway to update recruitment materials with the new look and feel to support our vision of being one of the top Trusts that staff recommend as a place to work.

People Plan Programme 10 – Temporary Staffing

The Agency Reduction plan continues to support the Trust to be within or below the national target of 3.2% for the percentage spent as a proportion of the total pay bill - May recorded our position as 1.13%. Initiatives such as moving to a Preferred Supplier List for agency nurse provision will increase our compliance with NHS agency price caps and drive down costs. Work is underway with new suppliers to support the smooth implementation in July 2024.

Bank rate review concluded with an agreement from Executive Team and Staff side to align Bank rates with our BSW partners adopting a paid to grade approach. This demonstrates equity across staff groups and work underway to make these changes

Quality

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

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:

- Pressure Ulcers category 3

Under-performing:

Pressure Ulcers category 3

The Trust recorded 1 category 3 pressure ulcer in April 2024. From July (May data)

reporting will include the Trust wide Pressure Ulcer point prevalence to provide assurance on the quality of the incidence data.

% of complaints responded to within target
The number of complaints closed per month within target remains variable but overall displays an improving trajectory. The number of formal complaints remains low, however the complaints are increasingly complex. Since April 2023 the Patient Support and Complaints Team (PCST) have provided a single point of access for those who wish to raise concerns, providing support to raise a concern or complaint which best meets the needs of the individual whilst achieving resolution to their concerns and identifying learning for the Trust. This has meant that, generally, only the most complex of concerns are investigated as formal complaints.

In April the Surgical Division responded to 56% of complaints within the timeframe (5 of 9 complaints). The late responses were partly late due to the absence of a key member of staff and the complexity of the complaints received.

Family & Specialist Services (FaSS) Division had 1 late complaint response which was partly delayed by the case being transferred between divisions. The patient could have been contacted by the division to alert them that there could be a delay.

Registered Nursing and HCSW Dashboard update
RN vacancy has increased in Emergency Medicine and there is a current focus on Emergency Department paediatric posts. All band 5 vacancies will be recruited between May and September.
FaSS has an improving position in their paediatric service following the full amount of safer staffing investment. Active recruitment continues for these vacancies.
Medicine have seen an improving trend as ward 4 is implemented at St Martins and the closure of B41/B36.
Surgery is further over established in the short term due to the transfer of services to a single ITU footprint (B12) in April.
Work is ongoing to provide validation and assurance of actual HCSW vacancy rates. Overall current vacancy rates are decreasing.

Infection Prevention and Control Update
Thresholds for reportable infections for 2024/25 have not yet been published by NHSE. There were 7 cases of Clostridioides Difficile during April and 9 cases of E.coli. This would be considered a high rate of infections for one month. There were however no links with any of the individual cases. There were 88 cases of COVID-19 during April. This was an increase on the previous months data.

Maternity Update
- Stable birth to midwife ratio, no episodes of 1;1 care in labour not being provided or the supernumerary status of the Labour ward Co-ordinator being impacted.
- Data capture problem identified since transition to digital MDT audit tool rectified, transition back to paper audit tool from April 24, compliance 97%, plan to stabilise and revert to exception reporting.
- Average fill rates affected by additional tiles on HealthRoster, working with

team to review rota requirements and removal of unused tiles to improve position.

- There has been 1 Neonatal Death in the month following elective caesarean section. This has been referred to the Coroners, PMRT process and Maternity independent advocacy adviser. No immediate care concerns have been identified.
- No MNSI referrals have been made in month.
- The 'Themes from service insights report' identified 3 priority areas for 24/25:
    - To improve the provision to ensure informed consent is obtained in all clinical care planning
    - To ensure fetal monitoring with a specific focus on Intermittent Auscultation is conducted efficiently in line with local and national standards.

To improve the experience of women and families within their postnatal care and recovery.

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

3.	Legal / Regulatory Implications
Trust Single Oversight Framework.	

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

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

6.	Equality and Diversity
NA	

7.	References to previous reports
Standing agenda item.	

8.	Freedom of Information
Private	

9.	Sustainability
None identified.	

10.	Digital
None identified.	

Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report

June 2024 (May data)

The RUH, where you matter

Trust Priorities 2024/25

Royal United Hospitals Bath NHS Foundation Trust

The people we care for

The people we work with

The people in our community

Trust goals

- Patient safety incidents (moderate to catastrophic)
- Number of patients over 65 weeks
- Overall patient experience score
- % recommend RUH as a place to work
- % staff say the organisation acts fairly with regard to career progression
- % staff experiencing discrimination at work
- Delivery of breakeven position
- Equity of access to RUH for all
- Carbon emission reduction

Breakthrough goals 24/25

Why not home? Why not now?
Reducing inpatient length of stay top 25% of acute trusts

Discrimination
% of staff reporting they have experienced discrimination at work

Making best use of available resources
Delivery of financial plan

Enabling Breakthrough Goal: We "Improve Together" to make a difference
(measured by the adoption of tools, routines and behaviours of Improving Together via a quarterly maturity assessment)

Trust-wide projects

- **Patient Safety Programme -** Quality Management System, Patient Safety Incident Response Framework, Paperless Inpatients
- **Atrium Redesign**
- **Patient Experience Programme** - DrDoctor Patient Platform, Website
- **Clinical Estate -** One ICU, Maternity DAU, Dyson Cancer Centre Benefits Realisation
- **Community Services Tender**
- **Elective & Cancer -** Community Diagnostic Centre & Sulis Elective Orthopaedic Centre

- **Foundations Programme** – Basics Matter & People Hub
- **Workforce Plan**
- **Employee Experience & Engagement –** Joy at Work, Employee Recognition
- **Restorative, Just & Learning Culture**
- **Equality, Diversity & Inclusion Programme** – Positive Action & Dignity at Work
- **Leadership Development Programme**

- **Health Inequalities Programme** – Preventative services, Anchor Plan
- **Estate Decarbonisation**
- **Financial Improvement Programme** – Clinical productivity, Pay Bill, Income and cost controls
- **Single EPR**
- **Acute Hospital Alliance reset** – Clinical and Corporate Services

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

Executive Summary: Performance

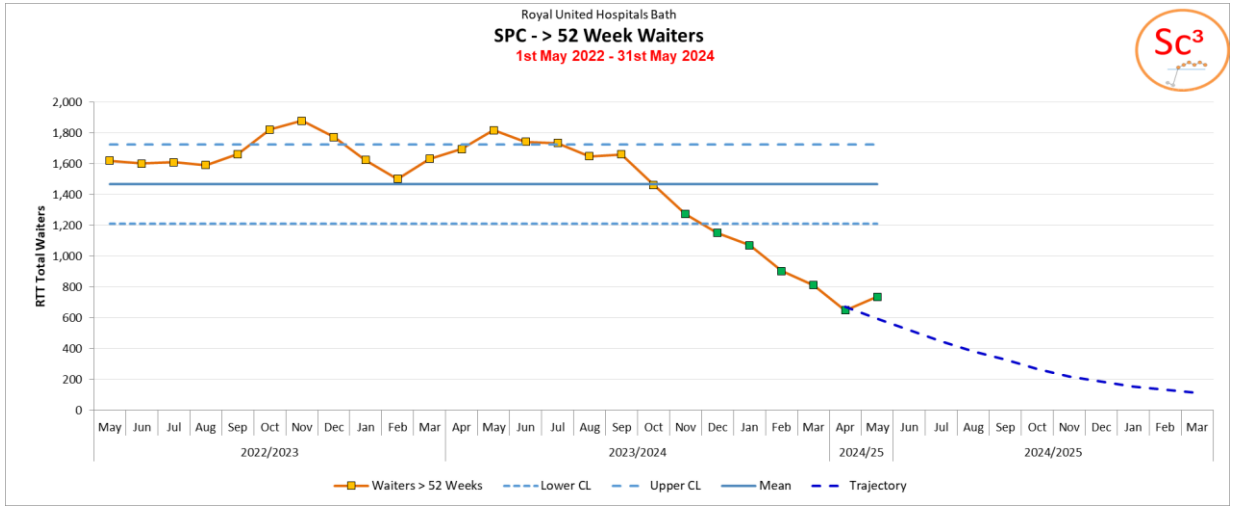
Strategic Goal		Performance Indicator	Target		2023/24				2024/25		Trend	Movement From Previous Month
			Performing	Under Performing	Dec	Jan	Feb	Mar	Apr	May		
Trust Goals	People in our Community	Ambulance Handover Delays	>=39	<39	822	810	887	995	1194	938		
Breakthrough Objectives	People We Care For	4 Hour Performance (Total RUH Footprint, including MIU & Booked)	>=76%	<76%	67.7%	66.4%	68.7%	69.8%	68.6%	68.6%		
	People in our Community	Non Criteria to Reside	<=62	>62	83	82	81	86	88.0	92.8		
Key Standards	People We Care For	RTT - Incomplete Pathways in 18 weeks	>=92%	<92%	60.2%	60.4%	62.3%	63.6%	65.4%	66.4%		
		Combined 31 Day Cancer Targets	>=96%	<96%	92.2%	90.7%	94.3%	88.6%	90.9%	(LAG 1)		
		Combined 62 Day Cancer Targets	>=75%	<75%	71.8%	66.5%	66.3%	73.5%	72.4%	(LAG 1)		
		Diagnostic tests maximum wait of 6 weeks	<=1%	>1%	32.7%	26.8%	19.6%	18.5%	23.4%	28.2%		

Measure	Change	Executive Summary
Ambulance Handover	↓	In May, the Trust lost a total of **2,296** hours in ambulance handovers, a reduction from the previous month. The percentage of Ambulances handed over within 30 minutes also improved in May (42.7**%**). Through the BSW Ambulance handover improvement group, there is an action to review the handover process with SWASFT to align across BSW aiming to streamline processes iand improve quality standards including patients seen within 15 minutes of arrival. The UEC improvement plan will support flow out of ED, which will increase the number of patients handed over within 30 minutes. The RUH is continuing to experience discrepancies regarding ambulance handover data in May, which, following validation, totalled 132 hours which would make our hours lost position for May 2,164 hours work continues with SWASFT as the hours lost relate to SWASFT processes which include leaving the Combe Park site freeing capacity for the next ambulance arrival.
4 Hour Performance	→	RUH 4-hour performance in May was **68.6%** and **60.0%** on the RUH footprint (below the unmapped trajectory of **70.05%**). The same position as April 2024. Attendances during May were 9,121, an increase from April and the second highest monthly attendances seen through the department. The non-admitted 4-hour performance was adverse to plan due to an increase in the predicted number of attendances to UTC and current staffing model was not able to support this demand level to deliver within 4 hours. Admitted performance was affected by an increase in the occupancy of patients without a criteria to reside (92 patients), occupancy at 94% (target 92%) and ward discharges occurring after midday. Improvement in performance will be supported by the delivery of the UEC improvement plan, specifically the integrated front door workstream for non-admitted 4- hour performance and the In Hospital workstream which will support the 4-hour admitted pathway recovery.
Non Criteria to Reside (NC2R)	↑	During May the Trust had an average of 92.8 patients waiting who had no criteria to reside, which is 4.8 higher than the previous month. All localities saw an increase in average numbers of NCTR, Banes averaging 30.1, Wiltshire 39.4, however Somerset have seen a reduction to 17.3.
Referral to Treatment	↓	In May the Trust had 2 patients waiting over 78 weeks and 41 patients waiting over 65 weeks breaches. The longest waiters are in General Surgery, Gastroenterology, Trauma & Orthopaedics and ENT. RTT performance was 66.4% in May, an increase of 1.0% and a continuing upward trend
Cancer 62 Days	↑	April 62 Day performance was 74.8%, a further improvement above the 70% target set by NHSE in the 2024/25 Operational Planning Guidance. Urology recorded the most breaches with two thirds of breach being for prostate patients, but performance remained above 70%. MRI scans was the most frequent contributing factor, although waiting times for joint clinic appointments post-MDT also led to breaches. Colorectal remained the most challenge pathway although performance did improve to 46%. Diagnostic waiting times continued to be the common factors in breaches. Lung performance also improved with surgical waiting times at UHBW continuing to reduce.
Diagnostics	↓	The national operational standard for diagnostics is 95% to be delivered within 6 weeks (DMO1) by the end of March 2025. In May 2024 >6-week performance was 71.77%, a deterioration compared to 76.61% in April and not in line with the trajectory for May of 81.1%. The number of patients waiting more than 6 weeks increased has increased in month by 4.84% accounting for the deterioration in performance between April and May that is equivalent to an additional 872 patients breaching. Performance has been affected by an increase in demand for diagnostics (13% across all modalities since April 2024), with a noted increased in the suspected cancer referral cohort, which impacts directly on the available capacity for the routine 6-week (DM01) activity. The diagnostic modalities of MRI, Sleep Studies and Ultrasound remain the top contributors to adverse performance. Year to date Sulis-CDC has delivered 1957 diagnostic investigations and have currently booked 714 patients for June 2024. Focus for June is to recover the performance across all modalities in line with the revised performance trajectory including additional activity

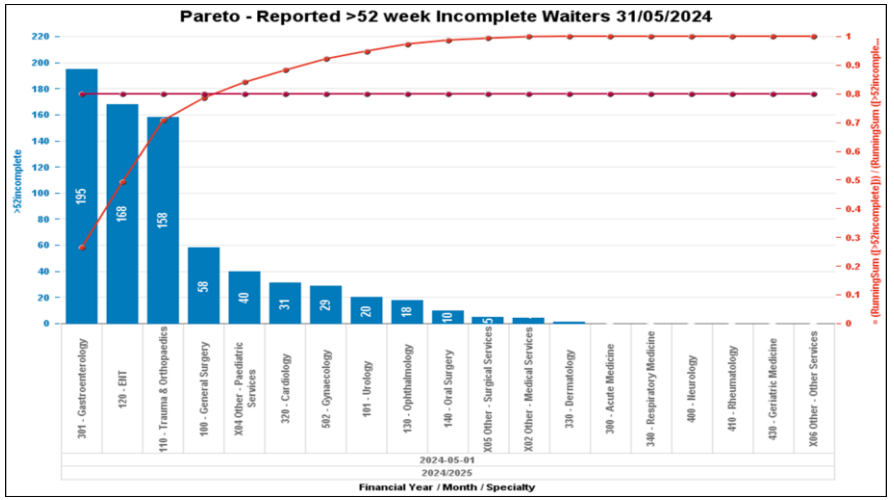
Trust Goal | Referral to Treatment

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

Historic Data



Supporting data - *Pareto 52+ by Specialty*



Is the standard being delivered?

- In May 24 the Trust had 737 patients waiting > 52 weeks, an increase of 13% from April.
- For waiters **> 65 weeks**, the Trust also saw an increase in May from 33 to 41 patients. This included two patients waiting over 78 weeks due to administration errors. One has stopped, the other will be treated in June.
- RTT performance was 66.4% in May. RTT performance has improved every month since Sep-23.
- For waiters over 52 weeks, the three largest specialties combined represent almost 80% of the waiters. These are Gastroenterology, T&O, and ENT.
- Gastroenterology saw a small decrease in >52 week waiters this month from 206 to 195.
- ENT experienced a large increase in >52 week waiters in May compared to April, rising from 133 to 168 patients.
- Trauma & Orthopaedics saw an increase of 19 additional >52 week waiters in May.

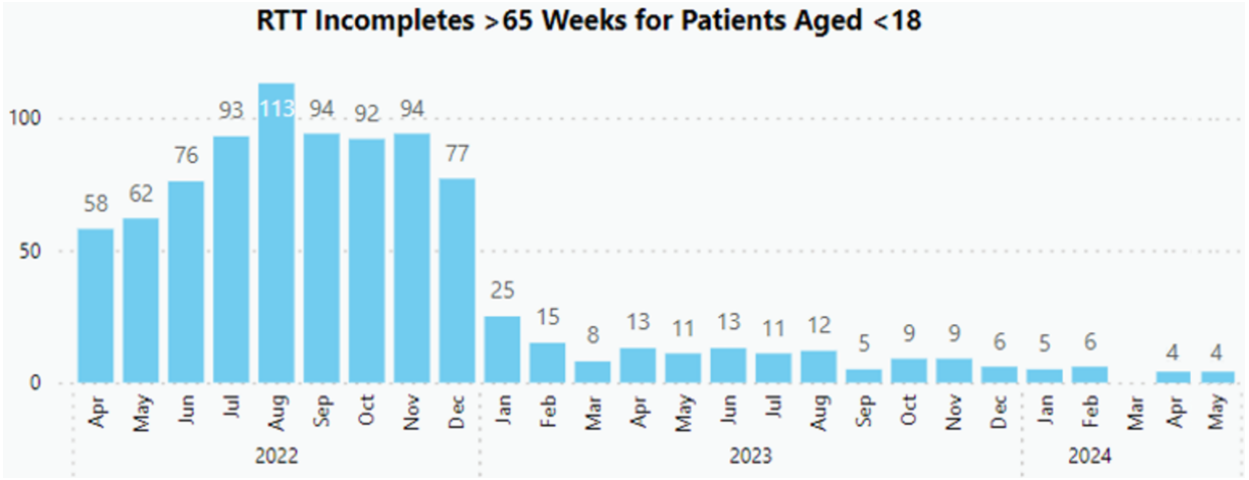
What's the top contributor for under/over achievement?

- 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 with additional capacity also being sourced via DMAS @ Newhall. Paediatric T&O continues to be a challenge – additional capacity at registrar level will be available from late August/early September 24
- Despite improvements Gastroenterology remain the biggest contributor to over 52 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 Sept 24 – currently Gastro, T&O, Gen Surg, ENT	Dando	End of Q2 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	Dando	Ongoing

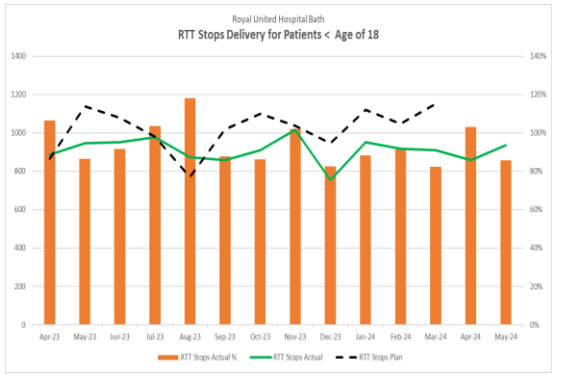
Trust Goal | >65 week waiters (Paediatrics)

Historic Data

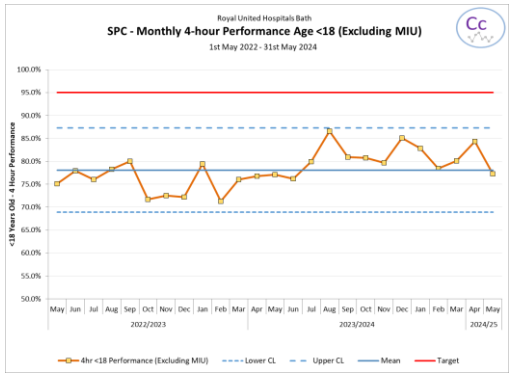


Supporting data

Stops v Plan



4 hr performance



Is the standard being delivered?

- RTT non-compliant – In May we reported 0 patients <age of 18 waiting >**78 weeks** and 4 patients waiting over 65 weeks. These were all within Paediatric Trauma and Orthopaedics, and have next steps in June. We are exploring mutual aid through DMAS to seek other capacity opportunities.

- Cancer 28 Day Diagnosis compliant – 100% April, 66.7% in May. Two breaches, both in breast, both confirmed non-cancer. One was due to capacity and one was due to cancelled clinic

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

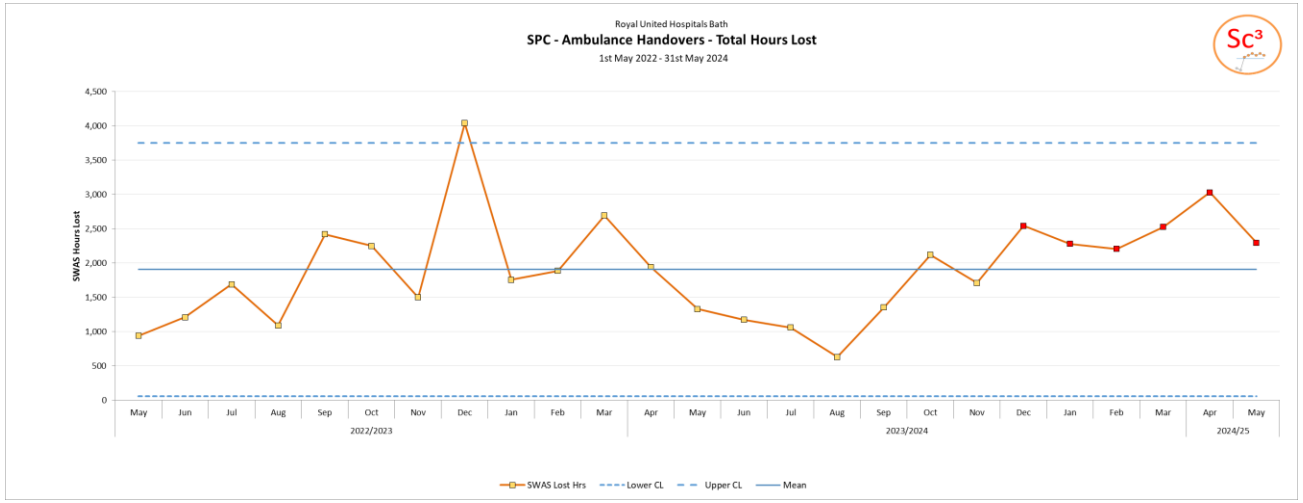
Paediatric Orthopaedic capacity remains challenged – a business case for an additional surgeon has been developed and is awaiting approval. Additional capacity will be provided at registrar level from late August/early September 24.

Countermeasures / Actions	Owner	Due Date
Working with NHSE to utilise DMAS for paediatric capacity out of area.	J Dando/S Roberts	June/July
CED/PAU - working together to improve 4hr performance - FirstNet screen installation and improved comms - PAU away day 2/7/24	Gilby / Potter	In progress
CAMHS pathway – new low risk pathway to expedite CAMHS discharge process. Awaiting sign off by consultant psychiatrist.	Goodwin	In progress

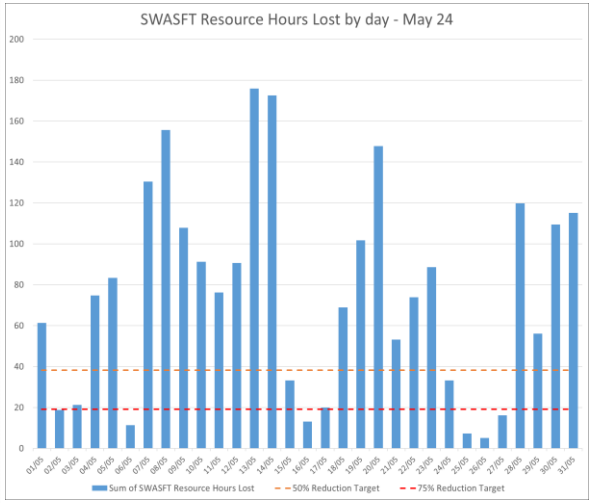
Is this a key standard?| Ambulance handover

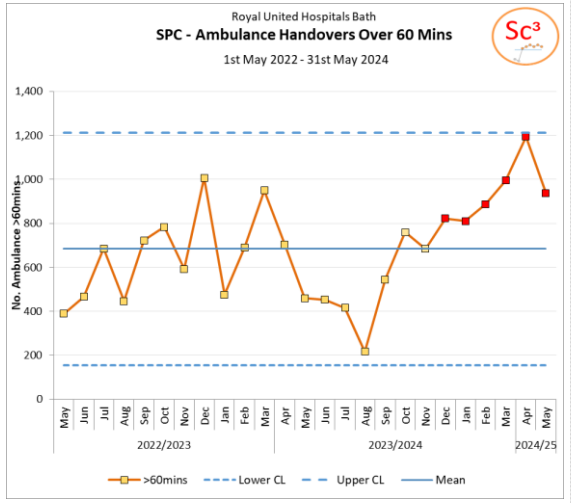
Performance target: lose no more than 500 hours per month

Historic Data: Hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

In May, the Trust lost a total of 2,296 hours in ambulance handovers, a reduction from the previous month. The percentage of Ambulances handed over within 30 minutes increased for May to 42.7% compared to previous month (30.9%). The Trust continue to experience discrepancies regarding ambulance handover data in May which, following validation, totalled 132 hours which would make our hours lost position for May 2,164 hours. SWAST have confirmed that manual updates to X-CAD will no longer be possible, however the RUH continue to validate ambulance arrivals over 4 hours. The UEC Improvement Plan will support flow out of ED, which will increase the number of patients handed over within 30 minutes.

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

The Trust improved the number of hours lost (albeit still over target), and improved the percentage of handovers completed within 30 minutes in May. The Trust saw ongoing flow pressure with bed occupancy above trajectory at 94.3%), increased NC2R, high ED attendances (for ambulance arrivals and walk-ins) 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:

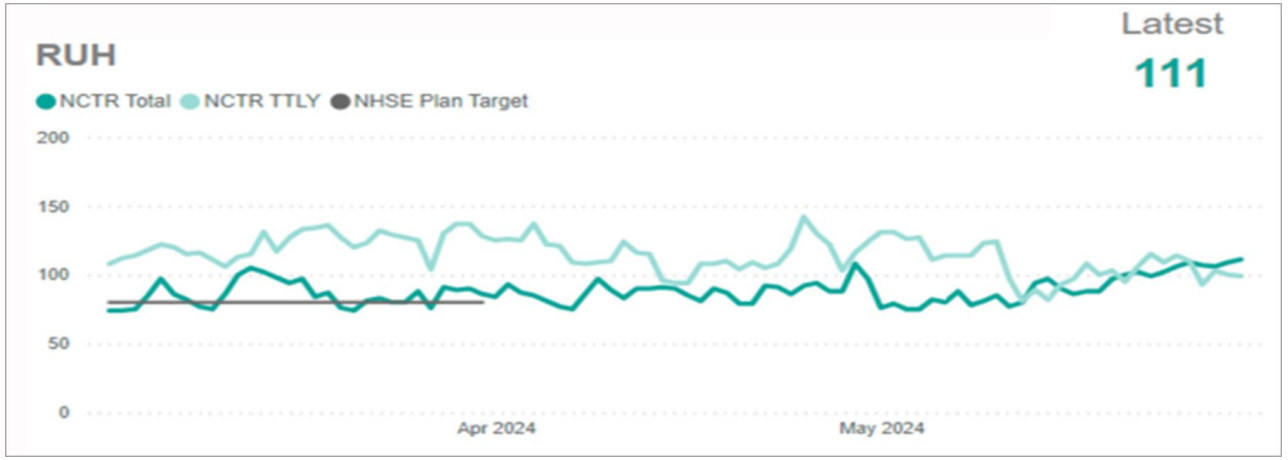
- X-CAD only utilised in ED which is leading to data errors particularly when cohorting patients
- Challenges with validating ambulance handover delays when a patient is placed into a Cohort Area. Daily validation is ongoing but manual validation will not override X-CAD recorded time
- Days when SDEC Units full so expected patients arrive in ED & UC contributing to overcrowding
- Challenges with flow out of the ED supported by an increased LoS in Pitstop and Ambulance Cohort areas. In May, an extra 283 patients were placed into a cohort area.

Countermeasures / Actions	Owner	Due Date
Continue to complete daily validation of ambulance handover delays more than 4 hours	E. Tate	Ongoing
Relaunch RAT working Group to support review of RAT/Pitstop Process with clearly defined SOP	M. Price	30.06.2024
Draft internal escalation cards	C. Irwin-Porter	30.06.2024
Review output of 6A Audit once data available from BSW and link to UEC improvement plan for ambulance handovers	M. Price	30.06.2024
Review Fit to Sit protocol and purpose of Ambulance Cohort Areas	C. Forsyth & T. Thorn	01.07.2024

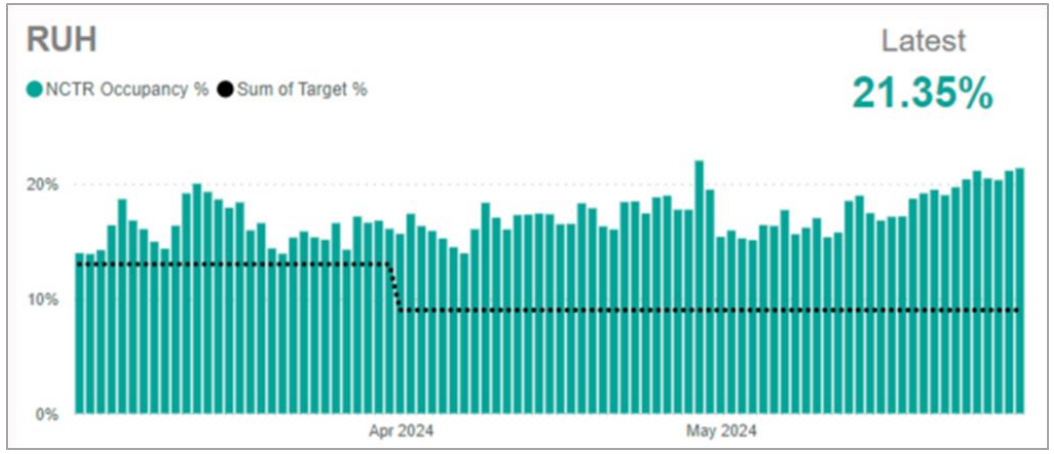
Is this a key standard?| Non criteria to reside

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

Historic Data: as of 29/05/24



Supporting data



Is the standard being delivered?

During May the Trust had an average of 92.8 patients waiting who had no criteria to reside, which is 4.8 higher than previous month. This remains above the system refreshed target of 55 and is seeing a gradual month on month increase.

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

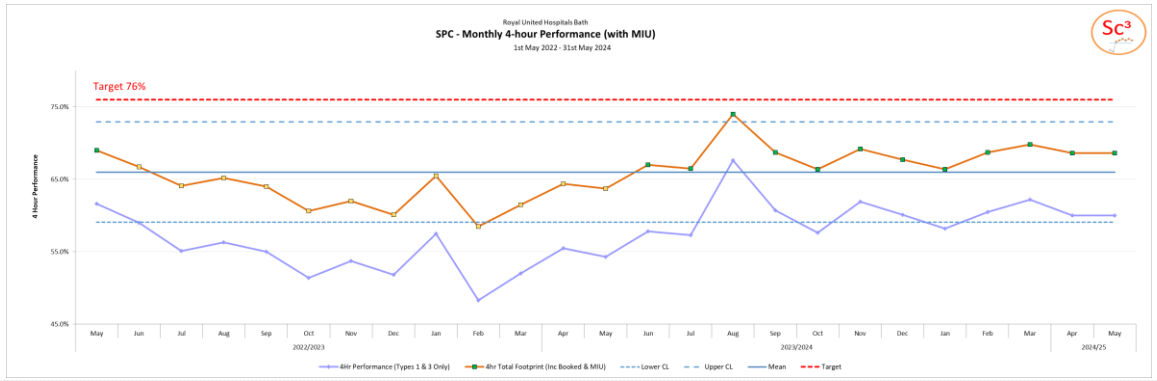
- Top right graph shows the daily percentage of beds occupied at the RUH by NCTR patients
- Reduction in Bedded capacity waits for NCTR have reduced
- Banes have seen an increase in NCTR for P1 patients due to a change in process – process being reviewed
- Ward 4 processes has caused cancellations in planned discharges contributing to delays sue to communication between partners

Countermeasures / Actions	Owner	Due Date
Recovery plan and measures in place to support Wiltshire system	Goddard	On going
Home is Best focus on admission avoidance with system colleagues	Allison	Q1 23/24
Review process for accepting NCTR repatriations back to the RUH	West	June 24
Implementation of electronic whiteboards to streamline discharge planning	Allison	Q2

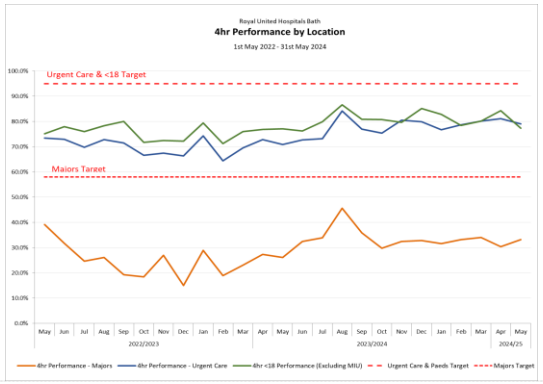
Key Standards | 4 hour Emergency Standard

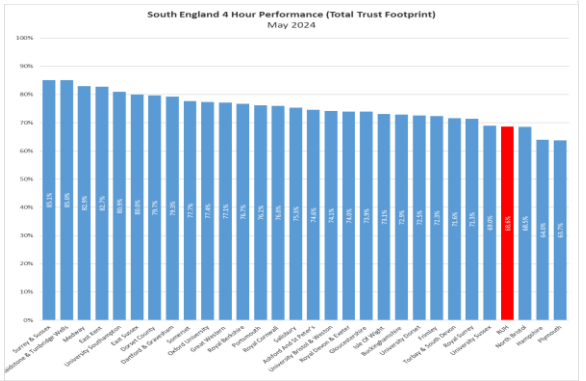
Performance target; 76% of patients discharged or admitted from ED within 4 hours

Historic Data



Supporting data





Is the standard being delivered?

RUH 4-hour performance in May was **68.6%** and **60.0%** on the RUH footprint (unmapped). The same position as April 2024, missing the 2024/25 trajectory of **70.05**% unmapped. Attendances during May were 9,121 an increase from April and the second highest monthly attendances seen through the department. The non-admitted 4-hour performance was adverse to plan due to an increase in the predicted number of attendances to UTC and current staffing model was not able to support this demand level to deliver within 4-hours. Admitted performance was affected by an increase in the occupancy of patients without a criteria to reside (92 patients), occupancy at 94% (target 92%) and ward discharges occurring after midday. Improvement in performance will be supported by the delivery of the UEC improvement plan, specifically the integrated front door workstream for non-admitted 4- hour performance and the In Hospital workstream, which will support the 4-hour admitted pathway recovery.

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

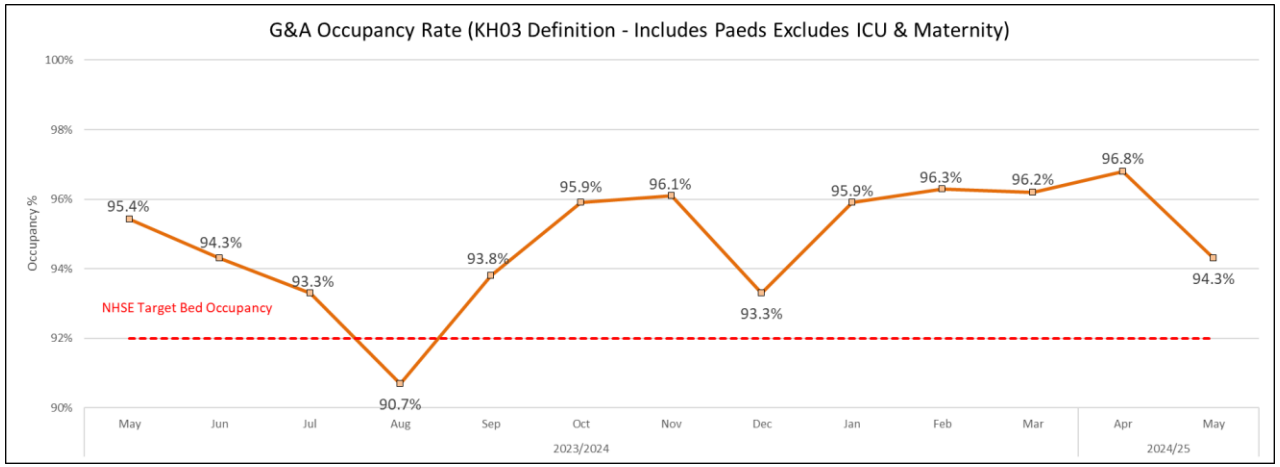
- Increase in attendances in May (9,121) on the previous month 8,258 - second highest month recorded. This was seen across ambulance conveyances and walk-ins.
- Ambulance conveyed patients also increased to 2,372 compared to previous months (April 2,247).
- Although the overall number of attendances increased, the ED admission rate reduced.
- Majors improved to 33.18%, however Urgent Care and Paediatrics saw a slight reduction in their 4hr performance.
- Time to Initial Assessment performance dropped in May, as well as Time to Treatment performance.
- Non-Criteria to Reside numbers have increased further (92) which is similar to that of October 2023 and 21+ LOS has increased slightly.
- A positive increase in GP/specialty expected patients going direct to the SDEC units.
- 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.
- Trust bed occupancy still above trajectory during May at 94.3%

Countermeasures / Actions	Owner	Due Date
Validation Guide to support live validation drafted. For ED triumvirate to sign off – aiming to undertsand the root casue of breaches, and align to the UEC PIP actions	ED Tri	30.06.24
Maintain 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	C. Irwin-Porter	30.06.24
Reduce non-admitted Majors breaches and escalate individual patients through the ED daily huddles and senior progress chase roles – review progress and support sustaining process.	ED huddles	Ongoing
Clinical Divisions to provide capacity 24/7 for expected patients to prevent ED attendance – improvement seen in May – progress further in June 2024	S. Hudson	30.06.24

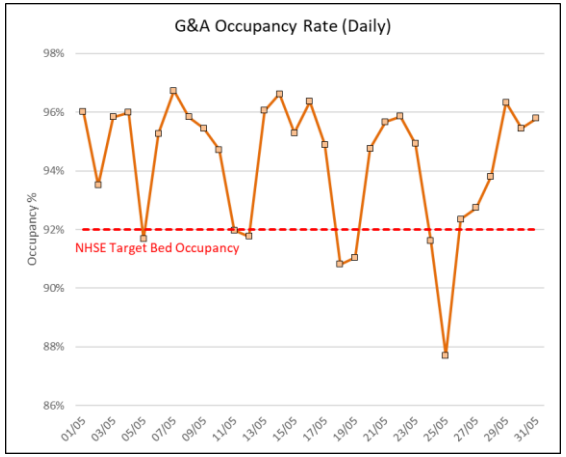
Key Standards | Bed Occupancy

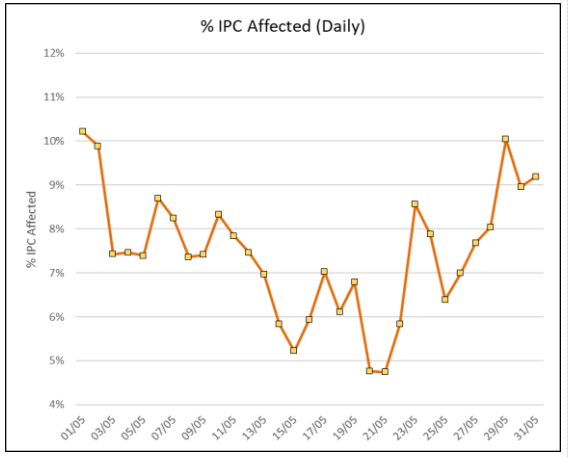
Performance target; Bed occupancy should be no greater than 92%

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 May the Trust's bed occupancy was 94.3%.

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

- We have seen a reduction through the first half of May for IPC related bed closures with an increase seen in the second half of the month due to covid
- SDEC continues with high usage of 36% - pathways continue to be improved
- Non-elective LOS reduced to 3.7 (0.3)
- Pre midday discharges saw a reduction to 22.6% of all discharges
- 20.8 % of discharges utilised the discharge lounge in May which is a reduction of 20%

Countermeasures / Actions	Owner	Due Date
Embedding of Discharge lounge SOP to increase utilisation and compliance	West	Q1 24/25
Continued Improvement work on pre-midday discharges and utilisation of discharge lounge	Divisions	Q1 24/25
Launching review of board rounds and comparing against the Royal College of Physicians guide on modern ward rounds	Medicine	Q1 24/25
Relocation of Discharge Lounge to main block to increase utilisation (avoids weather dependent transfers)	Allison	Q2 24/25

Key Standards | Elective Recovery

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

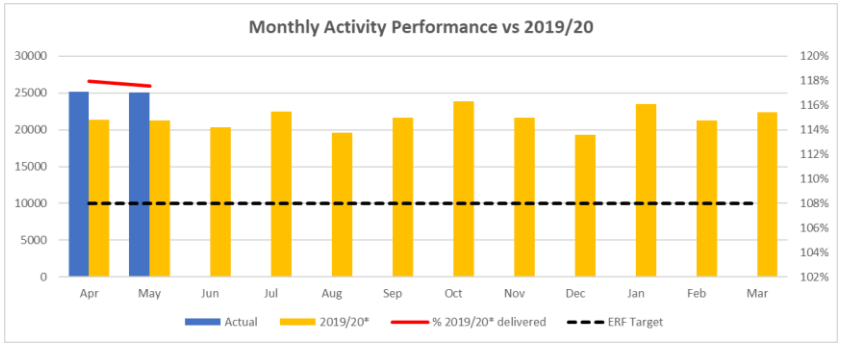
ERF Performance

	vs 19/20									
Division	M1	M2	M3	M4	M5	M6	M7	M8	M9	YTD
FASS	147%	150%								147%
Medicine	140%	124%								140%
Surgery	120%	108%								120%
RUH	130%	119%								130%

	vs 24/25									
Division	M1	M2	M3	M4	M5	M6	M7	M8	M9	YTD
FASS	109%	109%								109%
Medicine	101%	99%								101%
Surgery	113%	105%								113%
RUH	109%	104%								109%

Supporting data

ERF Activity Delivery



Is the standard being delivered?

24/25 has started well with the strong position for M1 continuing into M2, despite unforeseen challenges such as the closure of the Modular Theatre. We delivered 119% of 19/20 activity and 104% of our 24/25 M2 plan. This translates into a financial performance of 119% of 19/20 and 104% of our M2 24/25 plan. This has delivered a surplus of over £322k in-month and just over £1mln year-to-date, with Day Case and Outpatient New attendances being the significant contributors to this position.

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

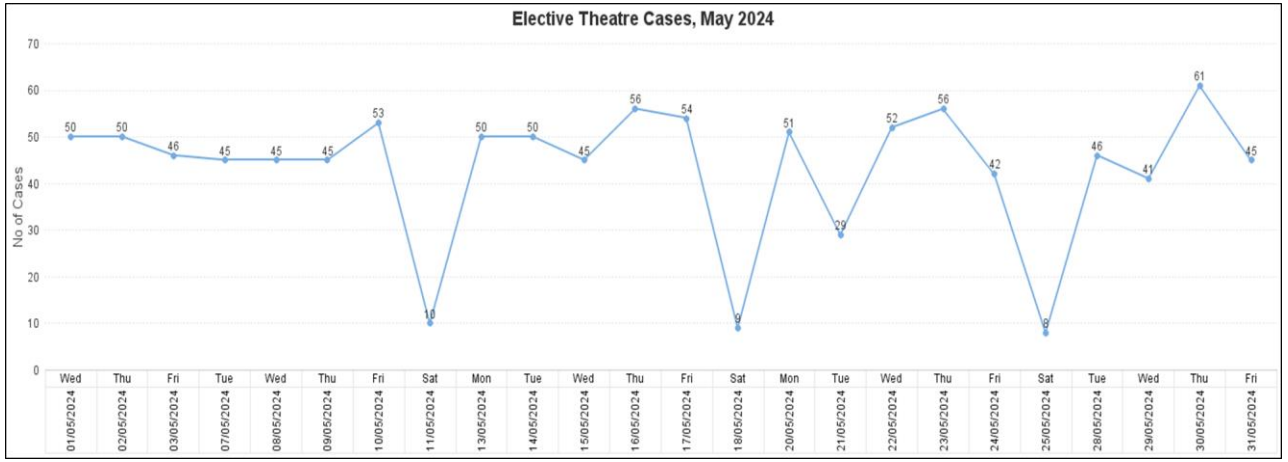
The biggest contributors to this performance in month over 2019/20 in each Division are as follows:

- Surgery
  - T&O ENT, General Surgery and Urology continue to be the main contributors to the Surgery performance.
  - T&O continues to be over 19-20 but has seen a reduction of £180k compared to Month 1. This is due to the closure of the modular theatre.
  - Urology is performance is £179k over plan, which is mostly all day-case activity
- Medicine
  - Gastro, Cardiology and Rheumatology adults continue to be the biggest contributors towards Medicines performance
  - Dermatology in-month position is £140k is mostly day cases offset by a reduction in OP procedures.
  - There appears to be a coding issue with Endocrinology activity with no day case activity appearing in SLAM for Months 1 & 2. An average tariff estimate has been applied, while the details are being worked through.
- FASS

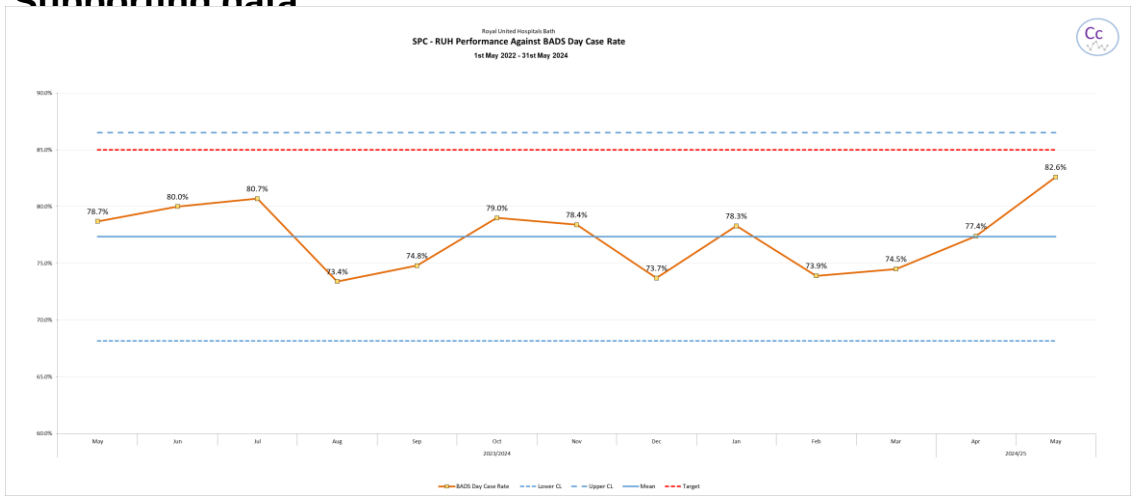
Countermeasures / Actions	Owner	Due Date
Transformation workstreams focused on supporting increased activity within Theatres and Outpatients. Extending to endoscopy/ Cath labs	Divisions	Through Q1 24/25
Identifying opportunities for clinic template changes to increase news - as part of Outpatient Steering Group	Divisions/ Improvement team	Through Q1 24/25
Reviewing M2 Non-elective activity to ensure all appropriately coded	Wisher-Davies	May/June 24
Meeting with Coding to form action plan to catch up on coding backlog	Wisher-Davies	Q1 24/25

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 May theatres were booked to 80.0% a reduction from April at 82.2%; the capped utilisation was 74.5% (target 85%) a small drop from 75.2% in April.
- The British Association of Day case Rates (BADs) increased to 82.6%, nearly achieving the 85% National Target.
- There have been significant improvements however in day case laparoscopic cholecystectomy rates, now at 84% (National target 75%), and further improvements on utilisation of our DSU for paediatric cases rather than the Children's Unit allowing increase in cases per day/week.

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

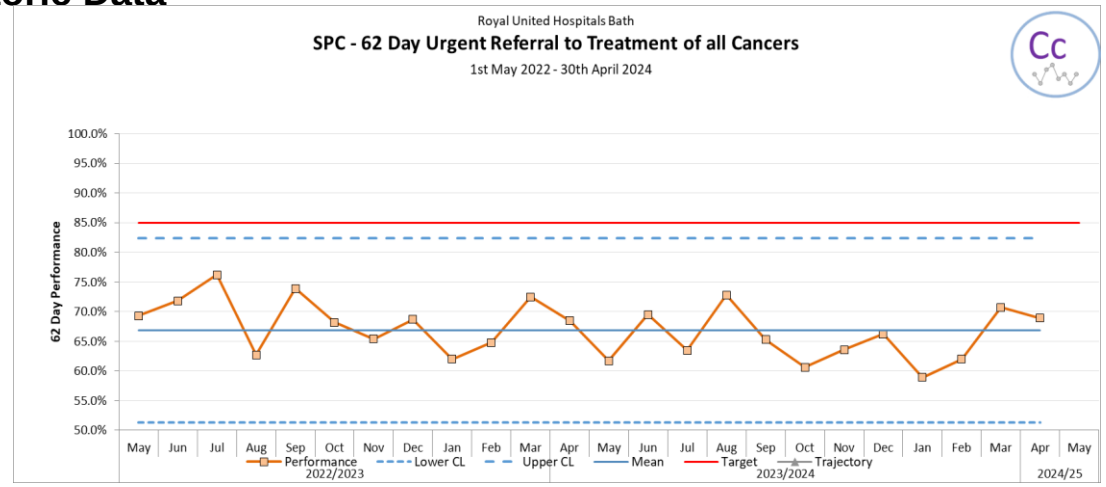
- In May, the Sulis Modular theatre was out of commission for two weeks, reducing the theatre capacity to run elective lists, this impacted several specialities, with the biggest impact due to list loss being seen in T&O.
- The cancellation on the day were 42, an increase from April, the number of cancellations due to list overruns increased in May, which is in part driven by lack of overtime availability. However, the number of lists finishing late reduced from April to May.
- The Improvement Team continue to support theatre efficiency projects with focus on bookings and ophthalmology cases per session (a very successful visit to SFT Eye theatre last has highlighted

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	Q1-Q4 24/25
Review/refresh of booking and procedure times to ensure lists booked more accurately .	D Robinson	Q4 24/25
Development of speciality specific productivity dashboard to become breakthrough objective for each speciality	S Williams	Q1 24/25

Key Standards | Cancer 62 days

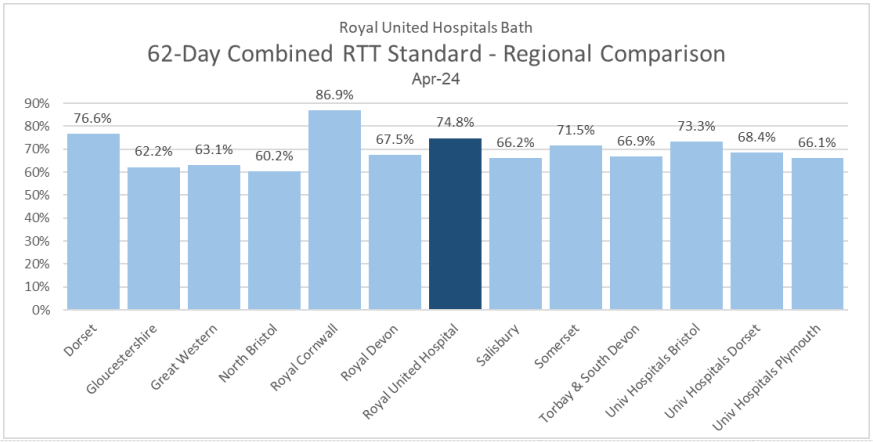
Performance target; 70% of patients treated within 62 days of referral on a cancer pathway

Historic Data



Supporting data

Regional 62 Day Combined RTT Comparison



Is the standard being delivered?

April performance showed continued improvement to 74.8% (March to 72.5%)

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

62 Day Treated:

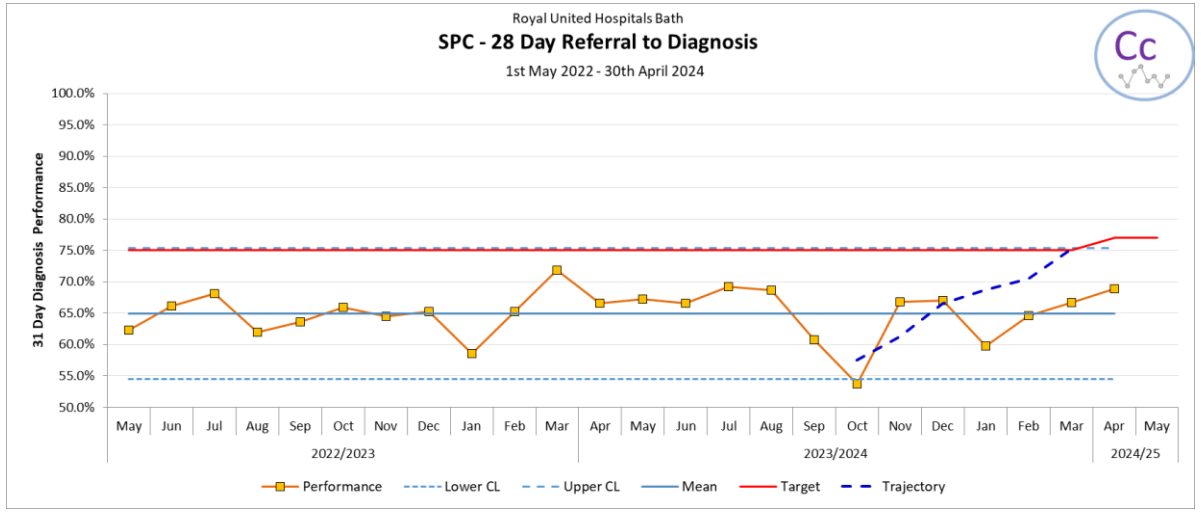
- Urology recorded the most breaches in month, increasing by 2, reducing performance to 71.7%.
- Over two thirds were for patients with prostate cancer who experienced longer waiting times for MRI scans and joint clinic appointments following MDT.
- Surgical waiting times have also been affected due to a consultant vacancy.
- Colorectal had the lowest performance with 46.4% but this was a notable improvement from March (30.2%) with 4 fewer patients breaching. Waiting times for endoscopy and CT/CTC remained the top contributing factor in breaches.
- Complexity of patient pathways and patient unavailability also added to overall pathway length.
- Skin performance deteriorated with 5 more patients breaching. The common factor in breaches was patients undergoing a biopsy and then requiring excision, an issue which has been mitigated in recent months through redirection of substantive consultant capacity to running the initial outpatient clinics.
- Lung breaches reduced from 10 to 6. Thoracic surgery waiting times at UHBW for Lung cancer continue to improve. The initial CT scan however remains longer than the target timeframe.
- As referred to in countermeasures the Trust is progressing with delivery of a wide range of clinical and non clinical posts/schemes to support 62 day improvements approved with some schemes already commenced and other commencing in June/July.

Countermeasures / Actions	Owner	Due Date
Urology - Substantive consultant recruitment	J Prosser	October 2024
Endoscopy – Increased recovery space – works delayed, June completion date uncertain	R Weston	Mid-July 2024
Skin – Locum consultant recruitment	G Lewis	July 2024
Skin – Insourcing for minor ops – proposal submitted for review	G Lewis	July 2024
Anaesthetics – Daily drop-in pre-op/anaesthetic assessment clinics being implemented (funded by Cancer Alliance)	R Leslie	Autumn 2024
Colorectal – Imaging and histology results going directly to requesting non-medical practitioner	N Lepak	July 2024

Key Standards | Cancer 28 days

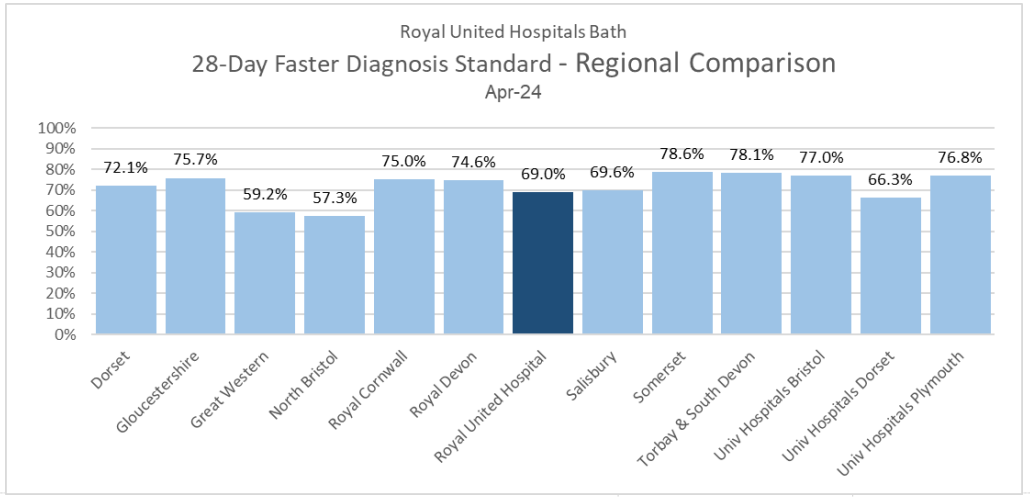
Performance target; 77% of patients given their diagnosis within 28 days of referral

Historic Data



Supporting data

28 Day FDS Regional Comparison



Is the standard being delivered?

- In April, against the new 77% target, the RUH recorded 69.0%, an improvement from March (66.6%)

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

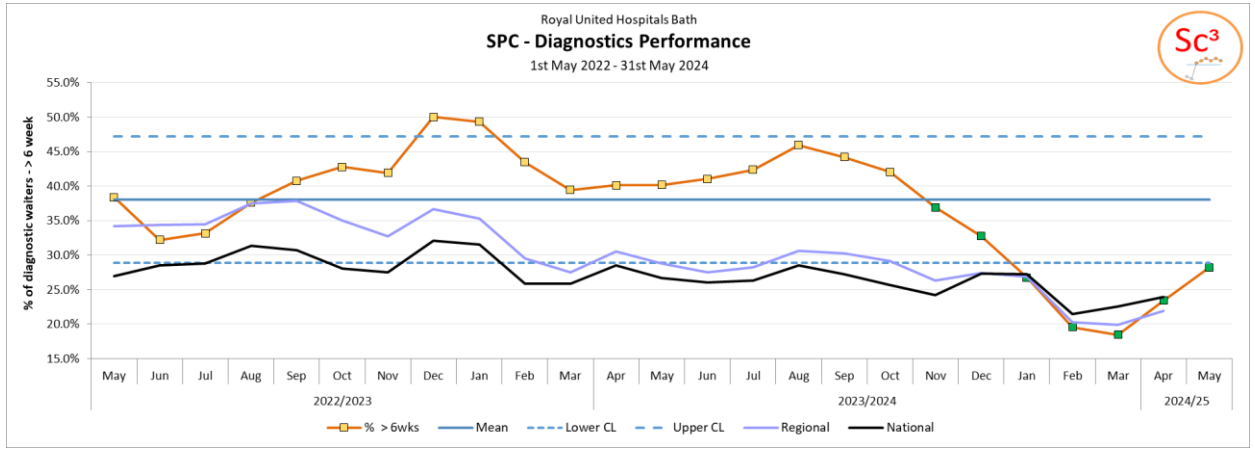
- Trust to enter NHSE tiering due to 28 day performance – meetings from June.
- Top contributor for FDS is colorectal. Performance has remained similar at 29.3%. Diagnostic delays (endoscopy, CT/CTC) alongside gastro outpatient appointment waiting times remain the cause of the majority of breaches.
- A lack of clarity in endoscopy reports on whether a cancer pathway is continuing or has stopped also leads to some breaches.
- Histology waiting times increasing across most tumour sites. 2 consultant vacancies, significant challenges in recruitment due to national shortage of posts. Locum in place and recruitment packages to be offered in future job adverts.
- Anticipating significant improvement in FDS performance following introduction of one stop model in Breast in August/September 2024 with trial set for beginning of August.
- Future performance risk in June and July due to long waiting time for first outpatient appointments in Skin and Urology.

Countermeasures / Actions	Owner	Due Date
Endoscopy – Establish pre-assessment service – roles appointed, final staff training ongoing	R Weston	Mid-July 2024
Endoscopy – Improvement documentation – Confirmation in reports of cancer pathways continuing or stopped	R Weston	July 2024
Colorectal – Transfer of STT colonoscopy patients to Sulis	N Lepak	June 2024
Skin/Urology – Development of insourcing proposals for outpatients	G Lewis J Prosser	July 2024
All – Non-cancer template letters – reducing waiting time from non-cancer decision to patient being informed	E Nicolle R Krysztopik	July 2024

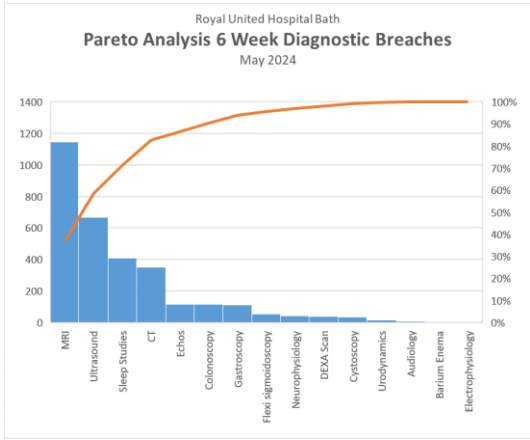
Key Standards | Diagnostics 6 weeks

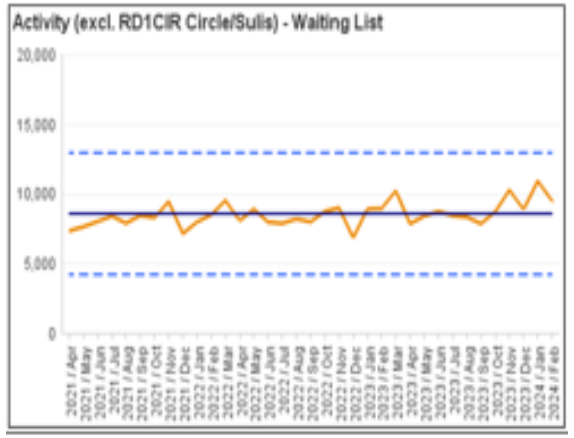
Performance target; No more than 5% of patients waiting over 6 weeks for their diagnostic test

Historic Data



Supporting data





Is the standard being delivered?

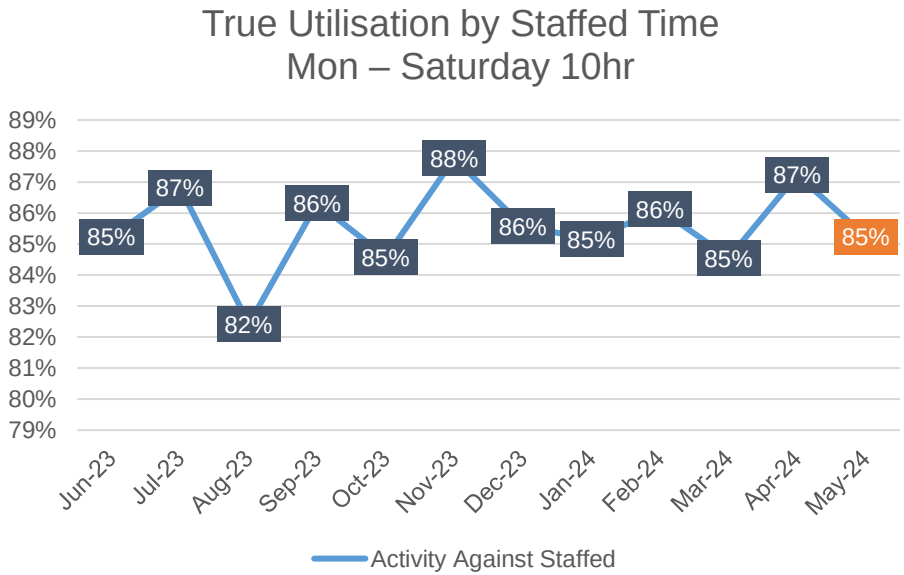
May 2024 >6-week performance was **28.23% (71.77% compliance).** The number of patients waiting > 6 weeks increased by **4.84% (+ 872 breaches).** The total waiting lists increased by 1469 patients. MRI, Sleep Studies and USS remain the top contributors for overall performance. Performance affected by an increase in demand for overall diagnostics, with a noted increased in suspected cancer referrals which impact directly on the available capacity for DM01 activity. Focus for June is on revised trajectories and recovery actions for all modalities, to support improvement of performance and, when possible, acceleration of recovery trajectory, which includes additional activity transfer above plan for 2024/25 to Sulis-Community Diagnostic Centre.

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

- Top contributors: MRI, Sleep Studies and USS.
- Improvement in performance in DEXA, Echocardiography and Audiology.
- Decline in performance in-month for MRI, CT, USS, Sleep Studies, Endoscopy and Cystoscopy.
- Increased demand for Radiology diagnostics (+13% from previous month) driving worsening performance. Within total demand, urgent/suspected cancer cohort increasing above plan and impacting directly on available capacity for routine DM01 referrals.
- Sleep Studies position remains unchanged until whole service transfers to Sulis CDC in August

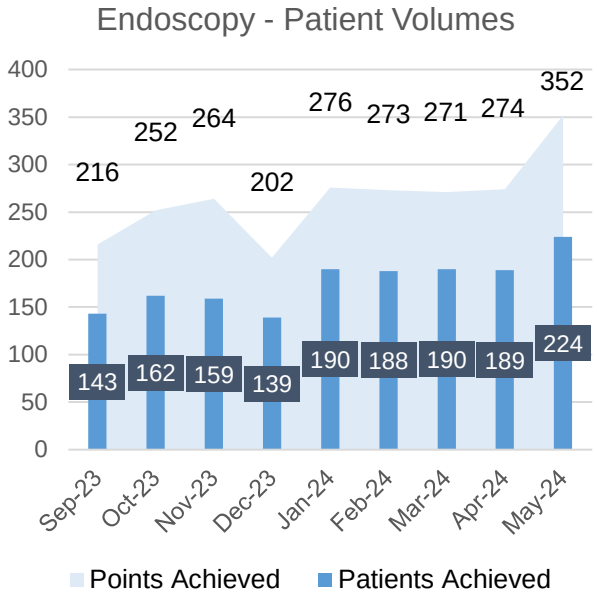
Countermeasures / Actions	Owner	Due Date
Sustain and increase radiology activity at Sulis CDC - monitored at weekly meetings to ensure full utilisation of all available capacity. Review of plans for direct access to CDC for GP's and CDC reporting DM01 for activity delivered.	NA / TB / MC	June-24
MRI/CT increased capacity - additional mobile Unit days and explore additional weekend work (staff dependant)	NA	July-24
Mitigation actions for Echocardiography - increase activity and reduce backlog. Plan to mitigate ongoing staffing issues.	MB / BI	May-24
Increased Endoscopy capacity at Sulis + GWH.	RW / JE	June-24
Plan for overdue surveillance endoscopy: add to active DM01 list (as per National Guidance – 50% by Q1, 100% by Q2). Links with Medilogik go-live and revision of working lists.	RW / JE	June-24
Transfer of Sleep Studies service to Sulis CDC	MHW	August-24
Review and early action: • > 13 weeks breaches review and booking	JS/NA	Ongoing

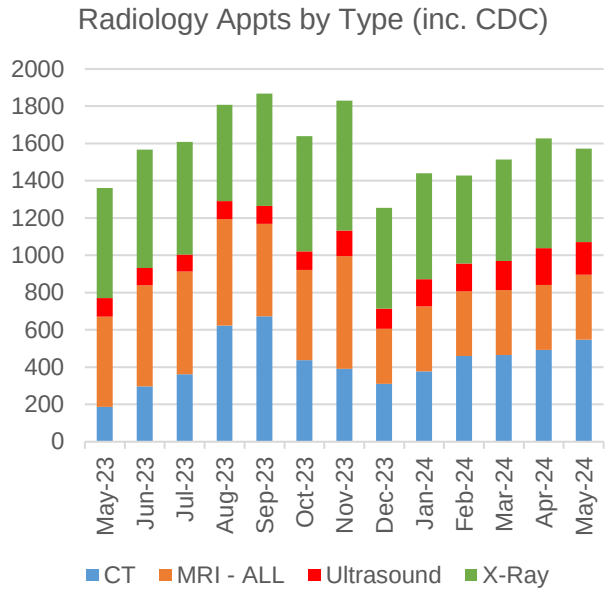
Key Standards | Sulis Hospital



RTT: **72%** - **0%**

Weeks	PT QTY
78+	0
65+	5
31-65	459
19-30	684
0-18	1952





Is the standard being delivered?

- Theatre uptake was declined to 97%. (MOM slight decline due to consultant sickness and lack of private pipeline)
- 85% activity utilisation 10 hour metric (MOM down 2% but maintained the target 85%)
- Endoscopy session up-take up to 84%. Activity levels increased along with this capacity increase. Activity volume of JAG points 352 (224patients) - (95% utilisation against staffed time).
- Radiology volumes decrease -3% MoM. Radiology volumes of CDC Programme are up 5%.
- Ultrasound/MRI/CT activity was good against plan. XRAY volumes considerably underperform as aging equipment continues to pose risk. Reviewing external capacity options.
- Sulis RTT position static at 72% compliance overall – Improvements required in validation. Long waiting patients are on a reducing trend.

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

- Main highlights are Endoscopy activity utilisation up to 95% and session up-take above 80%
  - More clinicians available against facility availability.
- Theatre activity hit by consultants going off sick and private activity pipeline concerns.
- Under performance in CDC programme due to delays in capital project, aging Xray and challenges with some patient flow (Cardiology, Phlebotomy.

Countermeasures / Actions	Owner	Due Date
Review increasing Spinal outpatient pathway to support RUH backlog	Milner	June/July
Increase radiology capacity through the use of Paulton and Bath Clinic options. Extending Sulis Radiology working day to 7 days.	Milner	July
Reviewing staffing models to enable Sleep Study Service to be executive at Sulis Hospital	Milner	June
Review capital project plan and timelines for Radiology expansion and XRAY upgrade.	Milner	Ongoing

Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 2

The people in our community

The RUH, where you matter

Summary

BSW Integrated Care System

- The organisations in the BSW Integrated Care System must collaborate to develop Revenue and Capital Financial Plans with a view to achieving breakeven against allocations each year.
- The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to it's pre-pandemic levels.
- The BSW System has developed a financial plan with a £30.0m deficit for the year, of which the RUH is £5.3m deficit. There remains unidentified savings gaps within this System plan and system partners will be expected to deliver plans and seek to stretch these further.

RUH Group Financial Plan

- The RUH deficit plan of £5.3m is underpinned by £22.7m of non recurrent revenue financial support from commissioners and £6.3m of NHSE funding for revenue consequences of new capital investment
- The financial plan for the year requires full delivery of a £36.6m Savings Programme, which has been phased to show progressive reduction in costs and increases in productivity over the year
- Achieving the financial plan is an RUH Breakthrough Objective for 2024/25
- The organisation continues to operate under enhanced levels of Executive controls to ensure Savings plans are delivered and costs are controlled. Work continues to align Transformation & Improvement Planning activities and Divisional budgets are aligned and incentivised to the achieve this breakthrough objective using the Improving Together approach.

Revenue Financial Performance – Month 2

- At Month 2 the Group is at a deficit position of £4.06m, which is £0.1m worse than plan
- Savings of £3.1m have been delivered to date (8.5% of annual target in 16.7% of the financial year), including £1.6million of pay savings against budget, and the benefit of Elective Recovery Fund income and operating margin of 58%
- Non-Pay is overspent by £0.5m predominantly across supplies and services. This is being looked at, especially given the high level of activity in the month.
- This is being mitigated by higher than planned interest receivable.

Capital and Balance Sheet Position – Month 2

- Total capital expenditure is £1.6 million at Month 2, which is £6.4 million behind plan due to delays in both the SEOC and EPR programmes
- The closing cash balance for the Group was £27.6 million which is 25.6% higher than the plan due to the capital delays set out above

Risks and Issues

The Trust is managing a number of financial risks, of which,

- **Full delivery of the Savings programme** on a recurrent basis, including paybill reduction, is the most significant
- **Careful management of cash** through the middle of the year will be required as the capital programme is in part front-loaded and the savings programme back-loaded
- **The Trust financial position is anchored on the wider Integrated Care System** and therefore contribution to RUH from working with other partners and the financial performance of other organisations could have a bearing on the financial position; which can be mitigated through collaborative working and problem solving

Executive Scorecard

	Performance Indicator	Description	Target: Performing	Target: Under Performing	Baseline	Actual 2024/25: Apr-24	Actual 2024/25: May-24
Sustainability Tracker Metrics	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	£0	£0m	(£0.08m)
	Forecast delivery of Group financial plan	Forecast variance from year to date plan	<=0	>0	(£5.30m)	£0m	(£0.08m)
	Group delivery of Plan	Total year to date financial performance	<=0	>0	(£5.30m)	(£2.26m)	(£4.06m)
	Delivery of QIPP	Total QIPP delivery	N/A	N/A	£36.6m	£1.8m	£3.1m
	Delivery of QIPP against plan	Performance against plan	<=100%	>100%	100.0%	100.0%	98.0%
	Reduction in agency expenditure	Agency costs as a % of total pay costs	<= 3%	> 3%	3.0%	1.2%	1.2%
	Sickness against plan	Actual levels of sickness against average pre-pandemic levels	<= 4.1%	> 4.1%	4.5%	4.5%	4.5%
	Reducing no criteria to reside patients	No criteria to reside to reduce by 40% from December 2021	<= 90	> 90	80	73	103
	Reducing staff vacancies	Total contracted vacancies reported each month	<=7.4%	>7.4%	4.0%	4.9%	1.7%
	Net impact of high cost drugs and devices	Total expenditure and income against plan for high cost drugs and devices	<=0	>0	£0	£0	(£0.4m)
	Increase productivity	Implied productivity based on financial and operational performance (Quarterly)	>=3%	3%	-20%	-23%	-23%
	Elective recovery	In Month Performance against planned levels of activity (Value based)	>= 100%	< 100%	n/a	109%	104%
	Non elective activity	In Month Performance against planned levels of activity (Value Based)	<= 102%	> 102%	n/a	119.0%	142.0%
	Delivery of capital programme	Variance from year to date planned capital expenditure (Internally Funded Schemes)	-5%	<5%	n/a	67.3%	51.9%
	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+ or - 5%	><5%	n/a	0	0
	Delivery of planned cash balance	Variance from year to date planned cash balance	- 10%	<10%	n/a	8.8%	25.6%

Overall Revenue Position

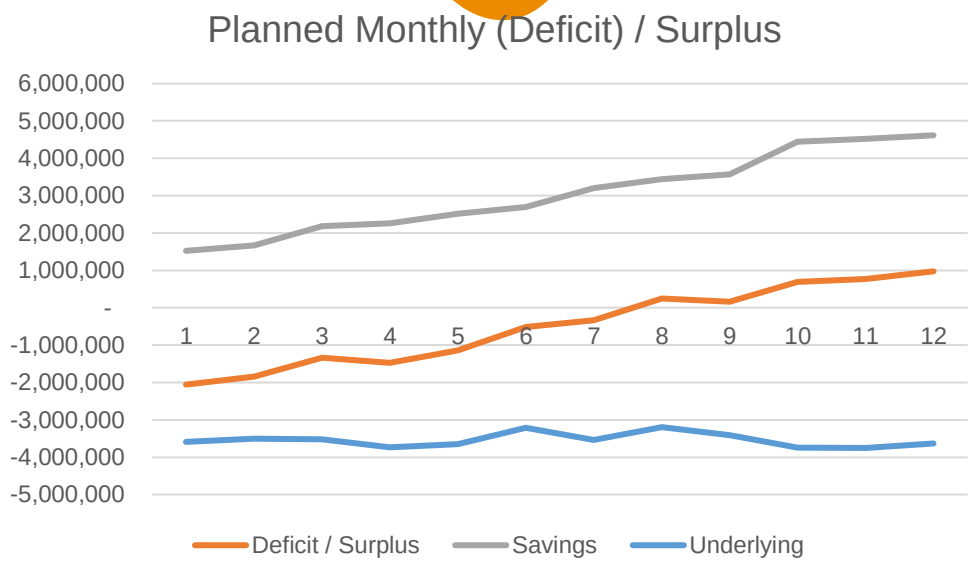
At Month 2 the Group is at a deficit position of £4.03 million which is £0.08 million adverse to plan.

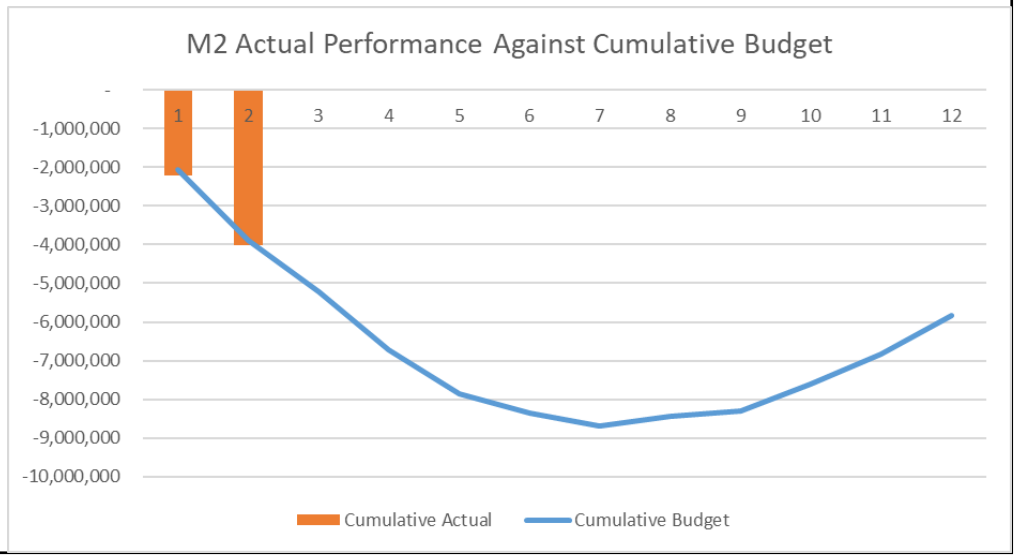
The Planned Monthly (Deficit) / Surplus graph shows the phased budget over the year. This shows the base case deficit around £3.5 million per month with savings recovering this position and a gradually increasing rate.

1. Reducing temporary staffing through the benefits of substantive recruitment and improved productivity increase progressively through the year
2. And there are three key steps changes:

- End of Q1 step up in Clinical Coding and Estates & Facilities savings
- End of Q2 close unidentified savings gap
- End of Q3 substantive pay bill reduction schemes

The second graph shows the Cumulative Actuals and Budget. The 'U' curve highlights the worsening of the position up to Month 9 from when the RUH delivers an in month surplus creating the improvement against the cumulative position.





True North | Breakeven position

Statement of Comprehensive Income Period to 202402	RUH						Sulis						Group Adjustment		Total Group Position					
	202402			YTD			202402			YTD			202402	YTD	202402			YTD		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Actual £'000	Actual £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Income Total	43,117	41,885	(1,232)	85,062	83,971	(1,092)	3,793	3,420	(374)	7,057	6,737	(320)	(197)	(394)	46,910	45,108	(1,802)	92,120	90,313	(1,806)
Pay	(28,026)	(27,722)	304	(55,723)	(55,713)	11	(1,995)	(1,853)	142	(3,876)	(3,667)	209	0	0	(30,021)	(29,575)	446	(59,600)	(59,380)	220
Non Pay	(13,332)	(13,309)	23	(26,343)	(27,014)	(672)	(1,389)	(1,273)	116	(2,667)	(2,505)	163	0	0	(14,720)	(14,582)	138	(29,010)	(29,519)	(509)
Depreciation	(2,019)	(2,019)	0	(4,038)	(4,038)	0	(245)	(238)	8	(491)	(474)	17	145	290	(2,265)	(2,112)	153	(4,529)	(4,222)	307
Impairment	(578)	0	578	(1,157)	0	1,157	0	0	0	0	0	0	0	0	(578)	0	578	(1,157)	0	1,157
Expenditure Total	(43,956)	(43,050)	905	(87,261)	(86,765)	496	(3,628)	(3,363)	265	(7,034)	(6,646)	389	145	290	(47,584)	(46,269)	1,316	(94,295)	(93,121)	1,175
Operating Surplus/(Deficit)	(839)	(1,165)	(326)	(2,199)	(2,795)	(596)	165	56	(109)	23	91	68	(52)	(104)	(674)	(1,161)	(487)	(2,176)	(2,807)	(632)
Other Finance Charges	(938)	(744)	194	(1,876)	(1,433)	442	(55)	(46)	10	(111)	(92)	20	34	68	(993)	(756)	238	(1,987)	(1,457)	530
Other Gains/Losses	0	2	2	0	3	3	0	0	0	0	0	0	0	0	0	2	2	0	3	3
Finance Charges	(938)	(741)	197	(1,876)	(1,430)	446	(55)	(46)	10	(111)	(92)	20	34	68	(993)	(753)	240	(1,987)	(1,454)	533
Surplus/(Deficit)	(1,777)	(1,906)	(129)	(4,075)	(4,225)	(150)	110	11	(99)	(89)	(1)	88	(18)	(36)	(1,667)	(1,914)	(247)	(4,163)	(4,262)	(98)
Adjusted Financial Performance																				
Add back all I&E impairments/ (reversals)	578	0	(578)	1,157	0	(1,157)	0	0	0	0	0	0	0	0	578	0	(578)	1,157	0	(1,157)
Remove capital donations/grants I&E impact	(640)	109	749	(980)	199	1,179	0	0	0	0	0	0	0	0	(640)	109	749	(980)	199	1,179
Adjusted financial performance surplus/(deficit)	**(1,838)**	**(1,798)**	**41**	**(3,898)**	**(4,026)**	**(128)**	**110**	**11**	**(99)**	**(89)**	**(1)**	**88**	**(18)**	**(36)**	**(1,729)**	**(1,805)**	**(76)**	**(3,987)**	**(4,063)**	**(76)**

Note. The 24/25 Financial Plan is underpinned by £22.7m of non-recurrent revenue financial support from commissioners (£1,891k per month); and £6.3m of funding from NHSE to support revenue costs of strategic capital investment.

For NHSE financial performance the consolidated RUH Foundation Trust and Sulis financial position is taken into account. Adjustments are made for technical accounting entries related to Impairments and Capital Donations

Tracker Measure | Sustainability – Workforce

Pay Spend by Staff Group	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000
Medical Staff	(94,709)	(15,581)	(15,087)	494
Nursing and Midwifery	(104,940)	(17,135)	(17,357)	(222)
Scientific, Technical and Therapeutic	(39,841)	(6,620)	(6,215)	404
Support to Clinical	(55,046)	(8,979)	(9,192)	(212)
Infrastructure	(41,101)	(6,553)	(6,539)	14
Other	(1,095)	(182)	(236)	(53)
Remaining Savings Target	17,995	330	0	(330)
Adjusted Pay	(318,737)	(54,720)	(54,626)	94
Pay Directly Funded	(6,020)	(1,003)	(1,087)	(83)
Pay Total	(324,758)	(55,723)	(55,713)	11

Pay Spend by Staff Group	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000
Substantive	(315,953)	(54,230)	(50,874)	3,356
Bank	(264)	(44)	(2,891)	(2,847)
Agency	(1,426)	(264)	(625)	(362)
Other	(1,095)	(182)	(236)	(53)
Total Pay	**(318,737)**	**(54,720)**	**(54,626)**	**94**
Pay Directly Funded*	(6,020)	(1,003)	(1,087)	(83)
Adjusted Pay	**(324,758)**	**(55,723)**	**(55,713)**	**11**

WTE by Staff Group	YTD Plan	YTD Actual Worked	YTD Variance to Plan	YTD Variance to Plan %
Medical Staff	764	772	(8)	-1.0%
Nursing and Midwifery	1,815	1,887	(72)	-4.0%
Scientific, Technical and Therapeutic	707	650	57	8.0%
Support to Clinical	1,898	1,640	258	13.6%
Infrastructure	914	859	54	5.9%
Remaining Savings Target	(209)	0	(209)	100.0%
WTE Total	5,889	5,809	80	1.4%

This report shows the paid WTE which aligns to the spend. This differs slightly from the worked WTE reported through Workforce reporting that includes the actuals worked in month. Some specifics include Bank & Agency usage and overtime which are predominantly a month in arears.

Is standard being delivered? Yes

What is the top contributor for under/over-achievement?
The RUH currently had the equivalent of 5,809 Whole Time Equivalents (WTE) paid in May against a plan of 5,889.

This Nursing and Midwifery has the largest overspend both financially and in terms of WTE. Some headroom is built into budgets to cover sickness and other absences, but this is being exceeded across most wards.

The Remaining Budget Savings shows the value of Pay Savings that have not yet been assigned to the pay group and division.

Countermeasures completed last month

Countermeasures for the month ahead

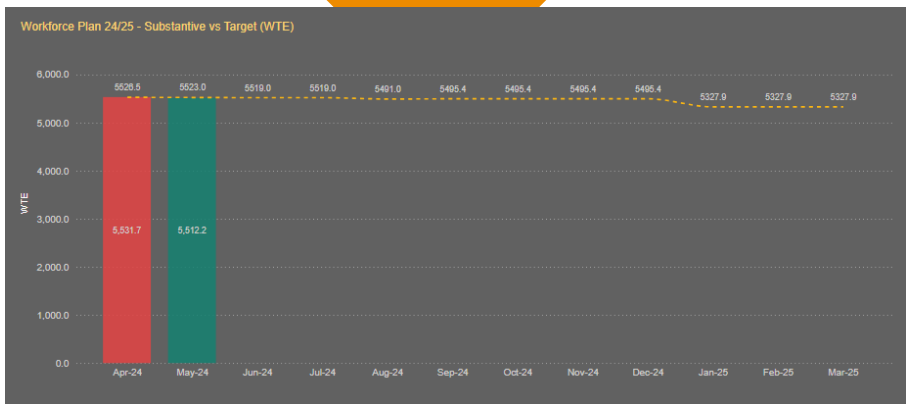
Countermeasure /Action	Owner
Monitor Workforce Controls and Review Effectiveness	Improvement Team, HR and Finance

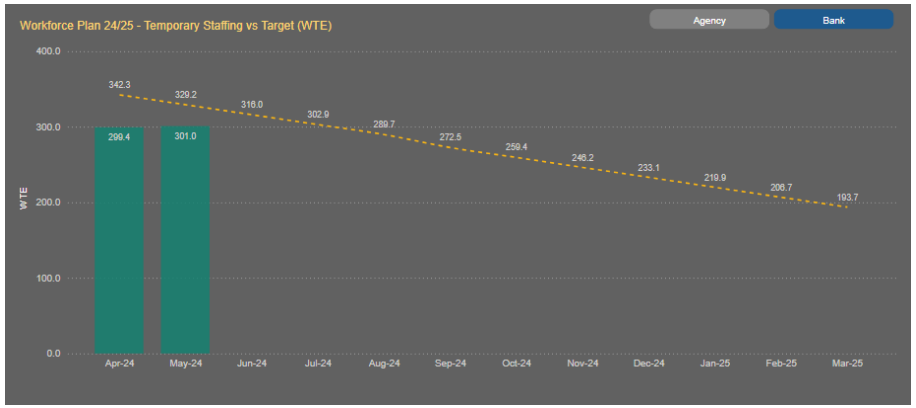
Workforce Analysis

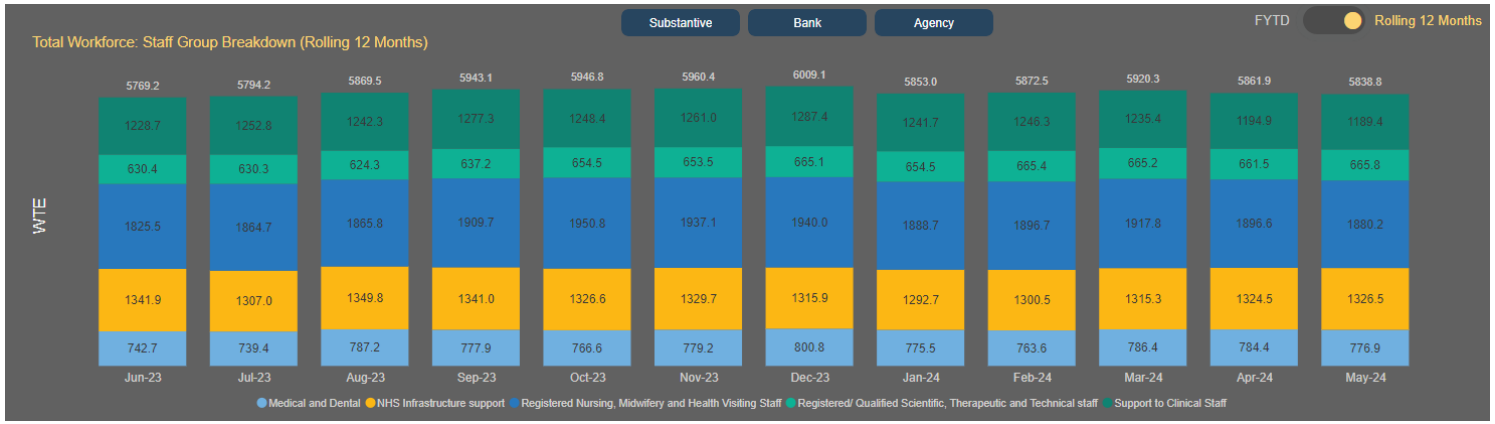
As well as tracking the overall value of Workforce Costs the Trust tracks the Whole Time Equivalent (WTE). The graphs show the Budgeted, Forecast and Actual WTE working per month.

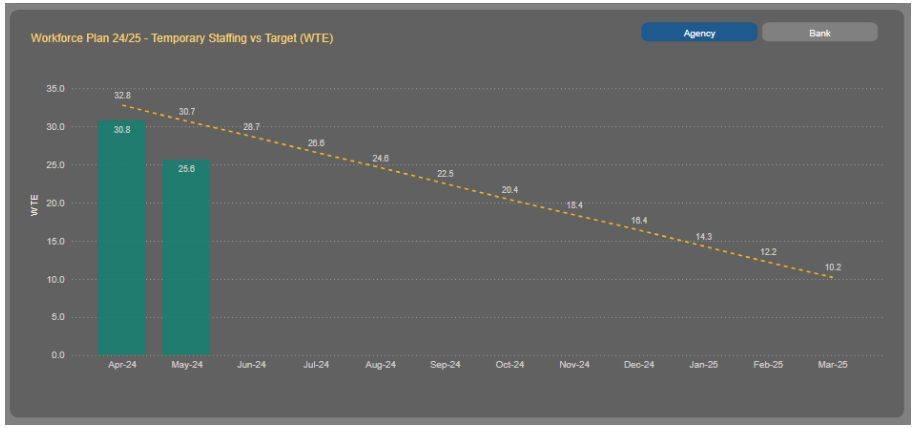
These reports show the actual worked in month. The calculation for Bank differs between Workforce and Finance Reporting. The Workforce plan assumes an average of 4.3 weeks in every month, compared to the reporting through finance that reflects the number of weeks paid, which could be 4 or 5. For reporting in May this equated to around 60 WTE more in the finance return than the workforce return.

These graphs highlight the planned reduction of WTE during the year and will measure the performance against that plan. The total WTE has reduced by 81.5 (1.4%) from 5,920.3 in March to 5,838.8 in May.





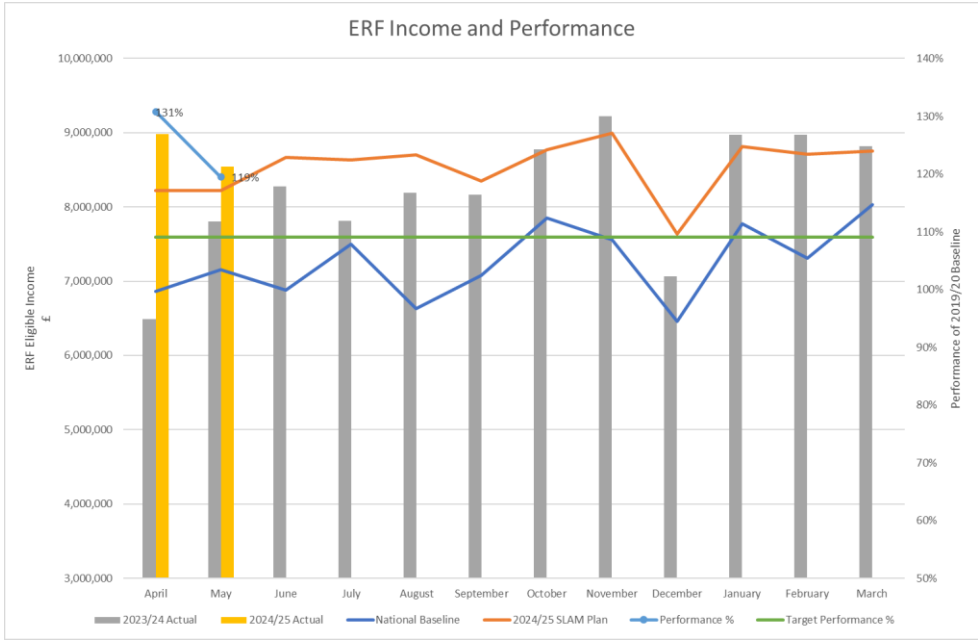




RUH ERF Performance Valued Activity

The ERF performance in month was 104% of plan and represents 119% of 2019/20 valued activity.
The total value of ERF activity was £8.5 million in month, a reduction of £0.4 million on the previous month. During May the additional modular theatre at Sulis was temporarily closed for 2 weeks, an estimated income reduction of c£0.15m

	Investment Expenditure			Elective Recovery Performance			Metrics	
	Plan	Actual	Variance	Plan	Actual Performance Against 19/20	Variance	Performance Against Plan	Margin
Division	£'000	£'000	£'000	£'000	£'000	£'000	%	%
FASS	120	160	(40)	907	1,178	271	108%	86%
Medicine	649	591	58	1,150	1,143	(7)	100%	48%
Surgery	871	707	164	365	1,182	817	110%	40%
Total	**1,641**	**1,458**	**183**	**2,422**	**3,503**	**1,081**	107%	58%



Performance in month:

- Actual investment costs are £0.7 million, under budget by £0.1 million. This generated additional income of £1,4 million, £0.3 million above target.
- The margin is 51% compared to a planned margin of 39%

Performance year to date:

- Actual investment costs are £1.5 million, under budget by £0.2 million. This generated additional income of £3.5 million, £1.1 million above target.
- The margin is 58% compared to a planned margin of 39%
- The Finance Department is undertaking an exercise to ensure all non pay consumable costs are captured in this analysis

QIPP | Financial Progress

Deliver by Month 2 by Improvement Programme Theme

	Year to Date Plan	Year to date Actuals	Variance
	£,000	£,000	£,000
1_Productivity Programme	£774	£1,078	-£303
2_Pay Bill reduction	£1,806	£1,547	£259
3_Cost Control/Comm Income	£275	£342	-£68
4_Other	£333	£158	£176
Total	**£3,188**	**£3,125**	**£64**

Deliver by Month 2 by Division

DIVISION	PAY	NON-PAY	INCOME	TOTAL
CORPORATE	£ 93	£ 15	£ -	£ 108
ED	£ 71	£ -	£ 2	£ 73
ESTATES & FACILITIES	£ 472	£ 44	£ -	£ 516
FASS	£ 202	£ 43	£ 245	£ 489
MEDICINE	£ 366	£ 119	£ 94	£ 579
SULIS	£ -	£ 8	£ 12	£ 19
SURGERY	£ 343	£ 220	£ 777	£ 1,340
Total	**£ 1,547**	**£ 448**	**£ 1,129**	**£ 3,125**

Summary

QIPP in month 2 delivered £3.125 million against a £3.188 million plan.

This was achieved predominantly due to:

- Productivity – mostly ERF income generation
- Vacancy Gap savings
- RMNs
- Procurement and medicine savings
- FYE savings from 23/24
- Sulis

The full year impact of the delivered savings was £4.5 million against the £36.6 million plan.

At end of May there is a forecast, through plans and opportunities, to deliver £32.3 million. However the programme and approvals continues at pace and currently only £4.4 million is unidentified with Plics/model hospital and clinical coding being utilised to identify opportunities to bridge the gap.

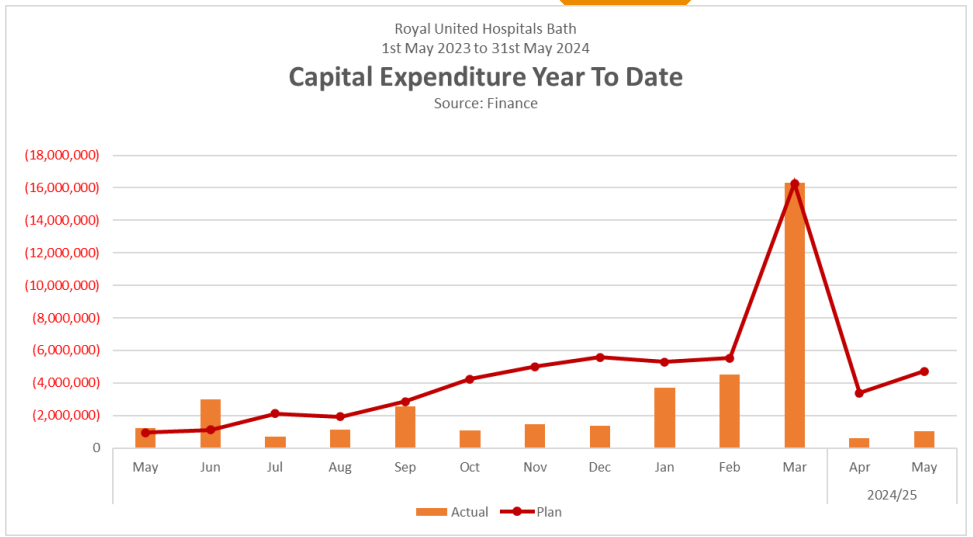
Key Risks to Delivery of Financial Plan

Finance				
Area	**Risk**	**Mitigation**	**Risk Value £m**	**Year to Date Impact £m Cost/(Reduction)**
Cost reductions	Cost reductions required are based on expenditure run rates in 2023/24.	Budgets for 2024/25 have been agreed and budget holders are developing plans to ensure run rates above 2024/25 budget have a robust plan to reduce to close the planned deficit.		(0.4)
High cost drugs & devices	Income expected from BSW to support planned drugs expenditure may not be cash backed.	Growth in activity and increase in costs to be managed as part of the savings programme with support from the system drugs group.	2.8	0.4
QIPP	Delivering sufficient QIPP to help meet the financial challenges.	Operational QIPP excluding ERF will be managed, monitored, and challenged through the Improvement Programme, IPSG, Divisional PRMs.	4.4	0.1
Endoscopy activity	Excess costs for short term sub-contract to deliver extra capacity to reduce DM01 wait times and backlog from Q3.	Further funding from NHSE CDC programme	0.5	
Urgent and Emergency Demand	Managing demands on our urgent and emergency services, particularly over winter, to meet operational targets and prevent a knock-on impact on elective activity.	Working with BSW ICS to report on driving issues and make use of community services to reduce inappropriate use of acute services and expedite discharges to maintain flow within the hospital. A bed capacity plan has been developed which is assumed will be funded through national winter funding.	0.9	
NC2R	High volume of patients with no criteria to reside continues within the Trust impacting on the ability to deliver elective activity.	The BSW system is currently working through options for managing and reducing the number of these patients in the acute hospitals across the system. The financial risk is included within the urgent care risk above.		
Inflation	Inflation increases being significantly higher that included in the plan.	Energy prices, in tariff drugs and consumable products could increase beyond national planning assumptions. Work to understand the potential impacts of this and how to manage with overall envelopes available. Additional interest receivable	3.1	

Tracker Measure | Sustainability – Capital (RUH and SULIS)

Capital Programme

Capital Position as at 31st May 2024	Annual Plan	Forecast @ M2	Year to Date		
			Plan	Actuals	Variance
	£000s	£000s	£000s	£000s	£000s
Internally Funded schemes	(13,559)	(13,559)	(2,131)	(1,106)	1,025
IFRS 16 Lease Schemes	(3,700)	(3,700)	0	0	0
Disposals - NBV write off - Internally Funded					0
Disposals - NBV write off-Lease					0
External Funded (PDC & Donated):					
SEOC PDC	(20,010)	(20,010)	(4,470)	(102)	4,368
BSW EPR PDC	(2,793)	(2,793)	(58)	(9)	49
Digital Diagnostic PDC	(213)	(213)	0	0	0
Community Diagnostic Centre PDC	(3,193)	(3,193)	(376)	(231)	145
Cancer Centre PDC	(422)	(422)	(150)	(177)	(27)
Salix Decarbonisation Grant	(10,819)	(10,819)	(500)	(1)	499
Donated	(2,580)	(2,949)	(413)	0	413
Total	**(57,289)**	**(57,658)**	**(8,098)**	**(1,627)**	**6,471**



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

Trust funded programme. As last month, the largest underspends are against the BSW EPR scheme (Trust funded element) and the single ITU scheme. The late sign off of the BSW EPR business case in March means that the Trust has not achieved the plan profile from the business case, this will need to be reviewed and managed in year. The single ITU scheme is expected to catch up in the coming month and is due to complete in October.

External funded schemes. The largest underspend is against the Sulis Elective Orthopaedic Centre (SEOC) scheme, due to delays in the planning permission being agreed and a large downpayment on equipment made in March to the main contractor. It is expected to take a few months for the costs to come back in line with plan.

The contract for the Decarbonisation scheme is yet to be signed with the preferred bidder.

We have received a variation to the Cancer Centre MOU giving a further £422,000 PDC funding for prolongation costs due to the delay in handover of the build by Kier.

Countermeasures completed last month

Countermeasure /Action	Owner
NA	

Countermeasures for the month ahead

Countermeasure /Action	Owner
CPMG to continue to monitor delivery of projects and schemes	Head of Financial Services

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

	31/05/2024 Plan £'000	31/05/2024 Actual £'000	Variance £'000
Non current assets			
Intangible assets	11,197	6,658	(4,539)
Property, Plant & Equipment	304,520	300,158	(4,362)
Right of use assets - leased assets for lessee	52,239	50,121	(2,117)
Trade and other receivables	1,997	1,922	(75)
Non current assets total	**369,952**	**358,860**	**(11,092)**
Current Assets			
Inventories	5,539	8,348	2,809
Trade and other receivables	27,938	30,296	2,358
Cash and cash equivalents	21,995	27,632	5,638
Current Assets total	**55,472**	**66,276**	**10,805**
Current Liabilities			
Trade and other payables	(48,934)	(48,310)	624
Other liabilities	(3,805)	(14,895)	(11,090)
Provisions	(224)	(634)	(410)
Borrowings	(2,177)	(3,104)	(927)
Current Liabilities total	**(55,140)**	**(66,942)**	**(11,802)**
Total assets less current liabilities	**370,284**	**358,194**	**(12,090)**
Non current liabilities			
Provisions	(1,527)	(1,370)	157
Borrowings	(57,981)	(53,686)	4,295
TOTAL ASSETS EMPLOYED	**310,775**	**303,138**	**(7,637)**
Financed by:			
Public Dividend Capital	258,439	253,534	(4,905)
Income and Expenditure Reserve	5,690	8,043	2,352
Revaluation reserve	46,646	41,562	(5,084)
Total Equity	**310,775**	**303,138**	**(7,637)**

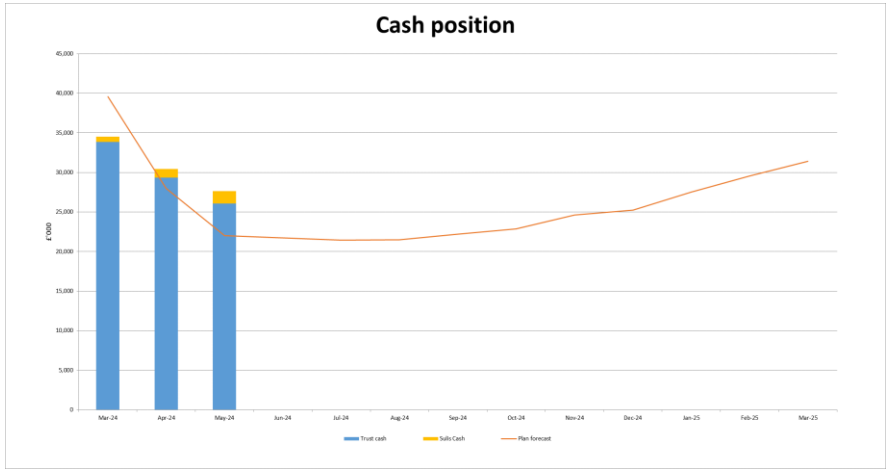
The Group Balance Sheet (RUH and Sulis)

Month 2 against plan:

- Non-current assets have decreased against the plan. The actual position reflects spend related to capital expenditure which is currently behind plan less movements in depreciation.
- Trust inventories have increased against plan assumptions but have remained steady in month.
- Trust receivables are higher less than plan and have increased in month. Increases in month mainly relate to income earned which has not yet been paid in relation to commissioner arrangements.
- Trust payables are below planned levels. This is net of movement of capital creditors and Public Dividend Capital dividend and increases in expenditure.
- Trust other liabilities are above plan however have increased in month. Key movements relate income received in relation to commissioner arrangements.
- Cash is above plan and has decreased in month as referenced on the slide detailing the cash movements.

Tracker Measure | Sustainability – Cash (RUH and SULIS)

Group Cashflow Statement Month 2



Is standard being delivered for cash? No

The Group cash balance is £5.6 million higher than planned.

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

The variance against plan is driven by capital expenditure behind M1 plan and movements in working capital.

Sulis cash position has increased by £487,000 against month 1.

Cashflow statement	**Actual £'000**
Operating Surplus/(deficit)	(2,807)
Depreciation & Amortisation	4,223
Income recognised in respect of capital donations (cash and non-cash)	(1)
Impairments	0
Working Capital movement	(6,620)
Provisions	159
Cashflow from/(used in) operations	**(5,046)**
Capital Expenditure	(1,767)
Cash receipts from asset sales	0
Donated cash for capital assets	1
Interest received	428
Cashflow before financing	**(1,338)**
Public dividend capital received	0
Movement in loans from the DHSC	(20)
Capital element of finance lease rental payments	(404)
Interest on loans	0
Interest element of finance lease	(89)
PDC dividend (paid)/refunded	0
Other financing activities	0
Net cash generated from/(used in) financing activities	**(513)**
Increase/(decrease) in cash and cash equivalents	**(6,898)**
Opening Cash balance	**34,531**
Closing cash balance	**27,633**

Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

June 2024 (May 2024 data)

The RUH, where you matter

Executive Summary I

	Performance Indicator	Performing	Outside Tolerance	National Survey 2022	National Survey 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	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Key Standard	Trust Vacancy WTE (Unit 4)			339.6	330.9	252.5	225.0	133.9	176.8	104.5	91.8	56.2	80.4	290.2	94.7
Contextual Information	Trust Establishment WTE (Unit 4)			5642.7	5645.5	5659.5	5694.5	5671.4	5693.8	5689.9	5690.5	5700.2	5699.4	5888.3	5693.9
Contextual Information	Substantive WTE (Unit 4)			5303.2	5314.6	5407.0	5469.4	5537.5	5517.0	5585.4	5598.7	5643.9	5619.0	5598.1	5598.6
Key Standard	Vacancy Rate	<=4.00%	>4.50%	6.02%	5.86%	4.46%	3.95%	2.36%	3.11%	1.84%	1.61%	0.99%	1.41%	4.93%	1.66%
Contextual Information	Total Pay Bill (exc R&D)													£27.5M	£27.2M
Key Standard	In Month Turnover	<=0.92%	>1.00%	0.80%	0.55%	1.01%	0.94%	0.63%	0.52%	0.49%	0.53%	0.51%	0.80%	0.64%	0.83%
Key Standard	Rolling 12 Month Turnover	<=11.00%	>12.00%	11.07%	10.48%	10.21%	9.94%	9.35%	9.24%	8.98%	8.78%	8.52%	8.40%	8.09%	8.34%
Contextual Information	Leavers Inside 1st Year WTE (Permanent Contract Held, All Reasons)			7.2	3.2	11.3	6.9	4.8	4.9	3.2	3.3	3.6	6.0	11.8	10.4
Contextual Information	Bank Use (Staffing Solutions Data)			311.8	222.2	219.9	234.4	255.0	241.2	196.2	204.5	193.6	183.3	189.2	199.1
Contextual Information	Agency Use (Staffing Solutions Data)			87.0	82.7	84.3	77.6	63.3	43.7	28.5	20.8	18.8	20.8	19.8	17.2
Key Standard	Agency Spend as Proportion of Total Pay Bill	<=2.50%	>4.00%	3.70%	3.81%	2.27%	3.27%	2.14%	2.47%	2.13%	0.33%	2.22%	1.05%	1.14%	1.13%
Contextual Information	Agency Spend			£976k	£981k	£636k	£874k	£590k	£683k	£588k	£87k	£600k	£446k	£315k	£310k
Contextual Information	% of agency usage that are off framework			25.38%	24.49%	13.63%	Not Avail	16.86%	2.88%	1.13%	1.58%	0.54%	3.62%	1.26%	4.89%
Contextual Information	% agency shifts that are above price cap			49.93%	55.69%	83.70%	Not Avail	73.74%	94.51%	81.9%	76.9%	81.4%	82.9%	95.6%	88.5%
Key Standard	Nurse Agency Spend as Proportion of Registered Nursing Pay Bill	<=3.00%	>4.00%	4.80%	4.45%	2.76%	4.81%	3.73%	3.73%	3.62%	0.85%	2.16%	1.57%	1.62%	1.71%
Key Standard	In Month Sickness Rate (Actual) - Reported 1 month behind	<=4.02%	>4.52%	4.26%	4.70%	4.24%	3.93%	4.53%	4.40%	4.66%	4.92%	4.83%	4.58%	4.47%	
Contextual Information	In Month Sickness - Estimated Cost (£m)			£679k	£780k	£691k	£655k	£794k	£736k	£807k	£860k	£812k	£812k	£792k	
Key Standard	Rolling 12 Month Sickness Rate - Reported 1 month behind	<=4.30%	>4.80%	4.82%	4.68%	4.66%	4.63%	4.59%	4.56%	4.46%	4.45%	4.47%	4.47%	4.49%	
Tracker	Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.08%	1.13%	1.14%	1.15%	1.18%	1.22%	1.22%	1.19%	1.20%	1.22%	1.20%	
Contextual Information	In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.19%	1.31%	1.18%	1.08%	1.24%	1.30%	1.22%	1.13%	1.25%	1.17%	1.12%	

* 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
Turnover	There are some early signs that turnover may be increasing and will be monitored going forward. At this stage, the increase doesn't breach the target.	Various drivers are reducing the turnover position, such as the 'Basics Matter' programme focusing on improving staff e xperience alongside the wider economic situation.
Sickness	Seasonally adjusted targets for April were not met, which means it will be more challenging to achieve the targeted rolling 12-month sickness rate of 4.3%	Managing absence is a key driver measure in the Nursing and Midwifery Improvement group in partnership with the People Team. A simplified guide on managing attendance has been published for line managers. The EAP service also re-launched in June 24.
Workforce Costs	Workforce whole time equivalent worked is below Month 1 plan and is underspent by £11k once cost premiums and skill-mix are taken into account.	The organisation continues to operate under enhanced levels of Executive controls to ensure Savings plans are delivered and costs are controlled.

Executive Summary II

	Performance Indicator	Performing	Outside Tolerance	Last 12 Months											
				Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-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	0.73	0.67	0.62	0.58	0.62	0.64	0.70	0.67	0.64	0.56	0.56	0.63
Contextual Information	% of Band 6/7 who are from Global Majority Background (WTE)			13.20%	13.18%	13.70%	14.15%	14.55%	14.88%	14.88%	15.21%	15.11%	15.36%	15.38%	15.29%
Contextual Information	% of Band8A+ who are from Global Majority Background (WTE)			5.89%	5.51%	5.44%	5.36%	5.03%	5.83%	6.16%	6.11%	6.08%	6.48%	6.55%	6.55%

	Performance Indicator	Latest Month Target	Outside Tolerance	Last 12 Months											
				Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Key Standard	Appraisal Compliance Rate	<=90.00%	>95.00%	74.93%	75.03%	73.41%	71.94%	71.44%	72.67%	74.84%	75.82%	77.04%	77.05%	77.69%	77.61%
Contextual Information	Global Majority Appraisal Compliance Rate	<=90.00%	>95.00%	74.73%	75.83%	72.73%	69.63%	67.63%	69.76%	71.82%	73.02%	75.69%	76.79%	76.92%	78.15%
Key Standard	Mandatory Training Compliance (exc Bank)	<=85.00%	>90.00%	87.60%	88.54%	89.54%	89.01%	89.37%	89.37%	89.82%	90.29%	90.84%	90.40%	90.34%	90.04%
Key Standard	IG Training Compliance (exc Bank)	<=95.00%	>100.00%	82.94%	84.23%	86.05%	86.20%	85.72%	86.18%	86.79%	87.62%	88.40%	87.72%	88.54%	86.82%
Key Standard	Safeguarding Adults Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	88.85%	90.88%	92.08%	91.41%	91.81%	91.62%	92.10%	92.44%	92.81%	92.43%	92.82%	92.85%
Key Standard	Safeguarding Adults Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	89.86%	90.75%	91.69%	90.74%	90.99%	90.68%	91.31%	91.02%	91.84%	91.34%	91.71%	91.84%
Key Standard	Safeguarding Adults Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	81.42%	88.29%	92.92%	93.58%	92.59%	96.26%	94.55%	93.75%	89.47%	93.21%	30.43%	36.01%
Key Standard	Safeguarding Children Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	88.79%	90.74%	91.93%	91.44%	91.81%	91.82%	92.23%	92.64%	92.88%	92.22%	92.58%	92.30%
Key Standard	Safeguarding Children Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	90.30%	91.23%	91.96%	91.26%	91.14%	90.97%	91.61%	91.74%	92.46%	91.57%	91.87%	91.52%
Key Standard	Safeguarding Children Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	87.43%	90.36%	89.85%	91.26%	90.88%	91.48%	91.24%	91.97%	90.95%	91.20%	91.32%	90.29%

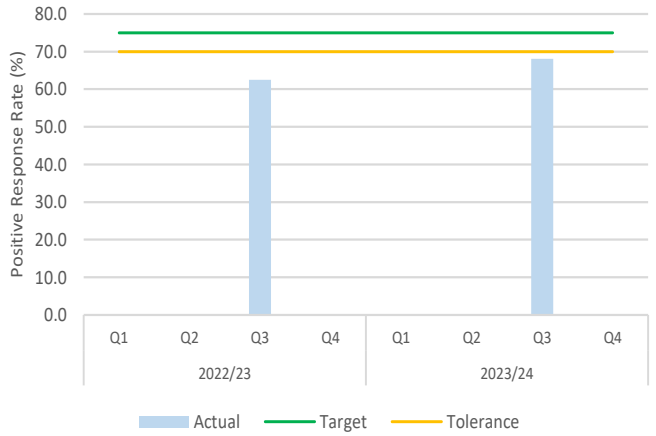
** Training data based on Learning Together from Jun-23; Appraisal and Training information re-stated due to new reporting methodology

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Appraisal Compliance	Appraisal compliance remains relatively static at 77.61% and there is little sign of the required improvement to achieve the 90% target.	Appraisal A3 presented to the May 24 People Committee and has counter measures to tackle the root cause.
Mandatory Training	Training compliance has again marginally fallen, with IG, Resuscitation and Safeguarding Adults Level 3 all rated red	Work established to look at increasing IG compliance.

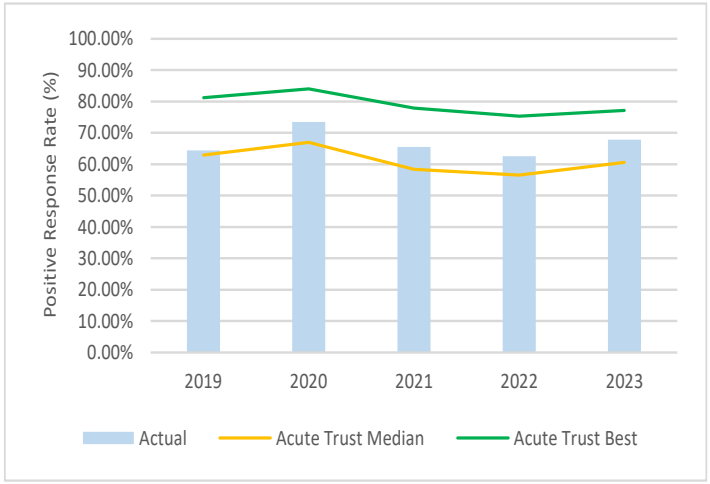
Trust Goal | Staff Recommend the Trust as a Place to Work

Making a Difference Survey Result



Latest Survey	68.1%

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%.

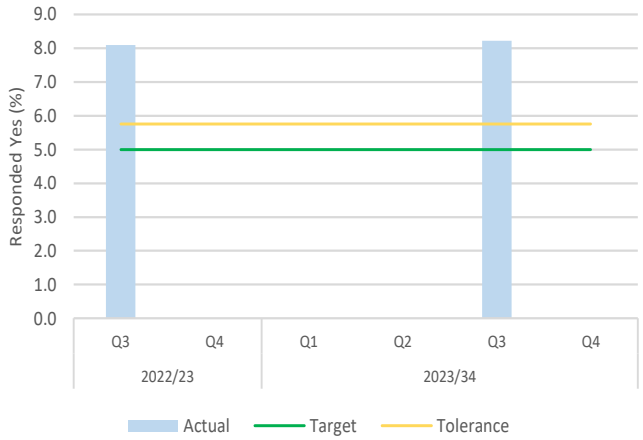
Countermeasure Summary

Countermeasure/Action	Owner
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
Division People Partners working through actions plans at Divisional and Specialty level.	Divisional People Partners/Divisional Leadership Teams
Basics Matter programme identified priorities from staff survey to inform the content of the workstreams.	Basics Matter Team

Breakthrough Goal |

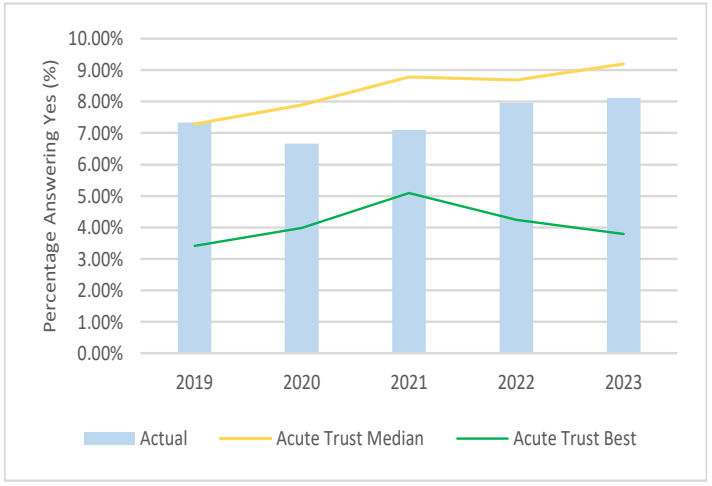
Reduce Proportion of Staff Reporting Experiencing Discrimination from Line Managers/ Colleagues

Making a Difference Survey Result



Latest Survey	8.22%

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?

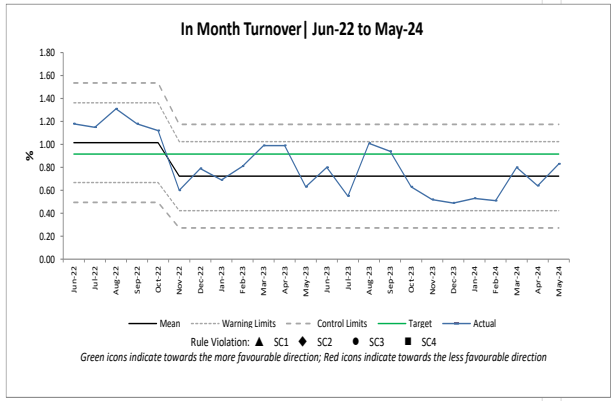
• Emergency Medicine had the lowest proportion of staff reporting that they had not experienced discrimination from a manager or colleague at 85.9%.

Countermeasure Summary

Countermeasure/Action	Owner
• Targeted team development interventions (in collaboration with HR) to address identified issues, including emergency medicine, theatres and cleaning. • Introduction of Report and Support in June 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 (planned for June 2024) • Refreshed breakthrough objective – 2024/25 focus on Disability and Long-Term Conditions, and embedding work on race (esp. Anti-Racist Statement)	People Hub / DPPs People Team for Culture Programme Lead for DaW

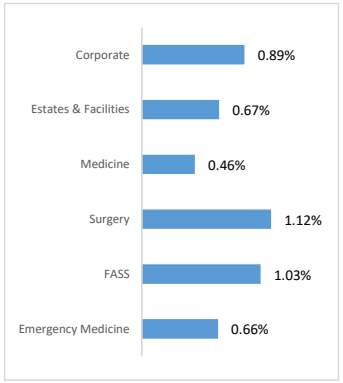
Key Standard| Turnover Rate

In Month Turnover - Trust

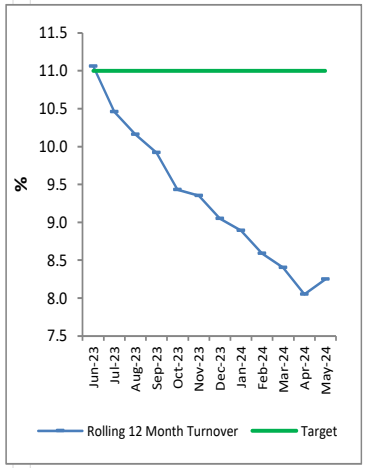


Turnover Rate	0.83%

In Month Divisional Turnover



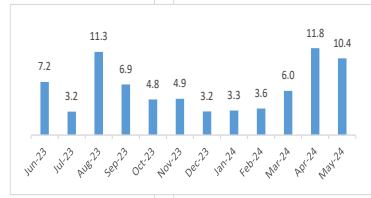
Rolling 12 Months Turnover - Trust



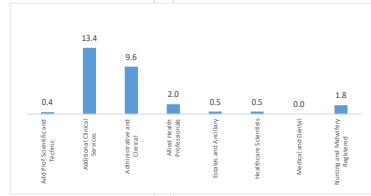
Turnover Rate	8.34%

Leavers Inside 1st Year (Permanent Contract)

Trust Trend



Staff Group - Last 3 Months



Is standard being delivered?

- In Month Turnover remains below target at 0.83%, however the is an increase compared to the previous month (0.64%). Turnover will need to be monitored over coming months.
- Rolling 12-month turnover has passed an inflection point, increasing to 8.34%. This does, however, remain below target.

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

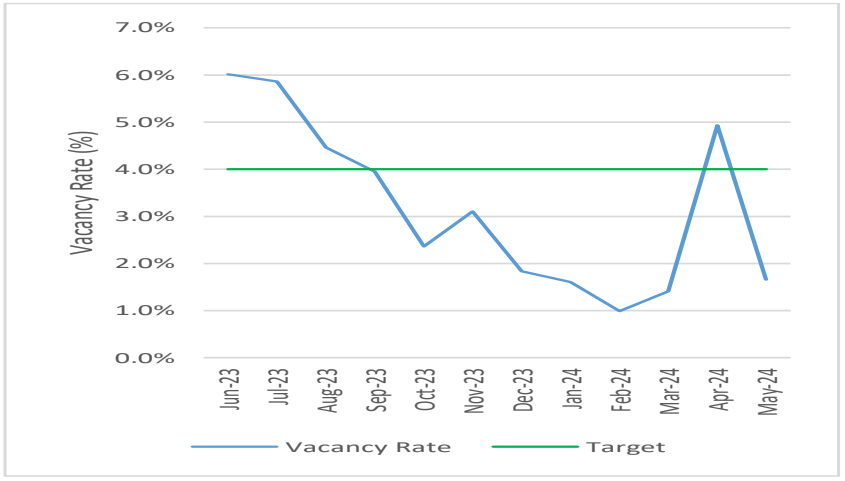
- For the first time in 6 months, Surgery (1.12%) and FASS (1.03%) have an in month turnover rate above 1%.
- Additional Clinical Services and Administrative and Clerical have seen upturns in their in month turnover rates in the past couple of months.

Countermeasure Summary

Countermeasure/Action	Owner
Foundations Programme focussing on: • Leavers guide for managers in draft stage ready for publishing in June 24. • Guidance for parents who are returning from parental leave in draft to create a supportive environment on their return.	Associate Director for People (Partnering and Programmes)
• Hot food - Landsdown reopened, basics team completed walk around with night staff to understand what staff would like to see as 24/7 hot food. Basics Matters programme continues to focus on improving staff experience	Basics Matter Team

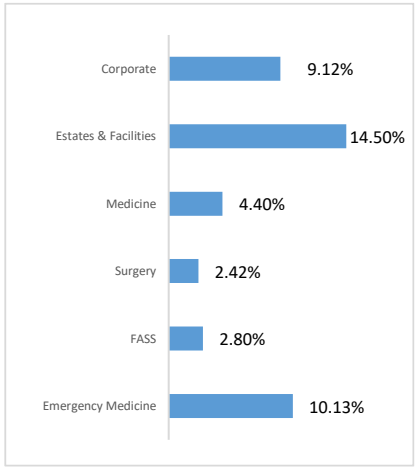
Key Standard| Vacancy Rate

Vacancy Rate - Trust

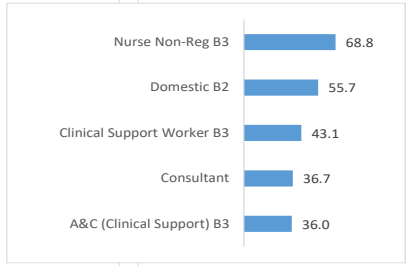


Vacancy Rate	1.66%

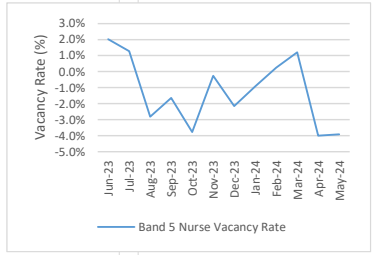
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

- The overall number of vacancies has reduced by almost 200 WTE on the previous month. This was referenced last month that the vacancy figure was subject to change as we work with finance on how to best present the reduction in WTE and actual vacancies. This work has taken place significantly reduced the overall vacancy rate down to 1.66% or 94.7WTE which is more in line with our previous rates to give a more accurate position.

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

• Currently Estates and Facilities (14.5%),Emergency Medicine (10.13%) and Corporate (9.12%) have the highest vacancy rates.

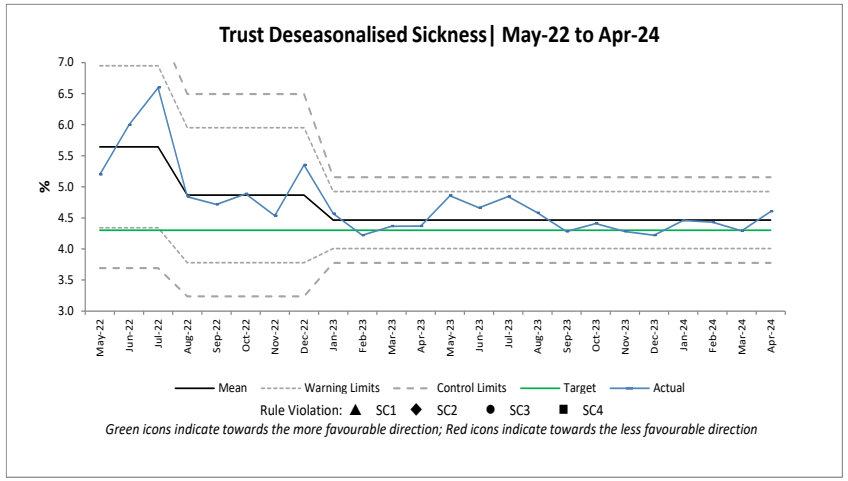
An increase in vacancy rate is expected as steps are being taken across the Trust to manage the financial via actions through Vacancy Control and Agency Reductional Panel.

Countermeasure Summary

Countermeasure/Action	Owner
Employee Value Proposition visuals shared with TME and approved. Work now underway to update recruitment materials with the new look and feel to support our vision of being one of the top Trusts that staff recommend as a place to work.	AD for Capacity & Head of Comms
To support our new Talent Acquisition ways of working – We've working in partnership with Wiltshire College running regular events on campus to promote our vacancies, career pathways and employment offer to the local community. The college will provide application support, careers advice and development. First event booked 6th June	Recruitment Team
Trust led Vacancy Control and Agency Reductional Panel continues to support right-sizing our workforce against our workforce plans. The new controls are supporting the Trust financial recovery plans.	Executive Team

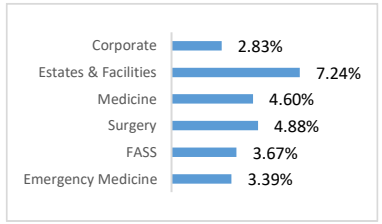
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

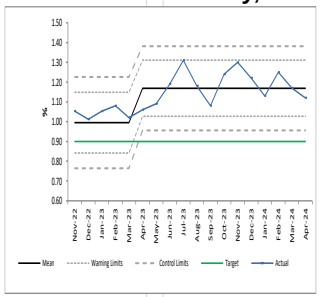


In Month Actual	In Month Deseasonalised	Rolling 12 Months
4.47%	4.60%	4.49%

In Month Divisional Sickness Rates



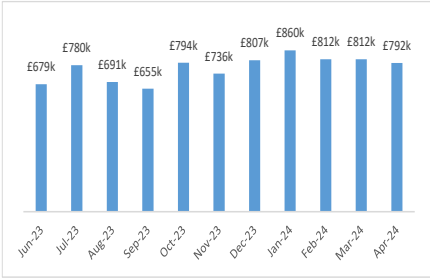
Anxiety, Stress & Depression - Trust



1.12%

Absence Rate

Estimated Absence Cost



RIDDOR Reporting - Employees

	2023/24				2024/25			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Dangerous Occurrence –release or escape of biological agents	-	-	-	-				
Exposed to harmful substance/ Work acquired Infection	-	-	-	-				
Lifting and handling injuries	-	1	3	-				
Physical assault	1	-	-	-				
Slip, trip, fall same level	-	1	3	1				
Struck against	-	-	-	-				
Struck by object	1	-	-	1				
Fell from height	2	-	1	-				
Another kind of accident	-	1	1	2				

Is standard being delivered?

- In Month Sickness Absence for April 24 was 4.47%, which is above the seasonally adjusted target for the month if the rolling 12-month target of 4.3% is to be achieved.
- The Rolling 12 Month Sickness rate remains above target having marginally increased to 4.49%

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

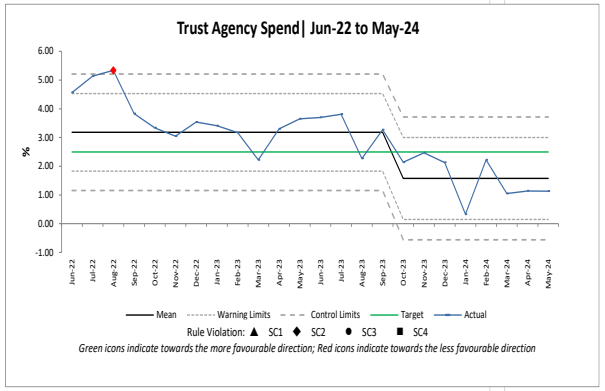
- Estates and Facilities continue to have the highest sickness rate amongst the main Divisions at 7.24%.
- The Anxiety, Stress and Depression sickness rate has fallen but remains elevated compared to the historical norm.

Countermeasure Summary

Countermeasure/Action	Owner
Managing absence is a key driver measure in the Nursing and Midwifery Improvement group in partnership with the People Team. HALO case management Halo build is now underway with an expected launch of the case management system in July 2024 and the self-service portal in Q3.	Divisional People Partners/ Nursing Improvement Group/People Hub Lead
RCA of MSK sickness has taken place, countermeasures being developed, costed and ROI identified.	H&WB lead
New EAP service launched in June 24 including ability for managers to self-refer.	Head of Counselling and EAP

Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

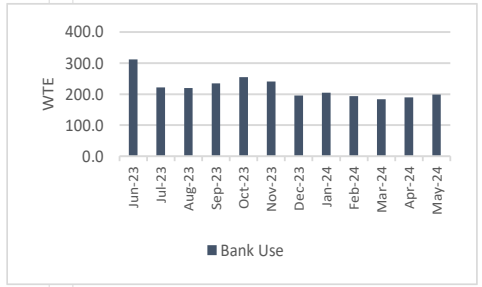


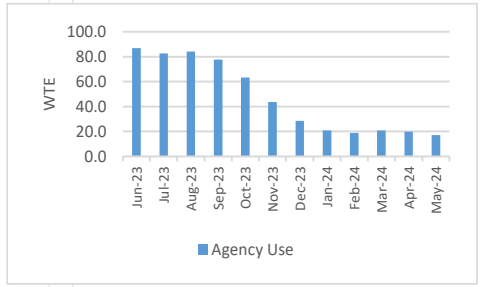
Proportion	1.13%

Agency Spend Breakdown

	In Month	FYTD
Consultants	£114,435	£240,681
Junior Medical Staff	£4,734	£4,734
Non Medical - Non-Clinical Staff	£41,553	£87,667
Registered Nurses & Midwives	£149,641	£292,383
ST&T - Allied Health Professionals	£0	£0
ST&T - Health Care Scientists	£0	£0
ST&T - Other	£0	£0

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

Agency spend was £5,000 less in May than in the previous month, with the total agency spend representing 1.13% of the total pay bill, which is below target our internal target.

We have also maintained a below national target position of 3.2% since August last year.

Registered Nurses has significantly reduced their reliance on agency with their spend as a percentage of the Registered Nursing pay bill reducing from 4.5% in May last year to 1.71% in May 2024.

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

• Registered Nurses and Midwives (£150k) and Consultants (£114k) accounted for 85% of all agency spend in May 2024.Enhanced Care Team was the department with the greatest spend, followed by Oncology Medical Staff, Cellular Pathology and Theatre Staff.

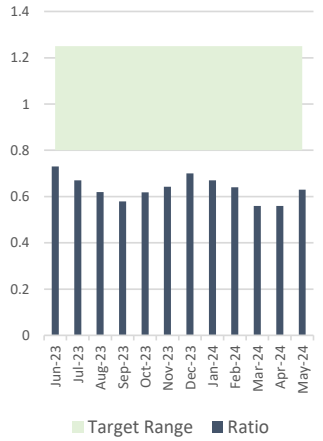
- Overall, agency demand remains low in comparison to same period last year. In May 2024 we used 17.2WTE across the Trusts whereas in May 2023 we booked 87WTE.
- Off-framework usage increased due to Locum Consultant within Oncology which is hard to fill (Approval obtained via Chief Exec). Exit plan is to recruit and plans shared at PRM in May with approval in place until end of September 2024.Central team continually trying to source framework alternative cover.

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
SW Regional Agency Rate card for Nursing live from April securing savings. A further planned stepped reduction taking place 1st July reaching NHS price cap compliance.	Associate Director for Capacity
Bank rate review concluded with an agreement from Executive Team and Staff side to align Bank rates with our BSW partners adopting a paid to grade approach. This demonstrates equity across staff groups and work underway to make these changes	Associate Director for Capacity

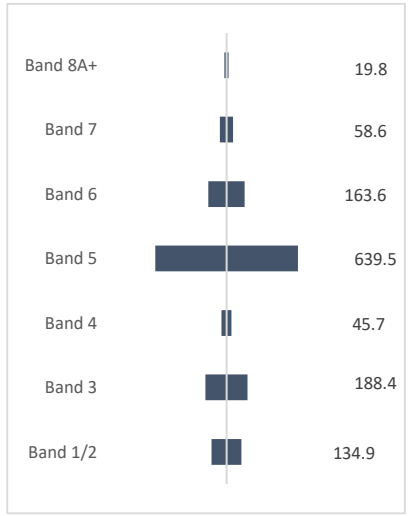
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

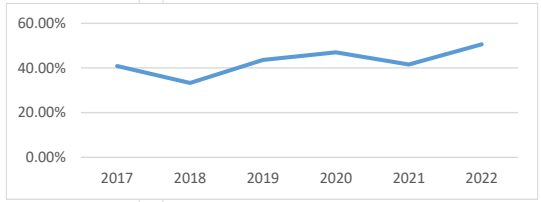


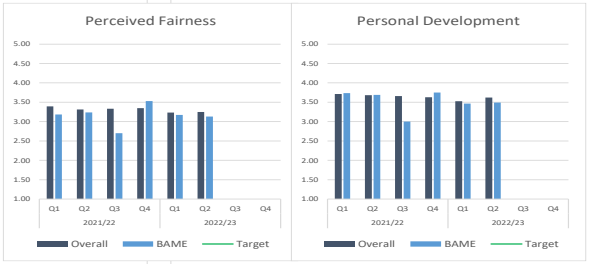
Proportion	0.63

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 remains at 0.63. Although a slight improvement, this is still below the targeted two-fifths range(0.8-1.25).

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

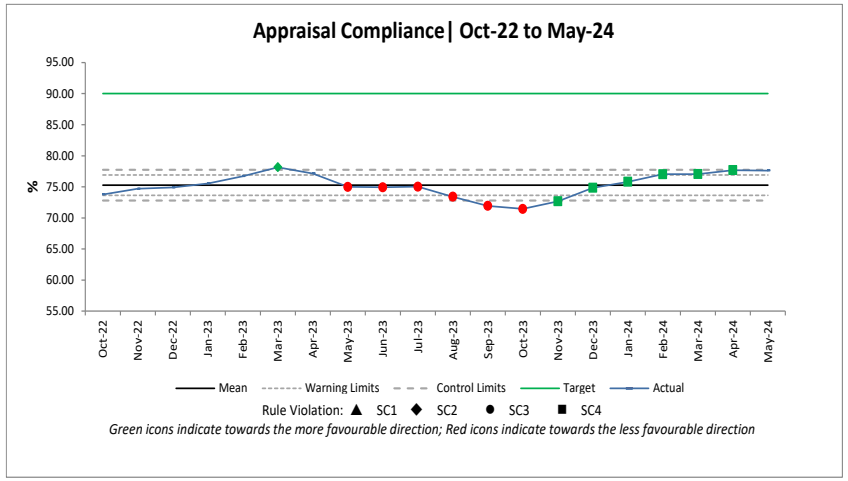
• Candidate distribution across vacancies is masked by the aggregation and this has a significant impact in determining the overall figure.

Countermeasure Summary

Countermeasure/Action	Owner
• Positive Action Programme ("Routes to Success") second cohort on track for October. Support for graduates of first cohort on going. • Launch of inclusion champions (May 2024) to support teams / leaders in more equitable recruitment practices. • Independent Advisors (RCN Cultural Ambassadors' Scheme) to focus on organisational recruitment practices and HR processes will support enhanced talent management and career progression for global majority colleagues.	ADP – Culture EDI Lead ADP – Capacity / Partnering and Programmes

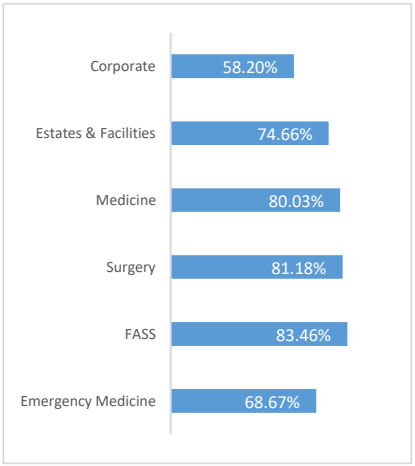
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	77.6%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff 77.5%

M&D Staff 79.4%

Consultants 94.6%

White 77.5%

BME 78.2%

Is standard being delivered?

• Appraisal compliance remains relatively static at 77.61% and well below the 90% target.

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

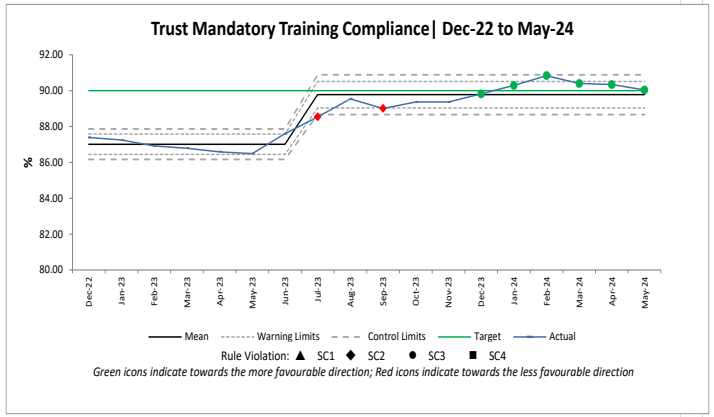
• No Division has a compliance rate that meets the 90% target.
• Corporate Division has the lowest compliance of the main Divisions (58.2%) - 10 percentage points below the next lowest (Emergency Medicine (68.7%).

Countermeasure Summary

Countermeasure/Action	Owner
Appraisal A3 has been presented to the People Committee in May 24 and contains actions to address the root causes of the uptake. Pilot training launched end of May 24.	Divisional People Partners/Divisional Management Teams
The Chief People Officer was sharing the results of the deep dive into Appraisals at the PRMs	Chief People Officer

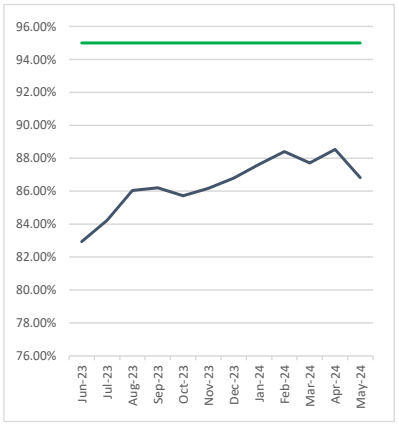
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



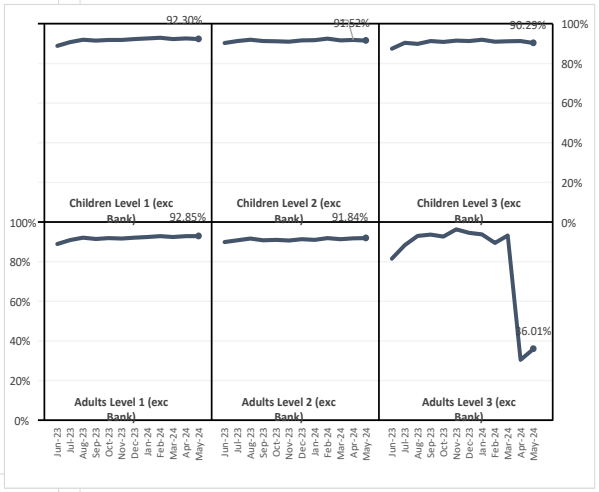
Compliance Rate	90.0%

Information Governance Training Compliance Rate - Trust



Compliance Rate	86.8%

Safeguarding Training Compliance Rates - Trust



Is standard being delivered?

- Mandatory Training compliance has slightly deteriorated to 90.04% but remains above target.

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

- The resuscitations subjects, Information Governance and Adult Safeguarding Level 3 are all rated red against their respective targets, though the latter is primarily due to the number of staff required to complete the subject having increased last month.
- Emergency Medicine (81.1%) and Estates and Facilities (81.3%) both have compliance rates below target.

Countermeasure Summary

Countermeasure/Action	Owner
Divisional People Partners ongoing focus on hotspots within Divisions via local boards.	Divisional People Partners
Work established to look at increasing IG compliance.	Head of OG and head of L&D
We have aligned to National Stat Man review, which seeks to standardise national approach.	Head of Learning and Development
Project to review resus model of training delivery to support attendance.	Head of Resus

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Quality Report

June 2024 (April 2024 data)

The RUH, where you matter

Executive Summary | Quality

Trust Integrated Balanced Scorecard - April 2024

Strategic Goal		Performance Indicator	Description	Target		2023/2024											2024/2025	Trend
				Performing	Under Performing	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
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			16	25	18	21	25	25	26	26	13	24	20	17	19	
Tracker Measures	People we care for	Patient safety incidents - rate per 1000 bed days	Total no of reported patient safety incidents for the Trust, per 1000 patient bed days.	>43	<=43	47	52	56	50	50	51	54	55	49	53	50	45	45	
		Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	3	4	4	3	2	2	3	6	2	2	3	4	3	
		Number of falls resulting in significant harm (Moderate to Catastrophic)		<=1	>=3	1	7	0	3	1	4	3	1	0	5	0	1	2	
		ED time to triage	Percentage of ED attendances triaged within 15 minutes			54.6%	54.1%	52.1%	55.6%	65.9%	58.8%	50.3%	52.6%	54.1%	53.1%	48.8%	49.2%	47.1%	
		Falls per 1000 bed days	Includes all falls			6.2	6.5	6.6	6.5	7.2	6.6	7.1	8.4	7.4	7.1	7.0	6.8	5.1	
		Medication Incidents per 1000 bed days	All Incidents			6.9	7.3	6.2	7.6	7.2	7.8	8.4	9.0	6.4	7.4	7.3	7.2	8.5	
		Number of Patients given medication by scanning device				22.7%	23.3%	22.9%	24.3%	27.5%	29.5%	30.1%	33.0%	35.7%	39.5%	40.6%	41.2%	42.1%	
		Early Identification of Deteriorating Patient				20.8%	20.5%	19.6%	18.1%	20.2%	20.3%	22.2%	25.6%	22.9%	25.4%	26.0%	23.2%	23.0%	
		Hospital acquired infections				24	22	16	24	16	11	13	15	15	22	29	22	23	
		Number of COVID nosocomial infections				39	26	7	14	6	20	53	13	15	44	21	12	37	
		Hospital Associated Infections including Flu, COVID-19 and Norovirus				63	49	23	40	22	31	69	28	34	66	52	36	60	
		Number of Hospital Acquired Pressure Ulcers Category 2	Includes Medical Device Related	<=2	>2	1	1	3	1	4	4	4	2	2	5	4	1	1	
		Number of Hospital Acquired Pressure Ulcers Category 3 & 4	Includes Medical Device Related	<=0	>0	1	0	0	1	9	1	3	3	0	0	2	0	1	
		Never events		0	>=1	0	0	0	2	1	0	0	0	0	0	0	0	0	

Notable practice

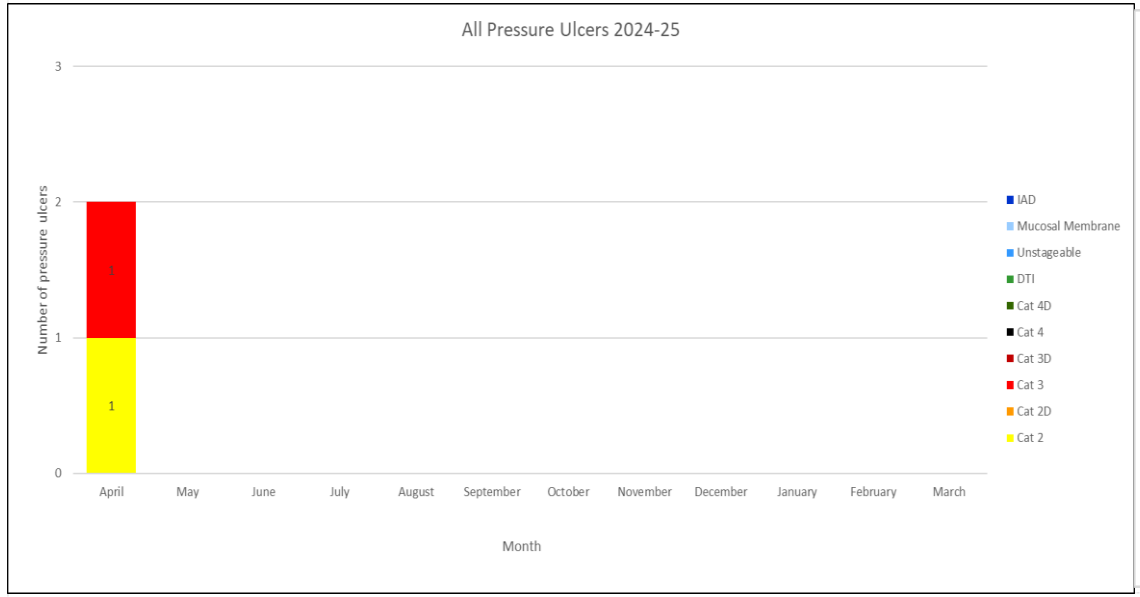
	Executive Summary
Serious Incidents with overdue actions	The Trust continues to maintain a low number of serious incidents with overdue actions with 3 in April 2024.
Number of Hospital acquired pressure ulcers category 2	There was 1 category 2 pressure ulcer in April 2024.

Measures requiring focus and a countermeasure summary this month are:

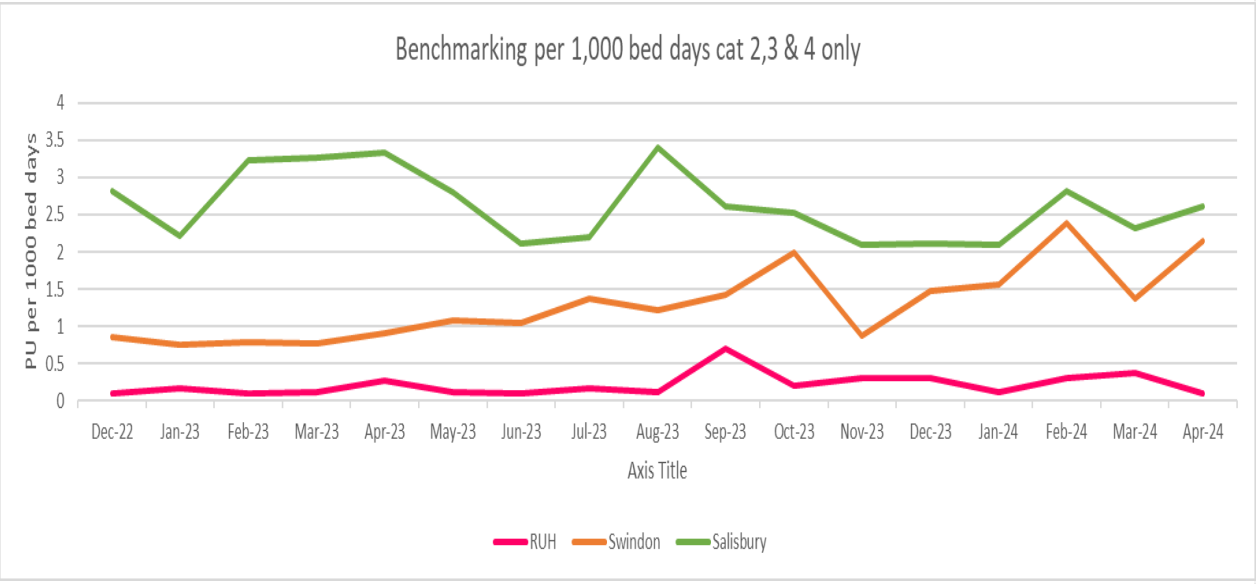
Measure	Executive Summary
Number of Hospital Acquired Pressure Ulcers category 3 & 4	The Trust notes 1 category 3 pressure ulcer in April 2024.

Tracker Measure | Pressure Ulcers

Trust Performance



Benchmarking



How do we benchmark?

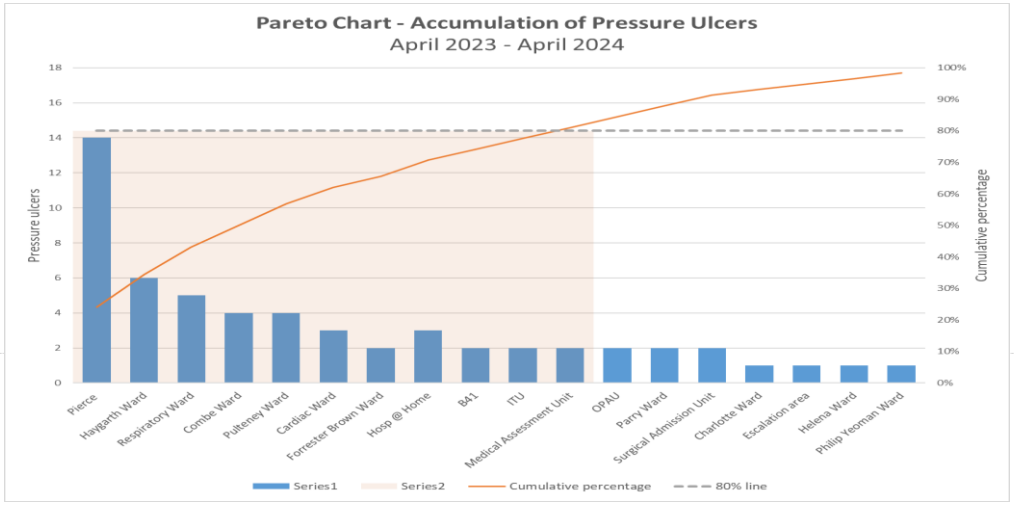
Benchmarking undertaken by the Integrated Care Board (ICB) Tissue Viability Nurses (TVN).
Monthly meetings are held to discuss, share and develop improvements.
From July (May data) reporting will include the Trust wide Pressure Ulcer point prevalence to provide assurance on the quality of the incidence data.

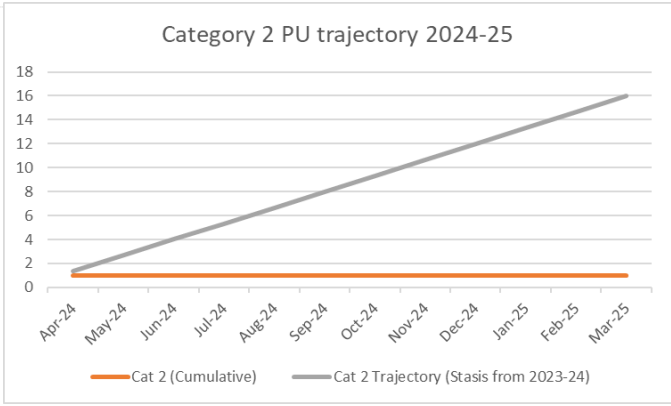
Tracker Measure | Pressure Ulcers

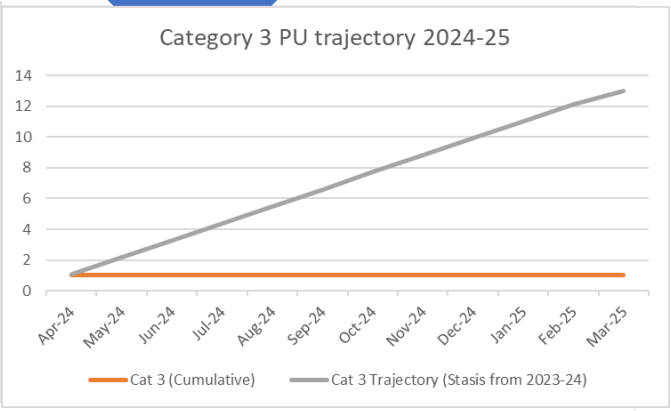
Is there a live A3 / Improvement project addressing this Trust Goal? Yes Reduce the incidence of medical device related PU by 50%

Insights

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







There have been no medical device related pressure ulcers
There have been no category 4 pressure ulcers

The Pareto chart shows that the ward with the most pressure ulcers is Pierce with 14 pressure ulcers reported between April 2023 and April 2024. The ward remains pressure ulcer free since October 2023.

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

Contributor	Countermeasure	Action	Expected Completion Date	Expected Outcome
Skin Assessment – variances across wards relating to medical devices	Process – for skin assessment to be standardised	Patient experience team to aid with collecting feedback	14/08/2024	Understand the challenges with skin assessment and skin care to reduce variance
Knowledge – training theory to practice gap	Focus on preventative actions	TVN to create a QR code for staff responses to assess knowledge	14/08/2024	Understand the gap and focus on how to increase knowledge and understanding to reduce variance

REGISTERED NURSING DASHBOARD APRIL 2024

Vacancy rate: An increase in vacancy for Emergency Medicine, however, all band 5 vacancies will be recruited between May and September. Family and Specialist Services (FaSS) has an improving position in their paediatric service following the safe staffing investment, active recruitment continues to reduce vacancies. Surgery is over established in the short term due to the transfer of services to a single Intensive Care Unit (ICU) footprint in April.
Turnover rate: Minimal increase observed, however remains significantly low.
Sickness Absence: Improvement observed across all Divisions Particularly the Emergency Department (ED) and FaSS.
Registered Nurse % roster fill rate: Improved day time fill rate except FaSS who saw a slight reduction on days but a significant improvement on night fill rate. ED saw a small reduction in night fill rate in April.
Red Flags: The increase in RN fill rate saw a 53% reduction in reported red flags associated with RN shortfall.
* additional work is being undertaken with Paediatrics and Maternity with right sizing roster templates.

Vacancy Rate RN Division

March	April
Emergency Medicine 11.10%	**Emergency Medicine** 16.51%
Family and Specialist Service 4.67%	**Family and Specialist Service** 1.19%
Medical -6.77%	**Medical** -3.05%
Surgical -2.42%	**Surgical** -5.34%

Turnover Rate RN (in month)

March	April
Emergency Medicine 0.79%	**Emergency Medicine** 0.00%
Family and Specialist Service 0.17%	**Family and Specialist Service** 0.41%
Medical 0.16%	**Medical** 0.16%
Surgical 0.54%	**Surgical** 0.47%

Sickness Absence RN

March	April
Emergency Medicine 7.89% (Feb 7.91%)	**Emergency Medicine** 5.93%
Family and Specialist Service 7.37% (Feb 7.71%)	**Family and Specialist Service** 3.6%
Medical 6.96%	**Medical** 6.84%
Surgical 6.70%	**Surgical** 6.32%

Red Flag Type	March 24	April 24
Delay of 30 minutes or omission of Medication	1	4
Omission of comfort rounds	2	5
Shortfall of 25% of RN time	17	8
Vital signs delayed or omitted	2	1
Grand Total	**24**	**18**

Division	March. RN % fill rate – Day	April. RN % fill rate – Day	March. RN % fill rate - Night	April. RN % fill rate - Night
Medicine	83.95%	85.47%	87.26%	92.81%
Surgery	78.90%	86.09%	85.59%	90.76%
FaSS *	82.56%	80.46%	50.90%	97.73%
ED	85.00%	91.53%	93.00%	87.25%

HEALTH CARE SUPPORT WORKER (HCSW) DASHBOARD APRIL 2024

Vacancy rate: Work is ongoing to provide validation and assurance of actual Health Care Support Worker (HCSW) vacancy rates which includes position number allocation and establishment alignment. Overall current vacancy rates are decreasing which is primarily down to the validation of HCSW only roles on the Electronic Staff Record (ESR).
Turnover rate: Minimal increase observed in Emergency Medicine, however, overall this remains significantly low. Increased accuracy of turnover rates will be realised as the work on the HCSW vacancy rate is completed.
Sickness Absence: An increase in all areas for HCSW sickness absence in April but this remains significantly lower than February 2024. Ongoing high sickness in ED.
Healthcare Support worker % roster fill rate:. Improved fill-rate on all shifts except FaSS which saw a reduction on days.

Vacancy Rate HCSW

March	April
Emergency Medicine 53.00% (14.5wte)	**Emergency Medicine** 45.60% (10.8wte 2.11)
Family and Specialist Service 37.87% (20.2 wte)	**Family and Specialist Service** 31.93% (15.3wte 8.0)
Medical 27.73%m (16.6wte)	**Medical** 10.17% (4.9wte 22.22)
Surgical 51.63% (37wte)	**Surgical** 49.01% (33.4wte 15.8)

Turnover Rate HCSW Division

March	April
Emergency Medicine 0% (0wte)	**Emergency Medicin** 2.21% (1.0wte)
Family and Specialist Service 0.78% (1.0wte)	**Family and Specialist Service** **0.78% (1.0wte)**
Medical 0.67% (2.0wte)	**Medical** 0.63% (1.9wte)
Surgical 1.81% (4.3wte)	**Surgical** 0.84% (2.0wte)

Sickness Absence HCSW

March	April
Emergency Medicine 7.72% (Feb 6.14%)	**Emergency Medicine** 8.26%
Family and Specialist Service 2.09% (Feb 10.06%)	**Family and Specialist Service** 3.33%
Medical 6.62% (Feb 8.8%)	**Medical** 6.95%
Surgical 9.15% (Feb 14.78%)	**Surgical** 10.32%

Division	March. HCSW % fill rate – Day	April. HCSW % fill rate – Day	March. HCSW % fill rate - Night	April. HCSW % fill rate - Night
Medicine	76.67%	87.98%	96.87%	97.59%
Surgery	66.57%	79.40%	84.94%	96.27%
FaSS *	71.82%	51.61%	58.17%	69.49%
ED	61.00%	87.61%	73.00%	87.25%

Royal United Hospitals Bath
NHS Foundation Trust

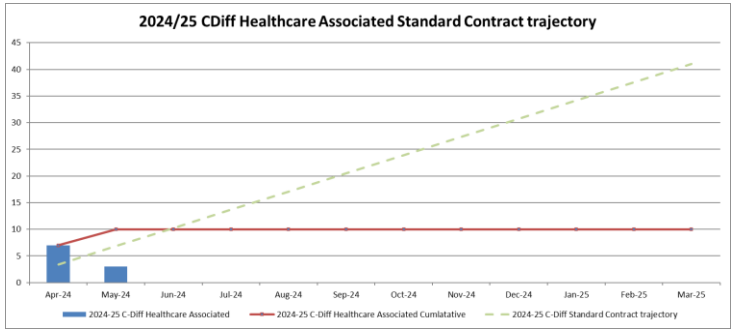
IPC Report

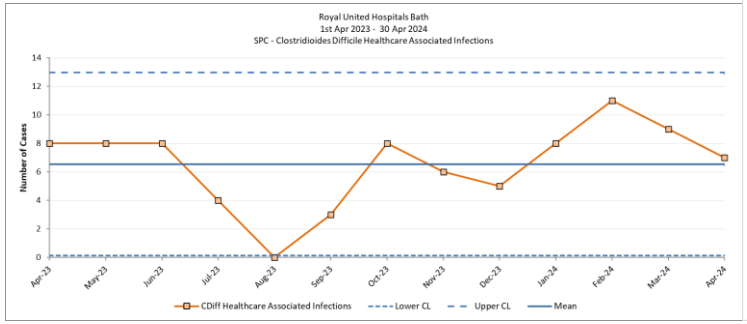
April 2024 data

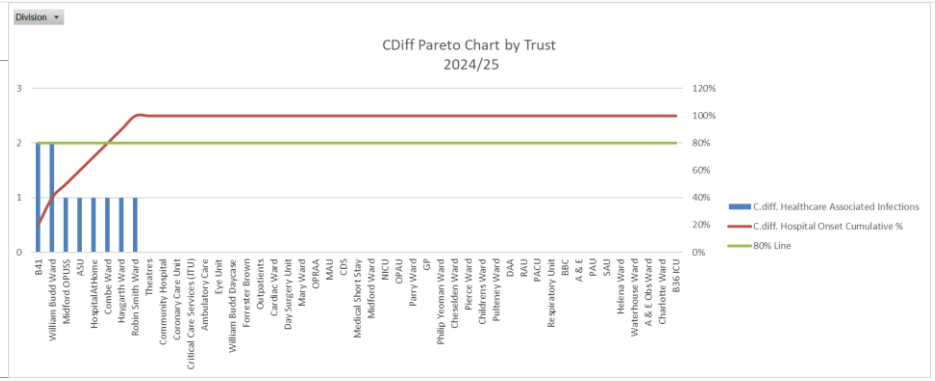
The RUH, where you matter

Breakthrough Objective | *Clostridioides Difficile*

Historic Data







Is the standard being delivered?

There were 7 cases of *Clostridioides Difficile* infection (CDI) reported during April 2 Hospital Onset Healthcare Acquired (HOHA) and 5 Community Onset Healthcare Acquired (COHA).

There are currently no thresholds set for 2024/25 from NHSE

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

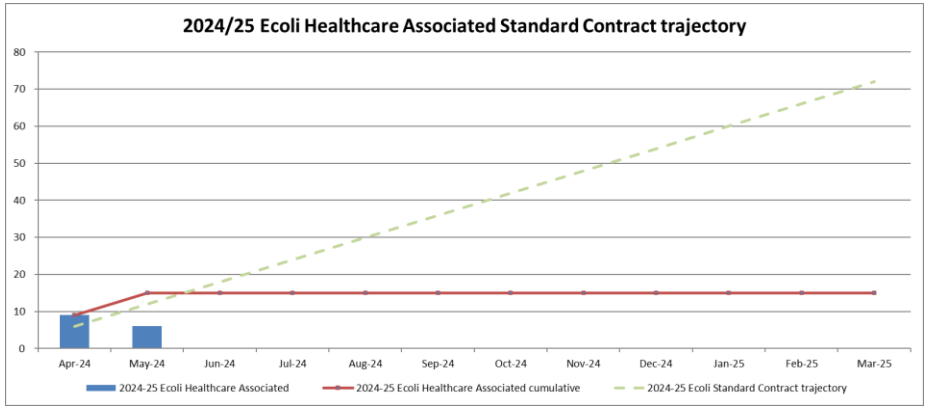
OPUSS ward and William Budd both triggered a Period of Increased Incidents (PII) during April 24.

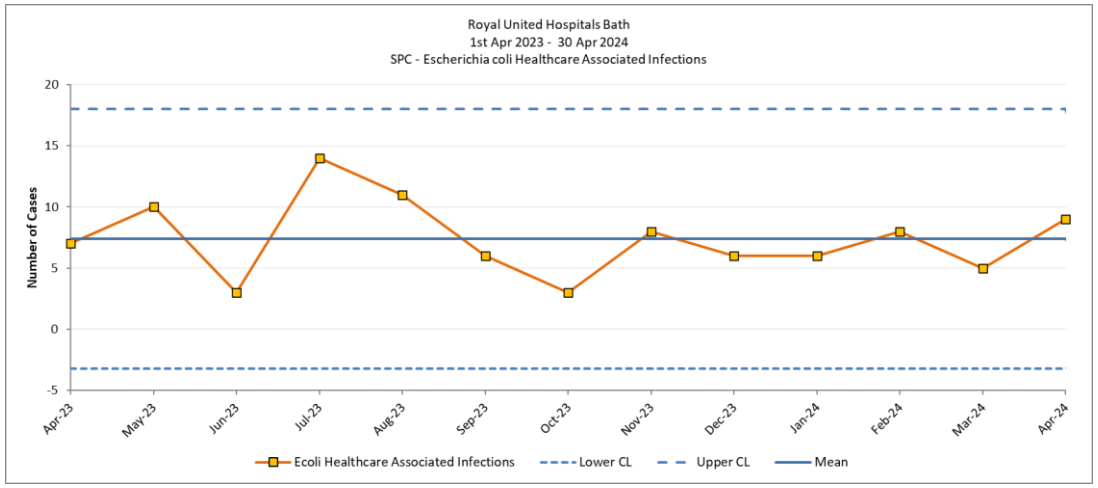
CDI Benchmarking data
Rate per 100,000
(April 23 - Mar 24)

Countermeasures / Actions	Owner	Due Date
Project to support Hand Hygiene with all patients being issued Clinell hand wipes when on their specialty wards, increasing compliance with accessibility to hand cleansing.	IPC and nutrition group	July-24

Breakthrough Objective | E coli

Historic Data





Is the standard being delivered?

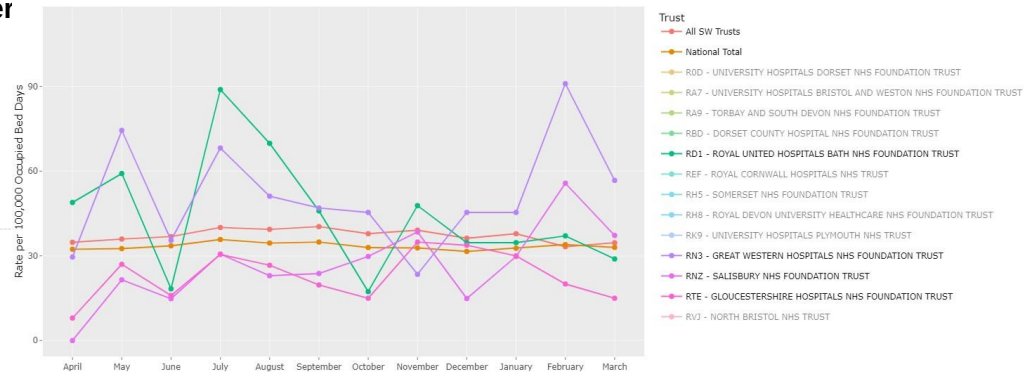
There were 9 cases of *E. coli* infection reported during April 2024. 4 cases were healthcare onset and 5 were healthcare associated.

There are no trajectories set by NHSE for 2024/25.

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

The cases were associated to Hepatobiliary (n=1) Upper Urinary Tract Infection (UTI) (n=1) Lower UTI (n=1) Gastro (n=2) Peripheral Inserted Central Catheter (PICC) (n=1) and Unknown (n=3)

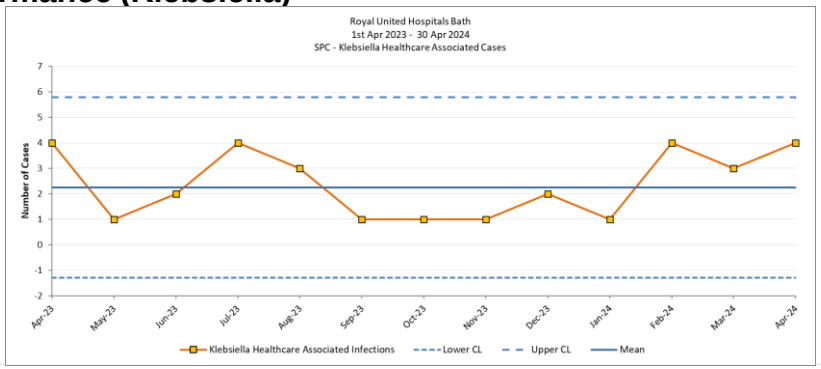
Benchmarking per (April 23- Mar 24)



Countermeasures / Actions	Owner	Due Date
Medicine are leading on a RUH hydration project.	Matron / Quality Improvement Centre	Jul-24
Review of urinary catheter insertion training and competency required, link with ICB and assigned RUH matrons	Senior nurses/ matrons	Overdue. Surgery is linked in with HRCG

Breakthrough Objective | Klebsiella and Pseudomonas

Performance (Klebsiella)



Is the standard being delivered?

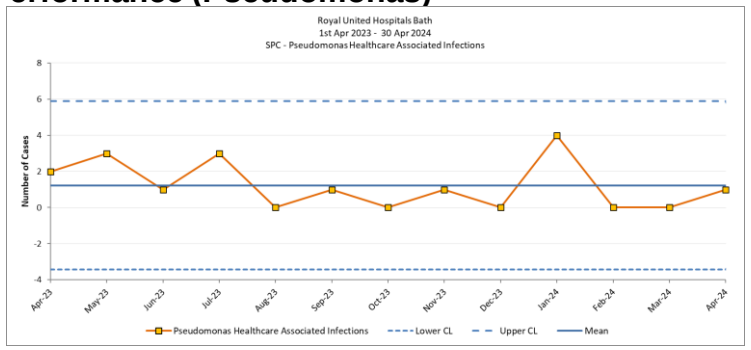
4 Klebsiella infection reported during April 24. 2 were healthcare onset cases and 2 healthcare associated. There are no thresholds set for 2024/25.

0 cases of Pseudomonas Aeruginosa infections reported during April 2024. There are no threshold set for 2024/25.

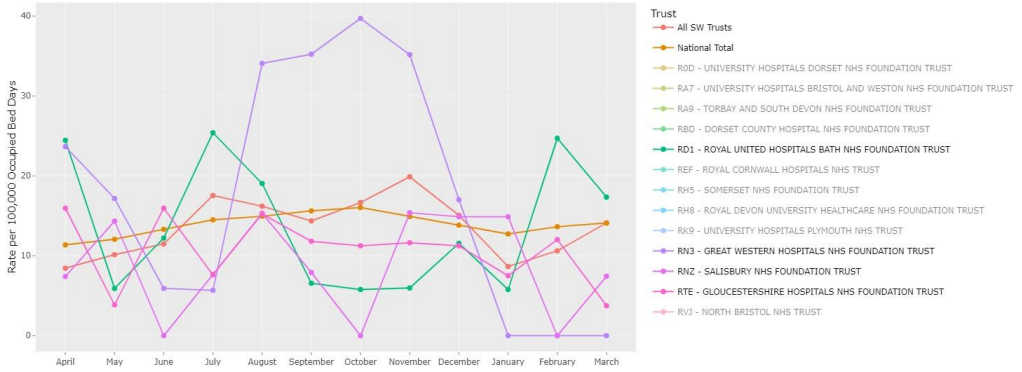
What's the top contributor for under/over achievement?

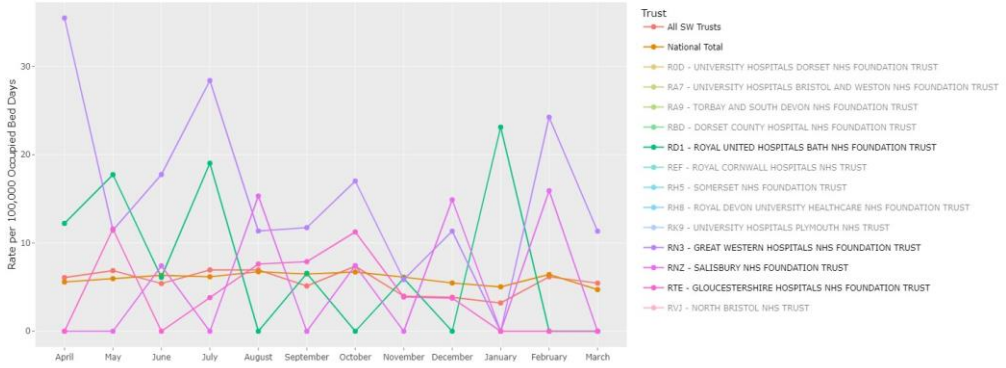
The Klebsiella cases were associated to Upper UTI & Catheter (n=1) Lower UTI (n=1) Skin and Soft tissue (n=1) and Lower Respiratory Tract Infection LRTI (n=1).

Performance (Pseudomonas)



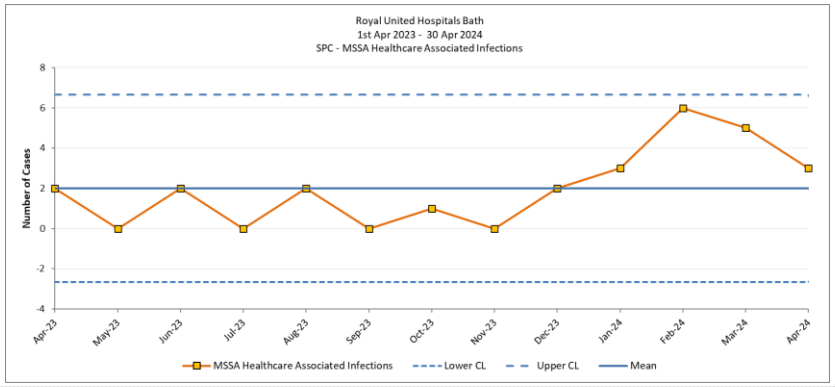
Countermeasures / Actions	Owner	Due Date
Review of urinary catheter insertion training and competency required. This is part of a bigger piece of work related to clinical skills.	Senior nurses/ matrons	Jul-24
Trust bowel and bladder lead to review of urinary catheter care practice and discharge processes as a preventive measure to infection developing- share learning from HCRG.	Continence group and matron	July-24



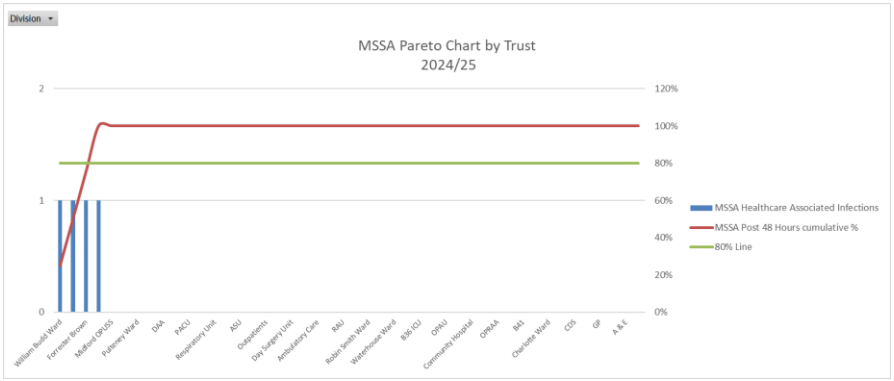


Breakthrough Objective | MSSA

Historic Data



Supporting data



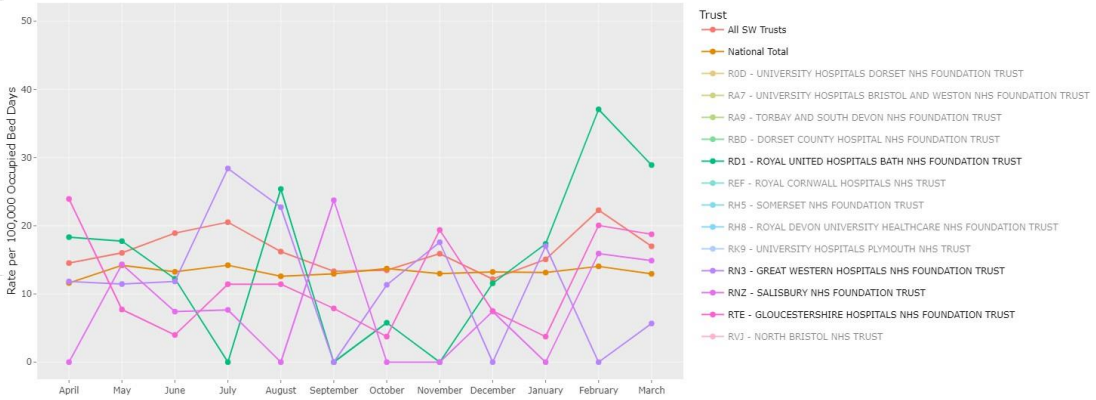
Is the standard being delivered?

There were 2 hospital onset and 1 healthcare associated Methicillin-Susceptible Staphylococcus Aureus (MSSA) blood stream infection during April 2024. There are no thresholds for this infection.

These were associated to URTI (n=2) Bone and Joint (n=1) and PICC line (n=1)

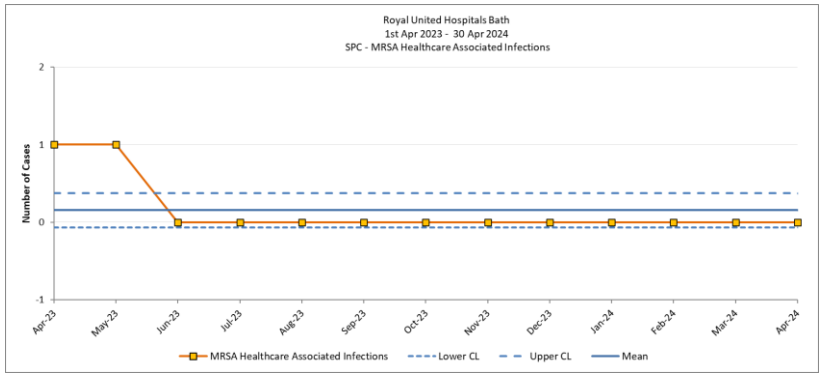
Countermeasures / Actions	Owner	Due Date
Implementation of the Hexi-prep skin decontamination, to replace Chlora-prep Roll complete April 2023	IPC and Phlebotomy	July-24

Benchmarking data:



Breakthrough Objective | MRSA

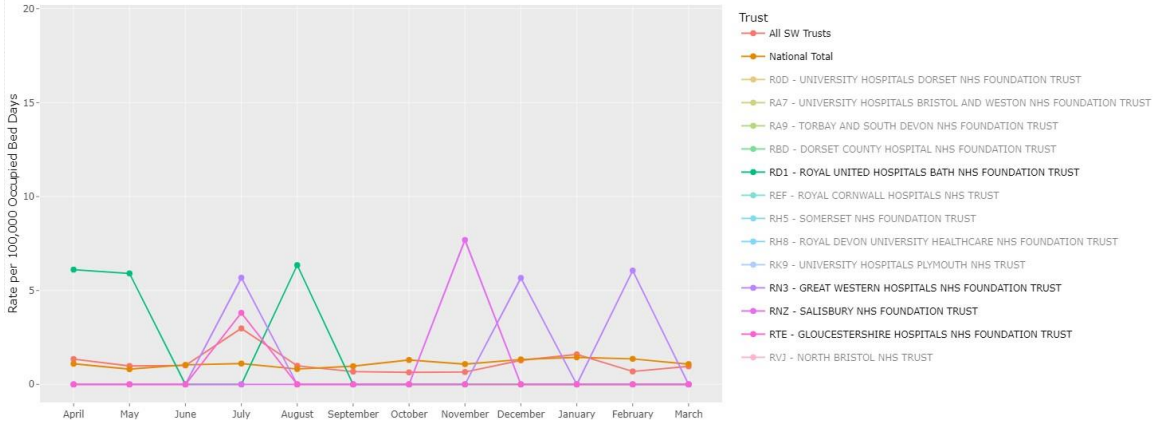
Historic Data



Is the standard being delivered?

There was no Methicillin Resistant Staphylococcus Aureus (MRSA) reported during April 2024. There have been no cases reported for 2024/25 against a zero tolerance.

Benchmarking data: MRSA April 2023/23



Countermeasures / Actions	Owner	Due Date
Review of IV cannulation and venepuncture training package and competencies of staff. Ongoing piece of work to be supported by Aseptic Non-Touch Technique (ANTT) / BD audits.	Senior nurses/ matrons	Sep-24
Review of 72 hour cannula guidelines with The education team to align with best practice and e-learning package	IPC/Clinical Education Team	Sep-24

Breakthrough Objective
Confirmed COVID-19

Historic Data

Is the standard being delivered?
There were 88 COVID positive cases detected during April 2024.
21 were definite and 16 were probable cases linked to outbreaks.
Of those confirmed, COVID-19 infections 2 people died during their admission.

What's the top contributor for under/over achievement?
COVID continues to present in waves, which continues to create cohort areas to manage the number of cases for weeks at a time.

COVID-19 vaccinations have been administered during the spring programme with the support of the ICB vaccination team.

Countermeasures / Actions	Owner	Due Date
Response planning conversations will remain live and responsive to needs and demands	IPC, Ops and Micro.	Aug-23
Inpatient vaccination offer for Flu and COVID-19 for winter 2024	Divisions, contracts team & IPC	Sep-24
Staff vaccinators to be trained to deliver both COVID and Flu vaccines to staff and patients	IPC and HR	Sep-24

Executive Summary

Trust Integrated Balanced Scorecard - April 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

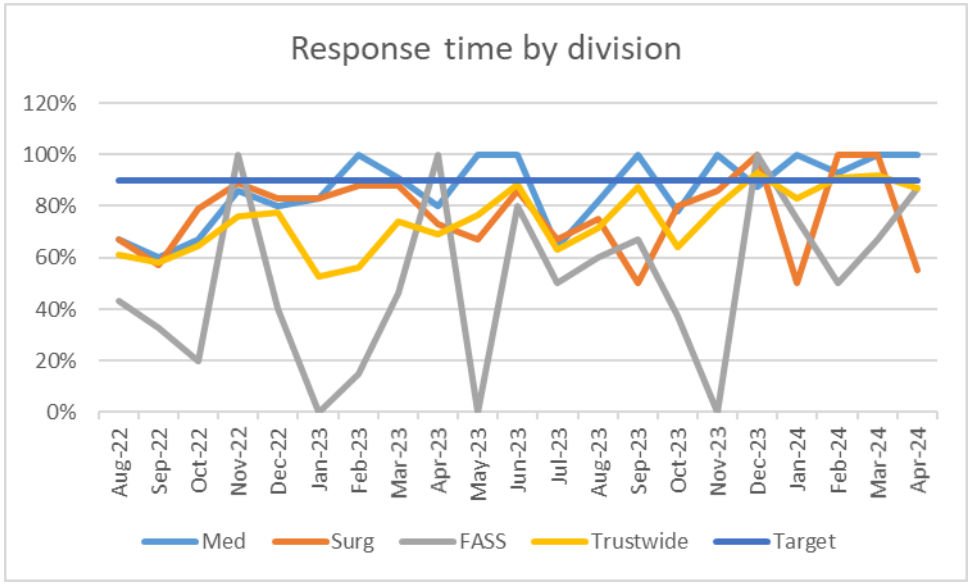
Strategic Goal		Performance Indicator	Description	Target		2023/2024												2024/2025	Trend
				Performing	Under Performing	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	
Tracker Measures	People we care for	% of Complaints responded to within target	35 working days'	>=90%	<90%	69.2%	76.5%	88.2%	63.2%	71.4%	87.5%	60.9%	80.0%	93.3%	82.6%	90.9%	92.3%	88.7%	
		Number of formal complaints		<30	>=30	14	31	22	19	20	20	19	32	30	21	38	32	21	
		Number of re-opened complaints		<=3	>3	2	4	4	1	4	2	0	3	1	3	5	2	1	
		PALS Response Time	Performance against 48hr standard resolution timeframe	>90%	<90%	59.0%	61.0%	57.0%	54.0%	59.0%	59.0%	54.0%	54.0%	53.0%	40.0%	53.0%	43.0%	-	

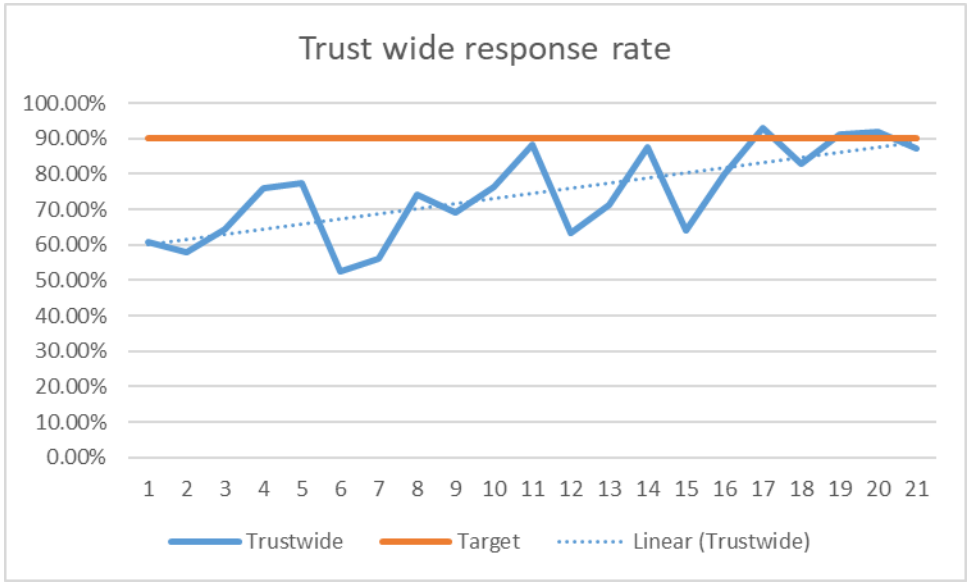
Measures requiring focus and a countermeasure summary this month are;

Measure	Executive Summary
% of complaints responded to within target	The Trust has seen a decrease in compliance to 88.7%. The expectation from NHS England is that complaints will be responded to within 6 months. Our target is that 90% of complaints should be responded to within 35 working days

Tracker Measures | % of complaints responded to within target

Trust Performance





How do we benchmark?

There is no central benchmarking data for complaint response timeframes. The expectation from NHS England is that complaints will be responded to within 6 months. Our target is that 90% of complaints should be responded to within 35 working days. The Trust did not achieve that target in 2022/23.
A review of other Trusts with available data shows significant variability with response timeframes and compliance. The Trust is reviewing the current response time and undertaking a gap analysis against the new NHS Complaints Standards. The standards support organisations to provide a quicker, simpler and more streamlined complaint handling service with a strong focus on early resolution and reviewing what learning can be taken from complaints.

The review of the Trusts current process will inform the Trust response timeframe in 2024/25 with an emphasis on early resolution and flexibility in response times up to 6 months for more complex cases.

Tracker Measures | % of complaints responded to within target

Is there a live A3 / Improvement project addressing this Trust Goal?

Insights

The number of complaints closed per month is variable and the number of formal complaints remains low, however the complaints are increasingly complex. Since April 2023, the Patient Support and Complaints Team (PCST) have provided a single point of access for those who wish to raise concerns, providing support to raise a concern or complaint which best meets the needs of the individual whilst achieving resolution to their concerns and identifying learning for the Trust. This has meant that, generally, only the most complex of concerns are investigated as formal complaints.

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

Contributor	Countermeasure	Action	Expected Completion Date	Expected Outcome
Complexity of complaints and availability of clinicians to investigate concerns – investigations requiring more time	Extensions negotiated with complainant	Plan mutually agreed timeframes and focus on early resolution where possible with variable time frames e.g. 3 standard timeframes 25,40 and 60 days – for discussion with Deputy Chief Nursing Officer	July-24	Response times which are realistic for the investigating clinician and managed expectations for the complainant
Introduction of NHS Complaints Standards	Maintain current process	Complete a gap analysis against standards	Completed Mar-24	Compliance with NHS Complaints Standards. Increased early resolution of complaints

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	Feb 24	Mar 24	Apr 24	SPC	Comment
Midwife to birth ratio	1:24	<1:24		>1:26	1:27	1:25	1:25		The birth Midwife to birth ratio is calculated nationally with the exclusion of temporary staffing. When including temporary staffing, the Midwife to birth ratio provides a realistic assessment of staffing levels.
Midwife to birth ratio (including bank)	1:24	<1:24		>1:26	1:24	1:23	1:23		
Consultant presence on BBC (hours/week)	98	>97			98	98	98		Meeting Royal College of Obstetrics and Gynaecology (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%	45%	78%	97%		Data capture issue recognised in response to digital transition. Please see countermeasures
Band 5/6 Midwifery Vacancy rate (inclusive of Maternity leave) WTEs	7.0 WTE	≤7.0		>10	+2.68	+3.34	4.90		
Neonatal Nurse QIS rate	70%	≥70%		≤60%	63%	63%	63%		On going training in place to increase compliance
Neonatal staffing meeting BAPM standards	100%	>90			100%	96%	96%		
Maternity 12 Month Turnover rate	≤5%	≤5%		≥7%	4.56%	4.65%			
Percentage of TC shifts with staff dedicated to TC care only		>90%		<80%	100%	100%	100%		

Table 1.

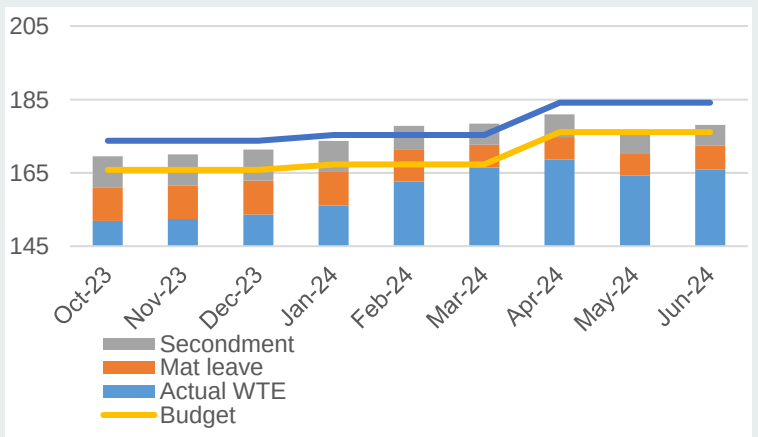
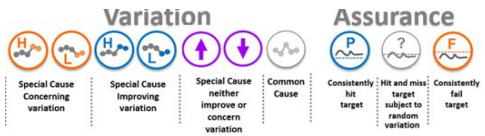


Table 2. Band 5/6 Midwifery Vacancy rate and staffing pipeline projections



Average Shift Fill Rates

		Feb 24	Mar 24	Apr 24
Midwives	Day	88%	75%	92%
	Night	89%	92%	97%
MCA/MSWs	Day	52%	48%	56%
	Night	37%	42%	47%

Countermeasure /Action (completed last month)	Owner
Birthrate+ Investment in budget, recruitment in progress. Specialist roles, infant feeding and fetal monitoring lead recruitment plan and recruitment in Q1	DOM
Successful recruitment into Obstetric vacancies in March 2024, commencing in post June 24	Clinical Director Maternity

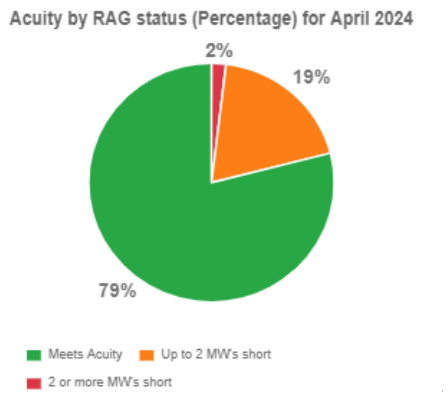
Countermeasure /Action (planned this month)	Owner
Continuing work to establish workforce plan for acute/community sites, continuity of carer and on call model	DOM
Continued work with HR and finance to ensure pipeline position is accurate and externally funded posts are visible to explain ESR variation	Acute Matron
Data capture problem identified since the transition to a digital audit tool for multidisciplinary ward round. Transition back to paper audit tool from April 24	Clinical audit midwife/ BBC Lead Midwife
ON going work with Health roster team to remove unused tiles and ensure roster requirements are validated for all maternity rota's	Acute Matron

Safe – Maternity& Neonatal Acuity April 24

	Target	Threshold G	Threshold A	Threshold R	Feb 24	Mar 24	Apr 24	SPC	Comment
Percentage of 'staff meets acuity' BBC (intrapartum care)	100%	>90%		<70%	62%	73%	79%		Please see countermeasures
Percentage of 'staff meets acuity' Mary Ward (inpatient care)	100%	>90%		<70%	Awaiting return of summaries function from BirthRate+				
Confidence factor in BirthRate+ recording BBC	60%	>60%		<50%	81.61	89.25	87.22		Percentage of possible episodes for which data was recorded
Confidence factor in BirthRate+ recording Mary Ward	60%	>60%		<50%	Awaiting return of summaries function from BirthRate+				
Maternity Absence rate	4.5%	<4%		>5%	4.88%	6.01%	5.7%		
1:1 care not provided in labour	0	0		>1	0	0	0		
Labour ward coordinator not supernumerary episodes	0	0		>1	0	0	0		
Number of red flags on Birth Rate + (NICE 2015 and RUH specific)	No target				142	61	38		All red flags reported during April were RUH set red flags
Birth outside of BAPM L2 place of birth standards	0	0		1	1	0	0		
Number of days in LNU outside of BAPM guidance	0	0		>2	0	0	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



Is the standard of care being delivered?

- No episodes of supernumerary Labour Ward coordinator status not maintained
- No episodes where 1-1 care in labour not provided.

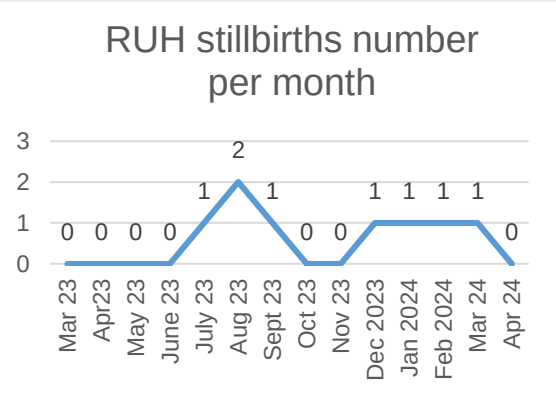
What are the top contributors for under/over-achievement?

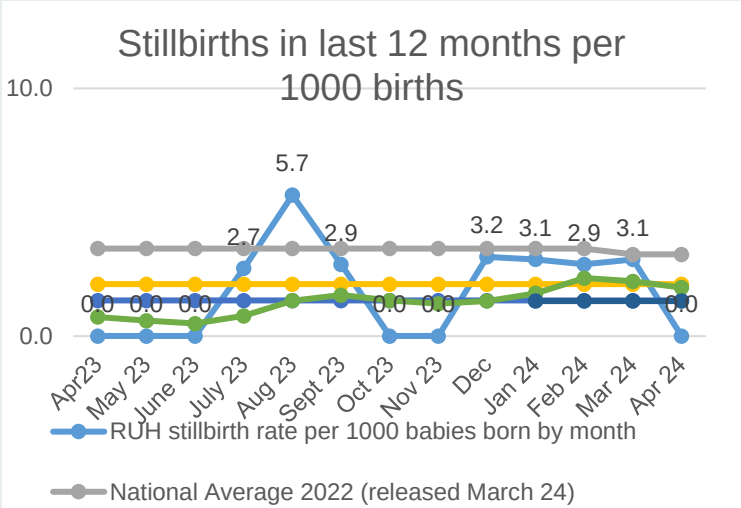
- Recruitment continues in response to BRA+ report recommendations
- Increased complexity of individual cases during the month of February resulting in increased acuity and drop in % of 'staff meets acuity'

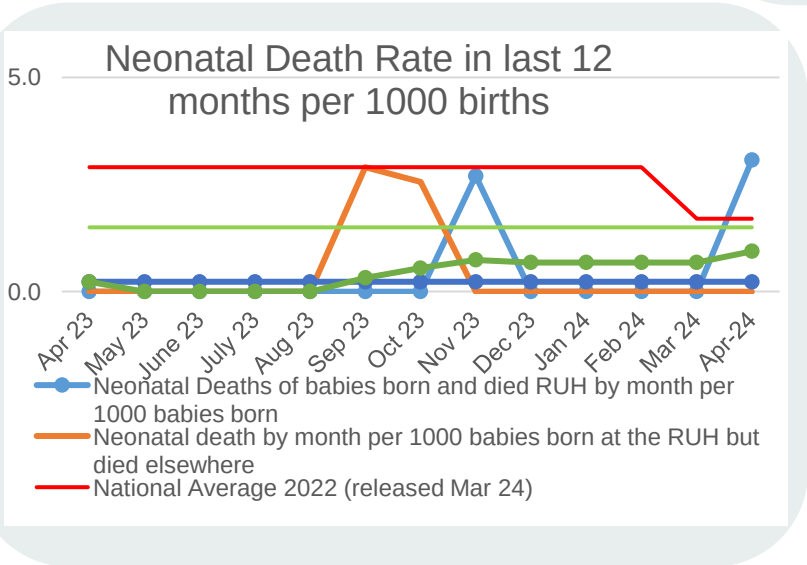
Countermeasure /Action (completed last month)	Owner
Commencement of recruitment into increased midwifery establishment as outlined within the Maternity Business case aligned to the Birth Rate + report of 2023	DOM
Triangulation of staffing metrics to understand decrease is staffing meeting acuity in February as absence rate and MW to birth ratio including bank staffing stable. Reduced staff meets acuity' attributed to increased complexity of individual cases and increasing acuity. Following further scrutiny of the Birthrate + data is has become apparent that during the month of February there were a larger proportion of High Dependency postnatal women and complex care antenatal women. With 45% of entries where staffing did not meet acuity attributed to postnatal HDU and 30% attributed to complex antenatal care needs.	Bath Birth Centre Lead Midwife/ Quality and Patient Safety Lead

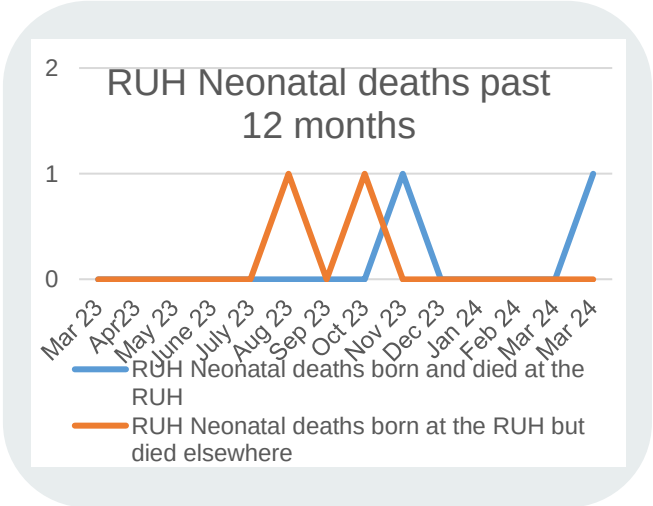
Countermeasure /Action (planned this month)	Owner
Awaiting re-commencement of the Mary Ward 'summaries' function of BirthRate + Acuity tool to present holistic view of acute services.	Inpatient Matron
Recruitment to current Neonatal Unit (NNU) vacancies	Lead Senior Sister
Review of current 'Red Flag' Birth Rate + Acuity triggers to ensure system wide, regional and national alignment. Meeting with Birth Rate + team to align the RUH BirthRate+ portal	Quality and Patient Safety Lead

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.

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.

Stillbirth and neonatal death rate 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 to accurately reflect RUH MBRRACE perinatal mortality rates ahead of stabilisation and adjustment of figures representative of the crude MBRRACE stats.

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.

During March 24 we received the MBRRACE-UK report of 2022 deaths at the RUH. This identified new national averages for both still birth and neonatal death therefore the charts on this slide have been adjusted to reflect the new national averages for accurate benchmarking.

During April of 2024 there was 1 Neonatal death following an elective caesarean birth. The death has been referred to the coroner and the PMRT process. A 72 hour review has been conducted please see incident slide.

Incidents

New Cases for April 24

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	SI? Reference
128377	18/04/2024	Moderate	Baby transferred to tertiary unit for increased care requirements due to sepsis	Family have no concerns or questions regarding care MDT review no modifiable factors identified to have avoided development of sepsis		
128260	16/04/2024	Moderate	Maternal admission to ITU	Family have no concerns regarding care MDT review no immediate care concerns identified		
127900	04/04/2024	Unexpected Death	Neonatal death following elective caesarean birth	Referred to Maternity Independent Advocacy service Will receive full PMRT	Discussed with MNSI did not accept as mother did not labour	

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	SI? Reference
122028	27/10/23	Moderate	Baby transferred to tertiary unit for active therapeutic cooling. MRI normal	Ongoing MNSI review at family request - draft factual accuracy process in progress - anticipated final report early May.	**MI-035529**	
124381	26/12/23	Unexpected death	Term stillbirth	PMRT review		
125436	25/1/2024	Unexpected death	Term Intrapartum stillbirth - Birth Before Arrival	MDT review – no immediate concerns identified For full PMRT review, Case referred to MNSI	**MI-036771**	
125988	09/02/2024	Unexpected death	Term stillbirth	PMRT review		
126853	4/03/2024	Unexpected death/ Moderate Harm	Placental abruption - Intra-uterine death	MDT review commenced – decision for local Patient Safety Incident Investigation (PSII) with terms of reference regarding review of holistic assessment of mother		

Closed Cases April 24

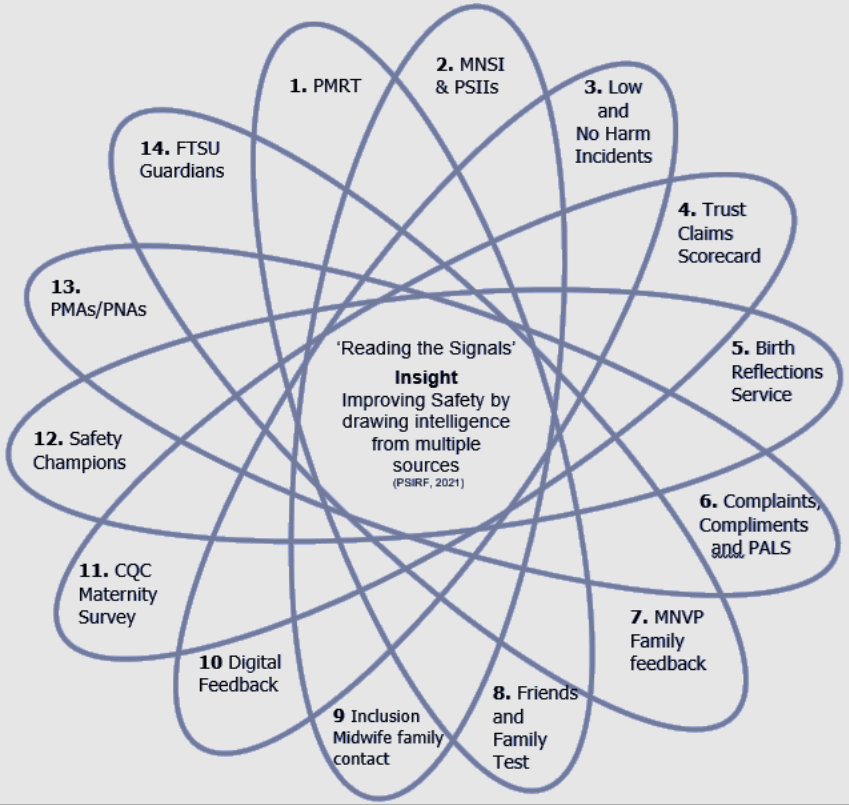
Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
121264	30/09/23	Moderate	Transfer to Tertiary Neonatal Unit for active therapeutic cooling. MRI normal	No safety recommendations within this report	**MI-034606**	
126740	01/03/24	Moderate	Uterine Rupture. Baby born in good condition	MDT review care appears in line with guidance		

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

Responsive

Family Feedback 'Insights' Triangulation Group 24

The Maternity and Neonatal 'Insights' Family Feedback triangulation group meet monthly to discuss the 'in month' feedback received across the service via the various sources listed below. This is with an aim to enable any commonalities trends or themes to be identified.



April 24 Themes

- No clear commonalities for improvement have been identified from service feedback received in April 24, collation of information will continue for thematic review
- 1 positive theme was identified in the month of April for the kindness and friendliness of staff reported by PALS, the MNVP and Online Compliments.

Safety Champions Staff Feedback

Key points raised

- Community midwifery newborn and infant physical examination (NIPE) training capacity for number of assessments required
- Body maps for neonates post birth not consistently completed
- Positive shared experience of culture in RUH Maternity
- Feedback from staff regarding the paid breaks consultation in progress – concern regarding break facilitation and impact on work life balance due to increased requirement for 'additional' shifts.

Next steps

- Completion of neonatal body maps added to safety briefings
- For a review of the current RUH NIPE training requirements for NIPE and local/regional benchmarking
- Staff Consultation in progress regarding paid breaks

Maternity and Neonatal Voices Partnership (MNVP)

32 pieces of service feedback received across various sources including in person conversations and birth workers.

- **Key points raised**
- Maternity Vaccination programme and feeling of repeating choices to decline vaccinations at each appointment,
- Emotive language when discussing risk as part of Induction of Labour counselling such as 'Stillbirth'
- Positive role modelling of communication by staff members to politely correct incorrect name use
- Positive feedback for the support from staff in parental choice for formula feeding
- Friendliness of midwives, obstetricians and anaesthetists

Next Steps:

- Plans for in-house Maternity vaccination team in progress currently out to advert
- Difficult balance between ensuring factual information provision to facilitate informed decision making, as part of a legal obligation under the Montgomery ruling (2015) and the experience of women and families during risk counselling sessions.

Compliments & Complaints

PALS
No commonalities identified within PALS contacts
1 neonatal complaint potential missed anomaly at NIPE.

Formal Compliments	**0**	**PALS Contacts**	**4**
Online Compliments	**14**	**Formal Complaints**	**1**

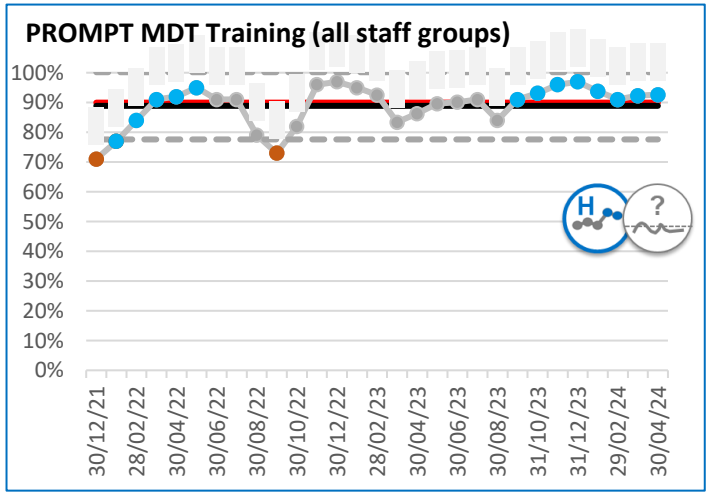
Friends & Family Survey

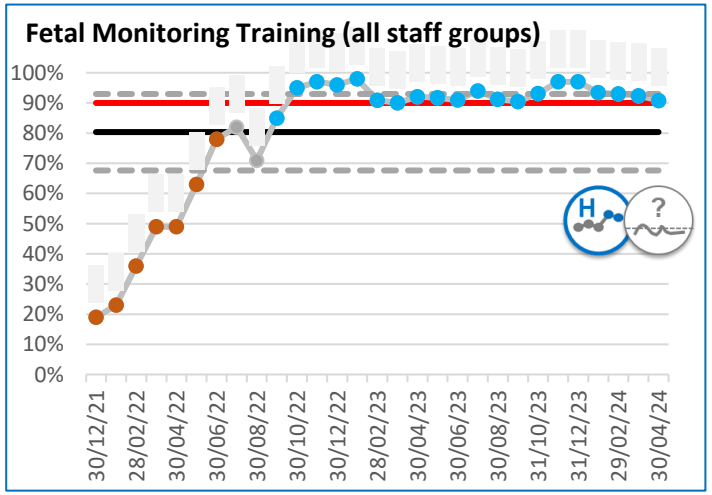
Key Achievements: 36 responses featuring comments of the kindness and civility of staff members
14 responses detailing comments of staff engagement and commitment to explaining things fully

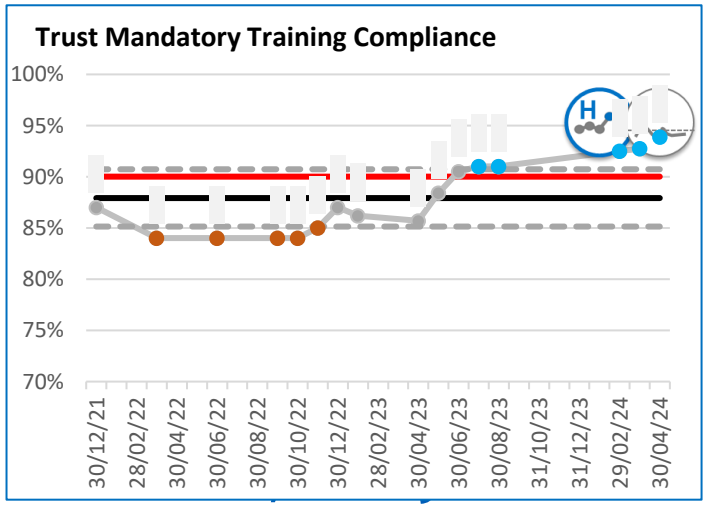
Identified Areas of Improvements:

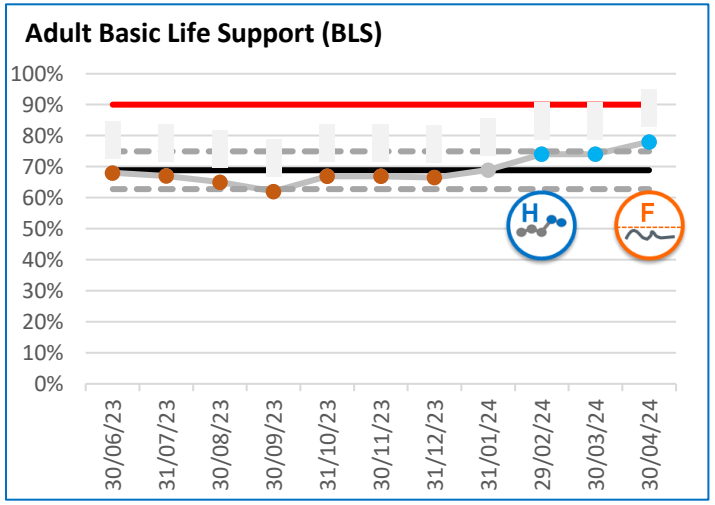
- 2 comments regarding a perception of short staffing on Mary Ward
- 2 comments regarding missed analgesia on Mary ward

Well-led – Training









Training
Compliance monitoring and booking system now in place supporting compliance. 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 completed decision to utilise Clinical skills facilitators to support sustainable delivery.
- Agreement for Adult Basic Life Support (ABLS) to become managed in specialty as part of the PROMPT programme.

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 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)**
- Maternity staff compliance with K2 (supplementary assessment for Fetal monitoring training) in person training compliance 95.1% K2 89.3%. Change in process to improve compliance.
- ABLS compliance Risk Assessment in progress for risk register

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

Notification of Full compliance of MIS year 5 in January 2023.

Maternity Incentive Scheme (CNST) Year 6

MIS Year 6 was released on the 31st of March 2024

Next Steps for Progressions: Service gap analysis underway

Ockenden 2022						
IEA	Blue	Green	Amber	Red	Total Actions	% of Compliance
1- Workforce Planning and sustainability	12	0	5	0	17	70.6
2- Safe Staffing	8	1	1	0	12	66.7
3- Escalation and Accountability	5	1	1	0	7	71.4
4- Clinical Governance Leadership	14	1	1	0	16	87.5
5- Incident investigation and complaints	7	2	0	0	9	77.8
6- Learning from maternal deaths	4	0	0	0	4	100.0
7- Multidisciplinary Training	10	4	3	0	17	58.8
8- Complex Antenatal Care	5	0	0	0	6	83.3
9- Pre-term Birth	3	2	0	0	5	60.0
10- Labour and Birth	7	1	1	0	11	63.6
11- Obstetric Anaesthesia	4	2	0	0	6	66.7
12- Postnatal Care	1	1	2	0	4	25.0
13- Bereavement Care	8	1	0	0	9	88.9
14- Neonatal Care	7	3	0	0	9	77.8
15- Supporting Families	3	1	0	0	4	75.0
Total	**98**	**20**	**14**	**0**	**130**	75.4

Ockenden and RUH NHSE Action plans of 2022

Percentage of compliance only attributed to those actions within the action plan which have been completed and evidence for assurance can be obtained if required (Blue)
Green - work on target for completion, developing assurance processes
Amber - work in progress however continued work required no assurance of compliance at present
Red - current non-compliance no work in progress currently

Key Achievements:

- Recruitment into consultant staffing vacancy - one position lead for postnatal care
- SBL v3 work increasing compliance across IEAs
- Increased assurance data received to increase compliance in IEA 11 (↑40%)

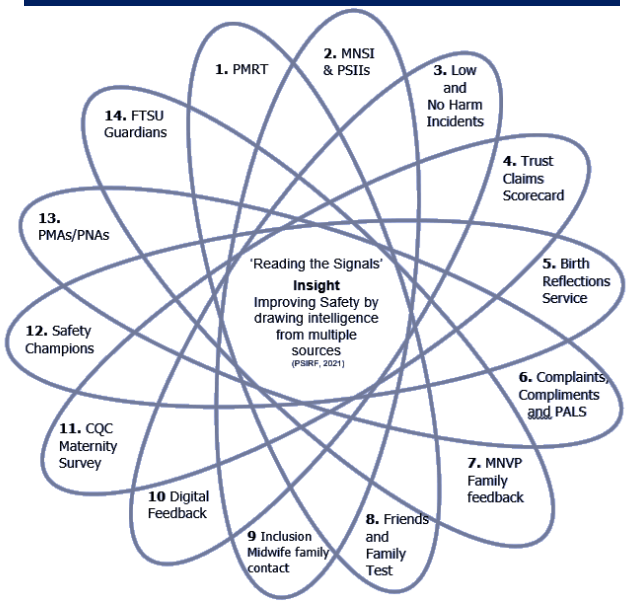
Next Steps for Progressions:

RUH Maternity Improvement plan collating Local and National improvement drivers for cohesive presentation of Quality Improvement progress within Maternity and Neonates. This encompasses Ockenden 2022 and the 3 year delivery plan.

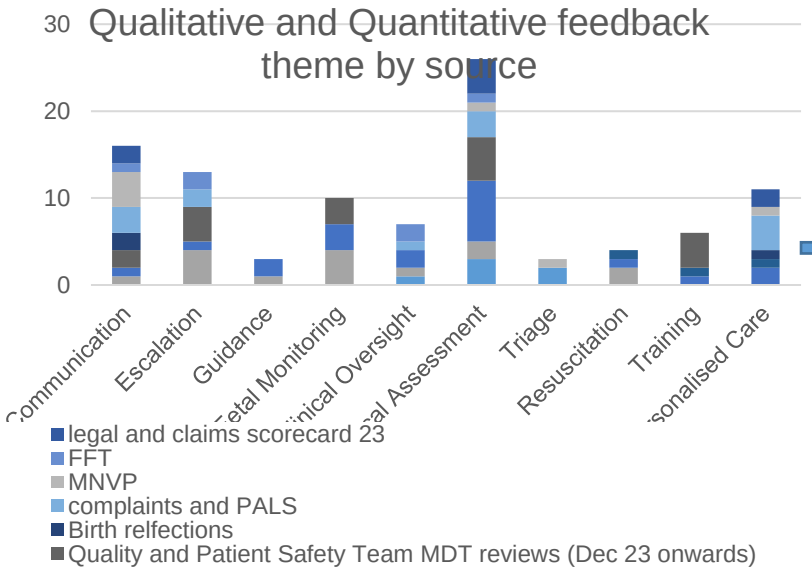
IEA 12 BirthRate+ ward acuity tool re-instated November 2023 awaiting re-instatement of 'summaries' function please see acuity slide to ensure holistic assessment of IEA 2 and 12.

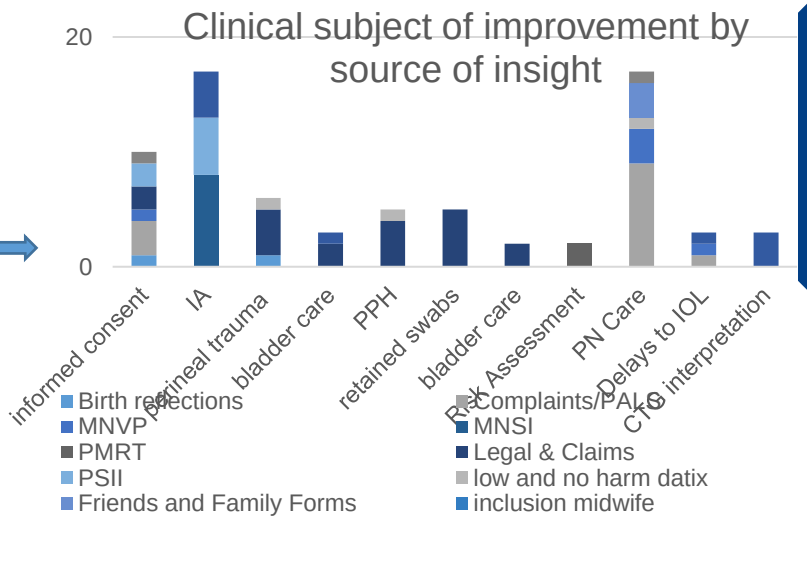
Themes from service Insights – The insight report 23-24

The insights report aims to look at the various ‘Insights’ Maternity and Neonatal services received in 23/24 and analyse for commonalities or themes taking a thematic approach to identifying key areas for priority improvements during 2024/24. The report also reviews the progress made against the identified areas during 2023.



The RUH, where you matter





Although the leading theme across qualitative and quantitative feedback from the service in 23/24 was clinical assessment , no commonalities were identified within the clinical subjects under the theme of clinical assessment.
Therefore a further review of clinical subjects across the themes was undertaken to identify clearer subjects for improvement

From this review 3 areas of priority become clear for RUH Maternity and Neonatal Services in 24/25.

- To improve the provision to ensure informed consent is obtained in all clinical care planning
- To ensure fetal monitoring with a specific focus on Intermittent Auscultation is conducted efficiently in line with local and national standards
- To improve the experience of women and families within their postnatal care and recovery

Trust Integrated Balanced Scorecard - May 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

Strategic Goal		Goal Description	Performance Indicator	Measure description	Target		Baseline	2023/2024				2024/2025	
					Performing	Under Performing		Dec	Jan	Feb	Mar	Apr	May
People Group Goals (5yr ambition, annual measure)	People we care for	Together we will support you, as when you need us most	To achieve 'much better than expected' score and best in class for our region	Annual CQC IP survey	8.5	7.8	8.2	-	-	-	-	-	-
	People we work with	Together we will create the conditions to perform at our best	% Recommend RUH as a place to work		>=70%	<62%	62%	-	-	59.0%	-	-	53.0%
	People in our community	Together we will create one of the healthiest places to live	RUH Social Impact Score?					-	-	-	-	-	-
Trust Goals (monthly or quarterly measure)	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					13	24	18	17	20	24
		Consistently delivering the highest quality healthcare and outcomes	Number of patients over 65 weeks	Ensure no patient waits over 65 weeks for treatment by December 2023	Target is 0 by March - trajectory being agreed during business planning			253	256	193	39	33	41
		Communicating well, listening and active on what matters to you	Overal patient experience score	? From patient surveys, FFT (if we can improve the response rate)				93.9%	93.9%	94.0%	93.6%	93.9%	93.7%
	People we work with	Demonstrating our shared values with kindness, civility and respect	% Recommend RUH as a place to work		>=70%	<62%	62%	-	-	59.0%	-	-	53.0%
		Taking care of and investing in teams, training and facilities	% staff say the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age					-	-	57.1%	-	-	57.0%
	People in our community	Working with partners to make the most of our shared resources and plan wisely for future needs	Delivery of Breakeven Position	Variance from Plan YTD (£'000)	>=0	<0		-4570	-5545	-6130	1665	527	192
		Taking positive action to reduce health inequalities	Equity of access to the RUH for all					-	-	-	-	-	-
		Creating a community that promotes the wellbeing of our people and enviornment	Carbon emission reduction	Monthly proxy measure - % carbon footprint reduction of electricity & gas, against 20/21 carbon footprint	<=0%	>0%		-	-	-	-	-	-
Breakthrough Goals	People we work with		% staff reporting they have personally experienced discrimination at work from manager, team leader or other colleagues					-	-	13.7%	-	-	14.0%
			We improve together					0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	People we care for		Why not home, why not today					0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	People in our community		Delivery of financial plan'	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	(£5.03m)	(£5.03m)	(£6.70m)	£0.01m	£0m	(£0.08m)

Key Standards

Strategic Goal			Description	Performance Indicator		Target		Baseline	2023/2024				2024/2025	
						Performing	Under Performing		Dec	Jan	Feb	Mar	Apr	May
Key Standards	People in our community			Deliver 109% of 19/20 Elective Activity		>=109%	<109%		112.0%	112.0%	114.0%	115.0%	130.0%	125.0%
	People we care for		Improve safety of patients needing unplanned care across the RUH from arrival at ED to discharge	% treated and admitted or discharged within four hours	To ensure 76% of patients can be treated within 4 hours of arrival at ED	>=76%	<76%		67.7%	66.4%	68.7%	69.8%	68.6%	68.6%
		L	C Diff Total Healthcare Associated (Hospital & Community) tolerance = 59	C Diff Total Healthcare Associated (Hospital & Community) tolerance = 59		<=3	>3	-	5	8	11	9	7	9
		SOF	RTT - Incomplete Pathways in 18 weeks	RTT - Incomplete Pathways in 18 weeks		>=92%	<92%	87.1%	60.2%	60.4%	62.3%	63.6%	65.4%	66.4%
		NT	31 day diagnosis to first treatment for all cancers	31 day diagnosis to first treatment for all cancers		>=96%	<96%	-	-	-	-	-	-	-
		NT	31 day second or subsequent treatment - drug treatments	31 day second or subsequent treatment - drug treatments		>=98%	<98%	-	-	-	-	-	-	-
		NT	31 day second or subsequent cancer treatment - radiotherapy treatments	31 day second or subsequent cancer treatment - radiotherapy treatments		>=94%	<94%	-	-	-	-	-	-	-
		NT	2 week GP referral to 1st outpatient	2 week GP referral to 1st outpatient		>=93%	<93%	-	-	-	-	-	-	-
		NT	2 week GP referral to 1st outpatient breast symptoms	2 week GP referral to 1st outpatient - breast symptoms		>=93%	<93%	-	-	-	-	-	-	-
		NT	28 day referral to informed of diagnosis of all cancers	28 day referral to informed of diagnosis of all cancers		>=70%	<70%	-	67.0%	59.8%	64.3%	68.3%	69.0%	(LAG 1)
		NT	Combined 31 Day Cancer Targets	Combined 31 day cancer targets for first treatment, subsequent surgery, subsequent drug, subsequent radiotherapy and subsequent other treatments; excludes subsequent active monitoring and subsequent palliative care)		>=96%	<96%		92.2%	90.7%	94.3%	88.6%	90.9%	(LAG 1)
		SOF	Combined 62 Day Cancer Targets	Combined 62 day cancer targets for GP referral, screening and consultant upgrade		>=75%	<75%		71.8%	66.5%	66.3%	73.5%	72.4%	(LAG 1)
		SOF	62 day referral to treatment from screening	62 day referral to treatment from screening		>=90%	<90%		-	-	-	-	-	-
		SOF	62 day urgent referral to treatment of all cancers	62 day urgent referral to treatment of all cancers		>=85%	<85%		-	-	-	-	-	-
		SOF	Diagnostic tests maximum wait of 6 weeks	Diagnostic tests maximum wait of 6 weeks		<=1%	>1%		32.7%	26.8%	19.6%	18.5%	23.4%	28.2%

Trust Integrated Balanced Scorecard - May 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

Strategic Goal			Performance Indicator	Description	Target		Baseline	2023/2024				2024/2025		Trend
					Performing	Under Performing		Dec	Jan	Feb	Mar	Apr	May	
Tracker Measures	People we care for	IT	% of Complaints responded to within target	35 working days'	>=90%	<90%	-	93.3%	82.6%	90.9%	92.3%	86.7%	64.5%	
			Number of formal complaints		<30	>=30		30	21	38	32	21	24	
		IT	Number of re-opened complaints		<=3	>3	-	1	3	5	2	1	3	
		IT	PALS Response Time	Performance against 48hr standard resolution timeframe	>90%	<90%	-	53.0%	40.0%	53.0%	43.0%	-	-	
			Total PSCT cases acknowledged within 72 hours		>90%	<90%	-	-	-	-	-	100.0%	(LAG 1)	
		IT	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	-	49	53	50	45	45	44	
		IT	Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	-	2	2	3	3	1	0	
		IT	Number of falls resulting in significant harm (Moderate to Catastrophic)		<=1	>=3	-	0	5	0	1	2	3	
		IT	ED time to triage	Percentage of ED attendances triaged within 15 minutes			-	54.1%	53.1%	48.8%	49.2%	47.1%	44.7%	
		IT	Falls per 1000 bed days	Includes all falls			-	7.4	7.1	7.0	6.8	5.1	6.4	
		IT	Medication Incidents per 1000 bed days	All Incidents			-	6.4	7.4	7.3	7.2	8.5	5.9	
		IT	Number of Patients given medication by scanning device					35.7%	39.5%	40.6%	41.2%	42.1%	46.3%	
			Early Identification of Deteriorating Patient					22.9%	25.3%	26.0%	23.2%	23.0%	27.6%	
			Hospital acquired infections					15	22	29	22	23	23	
			Number of COVID nosocomial infections					15	45	22	11	37	9	
		IT	Same Day Emergency Care (SDEC)	Non-elective adult admissions with 0 day LOS, Medicine only.	>=30%	<30%	-	30.9%	32.5%	32.7%	33.0%	35.5%	34.2%	
			Ambulance Handover Delays	minutes (below 39 is upper quartile)				822	810	887	995	1194	938	
		IT	Time from arrival in ED to decision to admit	Percentage of majors attendances with DTA within 3 hours of arrival. Excludes non-admitted patients with DTA.	>=80%	<80%	-	53.8%	52.7%	52.8%	48.0%	51.7%	49.9%	
		IT	Time from decision to admit in ED to admission	Percentage of majors patients admitted via ED that are admitted within 1 hour of DTA. Excludes non-admitted patients with DTA.	>=50%	<50%	-	23.4%	24.8%	25.9%	25.8%	22.7%	24.5%	
			% with Discharge Summaries Completed within 24 Hours					82.9%	84.3%	84.3%	84.7%	84.8%	84.4%	
			Non Criteria to Reside (Average per day)					83.0	81.9	80.7	86.2	88.0	92.8	
			HSMR - Total					95.9	(LAG 5)	(LAG 5)	(LAG 5)	(LAG 5)	(LAG 5)	
			HSMR -Weekday					96.3	(LAG 5)	(LAG 5)	(LAG 5)	(LAG 5)	(LAG 5)	
			HSMR -Weekend					94.4	(LAG 5)	(LAG 5)	(LAG 5)	(LAG 5)	(LAG 5)	
	People we work with	IT	Turnover - Rolling 12 months	Voluntary turnover only	<=11%	>12%		0.5%	0.5%	0.5%	0.8%	0.6%	0.8%	
		IT	Vacancy Rate		<=4%	>5%		1.8%	1.6%	1.0%	1.4%	4.9%	1.7%	
		IT	Sickness Rate	Rolling 12 months	<=3.5%	>4.5%		4.7%	4.9%	4.8%	4.6%	4.5%	(LAG 1)	
		IT	Mandatory Training Compliance		>=90%	<80%		89.8%	90.3%	90.8%	90.4%	90.3%	90.0%	
			% Staff with annual appraisal		>=80%	<80%		74.8	75.8	77.0	77.1	77.7	77.6	
	People in our community		Health Inequalities 1	% Difference in DNA rates between IMD1-2 and IMD 9-10				5.4%	4.0%	5.4%	4.2%	4.0%	3.8%	
			Health Inequalities 2	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD9-10				-1.5%	7.4%	0.8%	13.3%	0.6%	2.7%	
		IT	Sustainable Development Assessment Tool (SDAT) Score	Overarching measurement across all sustainability areas	>=44%	<44%	-	-	-	-	-	-	-	
		IT	Delivery of Financial Control Total - Variance from Revised Plan (£'000)	Under/Overspent, YTD	<=0	>0	-	-5094	-6438	-6807	3986	308	526	
		IT	Forecast Delivery of Financial Control Total at end of financial year		<=0	>0	-	-	-	-	-	-	-	
		IT	Delivery of Recurrent Finance Improvement Programme (£'000)	Variance from year to date planned recurrent QIPP	>=0	<0	-	-	-	-	-	-	-	
		IT	Forecast Delivery of Recurrent Finance Improvement Programme at end of financial year	Forecast variance from annual planned recurrent QIPP			-	-	-	-	-	-	-	
		IT	Reduction in Agency Expenditure	Agency costs as a % of total pay costs	< 19/20 %	> 19/20 %	-	3.0%	2.7%	2.7%	2.5%	1.2%	1.2%	
			% activity delivered off site (virtual and community)					21.8%	22.7%	21.8%	22.1%	22.0%	21.9%	

Strategic Goal			Performance Indicator	Description	Target: Performing	Target: Under Performing	Baseline	2023/2024: Dec	2023/2024: Jan	2023/2024: Feb	2023/2024: Mar	2024/2025: Apr	2024/2025: May	Trend
Other Measures	People We Work With		Total monthly fill rate, day hours, RN	Average per ward	>=90%	<90%		80.2%	79.9%	75.0%	82.3%	84.4%	86.3%	
			Total monthly fill rate, day hours, HCA	Average per ward	>=90%	<90%		72.5%	75.1%	78.4%	77.3%	77.3%	84.2%	
			Total monthly fill rate, night hours, RN	Average per ward	>=90%	<90%		94.6%	92.7%	92.0%	93.5%	93.4%	93.1%	
			Total monthly fill rate, night hours, HCA	Average per ward	>=90%	<90%		82.7%	83.8%	85.6%	85.4%	87.9%	88.8%	
			Information Governance Training Compliance		>=80%	<80%		86.8%	87.6%	88.4%	87.7%	88.5%	86.8%	
	People we care for	NR	Serious Incidents (NRLS) reporting (TBC)					1	3	1	1	-	-	
		NR	Hip fractures operated on within 36 hours		>=80%	<=70%		62.3%	66.7%	53.2%	46.9%	66.0%	39.6%	
		NR	Time to Initial Assessment - 95th Percentile					123	104	102	106	154	120	
		NR	% of mothers booked within 12 completed weeks		>=90%	<=85%		87.6%	84.7%	88.6%	87.4%	86.3%	85.0%	
		NR	% Women identified as smokers referred to specialist stop smoking service		>=90%	<=80%		97.0%	100.0%	96.6%	96.6%	96.4%	94.7%	
		NR	Midwife to Birth Ratio		<=1:27	>1:32		1:26	1:27	1:29	1:27	1:27	1:29	
		NT	TIA Treated within 24 hours		>=60%	<=55%		29.0%	44.2%	41.7%	21.2%	19.0%	20.8%	
		NT	12 Hour Breaches		0	>0		27	21	24	16	39	4	
		LC	Number of medical outliers - median		<=25	>=30		12	9	16	11	10.5	6	
		L	Readmissions - Total		<=10.5%	>12.5%		8.4%	7.4%	7.6%	7.9%	8.0%	8.7%	
		L	Discharges by Midday (excluding Maternity)	Includes transfers to the Discharge Hub	>=45%	<45%		19.7%	22.6%	21.9%	22.6%	23.3%	22.6%	
		NT	Number of 52 Week Waiters Incomplete Pathways					1151	1072	905	813	650	737	
		L	GP Direct Admits to SAU		>=168	<168		229	237	243	249	218	259	
		L	GP Direct Admits to MAU (including DAA)		>=84	<84		314	328	269	353	289	306	
		NR	Bed occupancy (Adult)		<=93%	>97%		93.8%	96.6%	96.9%	96.7%	97.5%	95.0%	
		NR	% Cancelled Operations non-clinical (number of cancelled patients) Surgical		<=1%	>1%		1.0% (29)	1.2% (43)	1.3% (46)	0.7% (24)	0.9% (33)	1.2% (44)	
		NT	Urgent Operations cancelled for the second time		0	>0		0	0	1	2	0	0	
		NT	Cancelled operations not rebooked within 28 days - Surgical		0	>0		1	0	0	0	0	0	
		SOF	Clostridium Difficile Hospital Onset, Healthcare Associated (counted)		<=3	>3		2	6	9	6	2	8	
		SOF	Clostridium Difficile Community Onset, Healthcare Associated (counted)					3	2	2	3	5	1	
		SOF	E.coli bacteraemia cases Hospital Onset, Healthcare Associated		<=6	>6		5	1	4	1	4	4	
		SOF	E.coli bacteraemia cases Community Onset, Healthcare Associated					2	5	4	4	5	6	
		SOF	MRSA Bacteraemias >= 48 hours post admission		0	>=1		0	0	0	0	0	0	
		L	Infection Control - Klebsiella spp post 2 days		<=2	>2		2	0	4	1	2	2	
			Klebsiella Spp Community Onset Healthcare Associated					0	1	0	2	2	2	
		L	Infection Control - Pseudomonas aeruginosa post 2 days		<=1	>1		0	4	0	0	1	0	
			Influenza Outbreaks					2	0	1	0	0	0	
			Norovirus Outbreaks					2	0	1	2	0	0	
		L	Hospital Associated Infections including Flu, COVID-19 and Norovirus					34	67	53	35	60	32	
			Number of Hospital Acquired Pressure Ulcers Category 2	Includes Medical Device Related	<=2	>2		2	5	4	1	1	1	
			Number of Hospital Acquired Pressure Ulcers Category 3 & 4	Includes Medical Device Related	<=0	>0		0	0	2	0	1	1	
		SOF	Never events		0	>=1		0	0	0	0	0	0	
		SOF	SHMI		<=Expected	> Expected		0.95	0.95	(LAG 4)	(LAG 4)	(LAG 4)	(LAG 4)	
			Mixed Sex Accomodation Breaches					97	163	170	182	170	221	
	People In Our Community	L	Delivery of Group financial plan	Variance from year to date plan	<=0	>0		(£5.03m)	(£5.03m)	(£6.70m)	£0.01m	£0m	(£0.08m)	
		L	Delivery of capital programme	Variance from year to date planned capital expenditure (Internally Funded Schemes)	-5%	<5%		-67.0%	-57.9%	-33.1%	-0.5%	67.3%	51.9%	
		L	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+/-5%	><5%		0.0%	0.0%	0.0%	-0.5%	0.0%	0.0%	
		L	Delivery of planned cash balance	Variance from year to date planned cash balance	+/-10%	><10%		14.0%	-5.1%	-8.6%	-12.8%	8.8%	25.6%	

Key		
	SOF	Single Oversight Framework
	NT	National Target
	NR	National Return
	L	Local Target - not in contract
	LC	Local Target - in contract
	IT	Improving Together

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors meeting**	**Agenda item:**	**12**
Date of Meeting:	**22nd July 2024**		
Title of Report:	**Quarterly Learning from Deaths Report**		
Status:	**For Discussion**		
Board Sponsor:	**Andy Hollowood, Chief Medical Officer**		
Author:	**Heather Boyes, Head of Legal Services**		
Appendices	**Appendix 1: Learning from Deaths Report Q3 &Q4**		

1. Executive Summary of the Report

77% of SJRs completed in Q3 and Q4 rated care as either good or very good and 0% of SJRs completed rated overall care as very poor but there were four findings (5% of SJRs) of poor care in Q4. The themes identified where care was deemed poor align with our patient safety priorities and learning has been fed into our improvement workstreams. Where concerns regarding poor care have been identified divisional teams have taken action to provide insight and where necessary guide improvement.

Over the last two quarters the number of outstanding SJRs remains static. The number of SJRs completed has risen quarter on quarter. The number of requested SJRs aligns with the number completed every month.

Eighteen inquests were opened and 20 were concluded during Q3 and Q4, seven following in-person hearings. In two instances, the Trust was on the periphery of the issues explored by the Coroner.

The two inquests that involved a greater analysis of the care provided focussed on antibiotic choice and the care of elderly trauma patients. This final issue requires continuing attention as there is a further inquest, which raises similar issues, occurring in March 2024.

The Trust did not receive any Regulation 28 Reports and the Coroner did not express any concerns about the care provided. However, there were some families who were disappointed with the outcome or remained concerned. The Trust are considering how those involved in the inquest process can be better supported.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to note the report.

3. Legal / Regulatory Implications

The Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* found that learning from deaths was not being given sufficient priority in some

organisations and consequently valuable opportunities for improvements/learning were being missed.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
If we are unable to consistently perform a structured judgement review within 2 months of a person's death due to a mismatch in the demand and capacity for SJR completion, then we will not generate timely insight into patient safety issues to guide improvement.	

5.	Resources Implications (Financial / staffing)
n/a	

6.	Equality and Diversity
n/a	

7.	References to previous reports/Next steps
Q2 Learning From Deaths Report	

8.	Freedom of Information
Public	

9.	Sustainability
N/A	

10.	Digital
N/A	

Royal United Hospitals Bath
NHS Foundation Trust

Learning From Deaths Quarters 3 and 4 October 2023 to March 2024

1.0 Introduction

The Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements/learning were being missed.

A process for mortality review for the RUH was devised in mid-2017 which required screening of all patients who have died in order to decide on whether a formal review of the patient's care in their final admission was required. The Royal College of Physicians had devised the Structured Judgement Review (SJR) as a means of standardising the way in which the review was conducted, which we adopted. It was not felt to be proportionate to conduct an SJR on every patient who died under the care of the Medical Division. As a consequence, a system was devised whereby each patient who dies is screened to decide on whether their death meets certain criteria that require an SJR to be enacted as follows:

- Learning difficulty
- Mental health issues contributing to the patient's death (especially if patient sectioned under Mental Health Act)
- Concerns expressed by the patient's relatives
- Concerns expressed by the medical/nursing team in charge of the patient's care
- Death following an elective admission
- Surgical patient
- Patients in various diagnostic or procedure-specific groups flagged by Dr Foster or other clinical outcomes measures as being an area of concern

This report firstly considers how effectively and efficiently the Mortality Review Process is operating, and secondly reviews what lessons have been learnt because of the data generated by that process.

2.0 Performance of the Mortality Review Process

The performance of the Medical Examiners is considered in greater detail in the quarterly Medical Examiner Office Reports.

2.1 Checklists

A checklist is completed by the Medical Examiner. At the time of writing the report there is a single outstanding checklist for a patient who died in 2023.

2.2 Screening

Medical Examiners review all the checklists and select the cases for Structured Judgement Review. A standard proforma is used to ensure consistency and thoroughness of approach. The performance of the screening process is included in the Medical Examiner Office Report.

2.3 Structured Judgement Reviews

The number of SJRs completed has increased quarter on quarter in 2023/24. In the 2023/24 242 SJRs were completed, compared to 186 in 2022/23.

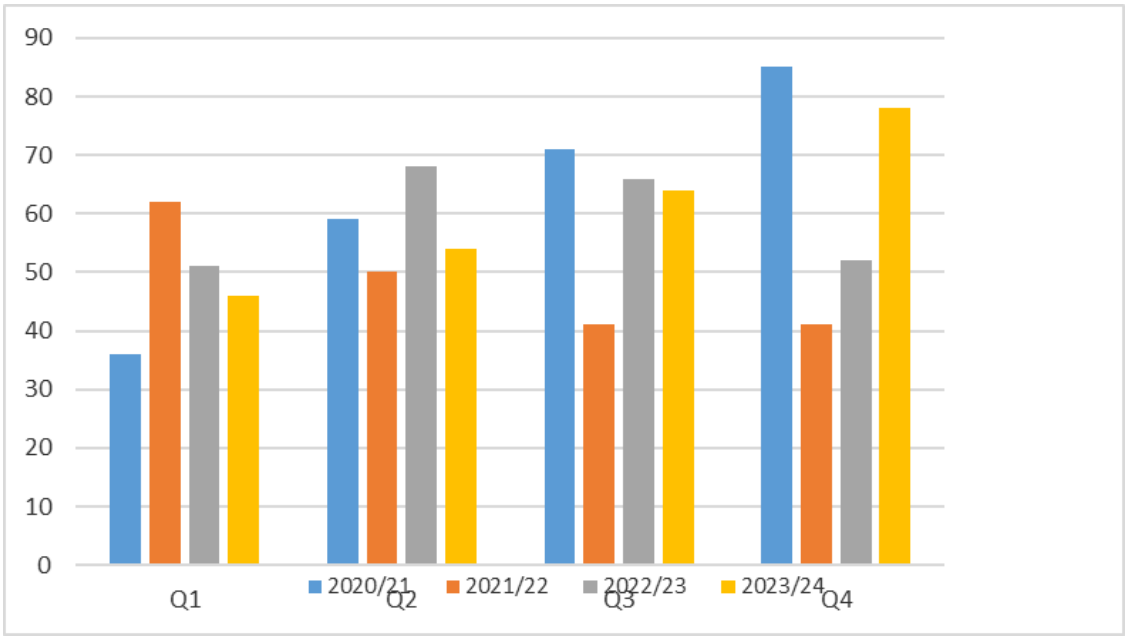


Figure 1: Number of completed SJRs by quarter.

The number of outstanding SJRs remains static (Figure 2).

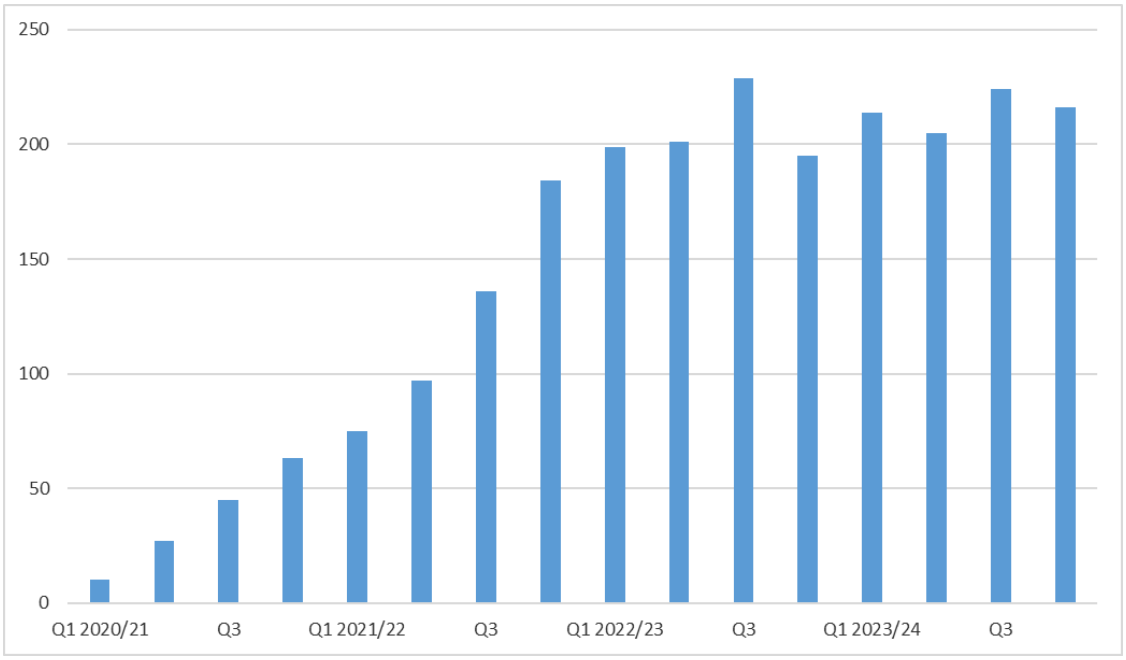


Figure 2 - Number of outstanding SJRs

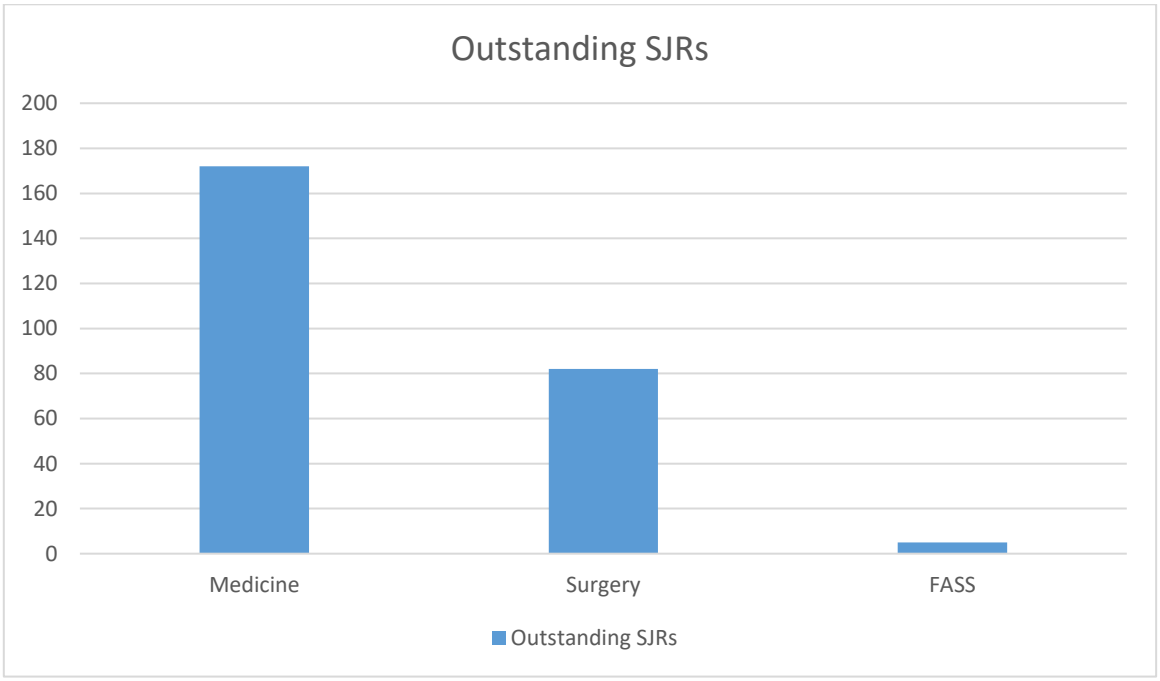


Figure 3: Outstanding SJRs by Clinical Division

The Trust target is to complete 95% of SJRs within two months of the patient's death. This is to ensure the conclusions of the review are available before the completion of a serious incident investigation or inquest. Compliance with this target is monitored and set out below. The Trust has not met this target since monitoring commenced in April 2020.

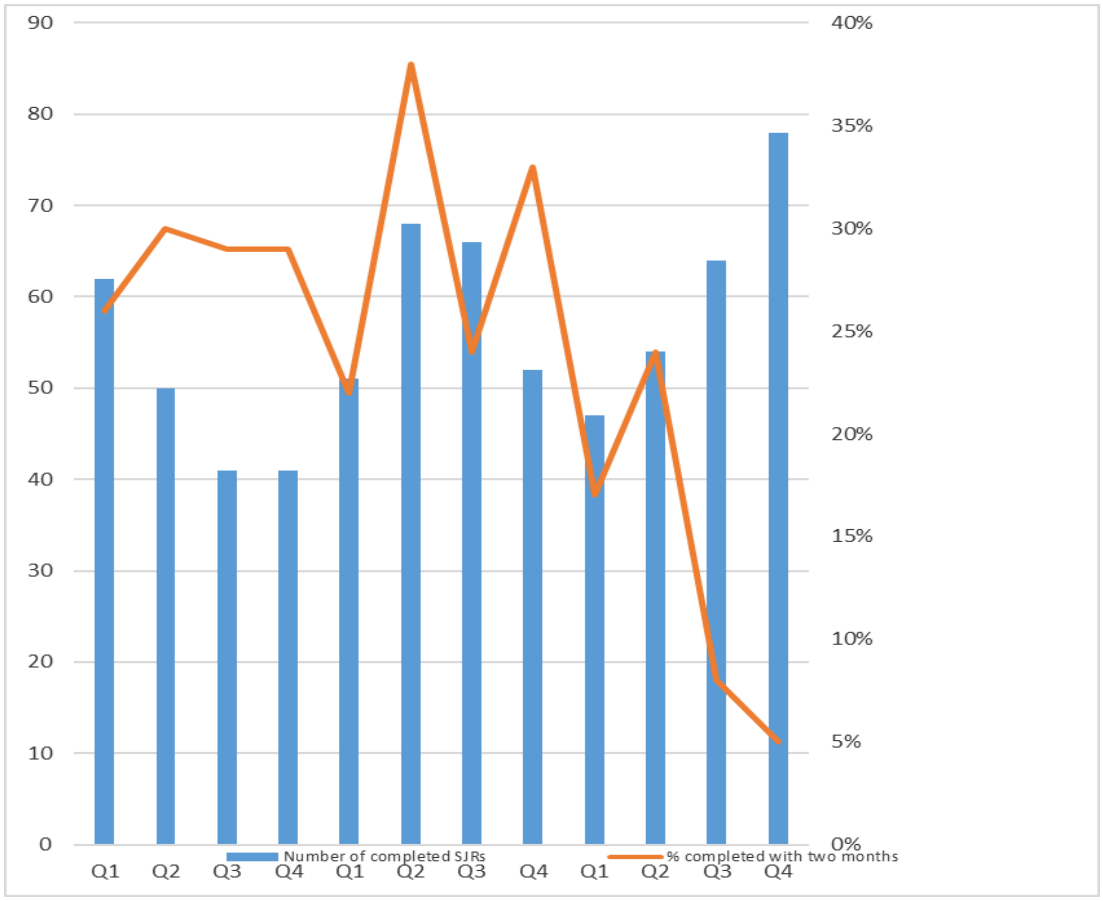


Figure 4: Number and percentage of SJRs completed within two months of patient death (Medicine Division)

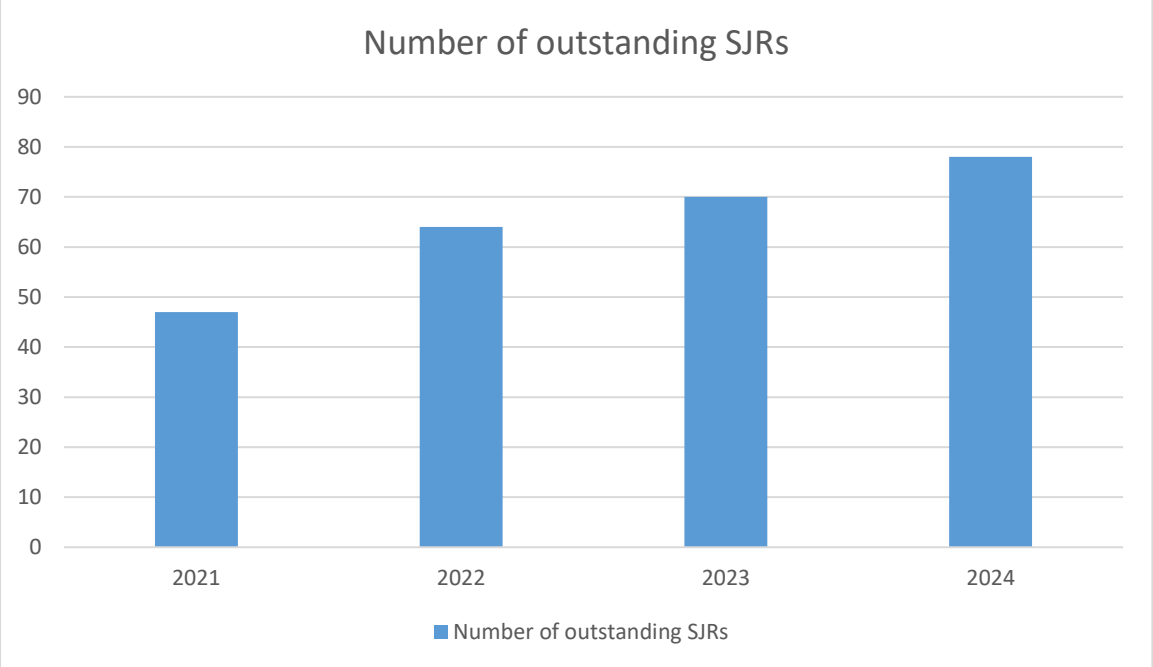


Figure 5: Number of outstanding SJRs by year.

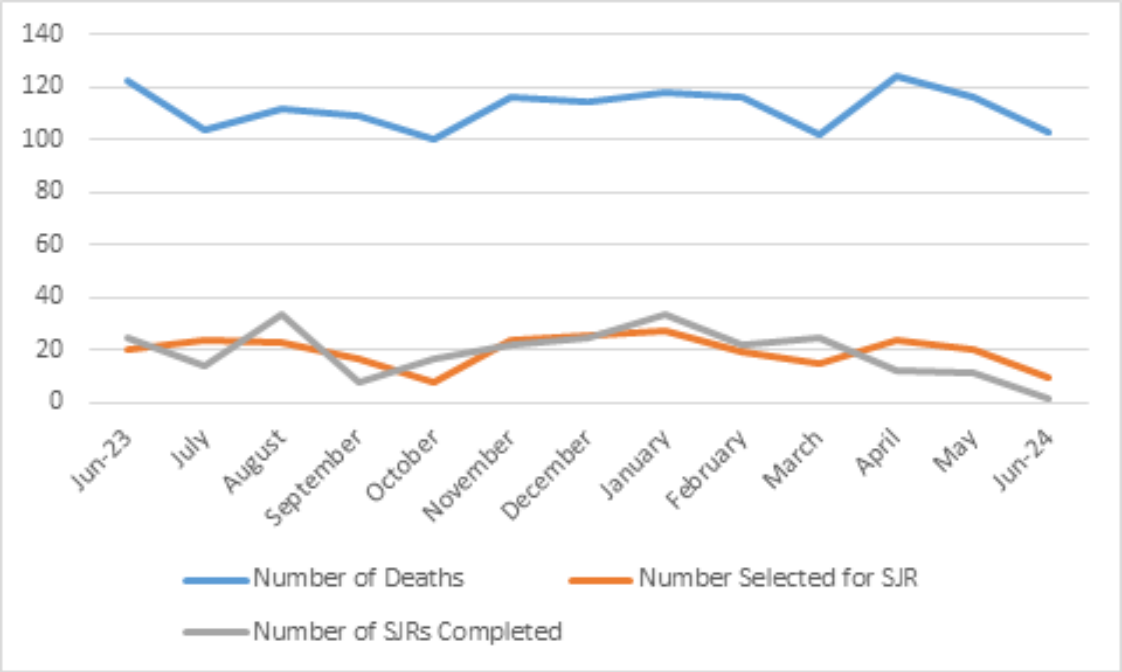


Figure 6 Number of deaths, SJRs requested and completed

The number of SJRs completed per month is aligned to the number requested. The data demonstrates more SJRs are being completed each quarter over the last year but the overall number outstanding remains static. The greatest number of outstanding SJRs are in 2024.

2.4 SJRs and Patient Safety Incident Reponses

The individual completing the SJR is asked to consider the quality of the care delivered and whether any care problems identified are likely to have contributed to the patient's death. A score of 1 or 2 (very poor or poor care) or concluding that the care problems contributed to death will result in the SJR being highlighted in a Serious Case Report within the Mortality Review Database.

Two SJRs completed during Q3 raised queries about the quality of the care the patient received. One of these had not been reported as an incident and weas identified to the clinical division for review.

Five SJRs completed during Q4 raised queries about the quality of the care the patient received. Two matters had not previously been identified both were flagged to the clinical division for review.

3.0 Learning from Structured Judgement Reviews

A quarterly report is submitted to the Mortality Surveillance Group for consideration of the trends appearing in the feedback generated by SJRs.

3.1 Overall Quality of Care

The table below sets out the ratings of care for each element of an inpatient admission. Of the SJRs completed during Q3 and Q4, 77% percent recorded overall care as either Good (a score of 4) or Very Good (a score of 5). This is consistent with previous quarters.

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.19	64	0	2	9	28	25
Ongoing Care	4.00	55	0	0	17	21	17
Care During	4.11	19	0	0	3	11	5
Return To Theatre	3.75	4	0	0	1	3	0
Perioperative Care	4.07	14	0	0	2	9	3
End Of Life	4.16	55	0	1	11	21	22
Overall	4.08	64	0	0	15	29	20
Patient Record	3.97	64	0	1	24	15	24

Figure 7: Q3 Phase of care ratings

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.29	83	0	2	7	39	35
Ongoing Care	4.06	69	0	4	14	25	26
Care During	4.29	24	0	0	3	11	10
Return To Theatre	3.50	4	0	1	1	1	1
Perioperative Care	3.89	19	1	1	3	8	6
End Of Life	4.37	71	0	0	9	27	35
Overall	4.10	83	0	4	15	33	31
Patient Record	4.05	82	0	2	25	22	33

Figure 8: Q4 Phase of care ratings

No patients were assessed as overall care being very poor in either Q3 or Q4. In Q4 there were four SJRs (5% of completed SJRs) where overall care was recorded as poor.

3.2 Themes

The figures below show the most commonly occurring themes arising from completed SJRs. In most cases, either no additional learning was identified, or it was recognised that the care delivered was of a good or excellent standard. The areas where poor care has been identified align with our current patient safety improvement work and no new themes have been identified that require additional improvement workstreams.

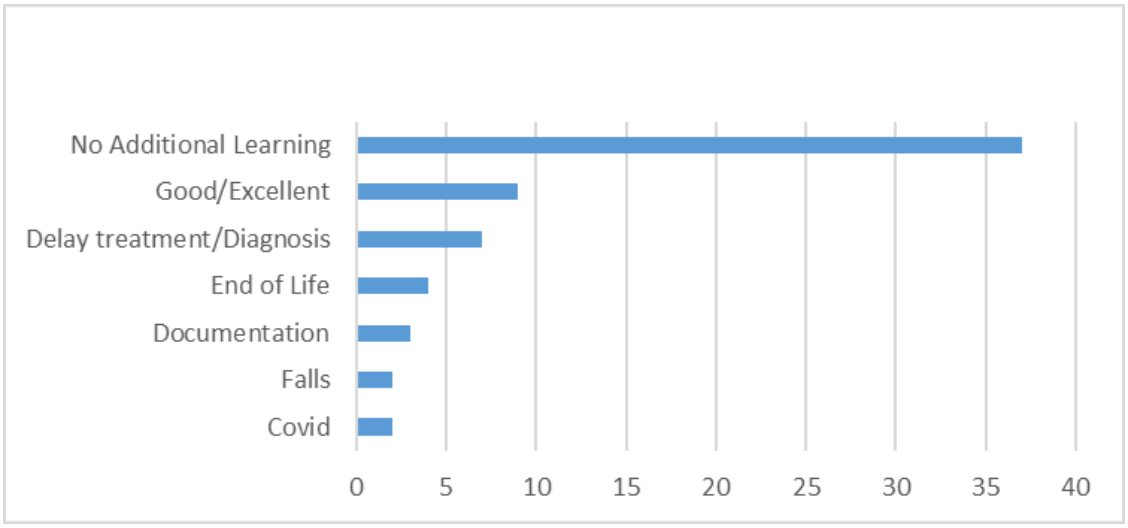


Figure 9:Q3 SJR themes

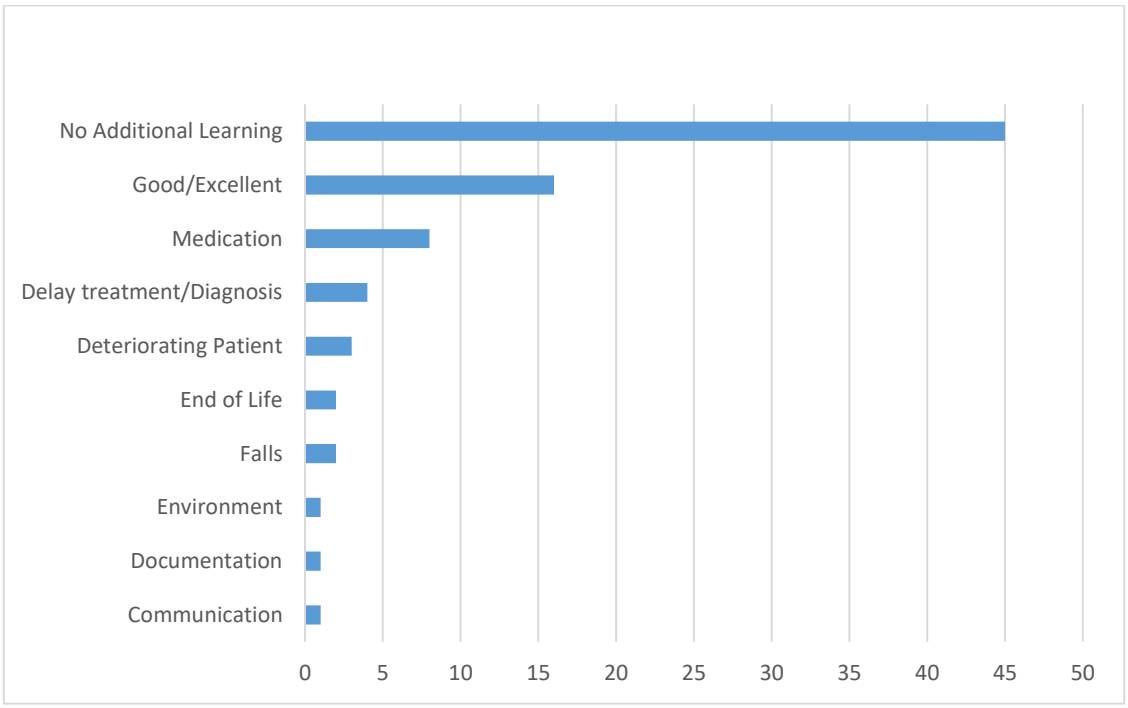


Figure 10: Q4 SJR Themes

3.2.1 Medication

Eight SJRs refer to issues relating to medication. Four are related to the prescription and administration of anticoagulants. Three SJRs relate to antimicrobial prescribing. Learning from these errors has fed into the QSIG programme for reducing medication errors and the Medicines Assurance Committee programmes.

3.2.2 Delays in treatment/Deteriorating Patient

Fourteen SJRs relate to issues with delays in treatment or the recognition of the deteriorating patient. The cases have reviewed within the Clinical Divisions and learning populated into the Deteriorating patient workstream within Quality and Safety Improvement Group.

3.2.3 End of Life Care

Four SJRs relate to care provided at the end of life. Two relate to communication and two relate to patient experience at the end of life. Local review and action have taken place.

3.3 Summary

77% of SJRs completed in the last two quarters rated care as either good or very good. In Q3 and Q4 none of the SJRs completed rated overall care as very poor. In Q4 there were four findings of poor care (5% of SJRs completed). No new emerging patient safety themes were identified from the Q3 or Q4 learning from deaths processes.

4.0 Inquests

4.1 Quarter 3

Ten inquests were opened and eight were concluded during Q3, four following in-person hearings.

The Trust did not receive any Regulation 28 Reports and the Coroner did not express any concerns about the care provided. In two instances, the Trust was on the periphery of the issues explored by the Coroner.

The two inquests that involved a greater analysis of the care provided focussed on antibiotic choice and the care of elderly trauma patients. This final issue requires continuing attention as there is a further inquest, which raises similar issues, occurring in March 2024.

4.2 Quarter 4

Eight inquests were opened and 12 were concluded during Q4, three following in-person hearings.

The Trust did not receive any Regulation 28 Reports and the Coroner did not express any concerns about the care provided. However, there were some families who were disappointed with the outcome or remained concerned. The Trust are considering how those involved in the inquest process can be better supported.

5.0 SJR recovery plan

June 2024:

- Data review (HB/RS):
  - Current reporting of data
  - Understand demand
  - Understand required capacity
- Outcomes:
  - Capacity and demand in report
  - Feedback demand to Clinical Divisions

July 2024:

- Backlog SJR risk review (HB / RS)
- Current capacity review (RS / Clinical divisions)
- Capacity assessment to deliver:
  - Recurrent demand
  - Recovery of backlog
- Outcome:
  - A3 for delayed SJR completion

August 2024:

- Options appraisal for recovery
- Outcome:
  - Paper to TQSG for proposed solutions and suggested trajectory for recovery

September onwards

- Implementation of accepted solution
- Outcomes:
  - Monitoring of recovery through TQSG divisional governance reports

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item No:**	**13**
Date of Meeting:	**22nd July 2024**		

Title of Report:	**Maternity and Neonatal Safety Report Quarter 4**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Author(s):	**Zita Martinez, Director of Midwifery**
Appendices	**Appendix 1.0 Transitional and ATAIN Audit report** **Appendix 2.0 Maternity and Neonatal 'Insights' report**

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.

In March 24 the Trust received the MBRRACE (2022) Perinatal Mortality Report. This report outlined that the crude data values for stillbirth and neonatal death at the RUH during 2022 was more than 15% lower than the average the comparator group of Trusts or Healthcare Boards of a similar size. However, when stabilised and adjusted (to account for socioeconomic demographics reflective of the national averages) the RUH rate becomes increased, returning a result of up to 5% lower than the average for the group. No values, when excluding deaths due to congenital anomalies, were identified as being greater than the comparator group average. This report identifies new national averages for stillbirth and neonatal death, current RUH rate benchmarking tools (see figure 1 and figure 2) have been adjusted to reflect this from March 24.

This RUH Maternity and Neonatal Safety report identifies at the end of Q4, the Royal United Hospitals Bath NHS Foundation Trust (RUH) rolling 12-month average stillbirth rate is 1.96 per 1000 births; this is below the reported national average of 3.3 per 1000 births (2022), however is an increase on the calendar year average reported at the end of Q3 of 1.42 per 1000. The service is closely monitoring the increased incidence of stillbirth noted during Q4, no causal commonalities have been identified within the stillbirths.

The RUH Neonatal mortality rate for Q4 is 0.68 1000 births. All stillbirths and neonatal deaths during Q4 have been reported to Mothers and Babies Reducing Risk through Audit and Confidential Enquiries-UK (MBRRACE-UK) and undertaken a Perinatal Mortality Review Tool (PMRT) process.

Within Q4, the service made 3 referrals to the Maternity and Neonatal Safety Investigations (MNSI) team hosted by the Care Quality Commission (CQC). 1 case has been confirmed and is a currently being reviewed. 2 of the referrals have not progressed following the MNSI triage process. One new internal Patient Safety Incident Investigation was declared in Q4.

The service received the finalised CQC inspection reports during March 2024 following their visit to Maternity services during November 2023. The service is proud to have maintained the rating of 'Outstanding'. The reports outlined 6 'should do' actions for which action plan formation is underway.

During Q4 the service developed the first draft of the 'Single RUH Improvement plan' encompassing Ockenden 2022, the 3 year single delivery plan 2023, the RUHs NHSE visit in 2022, Saving Babies Lives Care Bundle v3 and locally identified safety priorities. This plan will be used for easy access and ability to demonstrate progression towards full implementation/compliance.

Following submission in February 2024, this report outlines a submitted position of compliance for all 10 Safety Actions detailed within the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year 5, inclusive of a confirmed compliance of 73% implementation of the

Saving Babies Lives Care Bundle v3. On the 31st of March 2024 the service received Year 6 safety standards. Service evaluation is planned during Q1 of 24-25 with a gap analysis of year 5 to year 6 to identify next steps to ensure progression towards compliance.

The Avoiding Term Admissions into Neonatal Units (ATAIN) and Transitional Care reporting is included in this report. The ATAIN rate for Q4 remains stable, below the national target of 5%. This report outlines the quarterly statistics for external reporting as per MIS standards for Q4, and a thematic overview of the locally identified 'avoidable' admissions to the neonatal unit for 23/24 to identify any commonalties or trends for learning and continuous improvement.

In Q4 it was identified that the metric for '*babies remaining under Neonatal care rather than a transitional care pathway in response to the need for nasogastric tube feeding only, between 34-36+6 weeks*' has previously reported neonates staying on the Neonatal Unit as a corrected gestational age following an earlier pre-term birth as a missed opportunity to be cared for on the Transitional Care pathway. It is now understood, through discussions with MIS and the LMNS that this represents over reporting and these babies are being appropriately cared for on the Neonatal Unit as they do not fit the criteria for a transitional care pathway at their birth. Going forward, data will reflect this change.

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 Q4 Maternity and Neonatal, services presented 3 new risk assessments, which was approved for the risk register:

2717	Shared Father/Partner information within the multi-agencies	10
2718	Bacillus Calmette-Guerin (BCG) Vaccination programme	8
2724	Risk of loss of Obstetric USS reporting System	9

Current Open Risks in Maternity and Neonates Q4 23/24:

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	12
1948	Obstetric ultrasound scan capacity	8
2359	Maternity Information System IT support/capacity	8
2417	Maternity triage	12
2467	Maternity workforce	8
2481	Staff Entonox exposure in birthing environments	4
2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	4
2522	The Provision of maternity care to birthing people who do not identify as a female gender	4
2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millennium	4

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	8
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
2680	Unavailability of Fetal FibroNectin (FFN) in Maternity Services	12
2681	Mandatory Training room booking availability	9

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**
Previous monthly Perinatal Quality Surveillance reporting Safer Staffing Report – August 2023 CNST Maternity Incentive Scheme – Year 5 declaration of compliance Q1, 2 and 3 Maternity and Neonatal Safety Reports – Quality Governance Committee & Board of Directors	

8.	**Publication**
Public.	

9.	**Sustainability**
n/a	

10.	**Digital**
n/a	

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. From March 2024 the national averages have been adjusted to reflect the publication of the MBRRACE-UK report of 2022 perinatal mortality.

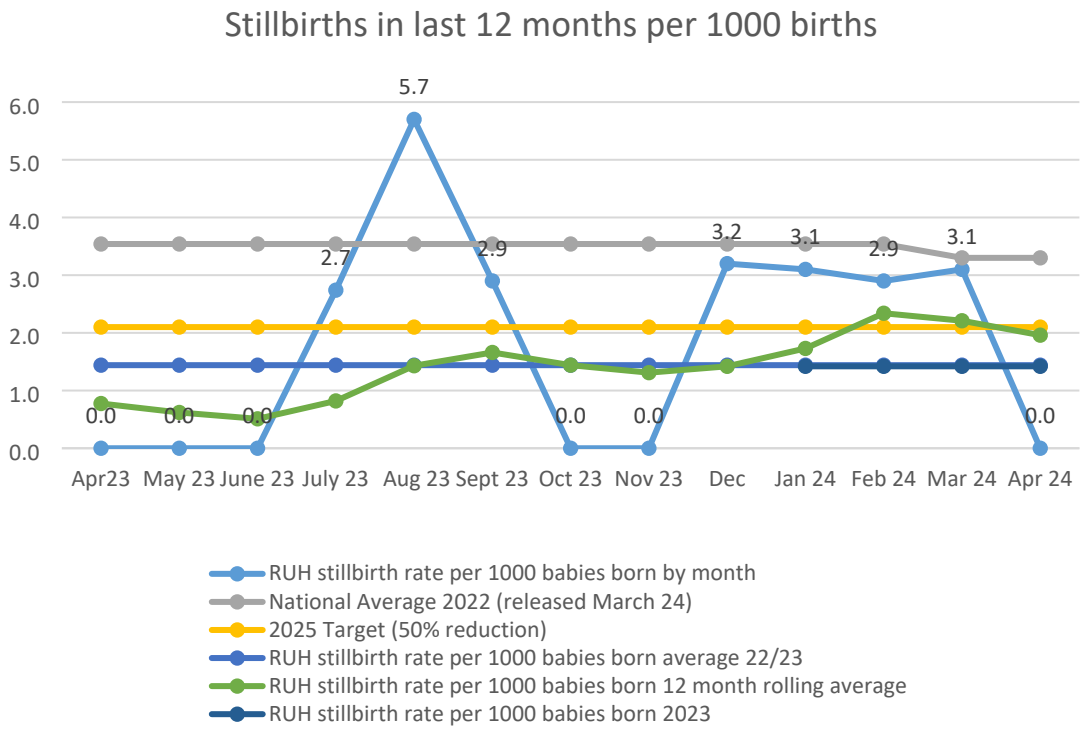


Figure 1: RUH NHS Trust stillbirth rate per 1000 births over last 12 months

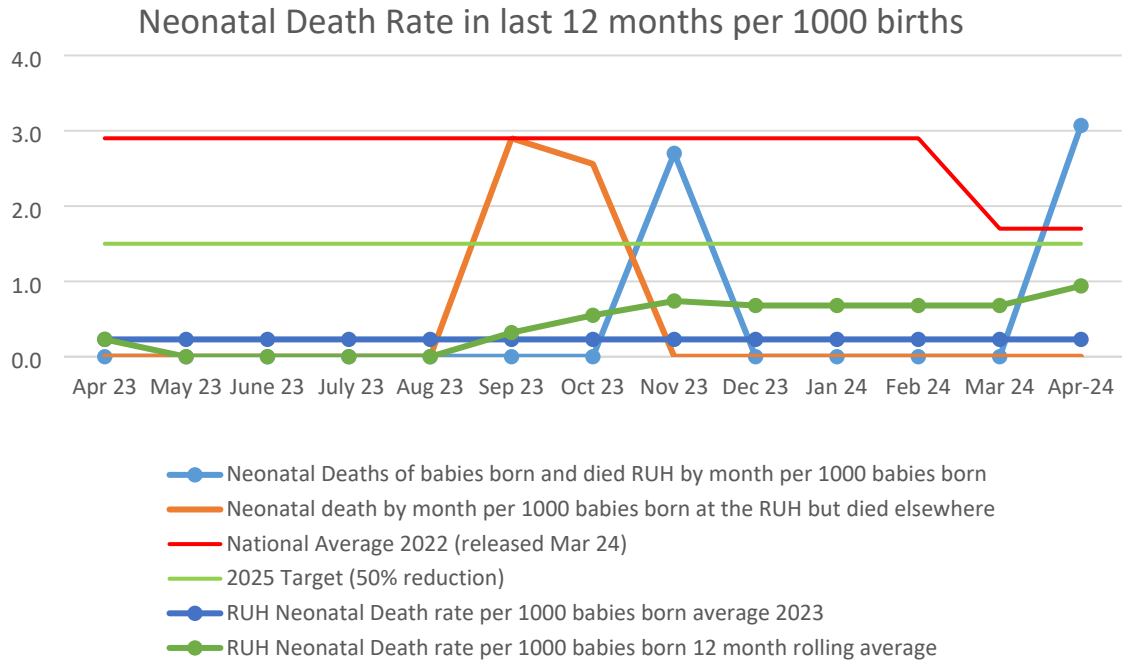


Figure 2: RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

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-UK perinatal mortality rate per 1000 births, results are subsequently stabilised and adjusted to reflect RUH statistics if representative of the national socioeconomic demographics. MBRRACE-UK collates the data for those babies who were born at the RUH and subsequently died elsewhere. This report has therefore separated these values to ensure alignment of internal mortality data figures ahead of reported and adjusted MBRRACE-UK figures, see Figure 1 and Figure 2.

Three perinatal deaths (excluding Medical Termination of Pregnancies (MTOP)) were reported in Q4. This consisted of 3 stillbirths of which 2 were of a term gestation (>37 weeks).

2023/24 (excluding terminations for abnormalities)	Q4 23/24	Annual total 23/24	Annual total 2024 (calendar year)
Stillbirths (>37 weeks)	2	4	2
Stillbirths(>24weeks-36+6weeks)	1	4	1
Late miscarriage (22+weeks-23+6weeks)	0	1	
Neonatal death at the RUH	0	1	0

Neonatal death elsewhere following birth at the RUH	0	2	0
Total	**3**	**12**	**3**

Table 1: Perinatal Mortality summary by number of cases, quarter 4 2023/24

During March 2024 the service received the MBRRACE-UK perinatal mortality review report of 2022 statistics. This report outlined that the crude data values for stillbirth and neonatal death at the RUH during 2022 was more than 15% lower than the average the comparator group of Trusts or Healthcare Boards of a similar size.

The report identifies a positive declining trend in crude data values for stillbirth and extended perinatal mortality.

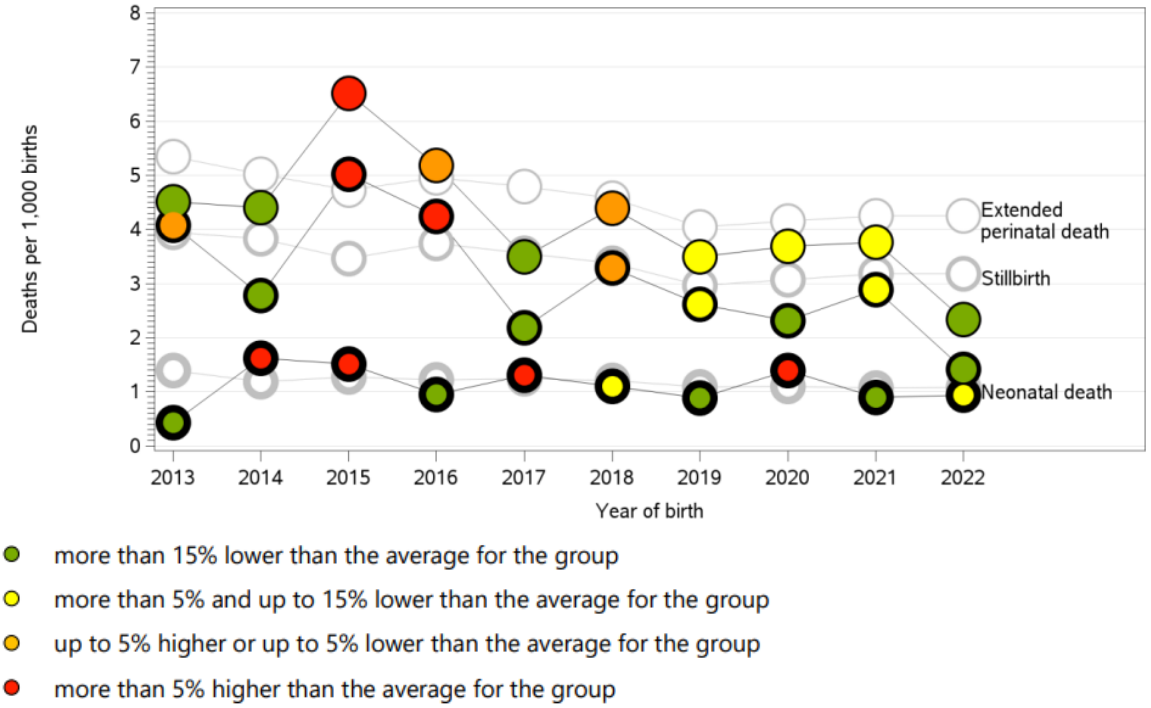


Figure 3: MBRRACE-UK perinatal mortality report relating to 2022 statistics

When the crude data has been stabilised and adjusted to reflect the national socioeconomic demographics such as ethnicity and Index of Multiple Deprivation (IMD), the RUH values become significantly increased from 1.44 per 1000 births to 3.12 per 1000 births. The aim of stabilisation and adjustment is to reduce the variance between service providers based upon those who access their services, this is often influenced by geographical location, ethnicity and IMD. For example, the disparity of maternity outcomes was identified within the MBRRACE-UK report of 2021 women of a black ethnic background are 2.3 times more likely to experience a stillbirth in the UK when compared to white women, and women from the lowest IMD are 1.98 times more likely to experience a stillbirth when compared to the highest. At the RUH the demographics of the women and birthing people we serve when compared to national averages, show an increased proportion of white women and higher IMD distribution. Therefore, the stabilised and adjusted rates for the RUH are increased on crude rates.

Figure 4: RUH stabilised and adjusted mortality rate by type of death in comparison to average mortality rate for Trusts and Health Boards in the same comparator group.

Following stabilisation and adjustment, the values place the RUH rates for 2022 within 5% of the comparator group average. When excluding deaths due to congenital anomalies, there were no categories identified within which the RUH statistics were greater than the group average.

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 Action 1 of the NHS-R Maternity Incentive Scheme year 5. All Q4 cases have been reported to MBRRACE-UK via PMRT. See Figure 5 and Table 1.

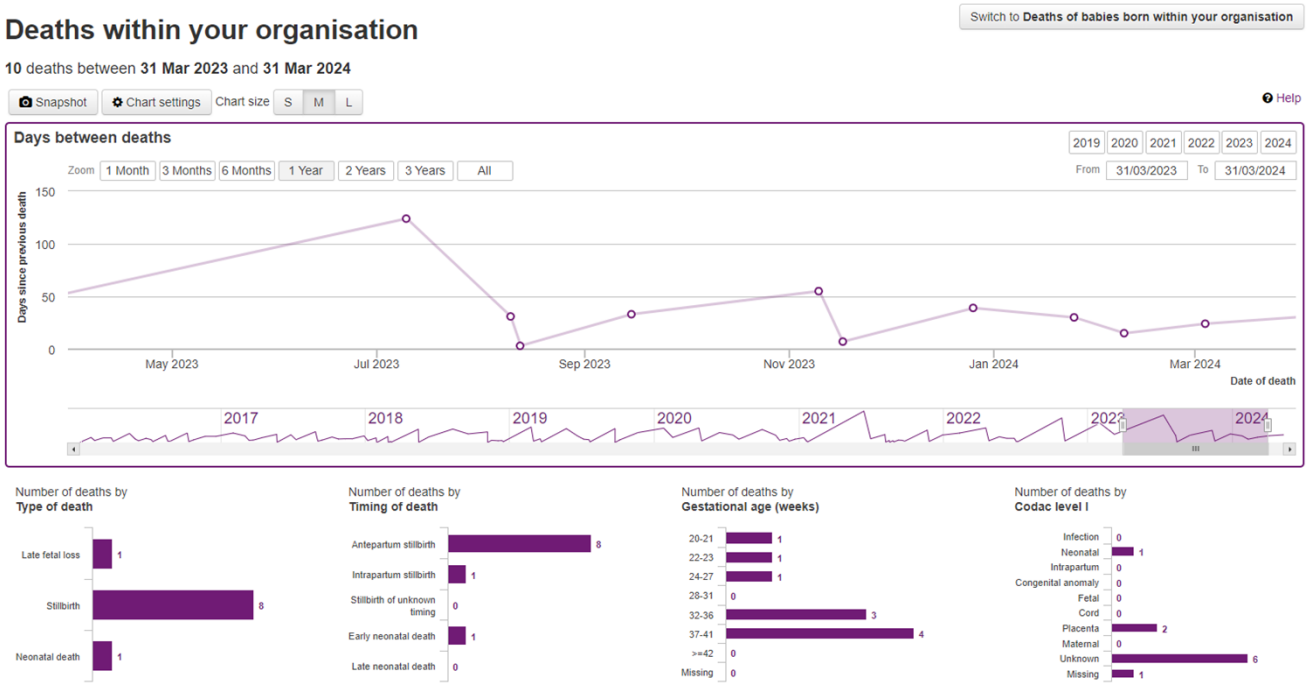


Figure 5: Reporting of RUH NHS Trust Deaths within Organisation for 2023/24

When reviewing the PMRT summary report of issues raised by PMRT for perinatal deaths within 23/24, aligned against the elements of the saving babies' lives care bundle version 3

18% (n=2) of the cases identified that on one occasion in each case the Symphysis Fundal Height (SFH) measurement was not plotted on the SFH chart. These have been retrospectively plotted and identified this would not have indicated a care pathway change.

0% of the cases were associated with reduced fetal movement management.

9% (n=1) of the cases identified care issues related to the prevention and prediction of pre-term birth, this related to a missed opportunity to have referred the mother to the pre-term birth clinic for cervical length scans in response to a uterine anomaly.

2.1 LEARNING FROM PMRT REVIEWS

1 PMRT reviews reached completion in Q4 of 2023. This pertained to the neonatal death of a baby in 2022 for which PMRT was re-opened in light of new information received by the service following post-mortem findings. This resulted in a re-grading of care and new PMRT report. This case is subject to an on-going coronial inquest.

The actions identified from this case are outlined in table 2:

Ref	Issue/area for improvement	Review Response/Action plan	Action target date
81294/1	Oxygen Saturation monitoring was not conducted in response to signs of respiratory distress.	• Universal Newborn Pre and Post ductal Oxygen saturation Screening referred to as Pulse Oximetry (POS) is currently being piloted by the neonatal team as part of all inpatient Newborn Infant Physical Examinations.	• November 2023 **Complete**
		• For POS monitoring to become part of all NIPE examinations	• Phased implementation in progress Phase 1 launched in Q3 of 23/24
		• Introduction of the national NEWTT 2 with prompt for oxygen saturation to be recorded if the family has concerns, already in place on Transitional Care, in progress for launch on the postnatal ward in April 24.	• April 2024 **Complete**
		• Increased signage attached to saturation monitors with pictorial information to support staff in undertaking oxygen saturation monitoring.	• December 2023 – **Complete**

		• Increased signage in the ward staff areas raising awareness of the importance of oxygen saturation monitoring when conducting observations in response to signs of potential increased work of breathing/respiratory distress.	• December 2023 **Complete**
		• We are developing additional training presentation for midwives as part of mandatory training programme on respiratory care; identifying increased work of breathing, things to consider, and importance of escalation.	• To be launched as part of Maternity Professional development day 2024/25
		• The family have also been in contact with the Quality Improvement and Patient Safety lead and have very kindly agreed to share their story as part of the education programme for staff in response to their care journey, highlighting the importance and difference oxygen saturation monitoring may make.	• Filmed recorded in March 24 **Complete**
		• The recording of oxygen saturation monitoring in response to respiratory distress will form part of the ongoing clinical audit programme to ensure improving trajectories towards high compliance monitored by Maternity and Neonatal Specialty Governance.	• On-going A repeat audit conducted in January 2024 showed increased compliance from 65% in October 2023 to 100%.
	The Child Death Policy was followed, which was appropriate, however in early neonatal deaths maternal serology may have provided additional information - the Child death policy does not currently outline a consideration to obtain/offer maternal serology, for early neonatal	For the Child Death Policy to be amended to include prompt for clinicians to consider the offer of maternal blood serology screening in the event of an early neonatal death.	• April 2024 **Complete**

	deaths.		

Table 2: PMRT Action plan

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

Three new referrals were made in Q4 to MNSI, two were rejected by MNSI following internal triage, and one progressed to review.

Table 3 identifies ongoing MNSI reviews into Q4. 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 Q4			
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.	July 2023	N/A
Ongoing			
MI-034606	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling. Normal MRI post	Sept 2023	N/A

	active therapeutic cooling, progressing at family request.		
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.	October 2023	N/A
New Referrals			
MI-036728	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling. Normal MRI post active therapeutic cooling.	January 2024 N/A no family consent	
MI- 036929	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling. Normal MRI post active therapeutic cooling.	March 24 N/A no family or Trust concerns regarding care	
MI-036771	Stillbirth of baby en route to hospital for labour assessment.	February 2024	MBRRACE/PM RT. Discussed with coroner.

Table 3. MNSI referrals and ongoing investigations Q4 2023/24

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY PATIENT SAFETY INCIDENT INVESITGATIONS

One patient safety review was completed in Q4, the findings and recommendations have been actioned as per paragraph 3.5. There were no Patient Safety Incident Investigations declared during Q4. See Table 4.

Ref	Details of Event	Review Response	External Notifications and Other Investigations
Completed reviews			
121463	Neonatal death at 27 weeks gestation following a difficult caesarean section birth.	Patient Safety Incident Investigation (PSII)	MBRRACE/PM RT STEIS
New reviews			

Table 4. Maternity and Neonatal Serious Incident reviews Q4

There were 6 moderate harm events reported during Q4, all have received a local review, the multidisciplinary review team (MDT) did not identify any care concerns casual to the event. Any and all co-incidental learning and findings have been actioned at specialty level feeding into the 'triangulation of feedback' data base to allow for assessment of commonalities or trends.

3.5 LEARNING AND IMPROVEMENT

One completed MNSI review and 1 completed local patient safety review were received in Q4 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.

Ref	Issue/area for improvement	Review Response/Action plan	Action target date
MNSI MI-030349	The Trust to ensure that staff are supported to escalate promptly to the obstetric team using the emergency call bell when fetal wellbeing is not assured.	Following receipt of this MNSI report in February 2024, a review of cases was undertaken where the use of the emergency bell has been raised as an issue. This triangulation of cases included the local review for case MI-036728 in January 24. Through informal discussions with staff members in maternity services it was identified that the culture pertaining to using the emergency bell is positive. However, in all 3 cases the learning pertained to the recognition that that a total loss of contact (LOC) of the Fetal Heartrate (FH) for a time period >3 minutes is an obstetric emergency. This should instigate emergency escalation inclusive of the emergency bell. Therefore, the action plan below is derived around this area of improvement. Actions towards implementation began in February 2024, it was identified in MI-036929 during March 24 the appropriate escalation took place in response to an inaudible FH.	
		Alignment of local staff guidance for consistent messaging regarding the management of an inaudible FH	• June 24
		This case to feature on the Maternity Mandatory Fetal monitoring study day as an index case to be shared alongside the other 2 case studies to demonstrate the link for the use of emergency bell in cases of LOC and perinatal outcomes, highlighting the importance and significance of escalation of LOC /inaudible FH as a recognition of an obstetric emergency	• May 24
		This case to be presented to the Multidisciplinary 'Perinatal' shared learning forum as above to support MDT care planning . To support MDT care planning	• April 24-complete

		Total LOC/inaudible FH and recognition that this is an obstetric emergency to be added to staff handover safety briefings	• Feb 24 - complete
		Staff sharing poster highlighting learning as above to be displayed in all staff areas and available electronically on Staff teams' new board. To be completed by March 24 in line with the quality hot spot	• March 24 - complete
		LOC/inaudible FH featuring this case to be the quality hot spot for the month of March 24	• March 24 - complete

Table: 5: Learning response action plan to MNSI case MI-030349

When reviewing Q4 incidents, learning and improvement alongside the claims scorecard for 2023, no direct correlations can be seen between the specifically identified improvements in LOC of the fetal heartrate and the claims made to the Trust. There are currently 9 open high value open claims, within which a failure to respond to abnormalities in the fetal heartrate is identified as a cause for claim in 3 cases. The direct context of these clinical scenarios cannot be extrapolated from the scorecard. The latest case related to care provided in 2018.

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 – Q4 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.

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	87.5
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	66.7
12- Postnatal Care	25.0
13- Bereavement Care	88.9
14- Neonatal Care	77.8
15- Supporting Families	75.0
Total	75.4

Table: 6: Q4 23/24 Ockenden 2022 Immediate and Essential Action (IEA) compliance

During Q4 an RUH single delivery improvement plan has been developed 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 Care Bundle v3, the NHSE visit in 2022, CQC report received in 2024 and locally identified safety priorities.

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, Saving Babies Lives Care Bundle v3 and the core competency framework v2.

During the CQC inspection in November 2023, the RUH Maternity and Neonatal Training compliance for Adult Basic Life support (ABLS) was below the local target of 90% at 66%. In response to the 'should do' recommendation, plans are in progress for this to become managed in specialty as part of the PROMPT programme to ensure progress towards high levels of compliance.

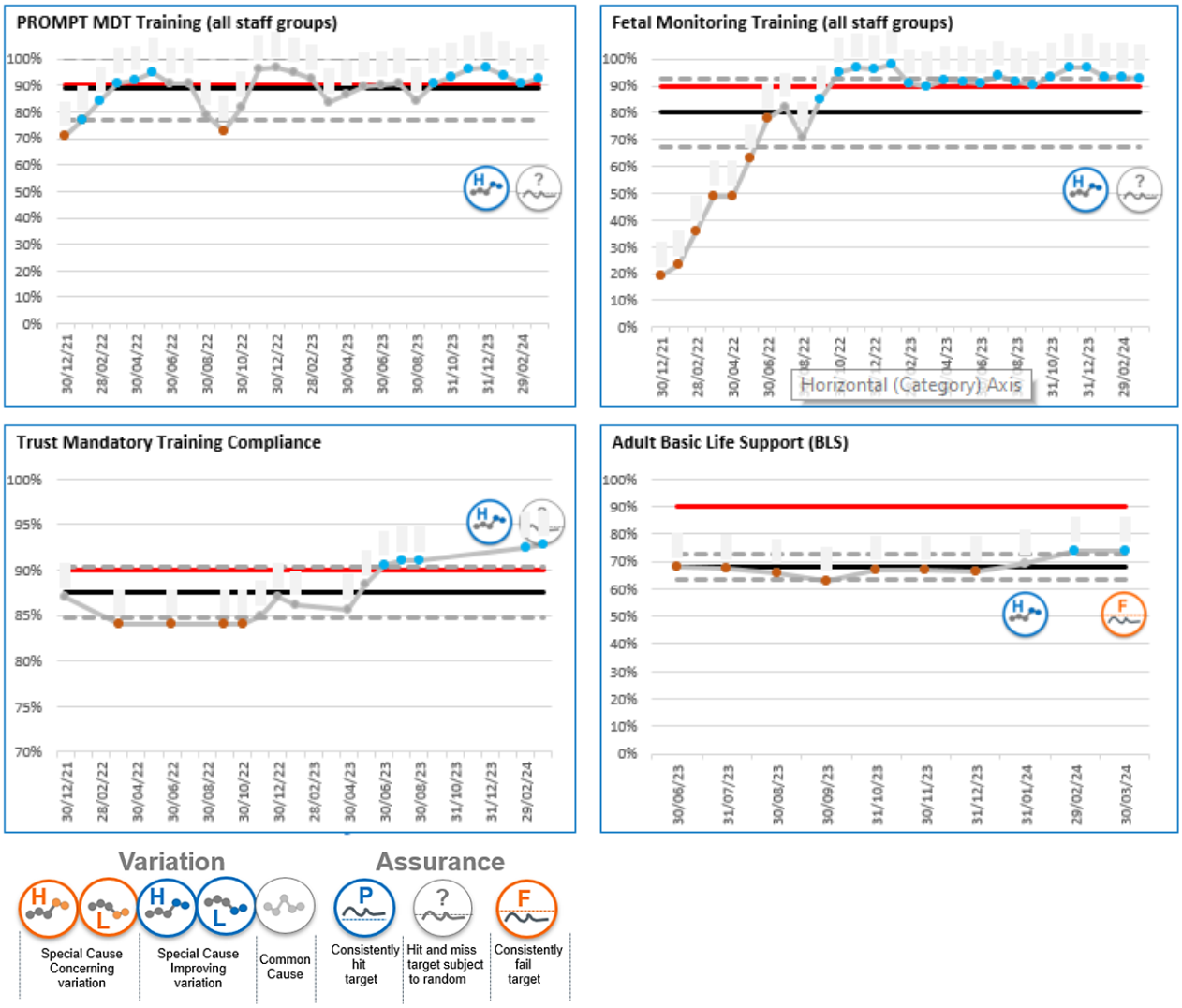


Figure 6. Maternity Training Statistical Process Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance, as of 31/03/2024

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 Q4 from a range of areas, including neonatal services, community midwifery and specialist midwives.

Themes raised during Q4 were:

- A reduction in Bank shift availability subsequent to increased staffing levels
- Positive feedback for the development of the Maternity Triage service
- Positive feedback regarding the leadership team being supportive and approachable

- Neonatal Unit access challenges for families when no ward clerk available to manage the intercom or during high acuity
- Challenges in recruitment to the community birth team
- Challenges with the current Electronic Patient Record system for data capture requirements.

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

- Anticipated completion of estates works and launch of Maternity triage in Q2 of 24/25
- The Neonatal Nurse Consultant is exploring facial recognition software for the intercom on the Neonatal Unit
- Maternity digital system – funding stream for new EPR system secured, implementation plans in progress with aimed 'go live' date of March 2025 - 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 Q4 2023/24

The service was able to declare full compliance with all 10 Safety Actions detailed in the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme in January 2024. See table 7.

	Maternity Incentive Scheme - Safety Action Detail	Submission RAG 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?	

Table 7: Declaration for compliance with MIS Year 5.

The Clinical Negligence Scheme for Trusts released their Safety Actions for Year 6 on 31 March 2024. Current service evaluation is underway, 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.

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

Saving Babies Lives Care Bundle Version 3 implementation was assessed externally by the LMNS using the national implementation tool on NHS Futures Platform. The RUHs evidenced position in Q4 is reported in table 8.

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 8. RUH Maternity position for implementation of Saving Babies Lives Care Bundle v3.

Ongoing work has continued during Q4 working towards full implementation of all elements of Saving Babies Lives Care Bundle Version 3.

Key areas of focus are:

- Element 1- Increased assurance data regarding the care pathways for smoking mothers to increase compliance to 100% via a new 'smoking mother's care pathway'. Quarterly audit report triangulating process indicators to clinical outcome measures
- 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- Increased training compliance for obstetric radiographers, in the performance of uterine artery dopplers, target training compliance projection for June 2024
- 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.

9.0 SAFE MATERNITY STAFFING

9.1 MIDWIFERY STAFFING

As of March 2024, the Band 5/6 Midwifery Vacancy rate was at an over establishment of 10.74 WTE of which 8.0WTE is to cover consistent 'gap' created in budget vs actual generated by Maternity leave within the Midwifery workforce. Therefore, the overall position is a 2.74WTE over recruitment.

The new funding attributed to the maternity business case comes into budget from Q1 of 24/25 resulting in the increase in budget seen in Figure 7 from April 24 onwards.

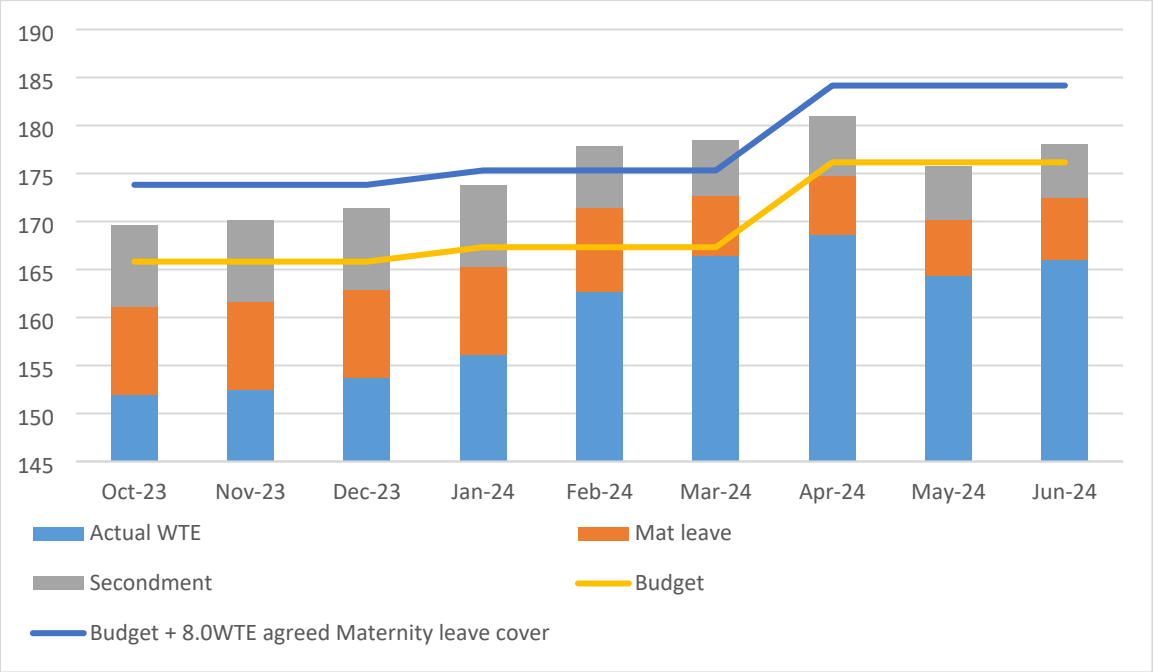


Figure 7. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness)

Measure	Aim	January	February	March
Midwife to birth ratio	1:24	26	27	25
Midwife to birth ratio including bank	1:24	23	24	23
Episodes of inability to maintain	0	0	0	0

Supernumerary labour ward coordinator status				
1:1 care not provided	0	0	0	0
Confidence factor in Birth-rate+ recording	60%	87.63	81.61	89.25

Table 9. Midwifery staffing safety measures

9.2 OBSTETRIC STAFFING

Measure	Aim	January	February	March
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%	62%	73%

Table 10. 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 Q4, 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.

An Obstetric workforce review has been completed and has identified a risk within the established funding of Obstetric Consultant posts. The maternity investment case has supported an increase of 2.0 WTE consultants, during Q4, there was successful recruitment into the available 2 posts due to commence their substantive posts in June of 2024 and the risk has been closed on the risk register.

10.0 INSIGHTS FROM SERVICE USERS AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

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

	January	February	March
Number of formal compliments	5	9	0
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	12	10	3
Complaints	0	1	1

Table 11. Complaints and compliments Q4 23/24

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 these are often received via informal routes, and kind gestures from families such as cards.

During Q4, the service received 3 complaints; no direct commonalities were identified between these three complaints, however the service insights from complaints, PALS and compliments received throughout 2023/2024 has been assessed to identify any commonalities or trends within family feedback data, see the Maternity and Neonatal Insights report (Appendix 2.0) where a key patient experience theme relating to postnatal care provision has been identified.

The information available to the service through review of the complaints, compliments and PALS contacts received are reviewed 'in month' within the Maternity and Neonatal Triangulation of Feedback group where key stakeholders with valuable insight into patient experiences across maternity and neonatal services meet to discuss their 'in month' data to allow for wider system collation and identification of emerging themes or concerns.

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 was undertaken in Q4, the priorities for the service are currently undergoing system-wide agreement within the Local maternity and Neonatal System (LMNS).

MNVP hours have been increased and agreed via the LMNS Programme Board to support the work plan across the Bath and North East Somerset, Swindon and Wiltshire (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.

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

During Q4, 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.

The Avoiding Term Admissions into the Neonatal Unit (ATAIN) working group identified 3 avoidable admissions into the Local Neonatal Unit (LNU) in Q4. Of the 3 incidents, 2 cases featured a modifiable factor linked to timely escalation to the neonatal team in the immediate postnatal period when neonatal condition is not optimal. Due to the small number these cases, both have fed into a thematic review of all of the ATAIN cases of 23/24 to facilitate identification of themes or trends within the avoidable admissions.

The thematic review has identified 2 areas of commonality within the 'avoidable' admissions within 2023/24. This relates to the provision of thermoregulatory care of the newborn and subsequent physiological cascade, and an identified commonality of the care provision in the immediate postnatal period after birth (the first hour after birth of the baby).
Full details of the service's action plan in response to these findings to drive continuous improvement are detailed within the report.

12.0 RISK REGISTER

In Q4 Maternity and Neonatal, services presented three new risk assessments, which were approved for the risk register:

2717	Shared Father/Partner information within the multi-agencies	10
2718	Bacillus Calmette-Guerin (BCG) Vaccination programme	8
2724	Risk of loss of Obstetric USS reporting System	9

Table 12. New Risks for the Maternity and Neonatal risk register Q4 2023/24

During Q4 three risks were closed,

Risk No	Title of Risk	Rationale for closure	
2483	Expiration of Maternity and Neonatal staff resource and guidelines	As of March 2024 96% of maternity guidance is in date or currently under-review due for ratification, therefore the risk has been closed in response to significant reduction in likelihood of consequence meeting target risk rating	8
2581	Obstetric Workforce establishment	Successful recruitment took place in March 2024 for an additional 2 obstetric consultants, therefore likelihood of consequence significantly reduced to meet target risk rating.	8
2664	Maternity Ligature risk	The individual Maternity Ligature risk assessment has been enveloped within the trust-wide Ligature risk assessment	5

Table 13. Closed Risks for the Maternity and Neonatal risk register Q4 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	12
1948	Obstetric ultrasound scan capacity	8
2359	Maternity Information System IT support/capacity	8
2417	Maternity triage	12
2467	Maternity workforce	8
2481	Staff Entonox exposure in birthing environments	4
2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	4
2522	The Provision of maternity care to birthing people who do not identify as a female gender	4
2562	There is a risk to the Electronic Patient Record (EPR) due to unsecured funding following withdrawal from Cerner Millenium	4
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	8

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
2680	Unavailability of Fetal FibroNectin (FFN) in Maternity Services	12
2681	Mandatory Training room booking availability	9

Table 14. Maternity and Neonatal Risk Register April 2024

13.0 RECOMMENDATION

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

Clinical Audit Report

Appendix 1: Transitional Care Pathway and ATAIN Audit
Q4 2023/2024

Speciality: Local Neonatal Unit

Division: Family & Specialist Services Division

Project team				
Kirstie Flood	Title/grade:	Lead Nurse	Data period:	Q4 January 2024 - March 2024
Sarah Goodwin	Title/grade:	Quality and Education Neonatal Sister	Report completion:	April 2024

Transitional Care Pathway and ATAIN Audit Q4 2023/2024

Contents

Executive Summary

Background

ATAIN is an acronym for **A**voiding **T**erm **A**dmissions **I**nto **N**eonatal Units. It is a national programme of work initiated under patient safety to identify harm leading to term admissions. The current focus is on reducing harm and avoiding an unnecessary separation of mother and baby. Mothers and babies have a physiological and emotional need to be together, hours and days following birth – this is important for physiological stability of baby and initiation of maternal infant interaction.

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

As part of the RUH Maternity and Neonatal services, the continued monitoring of admission data and modifiable factors which may have impacted upon the resulting admission allows the continuous evaluation of current systematic care provision and seeks to identify key areas of improvement.
This audit report is demonstrative of the upward reporting from the ATAIN working group's Terms of Reference (TOR) supporting the continued improvement of our 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 Neonatal Units (LNU) programme.*

Objectives

- To review that all 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. See Guidance Neo-100. Neonatal teams are involved in decision making and planning care for all babies in transitional care
- To monitor that the pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS) and Integrated Care System (ICS) quality surveillance meeting each quarter
- 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 Transitional Care, 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

- To analyse staff/parent data captured via a questionnaire around satisfaction and 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 progression with the action plan for sharing with the neonatal maternity safety champion, and Board Level Champions, LMNS and ICS quality surveillance meeting each quarter
- To provide an audit trail of evidence that reviews of all term babies transferred or admitted to the NNU, 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 requiring improvement. This is in line with the working group's TOR.

Key findings

Standard	**Compliance January 2024**	**Compliance February 2024**	**Compliance March 2024**	**Quarter 4 23/24 Totals**	**2024 Totals**
Audit findings shared with Neonatal Safety Champion	**Complete**	**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**	**0**
The number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could	**7**	**3**	**7**	**17**	**63 ** please see Transitional Care audit findings** **2**

have been cared for on a TC if nasogastric feeding was supported there. 34+0 - 36+6					
% of shifts TCP nurse provided as per TCP staffing model	**98%**	**100%**	**96%**	**98%**	**97%**
TCP open	**100%**	**100%**	**100%**	**100%**	**100%**
Number of babies readmitted to Neonatal Unit from TCP	**0**	**0**	**1**	**1**	**2**
The number of avoidable term admissions 37+0 weeks gestation and above admitted to the Neonatal Unit	**1**	**2**	**0**	**3**	**17**
The number of term babies transferred or admitted to the Neonatal Unit from other areas – for example Emergency Department, Children's ward.	**1**	**4**	**2**	**7**	**19**

Table 1: Compliance with standards

Clinical Audit Report

Project title
Transitional Care and ATAIN Audit Q4 2023/2024 January - March 2024

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 01/01/2024-31/03/2024to determine if the correct location of care was achieved.

- All babies born at 37+0 weeks gestation and above from 01/01/2024-31/03/2024 who were admitted to the NNU.

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

Audit type
Retrospective and live data collection.

1.0 Transitional Care Audit Findings

- In Q4, 50% of the total number of admissions to the Neonatal Unit (NNU) (87 babies) were cared for on the transitional care pathway (TCP) for some or part of their admission. Out of this, 75% (65 babies) spent the entirety of their admission on the TCP. The total number of babies was similar data to last quarter, however the % of babies spending their entire admission on the TCP was increased from 35% to 75%.

- The explicit staffing model outlined within the Maternity Safety Actions for staffing of the TCP supported 100% of shifts in Q4 for January, 100% February and 96% for March. The decrease in compliance in March was attributable to the NNU being at capacity and high acuity, in conjunction with vacancies in Band 6 and 5 posts, higher than average study leave (due to supporting staff to complete their Qualified in Speciality course) and a 6.1% sickness rate. This meant that some shifts required the TCP nurse to care for more than the four recommended babies. The staffing escalation guideline was activated and no harm occurred.

- The number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding only, but could have been cared for on a TCP if

nasogastric tube (NGT) feeding was supported there for 34+0 -36+6 was 63 for the year 2023/2024. The highest contributor for this value were those babies born prematurely, whose corrected gestational age meant they required NGT feeding and the mother was no longer a patient within Maternity and Neonatal services. We aim to improve this figure during 24/25 by the conversion of room G as an additional TC space to allow for discharged mothers to 'room in' with their babies during this period. This will allow for establishment of feeding and fulfilment of an extended TC pathway. The service is also exploring an increase in the neonatal outreach service to a 7-day service to facilitate at home NGT tube feeding support, which we hope will further reduce this value and the separation of mother and babies.

The service has sought clarification of this reporting standard during Q1 24/25, due to locally identified disparity of values within Maternity and Neonatal system providers. Following contact with NHS Resolution, Maternity Incentive Scheme (MIS) it has been identified this value should not account for the 'corrected' gestational age of premature babies however should only represent those babies born between 34+0-36+6. Therefore, this figure will change from Q1 onwards with an anticipated significant decrease. When corrected to national reporting as per MIS Safety Actions the value for 23/24 was two babies.

The service will continue to monitor the impact of the quality improvement measures identified due to the anticipated positive impact on patient experience.

2.0 ATAIN Audit Findings Q4

The ATAIN working group has identified three avoidable admissions to the NNU during Q4, this is a significant reduction from 7 that were reported in Q3.

- In Q4, there has been some recognised commonalities between the avoidable admissions identified at MDT. The first baby was assessed to be an avoidable admission was as a direct result of two missed opportunities to review and escalate care of the baby. On the initial assessment when the baby was noted to be grunting there was a delay in appropriate management of the baby.

- A second baby had a low Apgar at 5 minutes, which was not escalated until the baby had increasing respiratory distress. Had the baby been reviewed earlier and intervention commenced, it may have avoided their admission.

- The third baby had an avoidable admission with a similar history of a low Apgar at 5 minutes and a missed opportunity to escalate for neonatal support.

The learning from these cases has been discussed with the Consultant, Advanced Neonatal Nurse Practitioner (ANNP) and the Quality and Education Midwife and plans are in place to formalise some training focusing on observations of babies with respiratory distress and when to escalate concerns.

These sessions will be for Midwives and Maternity Care Assistants (MCA) in addition to sharing the outcomes at the Safety Catch and Quality Boards.

In line with Safety Action 3, Neonatal Unit transfers or admissions regardless of their length of stay, admitted to the Neonatal Unit from other areas within the RUH, are reviewed. This includes, Emergency Department and the Children's ward. In Q4, 2024, 7 babies were admitted, an increase from three on the previous quarter. Admissions are assessed against current admission guidance seeking to ascertain if the NNU was the appropriate care setting. The review looks for common themes within the source and cause of admission.

January Admissions

Admission of a 6 day old baby from home into the NNU but had never required any respiratory support and was self-ventilating on air and could have been nursed on the Children's ward as a more appropriate location.

February Admissions

Baby 1 was admitted via the Emergency Department (ED) on day 11 with a history of lethargy, poor feeding and increased work of breathing. The baby had a worsening condition on arrival and went on to be intubated and ventilated on the Neonatal Unit. This was deemed an appropriate location of care.

Baby 2 was a 1-day-old baby that was a referral from a community midwife with a history of tachypnoea. The baby came to Bath Birthing Centre by ambulance and was subsequently admitted to the NNU. This was deemed not the appropriate location of care and the Children's ward would have been more appropriate.

Baby 3 attended on day 5 for weight loss and was noted to have increased work of breathing, reduced oxygen saturations and tacyhpnoea. Admitted to the Neonatal Unit and commenced on high flow respiratory support with oxygen as required. This baby could have been cared for on the Children's ward.

The final baby was admitted from home in February, was a 2 day old with elevated respiratory rate, mottled appearance and cold. The neonatal Consultant advised the admission to the NNU in view of the baby's condition.

March Admissions

Baby 1 was born before arrival and was tachypnoeic and a result of the birth history the decision was advised to bring the baby into the NNU – appropriate admission.

Finally, a baby was born at home in the pool, had a low temperature, and was tachypnoeic. The baby being a newborn, it was assessed to be an appropriate admission.

The cases have highlighted learning that is cascaded to the teams. Learning has been highlighted on Vignette Safety Catches, Safety Briefs, Local newsletters, Quality Board displays and is shared at the Maternity Neonatal Governance meeting.

3.0 Summary of 2023/24 'Avoidable' admissions into the Neonatal Unit

During 2023/24 the ATAIN working party identified 15 babies throughout their reviews where modifiable factors in their care may have presented an opportunity to have prevented admission to the Neonatal Unit. These cases have been analysed for any commonalities, trends, or themes, which may indicate areas for improvement across our services aiming to reduce separation post birth.

3.1 Spread of 'avoidable' admissions to the NNU during 23/24

When reviewing the spread of the avoidable admissions during 2023/24 47% (n=6) occurred in Q3 of 23/24.

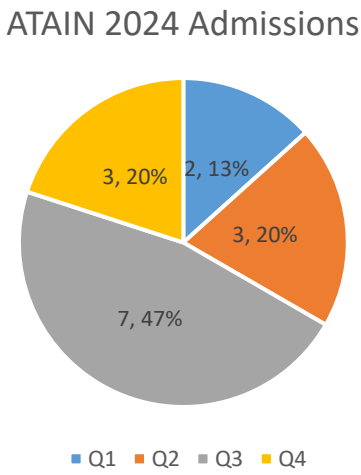


Figure 1: ATAIN admissions to the Neonatal Unit by Quarter

The increased number of avoidable admissions did not triangulate proportionately to an increased birth rate or acuity data during Q3, which was stable when compared to previous quarters. Although the service identified markedly increased activity in October (390), this was balanced by decreased activity in December. Four avoidable admissions occurred in November. Therefore, this review was unable to identify clear causal links between acuity and staffing on the ATAIN rate in Q3.

3.2 Neonatal hypothermia and subsequent physiological cascade.

Three of the 15 babies who were admitted to the Neonatal Unit were admitted with a primary or secondary cause of low temperatures with subsequent physiological complications such as hypoglycaemia. This presents 20% of the total avoidable admissions. In response, the service is featuring thermoregulation of the newborn as the 'quality hot-spot' for the Quality Boards in June 2024. This feature will include top tips to facilitate adequate thermoregulation, risk factors for hypothermia, and the physiological cascade that follows when thermoregulation is not maintained in the neonatal period.

3.3 Immediate postnatal period/transition at birth

Four of the 15 babies identified had factors within their care in the immediate postnatal period/ neonatal transition post birth where the review team assessed that modified factors may have altered their admission. The clinical subject for these factors was varied; non recognition of a snapped cord during skin to skin, missed opportunity to seek additional multidisciplinary support at 5 minutes when the APGAR was <7, and an obstructed airway during skin to skin, however, the commonality identified was the time frame within which the factors occurred.

It is recognised nationally in learning reports that the immediate postnatal period can be a period of high activity. The service is currently reviewing the role of the second clinician at a birth and developing guidance to for display in the clinical areas; supporting staff to recognise the significance and role the second clinician plays in oversight, aid and support during this time.

This theme has been identified further within a case cohort review undertaken in January 2024, reviewing the care of babies born within the service with a cord gas of <7.1. It was identified that 30% of samples were processed greater than 20 minutes after the birth of the baby, which can deteriorate sample values and impact upon neonatal care planning. The review found that the increased task demands during the immediate postnatal period affected the clinician's ability to process samples in a timely manner to mitigate against sample degradation. A Quality Improvement project was launched in Q1 of 24/25, 'to reduce the number of unnecessary neonatal care interventions in response to a low cord gas result by increasing the accuracy of neonatal cord pH samples post birth, with an aim for >90% of cord blood samples to be processed within 20 minutes of the baby's birth by December 2024.'

The project will be monitored through the Maternity and Neonatal Quality Improvement Hub/quarterly meeting, and the Trust-wide Quality Improvement Service Re-design course to ensure progress towards improvement. During 23/24, No babies were identified as an 'avoidable admission' in response to a delay in cord sample processing due to the limited evidence base to exclude poor neonatal condition as the primary cause for low cord gas value, in favour of cord sample validity. However, we hope that this project will reduce unnecessary neonatal interventions such as admission to the neonatal unit for cerebral function monitoring via improving the clinical information available to staff to make fully informed decisions regarding care planning.

4.0 Quality Improvement Projects/work

The service is committed to continuous improvement to reduce the separation of mothers and babies post birth; by both reducing the number of term admissions into the neonatal unit and increasing/ efficient utilisation of the service's Transitional Care Provisions, the following work streams/ projects have been launched to continue progress:

- Newborn Early Warning Trigger and Track (NEWTT2) charts and toolkit, was implemented for all TC babies in Q2 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 tool using the PIER principles 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 will the TCP. No challenges to using the charts has been reported. Audit results for the use of NEWTT2 charts identify full completion. Ten sets of notes were audited from Q4 of babies who had had observations documented on NEWTT2 charts on the TCP. Correct escalation of care was documented on all 10 notes reviewed in the sample group. This was an improvement from Q3, following communication to increase staff awareness of correct escalation pathway.
NEWTT2 was implemented on the post-natal ward in April 2024 and provisions are in place to commence a monthly audit of these documents.

- TCP guideline has been updated and recommendations from British Association of Perinatal Medicine (BAPM) included. Criteria for admission has been altered to include all 35/40 babies; babies less than second centile, and clinically stable ≥34 week babies whom previously may have been admitted to midwifery care. This does not appear to have increased overall numbers of babies being cared for on the TCP.

- Fund-raising continues to covert clinical room G into a four bedded TCP room, for additional TCP space and to offer TCP for 34/40 week babies where postnatal ward may not be correct environment. This will offer further opportunities to reduce mother and baby separation. Project due to start in June to convert the visitor toilet into a shower room. This will help to reduce the length of time babies are cared for on the Neonatal Unit by being able to room in mothers to establish feeding sooner. Collaborative meeting with NNU lead and Nurse consultant with the Maternity ward Sister has taken place to discuss ideas for improvement to TCP service and discuss plans for midwife to provide maternal care to mothers on NNU.

- TCP working group is in the process of being set up. This group will comprise of staff across all levels from Neonatal Unit, to work collaboratively with a maternity representative. Aiming to work together to implement change and improve and progress TCP service. This work is ongoing.

- Ongoing business case to increase the Community Outreach team to enable a 7-day a week service to support naso-gastric tube feeding at home.

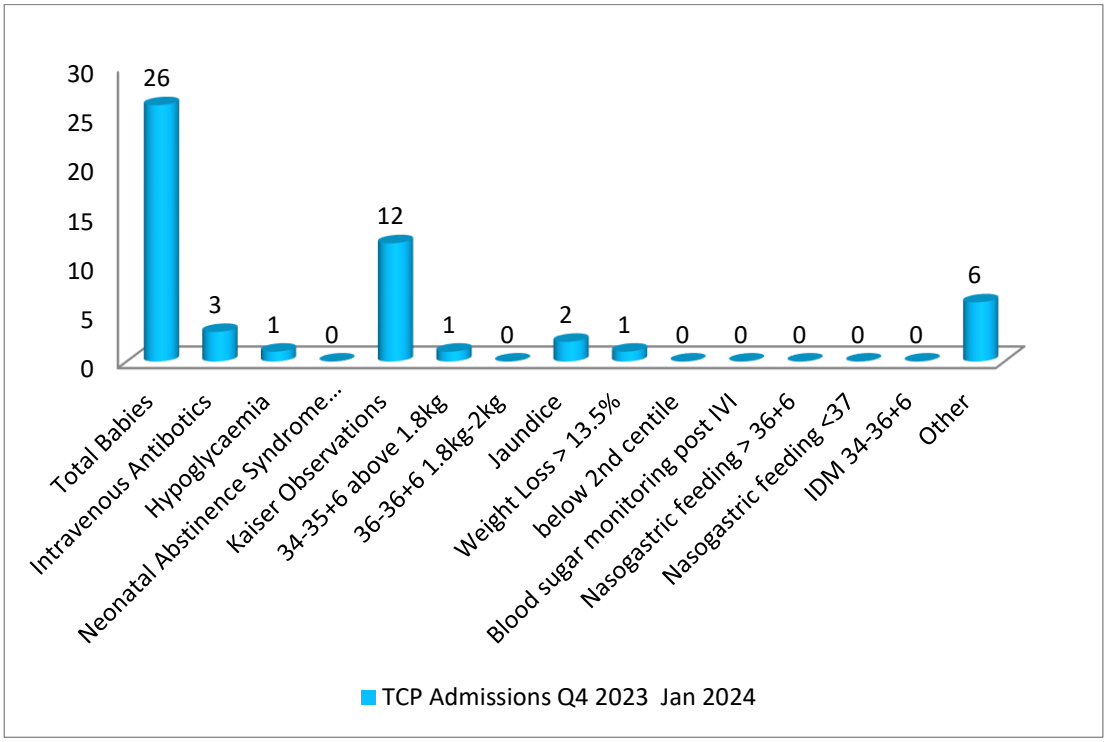
- Exploration of data caption concerning 37+ week gestation babies being re-admitted into neonatal services and included within the neonatal ATAIN rates. Benchmark against other Neonatal Units within the Southwest Neonatal Network

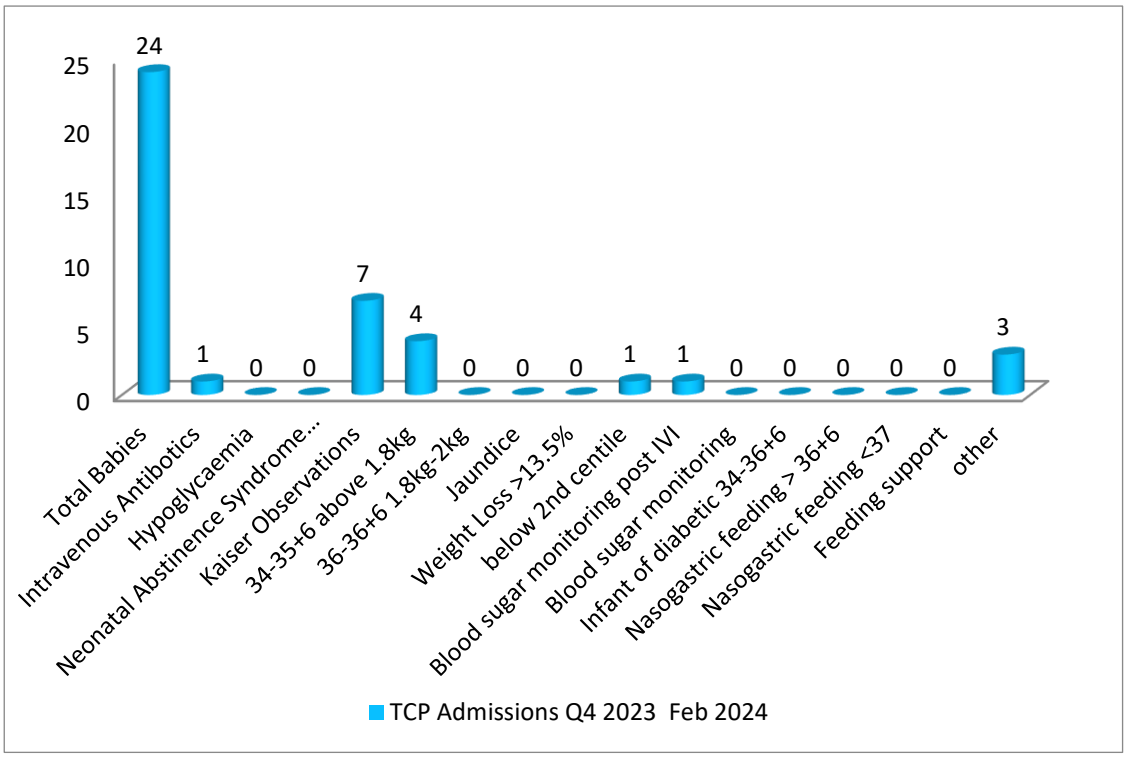
Action	No	Details	Progress	Lead	Due	RAG status	Completion date
1.Ensure the appropriate process is followed in line with NEWTT2 observations within the TCP							
Provide quarterly assurance by audit of 10 sets of notes. This tool is designed to support recognition and escalation of the deterioratin g Newborn	1	NEWTT2 outlines a standardised escalation response including who is responsible, time scale of review target, and support information for further escalation.	Quarter 3 2023/24 demonstrated compliance by 80% Staff training and awareness increased of correct escalation pathway Quarter 4 was 100% compliant	Neonatal transitional care lead	30June 2024		
2. What we need? **A conversion of Room G on the neonatal unit into a 4 bedded TCP**							
Conversion of clinical room G into a 4 bedded TCP room, to reduce the length of time babies are cared for on the neonatal unit by being able to room in mothers to establish feeding sooner	2.	To provide additional TCP space and to offer TCP for 34/40week babies where postnatal ward may not be correct environment	Project due to start in June to install rails to partition off each bed space Convert the Visitor toilet into a shower room	Neonatal transitional care lead and Maternity Matron	Anticipated October 2024		

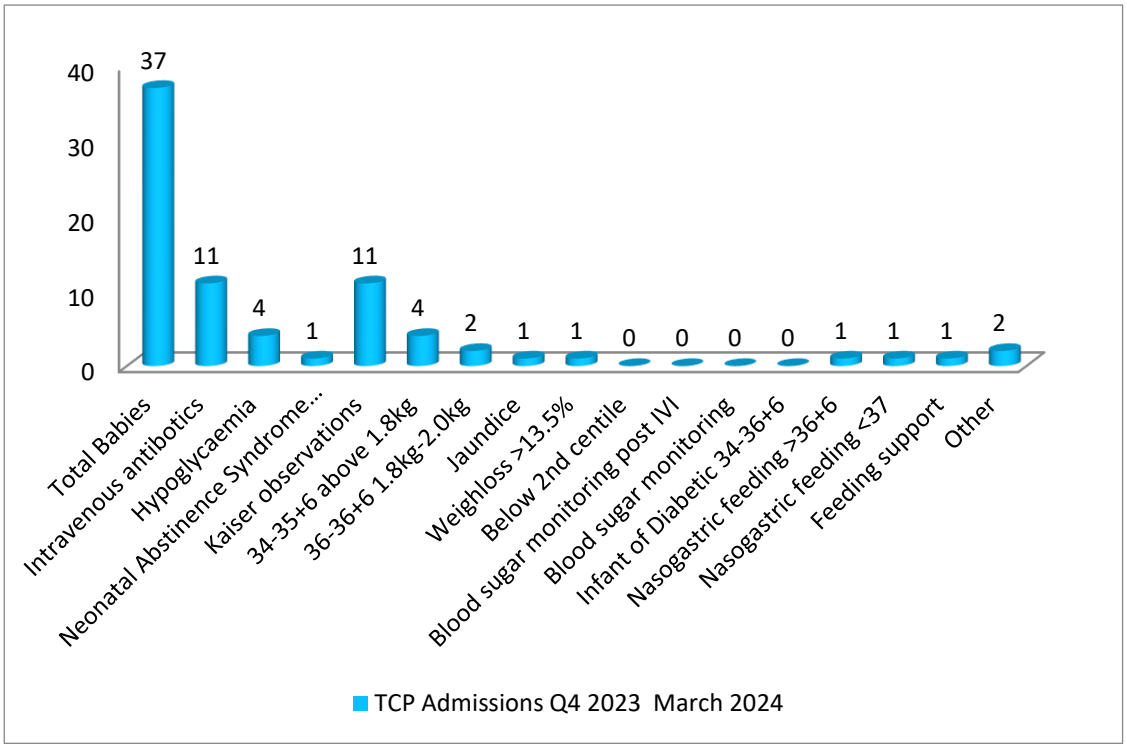
3. Collaborative Working Group to **implement change, improve, and progress TCP service.**							
TCP working group to be established to work together to implement change and improve and progress TCP service	3	This group will have members of staff across all grades from the neonatal unit with a senior maternity representative	1st group meet anticipated June 2024	Neonatal transitional care lead and Senior Midwife	June 24		
4. Business Case for provision of 7 day Community Outreach Service							
To increase the community Outreach team to enable a 7 day a week service	4.	To support naso-gastric tube feeding at home to reduce length of stay and reduce the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding.	Increased outreach offer to 1.8wte from Neonatal clinical budget Business case being compiled for further substantive funding	Consultant ANNP	Dec 24		

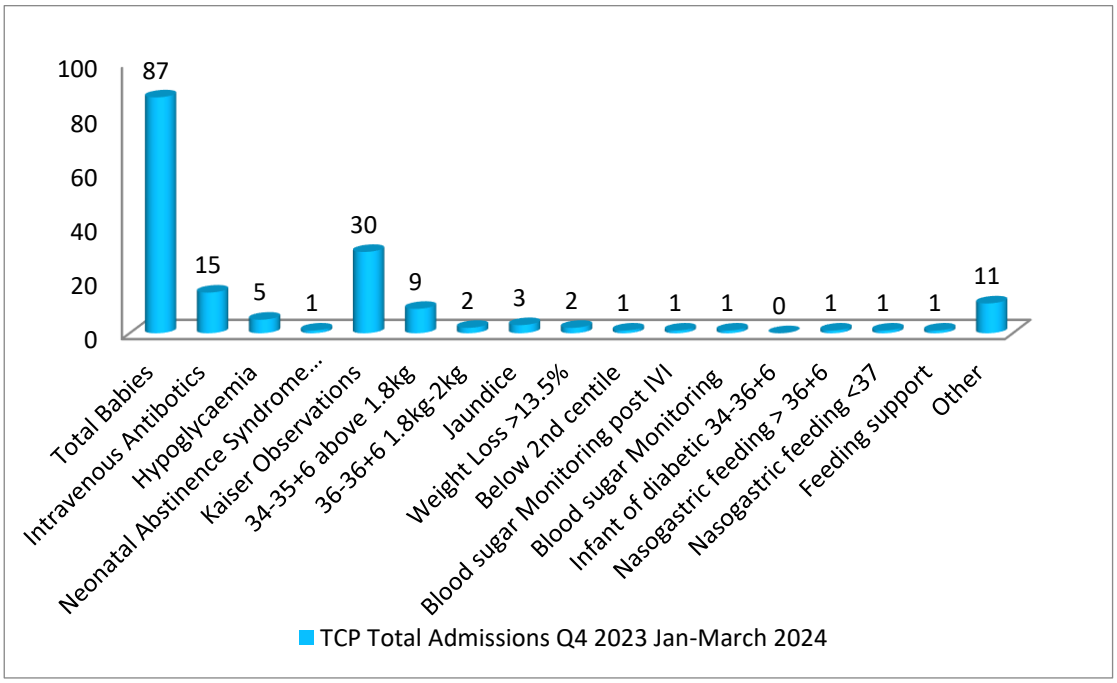
5. To ensure verification of ATAIN Data to ensure accuracy and equity of provision across the Network							
To examine the Southwest Operational Network Dashboard ATAIN Data	5	Have a greater understanding and awareness of Data with particular focus on readmission of 37+/40 babies from home or other areas within the RUH and that impact on ATAIN Data	To arrange a meeting with the Network Data Manager and Analyst Agreement to collate RUH specific data alongside SWODN data	Consultant ANNP and Quality and Education Neonatal Sister	Complete		

Appendix 1: Detailed analysis of babies requiring TCP

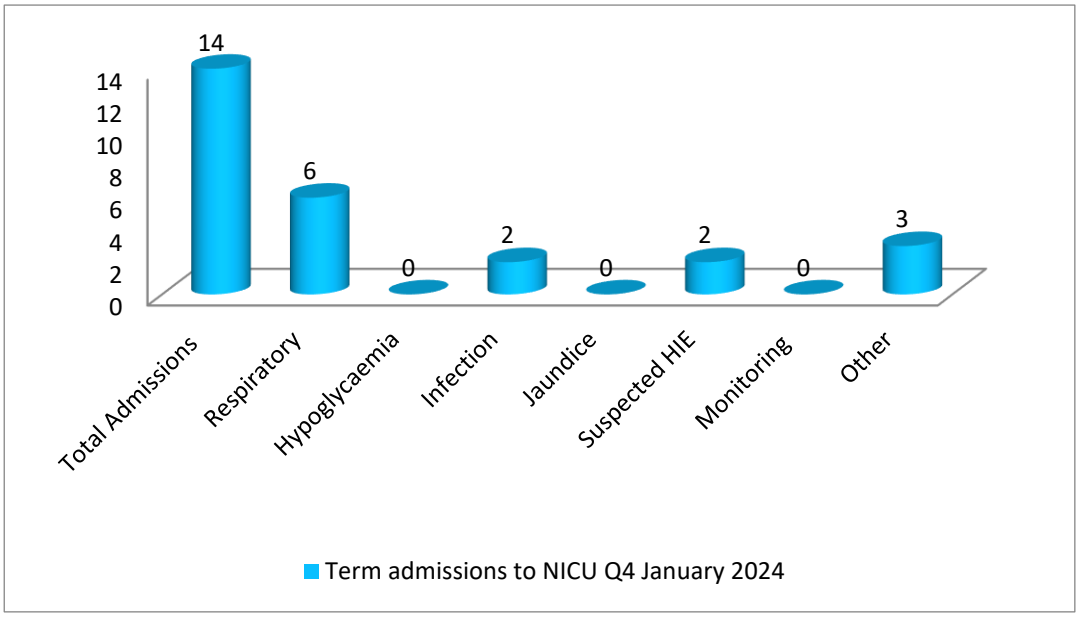


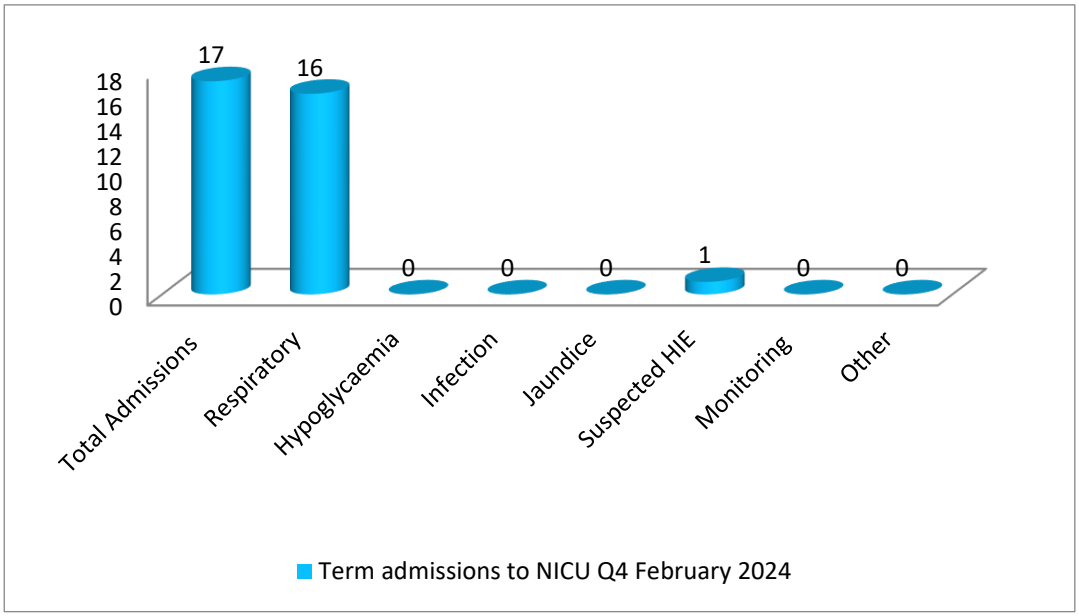


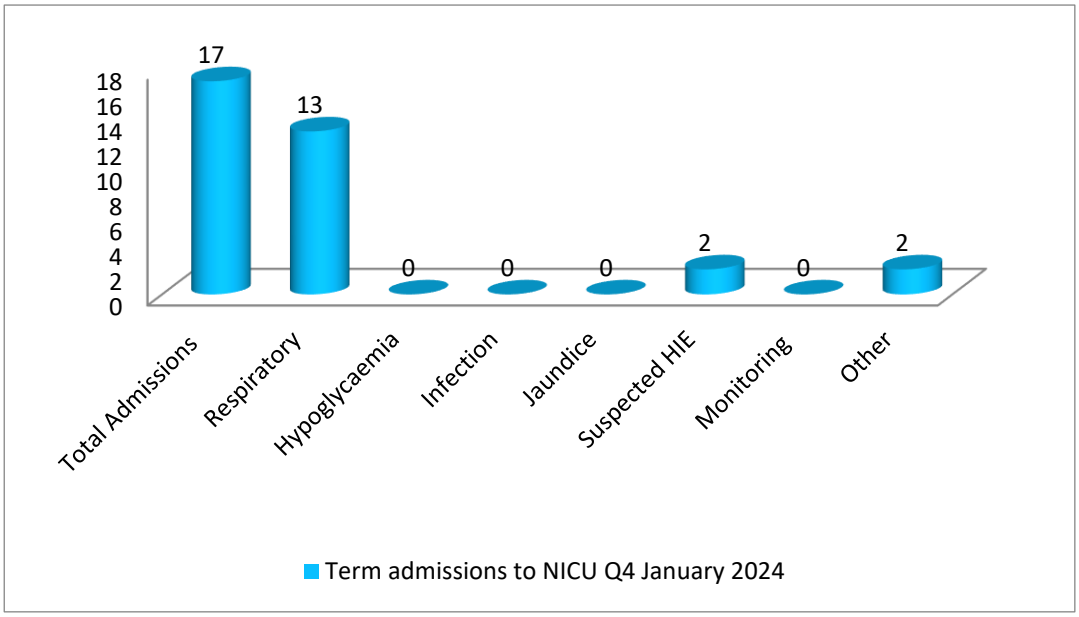

40
30
20
10
0
37
11
4
1
11
4
2
1
1
0
0
0
0
1
1
1
2
Total Babies
Intravenous antibotics
Hypoglycaemia
Neonatal Abstinence Syndrome...
Kaiser observations
34-35+6 above 1.8kg
36-36+6 1.8kg-2.0kg
Jaundice
Weighloss >13.5%
Below 2nd centile
Blood sugar monitoring post IVI
Blood sugar monitoring
Infant of Diabetic 34-36+6
Nasogastric feeding >36+6
Nasogastric feeding <37
Feeding support
Other
TCP Admissions Q4 2023 March 2024


100
80
60
40
20
0
87
15
5
1
30
9
2
3
2
1
1
1
0
1
1
1
11
Total Babies
Intravenous Antibotics
Hypoglycaemia
Neonatal Abstinence Syndrome...
Kaiser Observations
34-35+6 above 1.8kg
36-36+6 1.8kg-2kg
Jaundice
Weight Loss >13.5%
Below 2nd centile
Blood sugar Monitoring post IVI
Blood sugar Monitoring
Infant of diabetic 34-36+6
Nasogastric feeding > 36+6
Nasogastric feeding <37
Feeding support
Other
TCP Total Admissions Q4 2023 Jan-March 2024

Appendix 2: Detailed analysis of Term admissions to NNU






18
16
14
12
10
8
6
4
2
0
17
13
0
0
0
2
0
2
Total Admissions
Respiratory
Hypoglycaemia
Infection
Jaundice
Suspected HIE
Monitoring
Other
Term admissions to NICU Q4 January 2024

Report to:	**Board of Directors**	**Agenda item No:**	**13.2**
Date of Meeting:	**10 July 2024**		

Title of Report:	**Appendix 2: Maternity and Neonatal Service Insights report of 23/24**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Author(s):	**Zita Martinez, Director of Midwifery**
Appendices	**Nil**

1. Executive Summary of the Report

The East Kent 'Reading the signals' report (2022) into failings within maternity services identified that 'it should be possible for individual Trusts to monitor and assess whether they have a problem.' Failure to listen and recognise the wider experience of staff and families was identified within the report as contributory to poor care, experience and clinical outcomes.

This report aims to collate the wide, and varied insights into Maternity and Neonatal services at the Royal United Hospital (RUH) for cross correlation, and thematic analysis to identify key areas of improvement and learning. This will inform the safety priorities and focus of quality improvement for Maternity and Neonatal services in the year 24/25, in line with the Trust wide adoption of the Patient Safety Incident Response Framework (PSIRF).

This report considers 'insights' received by Maternity and Neonatal services from the findings and issues raised within the Perinatal Mortality Review Tool (PMRT), findings and recommendations from reviews undertaken by the Maternity and Newborn Safety Investigations (MNSI), learning identified from Patient Safety Incident Investigations (PSIIs), a review of the low and no harm incidents reported in 23/24, the Trust's legal and claims scorecard of 2023, feedback from the 'Birth Reflections' service, complaints, compliments and Patient Advisory and Liaison Services (PALS), feedback via the friends and family test (FFT), feedback from families in contact with the Inclusion Midwife, feedback from the Maternity and Neonatal Voices Partnership Plus, feedback from digital and social media platforms, results from the Care Quality Commission family survey, staff feedback received during Safety Champion walk-around, staff feedback to the Professional Midwifery/Nurse Advocacy (PMA/PNA) service and the Trust Freedom To Speak Up Guardian (FTSU).

This report further identifies the progress made towards the areas of commonalities identified in the Insights report from 2023. The continued improvement in these areas throughout 24/25 will be monitored via Maternity and Neonatal Quality and Safety Group reporting into Trust Quality and Safety Group to ensure progression. A subsequent report in Q3 24/25 will outline the progress against the identified safety priorities described in this report. Where applicable challenges, or risks, to the service have been escalated to the maternity risk register.

2. Recommendations (Note, Approve, Discuss)

Discuss.

3. Legal / Regulatory Implications

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

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

5.	Resources Implications (Financial / staffing)
The presentation of legal data alongside incidents, as within this report, is described within safety action 9 of the Maternity Incentive Scheme which carries both safety and financial implications.	

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

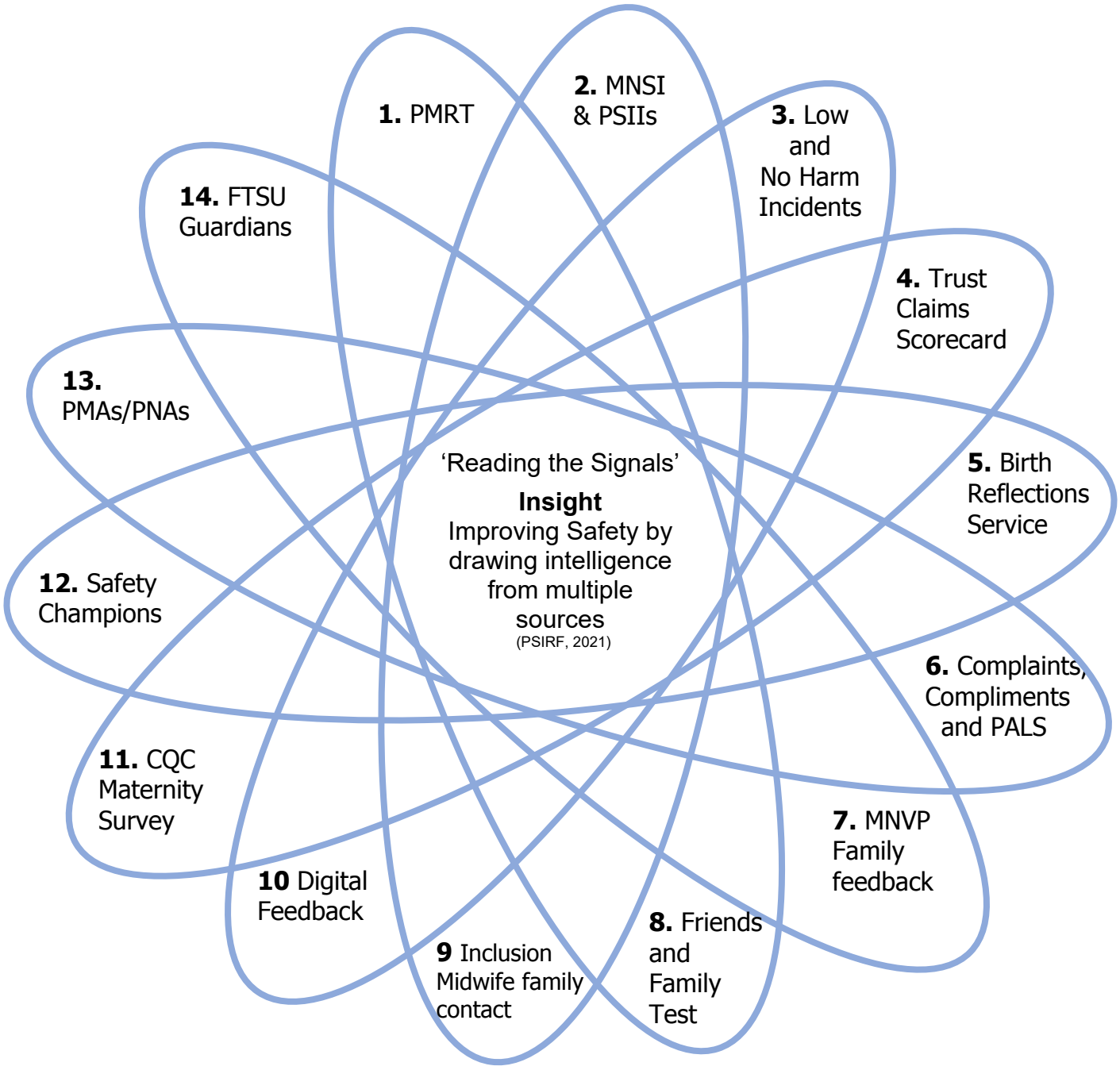
7.	References to previous reports
Previous monthly Perinatal Quality Surveillance reporting Maternity and Neonatal Safety Report Quarter 1 - July 2023 Maternity and Neonatal Quality and Safety report Quarter 2 - October 2023 Maternity and Neonatal Quality and Safety Report Quarter 3 - January 2024 Maternity and Neonatal Quality and Safety Report Quarter 4 - May 2024 Maternity and Neonatal Insights Report, Q1 – Maternity and Neonatal Safety Champions, July 2023 Patient Safety Incident Response Plan (PSIRP) 2024 Patient Safety Incident Response Framework 2021	

8.	Publication
Public	

REPORT OVERVIEW

'Reading the signals' report (Kirkup: 2022) from East Kent Maternity Services identified that 'it should be possible for individual trusts to monitor and assess whether they have a problem'. Failure to listen and recognise the wider experience of staff and families was identified within the report as contributory to poor care, experience and clinical outcomes. Patient Safety Incident Response Framework (PSIRF) methodologies acknowledge NHS services in particular Maternity and Neonatal services have a large volume of information and feedback that can be difficult to collate to build a full picture of how our service looks, feels and provides care.

This report aims to draw upon the clinical insights across the financial year of 2023/24, taking a thematic approach to identify commonalities or themes for the improvement, development and learning within our service.



1.0 PERINATAL MORTALITY REVIEW TOOLKIT (PMRT)

A retrospective review of the PMRT data for 23/24 has been undertaken to inform this 'Insight Report', looking at the 'issues' raised by PMRT through the review process. 9 perinatal deaths were eligible for review via PMRT during the period of 1April 23 - 31 March 2024.

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
16	7	4	5	0

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
2	2	0	0	0

Table 1: PMRT outcomes

The issues raised have been sub categorised to enable thematic review alongside other insights.

Category	Issue raised by PMRT	Total
Communication	1	**1**
Escalation		
Guidance		
Fetal Monitoring		
Clinical Oversight		
Clinical Assessment	3	**4**
Triage		
Resuscitation		
Training		

Table 2: Issues identified by category

During 2023/2024 there were a total of 11 perinatal deaths at the RUH, 2 of which were not eligible for review via PMRT: both neonatal deaths. 1 was a pre-viability infant who showed signs of life at birth and 1 following a termination of pregnancy where the baby was born showing signs of life at birth.

PMRT referrals	Total
Stillbirths <24/40	8
Late Loss >22<24	1
Neonatal Death at the RUH	2
Neonatal death elsewhere following birth at the RUH	2
Total Perinatal Deaths	**12**

Table 3: PMRT referrals

2.0 MATERNITY AND NEWBORN SAFETY INVESTIGATIONS (MNSI) AND LOCAL PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

2.1 MNSI FINDINGS

MNSI provide findings and recommendations to the Trust for service learning and improvements.

I. Findings reflect information that was discovered through analysis of the evidence collected during the investigation.
II. Safety recommendations are made to organisations when the findings identified during an investigation are considered to be contributory to the outcome.

A total of 5 MNSI reports were received in 2023/24.

For the purpose of learning and improvement, a review of all the findings and recommendations made by MNSI has taken place. In totality, these indicate room for improvement in maternity and neonatal services. During 23/24, 7 recommendations and 20 findings were identified, (this does not account for those findings that identify care which was in line with guidance). Some findings or recommendations sit within two or more categories; therefore, the overall totals below may differ from those above:

Category	Findings	Recommendations	Total
Communication	2	0	**2**
Escalation	1	2	**3**
Guidance	1	0	**1**
Fetal Monitoring	6	3	**9**
Clinical Oversight	3	0	**3**
Clinical Assessment	7	3	**10**
Triage	0	0	**0**
Resuscitation	5	0	**5**
Training	0	0	**0**

Table 4: Review of findings by category for 2023/24

2.2 PSII FINDINGS

4 local Patient Safety Incident Investigation reports were completed in 2023/2024, the findings and recommendations have been categorised. Some sit within two or more categories, therefore the overall totals below may differ from those above:

Category	Initial review finding/ Term of Reference	Recommendations	Total
Communication	1	0	**1**
Escalation	0	1	**1**
Guidance	1	1	**2**
Fetal Monitoring	1	2	**3**

Clinical Oversight	1	1	**2**
Clinical Assessment	5	2	**7**
Triage	1	0	**1**
Resuscitation	1	1	**2**
Training	1	2	**2**

Table 5: the findings and recommendations have been categorised

3.0 INCIDENT REPORTS

From April – April 2023/24 there were 2140 Datix submitted across maternity and neonatal services. The spread of these Datix across the services are outlined below:

Specialty	Total
Maternity	1662
Obstetrics	227
Neonatal Unit	251

Table 6: Incidents recorded on Datix by reporting speciality

Of these, the clinical subject largest contributors were:

Category of report	Total
Unexpected Re-admission (inclusive of readmission of baby to ward)	232
Post-Partum Haemorrhage >1500mls	145
Unexpected admission of baby to the neonatal unit	143
Perineal Tear - 3rd Degree	113
Arterial Cord Ph <7.1	103
Apgar <7 at 5 minutes	96
Shoulder Dystocia	86

Table 7: Clinical reason reported as an incident on Datix

The Quality and Patient Safety team conduct a weekly multidisciplinary safety meeting where individual incidents are discussed, and potential learning identified. From December 2023, the analysis of the learning points both co-incidental and causative identified during these reviews have been collated into a tracker and sub categorised into themes to allow for the triangulation within this report.

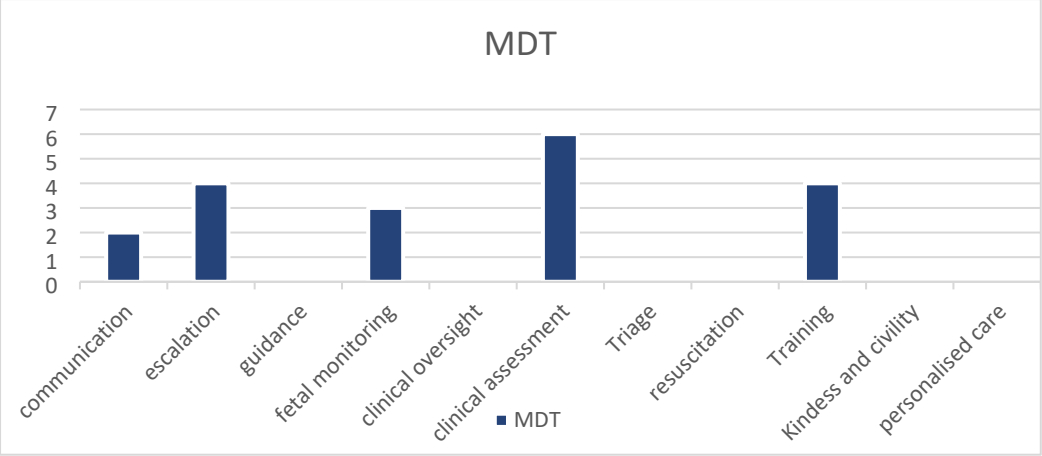


Figure 1: Co-incidental and causative findings identified during these reviews

4.0 TRUST CLAIMS SCORECARD - OBSTETRICS

The Trust's latest scorecard correlates open and closed claims managed by the Trust legal team during 2023. The legal claims span a time frame from 2013-2023. The latest Trust claim incident was in 2022.

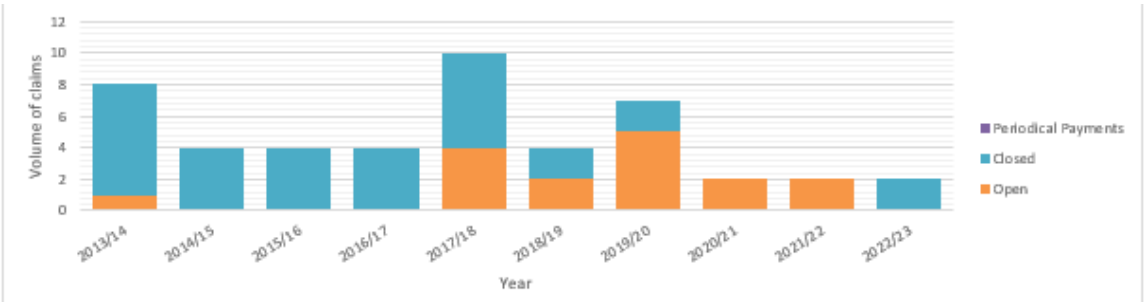


Figure 2: Obstetric legal claims made to the trust by year.

Obstetrics accounted for 18% of claims made to the Trust, however, they represented 66% of the value of Trust claims. The scorecard outlines the top five injuries and top five causes resulting in legal claims because of care.

This is listed as volume of claims and value of claims made (not monies paid in a successful claim), 1 claim can sit into two or more causation therefore the total volumes listed below may differ than that of the number of claims listed in figure 2.

Claims by value:

Top 5 causes by value for Obstetrics

					% of Specialty	
	Causes	Volume	Value	Ave Claim Value	Volume	Value
1	Fail / Delay Treatment	8	43,230,963	5,403,870	16%	36%
2	Fail To Monitor 2nd Stg Labour	4	28,350,234	7,087,559	8%	24%
3	Failure/Delay Diagnosis	6	14,819,439	2,469,907	12%	12%
4	Other	3	14,702,712	4,900,904	6%	12%
5	Fail To Monitor 1st Stg Labour	2	14,235,001	7,117,501	4%	12%
Total Top 5 causes by Volume for Obstetrics		**23**	**115,338,350**	**5,014,711**	**47%**	**97%**

Top 5 injuries by value for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Hypoxia	4	56,420,001	14,105,000	8%	47%
2	Cerebral Palsy	2	28,275,001	14,137,501	4%	24%
3	Brain Damage	2	28,260,002	14,130,001	4%	24%
4	Erb's Palsy	1	1,350,000	1,350,000	2%	1%
5	Bowel Damage/ Dysfunction	3	1,137,806	379,269	6%	1%
Total Top 5 injuries by Volume for Obstetrics		**12**	**115,442,810**	**9,620,234**	**24%**	**97%**

Table 8: Claims by value

Claims by Volume:

Top 5 injuries by volume for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Unnecessary Pain	9	696,598	77,400	18%	1%
2	Psychiatric/Psychological Dmge	8	650,334	81,292	16%	1%
3	Adtnl/unnecessary Operation(s)	4	431,116	107,779	8%	0%
4	Hypoxia	4	56,420,001	14,105,000	8%	47%
5	Stillborn	3	74,785	24,928	6%	0%
Total Top 5 injuries by Volume for Obstetrics		**28**	**58,272,834**	**2,081,173**	**57%**	**49%**

Top 5 causes by volume for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail / Delay Treatment	8	43,230,963	5,403,870	16%	36%
2	Failure/Delay Diagnosis	6	14,819,439	2,469,907	12%	12%
3	Foreign Body Left In Situ	5	91,937	18,387	10%	0%
4	Intra-Op Problems	4	421,734	105,433	8%	0%
5	Fail To Monitor 2nd Stg Labour	4	28,350,234	7,087,559	8%	24%
Total Top 5 causes by Volume for Obstetrics		**27**	**86,914,308**	**3,219,048**	**55%**	**73%**

Table 9: Claims by volume

Table 10 outlines the current position of completed claims during 2013-2023, including distribution of closed cases for which no damages were paid (40%) and those where damages were paid (60%) and total monies paid.

Claim Outcomes

	Volume	Value	Ave Total Value	%
Closed - Nil Damages	12	362,720	30,227	40%
Settled - Damages Paid	18	2,410,215	133,901	60%
Periodical Payments	0	-	-	0%
Total	**30**	**2,772,935**	**92,431**	

Table 10: Current position of completed claims

Of the damages paid identifying issues with care and areas for improvement the leading causes for claims by volume were:

- Retained products of Conception +/- Major Obstetric Hemorrhage (n=4) (unnecessary pain, unnecessary operation, fail/delay treatment psychological damage)
- Perineal trauma (n=4)
  (Unnecessary pain, fail/delay treatment, unnecessary operation, psychological damage)
- Retained swabs (n=5 all during 2013/14)
  (Unnecessary pain, foreign body left in situ)

- Informed consent (n=2)
  (Fail/delay treatment, psychological damage)
- Bladder Injury (n=2)
  (Fail/delay treatment, psychological damage)

5.0 QUALITATIVE FAMILY FEEDBACK DATA 23/24

The qualitative family data that the service has received across 2023/2024 has been analysed for any commonalities or themes, areas identified from the relevant sources have been identified in figure 3. Singular feedback is not listed to enable thematic review, however this is fed into the overall feedback numerical count and the triangulation of data during this analysis.

Areas raised:

5. Birth Reflections (n=231 appointments)

- Communication:
  - Desire for more information
  - Use of medical terminology which is hard to understand
  - The power of language and choice of words
- Informed consent - not feeling confident to make fully informed choices (timing) and a desire for more information to be tailored to them individually

6. Complaints (n=9)/PALS (n=31) contacts:

- Care on Mary ward – perception of short staffing and lack of clarity of communication and care plans (n=9)
- Concerns regarding previous births >2-year interval (n=7)
- Timing of birth specifically timing of Lower Segment Caesarean Sections (n=2)
- Not feeling listened to (n=4)
- Clinical assessment skills (n=3)
- Informed consent (n=2)

7. Maternity & Neonatal Voices Partnership (MNVP):

- Conflicting or confusing infant feeding advice
- Desire for more information/support for postnatal recovery
- More information and support for care after caesarean birth
- Informed consent for intervention such as IOL

Positive Feedback:

5. Birth Reflections (n=231 appointments)

- Kindness and compassion of staff members
- Individual staff member impacts on overall experiences of birth and care

6. Themes from compliments (n=46)

- Kindness and compassion of staff members
- Personalised care provision
- Installing a feeling of empowerment
- Collaborative working across the service
- Individual staff member impacts on overall experience of birth and care

7. Feedback from MNVP 23/24:

- Staff willing to take the time to explain things thoroughly
- Clear explanations of procedures
- Personable, kind, and friendly midwives

Areas raised:

8. Friends and Family forms (n=418):

- Number of responses neither good nor poor, poor or very poor n=27

The handwritten comments have been analysed for any themes or commonalties

- Perception of short staffing on Mary ward (n=6)
- Clinical assessments/skills (n=3)
- Delays to IOL process (n=2)

9. Inclusion Midwife family feedback (n=10)**:**

- Awareness of access to unscheduled care (previously DAU now Maternity Triage) (n=5)
- No further commonalities identified for improvement

10 Digital feedback**:**

- No themes or commonalities were identified within negative social media feedback

Positive Feedback:

8. Friends and Family Forms (n=418):

- Number of responses with experience rated good or very good n=388

The handwritten comments have been analysed for any themes or commonalties

- Kind, friendly and compassionate staff n=156

9. Inclusion Midwife family feedback (n=10)**.**

'Kind' 'Caring' staff (n=6)

10. Digital Feedback:

- To give thanks to staff groups of specific staff members who care for them during their pregnancy and birth
- Calming and confident presence
- Facilitation of birth options/choices

Figure 3: Summary of family feedback

11.0 CQC INSPECTION AND PATIENT SURVEYS –

11.1 CQC INSPECTION NOVEMBER 2023

Maternity services were inspected by the Care Quality Commission in November 2023, with the service retaining their 'outstanding' rating. However, the reports did identify 4 'should take' actions for improvement.

- The service should ensure the compliance for emergency training and adult basic life support training meet the trust target for compliance
- The service should make sure all women and birthing people are asked the relevant safeguarding questions at each contact
- All staff should be compliant with infection control compliance and hand hygiene
- All staff should complete the daily checking of emergency equipment.

These actions have been considered and included within analysis as part of this review. A dedicated action plan in response to these findings is currently in progress.

11.2 CQC PATIENT SURVEY 2023

The 2023 Maternity CQC survey identified the following:

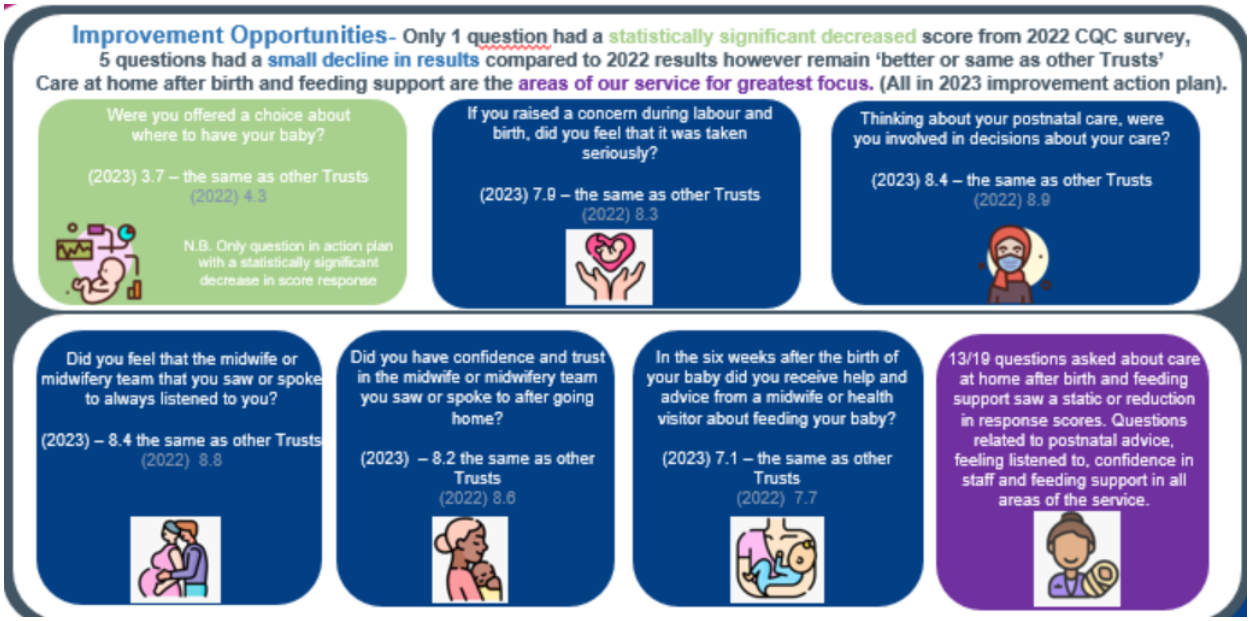


Figure 4: CQC service user feedback

In response to these findings the service as developed an action plan as outlined in table 11.

Areas for improvement	2023 score/ band	2022 score	Actions
1) Were you offered a choice about where to have your baby? (B3 – During your pregnancy)	3.7 Same as other trusts (Statistically significant decrease)	4.3	• Reinstate community birth offer • Implementation of community birth team • Recruiting to service establishment informed by Birth Rate plus report and 2023 business case
2) If you raised a concern during labour and birth, did you feel that it was taken seriously? (C13 - Your Labour and Birth)	7.9 Same as other trusts	8.3	• Implementing and embedding personalised care plans into all aspects of midwifery practice. (PCSP)
			• PCSP training launched September 2023
			• Momus leadership study day for all labour ward co-ordinators
3) Thinking about your postnatal care, were you involved in decisions about your care? (F1- Care at home after the birth)	8.4 Same as other trusts	8.9	• Implementing and embedding PCSP into all aspects of midwifery practice
			• PCSP training launched September 2023
4) Did you feel that	8.4	8.8	

the midwife or midwifery team that you saw or spoke to always listened to you? (F7- Care at home after the birth)	Same as other trusts		• Highlight to all staff enhanced experience when effectively listen and involve birthing people in care
5) Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home? (F9 – Care at home after the birth)	8.2 Same as other trusts	8.6	• Recruiting to service establishment informed by Birth Rate plus report and 2023 business case. Focus on recruitment into community vacancy to support community care provision
6) In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby? (F15 – Care at home after the birth)	7.1 Same as other trusts	7.7	• Implementation of 2023 Baby Friendly Strategy
			• Expansion of the Infant feeding team supported by 2023 business case
			• Recruiting to service establishment informed by Birth Rate plus report and 2023 business case. Focus on recruitment into community vacancy to support community care provision.
7) Care at home after birth and feeding support (E2, E3 – Feeding your baby, F1, F2, F5, F7, F8, F9, F11, F12, F15, F16, F17 – Care at home after birth)	All these questions saw a static or reduction in response rate of <0.3) compared to 2022 survey.		• Implementing and embedding PCSP into all aspects of midwifery practice
			• Implementation of community birth team

Table 11: Action plan in response to CQC survey results

12.0 BOARD LEVEL SAFETY CHAMPION WALKABOUTS

Maternity and Neonatal Safety Champions complete monthly 'walk-around' and virtual listening events open to all Maternity and Neonatal staff to discuss any safety concerns or queries they may have within the service.

The themes across 2023/24 are as follows:

- The re-model of community birth structure including the closure of Midwifery Led Units overnight reverting to the commissioned service of an on call operational model, and the development of a community birth team
- Difficulties in recruitment into the community birth team
- Concerns regarding the current digital electronic Patient Record (EPR) being not fit for purpose
- Concerns regarding the increasing number of women choosing to birth outside of local and nationally recommended guidance

The community birth team was established in 2023 to support facilitation of choice of place of birth. The recruitment campaign continues into this team and is currently out to external advert.

The service has secured funding for the procurement of a new Maternity EPR, implementation planning is underway with anticipated go-live date of April 2025.

13.0 PROFESSIONAL MIDWIFERY AND NURSING ADVOCATES (PMAS/PNAS)

107 members of staff individually accessed the Professional Midwifery Advocacy service in 2023/2024.

The team facilitated contact with a further 99 members of staff through group Restorative Clinical supervision sessions. Due to the confidentiality of the service only information with significant concern may be shared without staff consent. During this period no significant concerns were raised.

When reviewed thematically, the leading causes for contact to the PMA/PNA services were for professional working relationships and work-related stress. No further details were able to be obtained to identify specific areas of focus.

14.0 FREEDOM TO SPEAK UP GUARDIANS

4 contacts were made to the FTSU Guardians from Maternity or Neonatal Services during 23/24. All contacts were in relation to worker safety/wellbeing. No further details were able to be obtained to identify specific areas of focus.

15.0 COMMONALITIES & THEMATIC ANALYSIS 'INSIGHTS'.

Review of the above insights into RUH Maternity Services has allowed for the collation of themes and commonalities to be identified and present areas for focus, further exploration, and improvements.

The first thematic assessment took place looking at 'safety insights' by investigation route

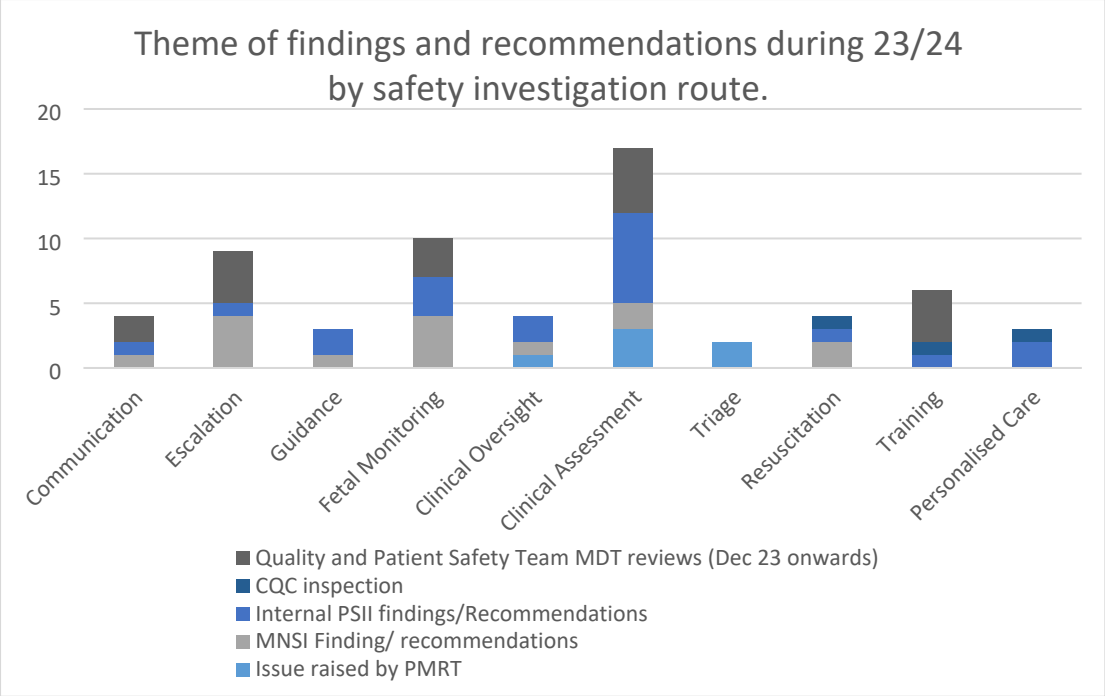


Figure 5. Theme of finding and/or recommendation received during 23/24 by safety investigation route

This identified the top themes for further exploration for potential safety improvements in the service to be:

- Clinical assessment
- Escalation
- Fetal monitoring

15.2 TRIANGULATION OF QUALITATIVE AND QUANTITATIVE 'INSIGHTS'

When aligning the categories, recommendations and findings by safety investigation route in maternity and neonates from 23/24, along with the qualitative data themes gathered from family feedback as part of 'insights' collation, the areas requiring improvement become clearer to improve both safety and experience for the birthing people and families we care for.

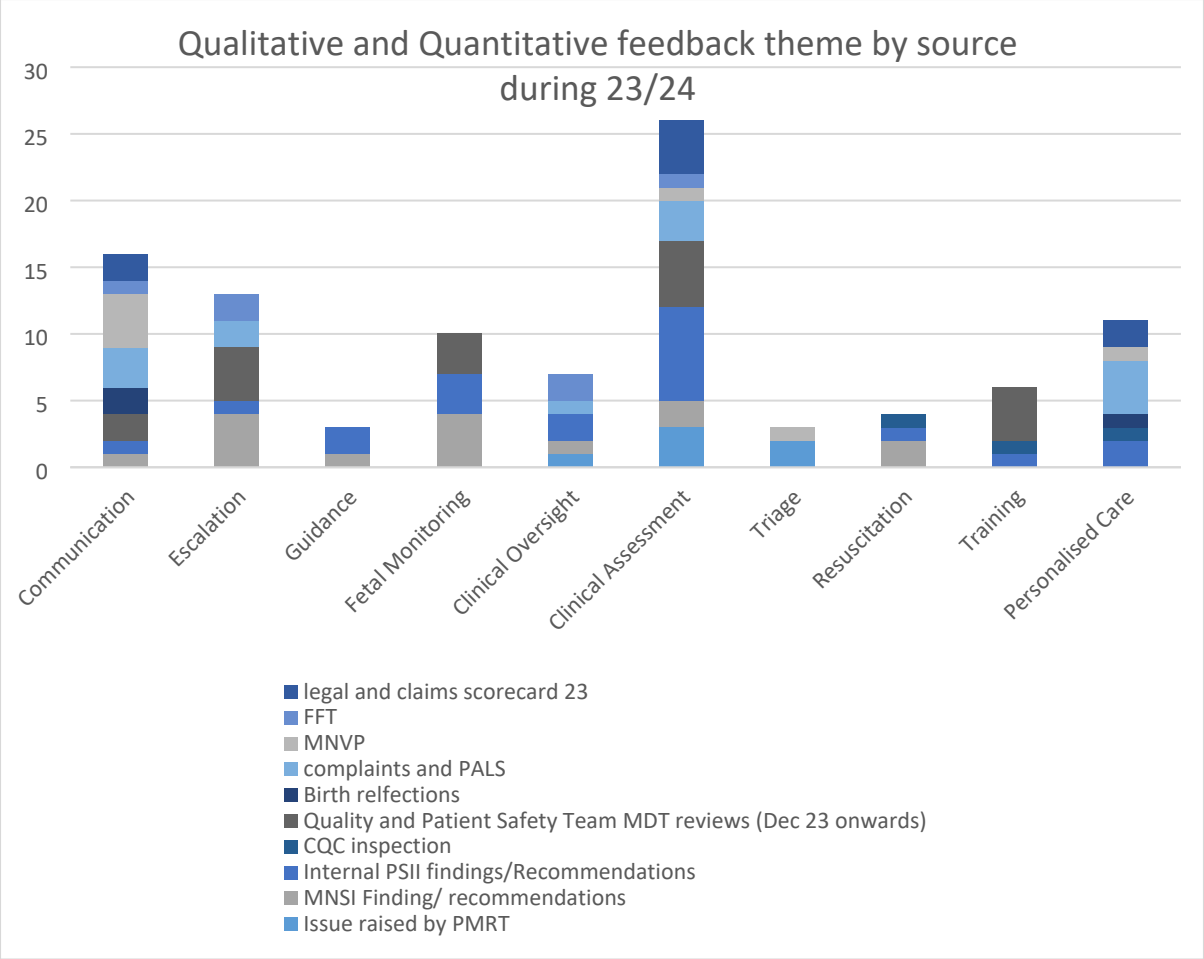


Figure 6: Collation of Qualitative and Quantitative feedback theme received during 23/24

Although the top cumulative category has been identified as clinical assessment when looking for themes or trends within the data, after exclusion of the claims and scorecard data as the last claim pertained to care provided in 2021, no correlations have been seen to clearly identify a specific area for improvement within current practices.

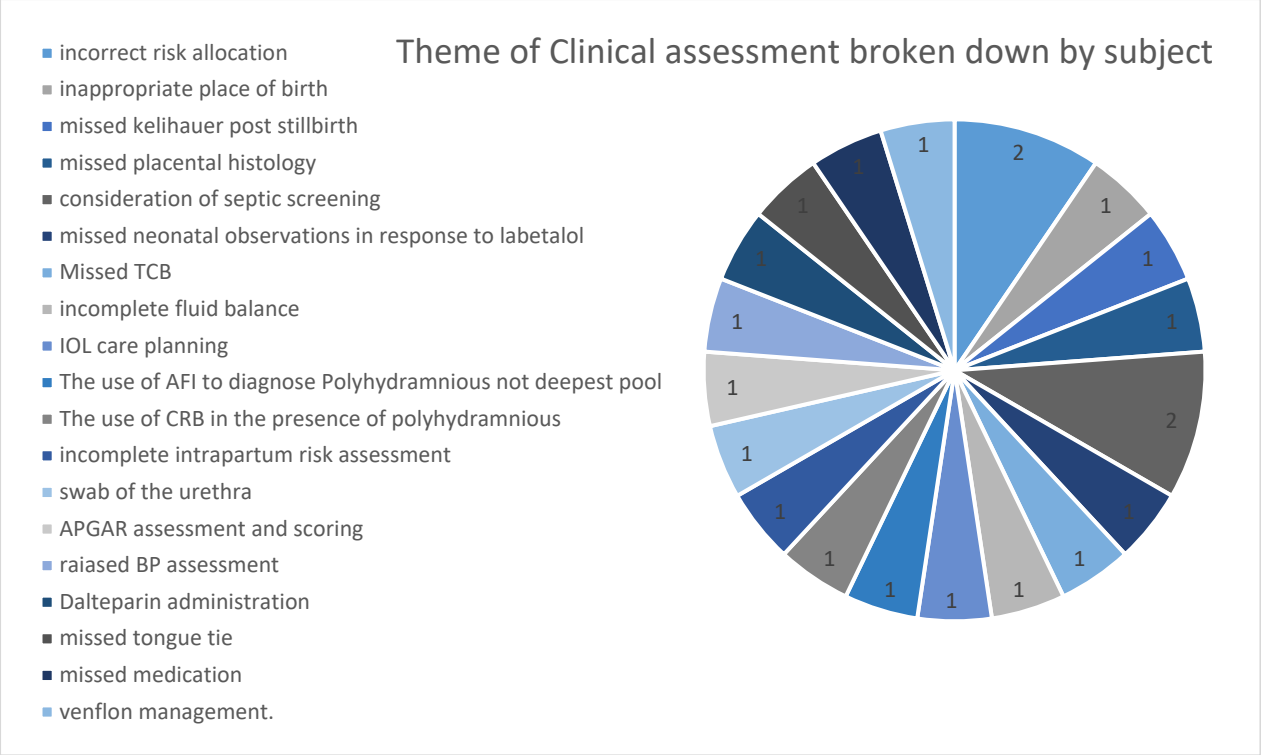


Figure 7: Category of Clinical Assessment broken down by clinical subject of concern.

Therefore, the data has been re-assessed across the sources of insight by clinical subject to identify the largest contributors providing focus areas for improvement in Maternity and Neonatal Services with safety priorities for 2024/2025.

16.0 IDENTIFIED AREAS FOR IMPROVEMENT – MATERNITY AND NEONATAL SAFETY PRIORITIES FOR 2024/25

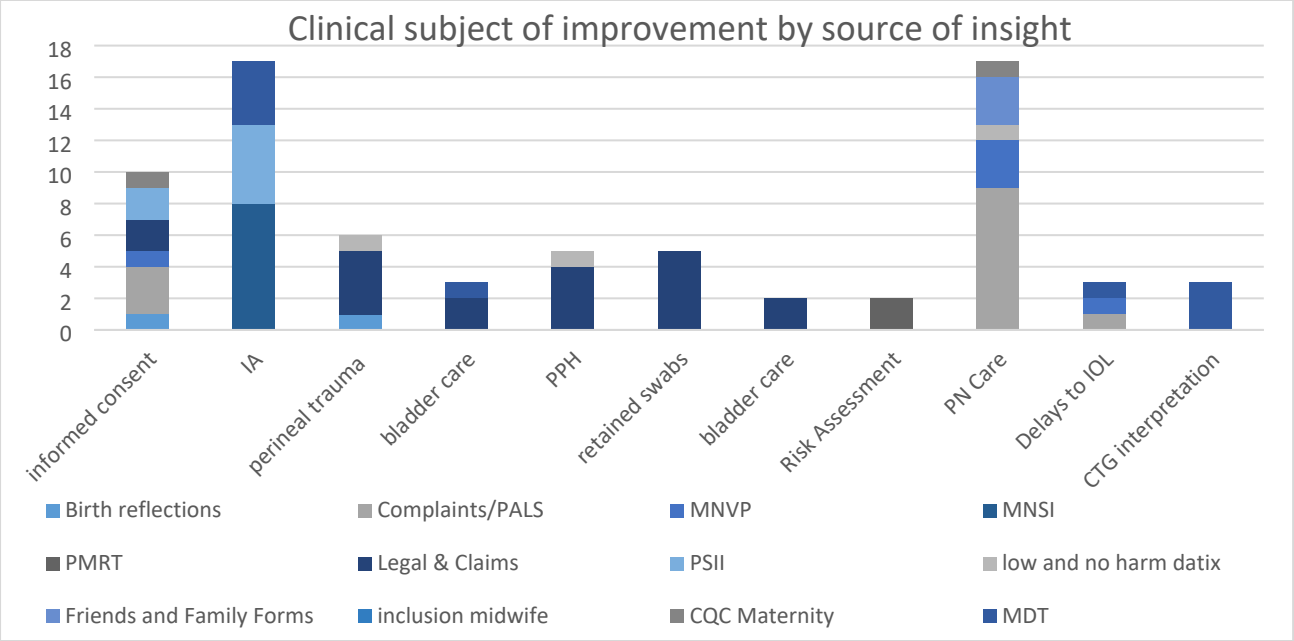


Figure 8. Category of Clinical Subject for improvement by service insight during 23/24.

When listed by clinical subject, 3 clear areas become apparent for improvement within Maternity and Neonatal services in 2024/2025.

- **To improve the provision to ensure Informed consent is obtained in all clinical care planning.** Informed consent equated to 5 of the 16 insights within the category of communication (Figure 8) and was identified as a theme within birth reflections, complaints/PALS, PSII findings and recommendations, MNVP feedback, the legal and claims scorecard.

- **To ensure Fetal Monitoring with specific focus on Intermittent Auscultation (IA) is conducted efficiently in line with local and national standards.** The conduction of sub-optimal IA equated to 8 of the 10 insights forming the category of fetal monitoring, and 5 of the 12 insights in the category of escalation (Figure 8).

- **To improve the experience of women/birthing people and families postnatal care and recovery.** Postnatal care provision was identified as the largest contributor to poor family experience of care identified within Complaints, PALS contacts, MNVP feedback, Friends and Family Test forms, and the CQC survey.

The three safety priorities outlined above will be subject to quality improvement work during 2024/25 to ensure progression towards improved outcome measures. The continued improvement in these areas throughout 24/25 will be monitored via Maternity and Neonatal Quality and Safety Group reporting into Trust Quality and Safety Group to ensure progression. A follow up report in Q3 24/25, will outline the progress towards the identified safety priorities within this report.

17.0 PROGRESS AGAINST THE 22/23 INISGHTS REPORT FINDINGS

Within the 'Insights' report of 22/23, 5 areas for improvement were identified. This section will outline the progress made within 23/24 against these areas.

- Guidance
- Bladder care
- Post-Partum Haemorrhage
- Information provision for informed decision making
- Response to abnormalities in fetal heartrate/ fetal monitoring

17.1 GUIDANCE

Local staff guidance in the form of guidelines, policies and standard operating procedures were identified as an area for improvement and risk to patient safety during March 2023, with approximately 60% of the service guidelines policies and SOPs being out of date. This was raised as a high risk on the risk register to ensure progress towards risk mitigation and increased compliance. The service redesigned the existing

process for the review, evaluation and ratification of guidance via the 'Maternity and Neonatal Clinical Effectiveness Forum', utilising 'Microsoft Teams' to enable concurrent reviews of documents by the Multidisciplinary Team (MDT). As of February 2024, 93% of Maternity guidance is currently live and in date, with 97% of guidance either live and in date or currently under review by a clinician. Therefore, the risk on the risk register has been closed.

17.2 BLADDER CARE

Bladder care issues fall under the remit of the perinatal pelvic health service, the RUH is part of a national pilot for the provision of a perinatal pelvic health service. The team consists of a specialist perinatal pelvic health midwife and a specialist pelvic health physiotherapist. During 2023/24, the pelvic health team reviewed and revised the existing bladder care policy with significant changes. The bladder care theme has not been a consistent issue which we have seen continue into 2023/24.

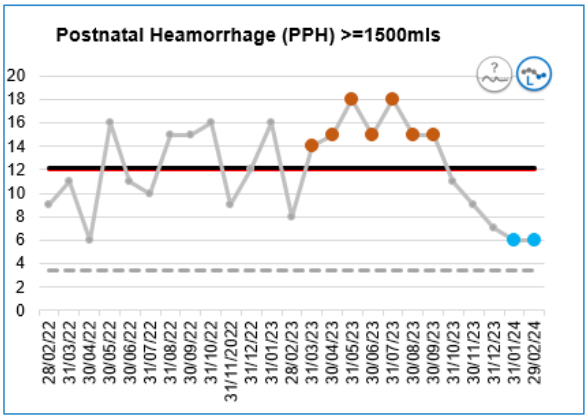
17.3 RESPONSE TO ABNORMALITIES IN FETAL HEARTRATE/FETAL MONITORING

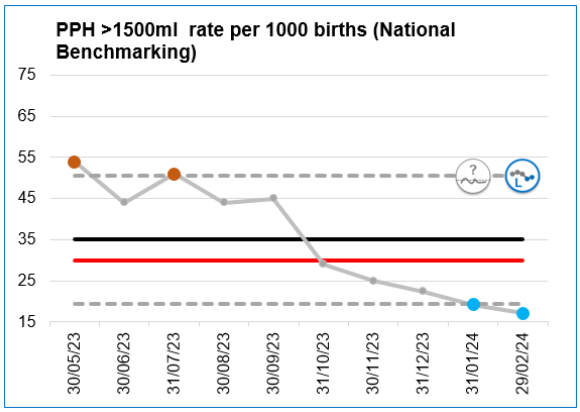
Although identified as a theme in 22/23, the insights report identified that the largest contributor to the theme was the legal claims scorecard which pertained to care provided between 2012 and 2017, and therefore due to practice changes during that time the opportunity for learning from those insights may have been lost, this continues to be the case for 2023/24. For this reason, the claims scorecard data pertaining to fetal monitoring was excluded from this year's analysis, to ensure the area of focus for quality improvement is concurrent with local procedures and practices. Fetal monitoring was not a commonality shared within the other insights of 22/23.

However, fetal monitoring with particular focus on the provision of Intermittent Auscultation (IA), as outlined within this report, is a commonality which the service has identified as a safety priority for 2024/25. Actions towards improvements have begun throughout 23/24 and will be monitored for effectiveness and progression via Maternity and Neonatal Quality Improvement Hub, and Maternity and Neonatal Quality and Safety Group.

17.4 POST PARTUM HAEMORRHAGE

During 2023, it was identified that the Trust was experiencing higher than average rate of post-partum haemorrhage (PPH) in comparison to the national average.
A case cohort review took place looking at the pre-disposing risk factors, identification of risk, identification of the emergency, emergency management, and any modifiable factors to inform future improvements. Subsequently following the recommendations made, the rates have seen a reduction to below the national average.





Figures 9 & 10: Post-Partum haemorrhage rates >1500mls at the RUH over time

17.5 INFORMATION PROVISION FOR INFORMED DECISION MAKING

The provision of all the information required for women/birthing people and their families to make informed decisions regarding their care, and what matters to them, is a legal obligation as outlined by the 'Montgomery ruling', 2015. This ruling stated that 'patients can expect a more active and informed role in treatment decisions, with a corresponding shift in emphasis on various values, including autonomy, in medical ethics' (BMJ, 2017).

As part of the PSCP launch in September 2023, the PCSP contains information regarding decision-making and informed choices including the application of the 'BRAIN' pneumonic:
B - Benefits
R - Risks
A - Alternatives
I - Intuition
N – Nothing

This is used to empower women/birthing people in shared decision making with clinicians, during their pregnancy, labour, and birth.

During 2023, the service developed a 'Birth outside of Guidance' service for women/birthing people and their families who are planning a birth which is not in line with locally or nationally recommended practices. This was developed to enable a collaborative multidisciplinary approach to ensuring women and their families receive the information required to make informed choices about their care pathways.

The provision of information for informed decision making continues to be an identified theme during 23/24 as outlined within this report.

18.0 KINDNESS AND COMPASSION

It is pleasing to see that the kindness and friendliness of staff as a consistent positive feature of family feedback throughout 22/23 and 23/24, and the CQC reports from 2023. This will be fed back to our teams via the Maternity and Neonatal Newsletters, mandatory training and the monthly quality boards.

19. RECOMMENDATION

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

Report to:	**Public Board of Directors**	**Agenda item:**	**14**
Date of Meeting:	**22nd July 2024**		

Title of Report:	**Bi-annual Midwifery and Neonatal Nursing Staffing Report**
Status:	**For approval**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Author:	**Zita Martinez, Director of Midwifery**
Appendices	**Appendix 1: BI-ANNUAL MIDWIFERY AND NEONATAL STAFFING REPORT**

1. Executive Summary of the Report

Maternity

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that Trusts develop procedures to ensure that a systematic process is used to review staffing establishment, to maintain continuity of maternity services, and to always provide safe care to women and babies across all settings.

This report gives a summary of the measures in place to ensure safe midwifery staffing; including clinical and specialist workforce planning, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus® Live Acuity Tool compliance with supernumerary labour ward coordinator (LWC) status, one to one care in labour and red flag incidents.

Birthrate Plus® (BR+) is the only recognised national tool for calculating midwifery staffing levels. The Trust report was published in April 2023; compliance with the report is a requirement of Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

In addition, Bath, Northeast Somerset, Swindon, and Wiltshire (BSW) Academy undertook a workforce planning review for the Local Maternity and Neonatal System (LMNS) in March 2023. A headroom of 28% was recommended taking into consideration the statutory and mandatory training requirement, sickness, annual leave, and maternity leave. Following a successful business case the headroom for maternity was agreed at 24% (plus agreed recruitment to maternity leave), this aligns to the headroom across maternity services in BSW. Since the review, further training has been mandated to include Oliver McGowan Learning Difficulty and Autism training and Adult Level 3 Safeguarding.

The vacancy in December 2023 (inclusive of maternity leave) is 12.12 whole time equivalent (wte), there have been 11.68wte new starters in this reporting period. Approval of the maternity business case saw investment of £425,958 for clinical and speciality midwife roles, equating to an increase of 15.91wte clinical midwives into the service. This has impacted the vacancy position in January 2024 and Q1 24/25 as budgets reflect the phased investment, with planned recruitment which is ongoing.

The reduction in annual turnover continues and shows stabilisation in the service from 19% in January 2023 to 5.96% in December 2023. Sickness rates for midwives remain below the Trust benchmark with a slight rise noted in December.

The new BR+ Midwife to birth ratio of 1:24 was introduced in July 2023 to align to the new BR+ report, this reflects the increasing acuity of mothers and babies and their subsequent care needs.

The midwife to birth ratio is calculated monthly using BR+ methodology and evidences an acceptable and safe level of staffing. The BR+ Acuity Tool is used to assess 'real time' workload arising from the number of women needing care during the processes of labour, birth, and postnatal period. The intrapartum tool shows compliance with 1:1 care in labour for the reporting period. There were three episodes when supernumerary status of the LWC was not maintained however reviews found this did not impact negatively on safe care. Monthly audits of supernumerary status of the labour ward co-ordinator and 1:1 care in labour shows a high level of compliance.

In addition, the ward-based acuity tool was relaunched in November 2023, this predicts the number of care hours required in 6-hour block periods which allows constant review of acuity and staffing in the acute unit. The reporting function of the ward-based tool is yet to go live, once launched this will be reviewed and monitored monthly as part of our speciality safety and quality committee.

Neonatal Services

NHS England – Specialist Commissioning Service Specification for Neonatal Critical Care Review (NCCR, 2024) covers the provision of Neonatal Critical Care, including neonatal intensive care, high dependency care, special care and transitional care.
There are four levels of Neonatal Units, the Dyson Centre of Neonatal Care is a level 2 Local Neonatal Unit (LNU).

Neonatal Critical Care is organised around Operational Delivery Networks (ODN) in close alignment with maternity services and the LMNS. The British Association of Perinatal Medicine (BAPM) and NHS Toolkit for High Quality Neonatal Services provide a framework and calculation tool to determine neonatal nurse staffing depending on cot capacity, acuity and is endorsed by Department of Health (DH) to ensure safe and productive working.

This report provides a summary of measures taken to achieve compliance with BAPM safe staffing for the LNU. The Southwest ODN conducted an annual review in Q3 using the Safer Nursing Care Tool – Shelford Group (2013) using triangulated data sets, inclusive of an annual workforce review, acuity, recruitment, retention, skill mix and Qualification in Speciality (QIS). In addition, the wider workforce is reviewed inclusive of allied health professionals (AHP) and medical establishment aligned to acuity.

The substantive nursing vacancy for December in the LNU for band 5 and 6 nurses is 1.97wte following recruitment of 2.08wte during the reporting period. LNU turnover rate is 1.7%. Sickness rates remain stable other than a slight rise in December comparable to midwifery staffing.

All Intensive Care Unit (ICU) and High Dependency Unit (HDU) babies should receive care from by a Neonatal Qualified in Speciality nurse (QIS), compliance is nationally agreed at 70% (National Quality Board, 2018). The Trust rate is currently 64.9%, this

will rise to 69.9% in April and again to 75% in July, with completion of existing staff on QIS course.

All LNUs should offer a transitional care service (BAPM, 2017), this is staffed from the LNU, with 95.6% shifts covered in Q3. The Trust currently provide a 4-bed service, however, Get it Right First Time (GIRFT) recommends we should offer an 8-bed service based on the current birth rate. However, all eligible babies in Q1-Q4 received transitional care.

It is also recommended neonatal services offer a 7-day outreach service for families (GIRFT 2022) who have been discharged from the LNU and have ongoing care needs. The Trust has a well-established 5-day service which provides direct patient and family time however there is limited resilience in our staffing model for sickness or annual leave, the service is reviewing the current model to support progression towards a seven-day service.

2.	Recommendations (Note, Approve, Discuss)
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). Trust to support Birthrate Plus® report 2023 and meet BAPM Neonatal staffing standards. MIS year 5 standards.	

4.	Risk related to staffing (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)	
2417	Maternity triage	12
2467	Maternity workforce	12
1763	Inability to fulfil BAPM AHP standards in NNU (Dietician, psychology, OT and Physio)	8

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

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

7.	References to previous reports/Next steps
MIS combined Maternity and Neonatal Safety Quality report Q1, 2, 3 & 4. Birth rate + report data from 2022, presented 2023. Perinatal Quality Surveillance Tools (PQST) presented monthly. MIS Year 5 Board declaration paper January 2024.	

8.	Freedom of Information
Public	

9.	Sustainability
Non-Applicable	

10.	Digital
Non-Applicable	

BI-ANNUAL MIDWIFERY AND NEONATAL STAFFING REPORT

1.0 Background

1.1 It is a requirement that NHS providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB, 2016) requirements.

1.2 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that Trusts develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

1.3 The Department of Health (DH 2009) recommended an adequate and appropriate workforce with the leadership, skill mix and competencies to provide excellent care at the point of delivery; organised into managed clinical networks, with hospitals providing neonatal care working together to ensure that babies and their families receive care in the most appropriate setting.

2.0 Executive Summary

This report provides a summary of the measures in place to ensure safe midwifery and neonatal nurse staffing; including clinical and specialist roles, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus® Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, and red flag incidents. It also provides a summary of measures taken to demonstrate working towards compliance with safe staffing for the LNU to include an annual workforce review, including a mid-year review and collaborative working with the ODN to ensure recruitment and retention, skill mix and flexible working.

3.0 Birth rate Plus® Workforce Planning (Midwifery staffing)

3.1 BR+ is the only recognised national tool for calculating midwifery staffing levels, the Trust commissioned and received a new report in April 2023. The Trust is required to support the findings of the report to ensure compliance with Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). MIS established 10 Safety Actions to support safer care. Trusts that demonstrate achievement of all 10 Safety Actions recover the additional 10% of the maternity contribution charged under the scheme plus a share of the monies paid in to the scheme by the hospitals that did not achieve.

3.2 The April 2023 report evidenced a variance in current funded establishment and required clinical and non-clinical establishment (specialist midwives) to support safe staffing at the RUH. These findings are summarised in table 1.

Current Funded Establishment bands 3 – 7	Uplift	Birthrate Plus establishment bands 3 – 7	Variance Bands 3 – 7

175.20	20%	183.66	-8.46
175.20	24%	191.83	-16.63
175.20	28%	200.64	-25.44

Table 1 Clinical and Non-clinical variance from current establishment

3.3 The required increase in uplift is influenced by a number of National and local drivers.

i. NHS Three-year delivery plan (2023) for maternity and neonatal services
ii. MBRRACE-UK report (2022)
iii. National Bereavement Care Pathway (2023)
iv. NHS Staff Survey (2022)
v. Patient Safety Incident Response Framework (PSIRF, 2022)
vi. Increase of women and birthing people's complex needs
vii. The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes
viii. Transitional care provided on the ward rather than in the LNU
ix. Safeguarding needs requiring significant input
x. Shorter postnatal stays require sufficient community midwifery resource
xi. Triage to cover a 24-hour period, seven days per week, with two midwives throughout the 24-hour period and an additional midwife for 24 hours per day required to provide effective telephone triage
xii. Midwives undertake the Newborn and Physical Examination (NIPE) in the community setting
xiii. Cross border collaboration
xiv. The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation; consequently, more women are meeting their midwife earlier. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss
xv. 7-day Neonatal outreach service

3.4 The Ockenden Final report (2022) advised maternity services as part of effective workforce planning review minimum staffing levels (to include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave).

3.5 A midwifery headroom of 28% was recommended by BSW Academy in March 2023 taking into consideration the statutory and mandatory training requirements, sickness, annual leave, and maternity leave.

3.6 The maternity business case funding was agreed in December 2023 with a headroom of 24% over a 3-year implementation plan to align to the headroom in the other maternity providers in BSW. Year 1 and 2 will see an increase in headroom to 24%, year 3 proposal to recruit a Consultant Midwife was not signed off and now forms part of the system wide Acute Hospital Alliance review of Midwifery workforce across BSW.

3.7 A number of clinical midwives are seconded into specialist roles, the majority of which are externally funded. The clinical posts are backfilled with fixed term contracts to ensure safe staffing numbers are maintained. The rate of secondments over the reporting period has been between 9wte and 6wte consistently.

3.8 In addition to clinical midwifery posts, consideration needs to be given to recommendations from national reports such as Ockenden, MIS and the 3-year Maternity Plan concerning new roles required to support safer high quality maternity services such as Pelvic Health, Trauma, and Inclusion Midwives. These are currently funded non-recurrently by the Integrated Care Board (ICB) until March 2024 and included in the secondment figures above. There needs to be consideration in future workforce planning relating to how these posts will continue if funding is not allocated from the ICB, which is a national issue within maternity services.

4.0 Recruitment and retention

4.1 Due to the complexities of maternity rosters, there have been challenges in ensuring accurate oversight of the midwifery workforce. In Q2, a thorough review of acute and community establishments was undertaken to ensure accuracy of the pipeline figures which are detailed in table 2. Maternity leave and secondment figures remain stable. There will be an increase in substantive vacancy in Q4 and Q1 24/5, due to the planned investment into the maternity service.

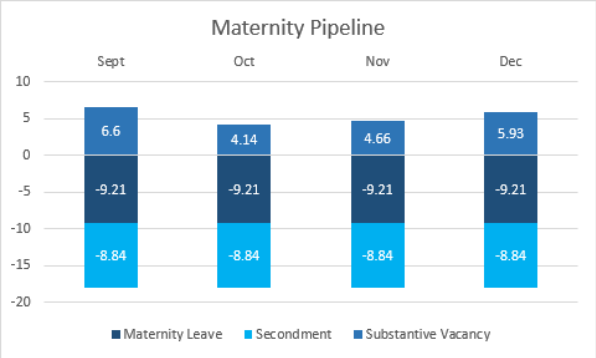


Table 2 midwifery pipeline

4.2 Over the past 24 months, maternity services have run active recruitment campaigns, including national and local advertising, successfully recruiting six Internationally Qualified Midwives and two registered Nurses who are undertaking the nurse to midwife MSC conversion course.

4.3 The success of our retention team has continued to support 100% retention of our Newly Qualified Midwives for 2 years.

4.4 Table 3 demonstrates the reduction in turnover rate from 19% in January 2023 to 5.96% in December 2023 with only five midwives leaving the Trust in this reporting period. In addition, a total of nineteen band 5 midwives have achieved their band 6 within this period.

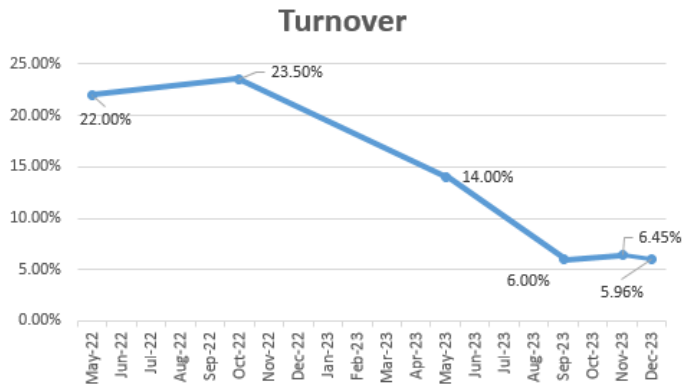


Table 3 Turnover %

5.0 sickness rates

Sickness has remained stable however it is noted an increase in December, this is mirrored in neonatal nurse staffing with the top reason for both areas being cold, cough, flu – influenza.

Month	sickness %
July 2023	2.52%
August 2023	2.65%
Sept 2023	3.56%
Oct 2023	3.32%
Nov 2023	4.70%
Dec 2023	5.62%

Table 4 sickness % for midwives

Reason	Episodes	Sickness days
Cold, cough, flu – influenza	14	27
Anxiety/stress/depression/other psychiatric	3	55
Genitourinary & gynaecological disorder	1	31

Table 5 top three reasons for sickness (overall % sickness hours) in December for midwives

6.0 Fill rates

6.1 Table 6 highlights the stabilised position for midwifery shift fill rates over the past 6 months. These will improve further as new starters end their supernumerary status in Q4/Q1.

Month	Day qualified %	Night qualified %
July 2023	85.4%	88.3%
August 2023	80.9%	88.9%
Sept 2023	77.6%	85.4%
Oct 2023	81.0%	86.6%
Nov 2023	87.2%	86.4%

Dec 2023	85.0%	89.8%

Table 6 Shift fill rates

7.0 Escalation

7.1 Improved staffing in the acute maternity unit has further reduced the requirement to redeploy community midwives, this is now only used in times of escalation or due to short term absence. Staffing and OPEL status is reviewed daily by the senior operational leadership team where redeployment is considered based on acuity to ensure safe staffing is maintained.

7.2 When staffing is less than optimum, the following measures are taken to maximise staffing into critical functions to maintain safe care for the women and their babies in line with the Maternity Escalation Policy:

- Request midwifery staff undertaking specialist roles to work clinically!
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and the labour ward coordinator remains supernumerary
- Activate the on-call midwives from the community to support Bath Birth Centre
- Request additional support from the on-call midwifery manager
- Consult closely with maternity services at opposite sites to manage and move capacity as required (mutual aid)

7.3 Although the staffing position has stabilised over the past 6 months there has been an ongoing need for on call attendance which appears to correlate to the birth activity (Table 7). As we recruit to the new establishments, the need for on call support in the acute setting is anticipated to decrease.

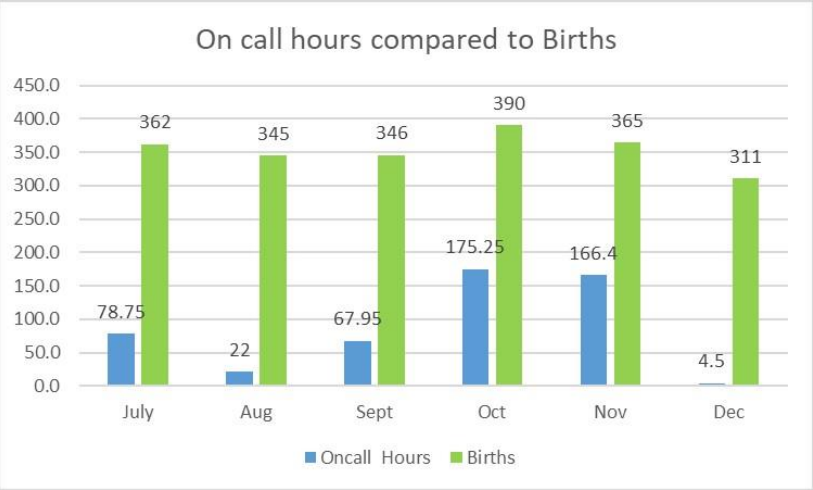


Table 7 On-call hours and birth number comparison per month

8.0 Midwife to birth ratio

The midwife to birth ratio is calculated monthly using BR+ methodology. The new BR+ Midwife to birth ratio 1:24 target was introduced in July 2023 to align with the outcome

RUH BR+ Report 2023, this reflects the increasing acuity of mothers and babies and their subsequent care needs.

Midwife to birth ratio	Target	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
Substantive only	1.24	1.31	1.29	1.29	1.32	1.30	1.26
Including bank	1.24	1.28	1.28	1.26	1.27	1.29	1.27

Table 8 midwife to birth ratio

9.0 BR+ Live Acuity Tool

9.1 The BR+ Acuity Tool is used to assess 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, birth and postnatally. It is a measure of 'acuity', and the system is based upon the clinical indicators used in the well-established BR+ workforce planning system.

9.2 The BR+ classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the LWC, this assessment identifies the number of midwives needed in each area to meet the needs of the women (based on the minimum standard of one to one care in labour for all women and increased ratios of midwifery time for women in the higher needs categories).

9.3 Availability of a supernumerary LWC is mandated in Saving Babies Lives V3 (2023) to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload without having a caseload to manage or a labouring woman. An internal performance review is conducted monthly to monitor compliance and reported via speciality governance. Table 9 outlines the compliance for the past 6 months.

Month	Days per month	Shifts per month	Compliance
July 2023	31	62	100%
August 2023	31	62	99%
September 2023	30	60	99%
October 2023	31	62	98%
November 2023	30	60	100%
December 2023	31	62	100%

Table 9 Supernumerary status of LWC

9.4 A review of incidents/events and outcome data provided assurance that reduced compliance did not impact negatively on safe care, nor did evidence the LWC provided 1:1 in labour care.

9.5 Women in established labour are required to have 1:1 care and support from an assigned midwife to ensure the safe, high-quality provision of care. If there is an occasion when 1:1 care cannot be achieved, the LWC follows a series of clinical or management actions depending on need, as part of the escalation policy – Maternity Escalation Guideline M69.

	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
1:1 care in established labour	100%	100%	100%	100%	100%	100%

Table 10 1:1 care in labour

10.0 Neonatal Nurse Staffing

The Neonatal Nursing Workforce Tool (2020) has been adapted from the Clinical Reference Group (CRG) Workforce Calculator (Dinning) Tool (2013) and provides a consistent method for calculation of nursing establishment requirements. NHSE (2016) recommends an uplift of 25%, this tool should be used for direct patient care in the LNU only.

Based on occupancy and activity calculations in 2022/23 for the LNU, Transitional Care (TC) and Outreach safe staffing levels were maintained. As recommended by NHSE, TC and Outreach should be delineated from the inpatient neonatal budget, there is on-going work to review the model of care to support alignment with these recommendations.

10.1 Overall vacancy in December is 1.97wte, recruitment was unsuccessful in October/November with bank staff being used to cover vacancy, further recruitment in January 2024 failed to fulfil vacancies thus post remain out to advert.

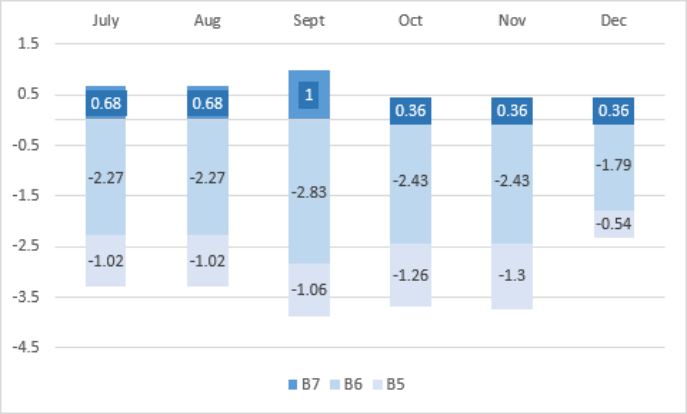


Table 11 nurse vacancy pipeline

10.2 Nurse turnover rate remains stable and well below the Trust rolling KPI of 11%.

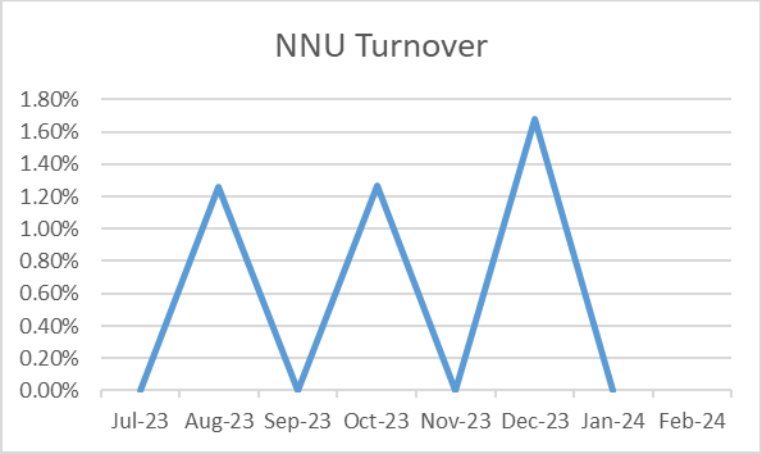


Table 12 nurse turnover %

11.0 Sickness

Sickness has remained stable however it is noted an increase in December, this is mirrored in midwifery staffing with the top reason for both areas being cold, cough, flu – influenza.

Month	sickness %
July 2023	5.03%
August 2023	2.60%
Sept 2023	1.47%
Oct 2023	2.19%
Nov 2023	2.90%
Dec 2023	5.62%

Table 13 Sickness % for registered nurses

Reason	Episodes	Sickness days
Cold, cough, flu – influenza	6	13
COVID-19	4	17
Heart, cardiac & circulatory problems	2	62

Table 14 top three reasons for sickness (overall % sickness hours) in December for registered nurses

12.0 Qualified in Speciality (QIS)

All ITU and HDU patients should be cared for by a nurse who is QIS trained, for special care babies it is best practice if they are QIS trained although standards can still be met if they are supervised by a QIS nurse. The Unit also requires one QIS trained nurse in charge of the unit and another for Transitional Care. The compliance level is 70% with our aspiration being for 100% nursing staff to be trained.

Our current QIS is 64.9% of the qualified workforce with 3.4wte undertaking their QIS in September and December 23/24. On completion of the first cohort compliance will increase in Q1 2024 to 69.9% and the second cohort in Q2 will see compliance rise to 75%. Table 15 represents QIS trained neonatal nursing staffing provision per shift over the review period.

MONTH	DAY SHIFT	NIGHT SHIFT
July 2023	100%	90%
August 2023	100%	100%
September 2023	73%	67%
October 2023	94%	90%
November 2023	97%	100%
December 2023	97%	100%

Table 15 QIS shift fill rates

During periods of high acuity staff are redeployed and rosters changed to ensure adequate QIS trained nurses are available for baby's needing intensive or high dependency care. This is further mitigated by all nurses completing the Southwest Neonatal Foundation programme and local induction programme, and all are supported with gaining experience in intensive and high dependency care.

13.0 AHP staffing

In addition to nursing staff, LNUs require key contributions from an essential group of AHPs to enhance service provision and optimise short and long-term neurodevelopment and mental health of infants and their families; this is advocated in the NCCR report.

The provision of Ockenden funds has supported recruitment of AHPs within our LNU however this does not fully meet the BAPM recommendations, the current provision and deficit are identified in table 16:

AHP	Current provision (WTE)	Deficit against BAPM (WTE)
Physio	0.2	0.6
OT	0.5	0.5
SALT	0.2	0.6
Dietician	0.2	0.7
Psychologist	0.3	0.6

Table 16 AHP wte comparison

14.0 Specialist roles

BAPM Service specification also states additional provision should be implemented for staff delivering quality, management and other non-direct patient-facing roles which are additional to the direct patient care ratios. Every provider of neonatal care should ensure that non-direct patient-facing roles including provision for a designated lead nurse, clinical nurse educator, supernumerary shift co-ordinator, discharge planning / outreach co-ordinator, patient safety and governance nursing lead and infant feeding lead are in addition to other roles outlined in the Toolkit for High Quality Neonatal Services (2009).

We currently have three such roles in place; 0.8wte as Neonatal Education and Safety Governance lead, procurement/stock rotation and 0.5wte Family Integrated Care Lead. Remaining specialist roles, in line with BAPM recommendations, are allocated to individuals within our clinical nurse budget and subject to being redeployed during times of staffing escalation.

It is also recommended neonatal services offer a 7-day outreach service for families (GIRFT 2022) who have been discharged from the LNU but have ongoing care needs. We have a well-established 5-day service which provides direct patient and family time however there is limited resilience in our staffing model for sickness or annual leave, the service is reviewing the current model to support progression towards a seven-day service.

15.0 Further actions to be undertaken over the next six months

1. Review the need to increased headroom required to support the BR+ 2023 report and findings from BSW academy review for maternity staff

2. Support effective retention and recruitment strategy to ensure continued stabilised midwifery workforce

3. Undertake review of externally funded posts and agree workforce planning strategy to mitigate risk of removal of national funding

4. To perform a fiscal review of nursing workforce to align with NHSE recommendations

5. To review the current model of care on LNU to support progression towards a seven-day outreach service.

6. To continue to seek funding to ensure compliance with BAPM standards for neonatal nursing and AHP staff

15.0 Conclusion

Maternity services are a high-risk specialism, the impact of poor care can be life changing for women and their families. Investment in safe maternity staffing not only safeguards the provision of high-quality care and best outcomes but also mitigates the reputational and litigious risk for the organisation.

Neonatal services offer the best start in life to babies who have care needs which will have a lifelong effect if not provided in line with National standards.

The Trust Board is asked to discuss the report and note the position of staffing in maternity and neonatal services.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**22 July 2024**		
Title of Report:	**Quality Assurance Committee Upward Report – 13 May 2024**		
Status	**For Information/Discussion**		
Author	**Ian Orpen, Non-Executive Director and Chair of the Quality Assurance Committee**		

Key discussion points and matters to be escalated from the meeting 13th May

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

No items to raise this month.

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

- **Ambulance Handover:** Ambulance handover remains a key area of concern and risk, with sub optimally mitigated clinical risk present for some of our most acute, undifferentiated patients, and further exacerbating ED crowding and exit block. Remedial/improvement actions thus far have not effected sufficient positive and/or sustained improvement, and RUH is currently under regional scrutiny based upon the current position. A number of improvement opportunities have been identified and work on implementing them is underway.

ASSURE: Inform the Board where positive assurance has been achieved

- **Litigation:** The Trust continues to receive fewer claims when compared to national benchmarking data for Trust of a similar type and size. What is encouraging is that that is a consistent, sustained picture. The other positive was an improving picture in relation to settled claims, in that we were seeing a smaller number that were taking us by "surprise" i.e. we had already identified that something had not gone as planned via the incident reporting route. Firstly, this suggests our incident reporting function is working, and secondly it means we are giving ourselves the opportunity to learn the lessons and make improvements at the earliest opportunity.

- **Medicines Management:** The Director of Pharmacy reported that the incident reporting rate had increased, and this was a positive sign as indicated a healthy approach to patient safety and is line with PSIRF. The percentage of medication errors had been halved and improvements had been seen in bar code scanning of medications.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- **Medicines Management:** There was a discussion about whether medicines shortages should be on the risk register. The Director of Pharmacy confirmed that this had been added to the risk register but pointed out that this was a national issue

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding
• **Medicines Management:** Focussed improvement had been seen in compliance with VTE risk assessment and all major risks had controls in place. An associated reduction in DVTs (Deep Vein Thromboses) had occurred marking a significant improvement in patient safety.
APPROVALS: Decisions and Approvals made by the Committee
No items to raise this month.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**15.1**
Date of Meeting:	**22 July 2024**		
Title of Report:	**Quality Assurance Committee Upward Report – 8 July 2024**		
Status	**For Information/Discussion**		
Author	**Ian Orpen, Non-Executive Director and Chair of the Quality Assurance 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

- No items to raise.

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

Structured Judgement Reviews (SJRs)

- 77% of the structured judgement reviews undertaken in Q3 and 4 assess overall care provided as good or very good. 5% (4) of SJRs conducted in Q4 assessed overall care as poor. Where care has been assessed as poor, detailed review has been undertaken by the appropriate clinical division and patient safety events reported and managed in alignment with our PSIRF principles. The themes identified through the detailed review align with our current patient safety priorities and learning has been fed into the improvement groups aligned to these.

  In Q3 and Q4 there has been an increase in the number of SJRs completed. However, the number of outstanding SJRs remains static and the percentage completed with 2 months has fallen. Capacity and demand review demonstrates that current capacity matches recurrent demand. The deterioration in performance reflects the prioritisation of SJRs from the backlog. A recovery plan is in development to address the backlog in SJRs. This will be monitored at Trust Quality and Safety Group and escalated to the QAC if necessary.

Paperless Inpatients Project (PIP)

- The Deputy Chief Medical Officer reported that the Trust was currently in the preparation phase and this was the focus of the paper presented. The Go Live date had been approved by TME (Trust Management Executive) for 13th August 2024. The Deputy Chief Medical Officer reported that the level of training remained a concern and the end of July would be when the final technical decision was made. He explained that the project had been featured on Q&A

sessions and a group had been set up with the Resilience Team to look at the impact on flow etc.

ASSURE: Inform the Board where positive assurance has been achieved

Quality Governance Project

- This is being led by the Deputy Chief Nursing Officer. The project priorities have focussed on implementing on the recommendations from the 2023 Aqua review, together with improvement opportunities identified following recent internal audits.

- The project has four workstreams as follows:

    - Quality Governance Architecture
    - Divisional Governance
    - Risk Management
    - Quality Metrics

- Specific elements to highlight include

    - The implementation of the revised quality governance structure is underway.
    - A Trust Clinical Effectiveness Committee will soon be established which will further strengthen the oversight of clinical effectiveness, morbidity and mortality, clinical audit and associated learning
    - A comprehensive review of our Divisional Governance framework has been commenced being led jointly by a Divisional Director and Divisional Director of Nursing.
    - Risk register domains have been updated and aligned to sub-board committees to strengthen oversight and regular monitoring.
    - All quality metrics have been reviewed with individual subject matter experts which also links to the development of an BSW quality scorecard.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- No items to raise.

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

- No items to raise.

APPROVALS: Decisions and Approvals made by the Committee

- No items to raise.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**16**
Date of Meeting:	**22 July 2024**		
Title of Report:	**People Committee Upward Report – 21st May 2024**		
Status:	**For discussion**		
Author:	**Paul Fairhurst, Chair of the People Committee**		

Key Discussion Points and Matters to be escalated from the meeting held on 21 May 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

- **Pay cost reduction & workforce planning:** the Board is alert to the 2024/25 workforce submission and to the challenging commitments to deliver £19.4m pay cost savings and a reduction of 388 whole time equivalents.
- **Fit for Purpose**: following the review by AQUA and the listening exercise, a programme of actions to address challenges in the People Directorate has been co-developed by the function and is being implemented. The People Committee Non-Executive Directors will receive regular updates in private on progress and impact.

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

- **FTSU (development)**: A strategy/vision document regarding governance of the Freedom to Speak Up Service (FTSU) will be presented to the Board in September and will include a recommendation as to which Committee FTSU will report to on an ongoing basis.
- **People Plan/ Basics Matter (ongoing monitoring):**
  - Leadership management programmes are ready for use but given the organisational change focus, people and culture change management skills has the priority. A risk may be added to the Board Assurance Framework regarding change management capabilities and the need to develop the ability of our leadership teams to lead change whilst at the same time being impacted by change.
  - The Committee heard a frank but highly constructive Staff Story from a recent new joiner as to her mixed but largely difficult experience of joining the Trust. Developing and designing an employee's first year is a focus area for this year's People Plan and will include a toolkit to support managers with the induction of new employees and talent acquisition training for managers.
- **Appraisal compliance (ongoing monitoring):** Appraisal rates remain significantly behind targets. The Head of Coach House and Programme Lead for Improving Together presented a deep dive on appraisal compliance. A3 thinking has helped identify common concerns/ themes/ root causes and countermeasures (which include increased visibility of appraisal compliance rates for corporate teams, an appraisal policy and training and support for staff on how to carry out an effective appraisal).

ASSURE: Inform the board where positive assurance has been achieved

- **People Plan/ Basics Matter (ongoing monitoring):**
  - The People Plan Dashboard continues to evolve with the aim to merge it with the Integrated Performance Report and include trend/ forecast data.

○ Progress continues across multiple programmes including: launch of the People Hub and the Halo case management system; getting pay right for new joiners and leavers; redesign of the parental leave process and policy; projects to enhance staff experience and engagement such as employee recognition and Joy at Work; discrimination; talent acquisition; wellbeing (noting an exception report around sickness absence due to anxiety, stress and depression which remains high); and temporary staffing (including the go live with the South West agency rate card).
RISK: Advise the board which risks where discussed and if any new risks were identified.
No items to raise this month.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
No items to raise this month.
APPROVALS: Decisions and Approvals made by the Committee
No items to raise this month.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**22nd July 2024**		

Title of Report:	**SIRO Data Security Protection Toolkit Report July 2024**
Status:	**For Approval**
Board Sponsor:	**Jon Lund, Interim Chief Finance Officer on behalf of Spencer Thorn, Acting Senior Information Responsible Officer (SIRO)**
Author:	**Graeme Temblett-Willis**
Appendices	**Appendix 1 – DSPT status and certificate of completion June 2024.**

1. Executive Summary

The purpose of this report is to update the Committee on the status of Information Security and Governance for the Trust and with reporting on the annual Data Security Protection Toolkit (DSPT) for the period July 2023 to June 2024.
The report covers relevant compliance and regulatory controls that the Trust adheres to and is working to improve in an ever-changing security threat environment.
The appendices are to provide an extra layer of detail for this Committee.
The final submission for the DSPT for 2023-24 has now been submitted following approval from the Non Clinicla Governance Committee and is the detail provided to NHS England to show final completion of this assessment. This is then available to the public and partners to show the Trust meets the standards of compliance in the management of patient data, clinical systems and technology used by the organisation less the granular detail that sits behind the assessment.

2. Summary

1. **<u>Annual Data Security Protection Toolkit (DSPT).</u>**

The KPMG DSPT internal audit has concluded and involved a deep dive into several areas not previously assessed. The detail that has been explored are:

a) The organisation has a framework in place to support Lawfulness, Fairness and Transparency
b) Staff contracts set out responsibilities for data security.
c) Staff have appropriate understanding of information governance and cyber security, with an effective range of approaches taken to training and awareness.
d) Your organisation engages proactively and widely to improve data security and has an open and just culture for data security incidents.
e) You closely manage privileged user access to networks and information systems supporting the essential service.
f) Process reviews are held at least once per year where data security is put at risk and following DS incidents.
g) All user devices are subject to anti-virus protections while email services benefit from spam filtering and protection deployed at the corporate gateway.
h) Organisations have a defined, planned and communicated response to Data security incidents that impact sensitive information or key operational services.
i) You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service.
j) A penetration test has been scoped and undertaken.

k) You securely configure the network and information systems that support the delivery of essential services.
l) The organisation is protected by a well-managed firewall.
m) Basic due diligence has been undertaken against each supplier that handles personal information.

There are challenges in a number of these assertions for the organisation and they must be considered in relation to risk, resource and time to deliver. The challenges that are involved in the assessment and require significant resource centre on the management of our network and information system vulnerabilities that are becoming more complex and the lack of a SIEM (Security Incident and Event Monitoring) tool that enables such vulnerabilities to be monitored out of hours poses a significant risk to the Trust and has been demonstrated in the recent cyber attack on the Trust firewall which has been discussed previously at this Committee.

The assertions that were included in this year's audit total 59 out of the 108 mandatory assertions that make up the full DSPT annual assessment. The remaining assertions that have not been assessed this year are assessed via a process of collection and engagement with the relevant staff across the Trust including medical records, coding, medical device management, networks, cyber, service desk leads, EPRR and procurement. The SIRO or Deputy SIRO are then provided with a full explanation of each of the 10 data security standards prior to final submission.

The final KPMG internal audit report has been given a rating of ***Significant assurance with minor improvement opportunities (Amber / Green)***.
The improvement opportunities that are detailed in the final report relate to the creation of new policies not previously published or required under UK GDPR but relate more to cyber assurance and the management process of medical devices as there is no formally documented plan for protecting devices that are natively unable to connect to the Internet. (This applies to any device (managed internally or by a third party) that does not have a route to/from the Internet, such as air-gapped networks or stand-alone devices, for example an MRI Scanner).

Areas of good practice identified by the internal audit included:

- The Trust provides a specific privacy notice tailored for children and young adults, which is an easy-to-understand version of the privacy notice for adults.
- Mandatory Information Governance and Data Security training is conducted annually for all staff, with compliance tracked through an Organisational Compliance Report.
- The access privileges to system logs in the central logging management system are strictly controlled, limiting access to authorised personnel only.
- The Trust has established a structured process for reporting and investigating data security incidents, ensuring timely resolution and mitigation.
- Key operational services are documented and categorised by priority levels, facilitating resource allocation and management.
- Secure infrastructure measures, including a frequent patching schedule, vulnerability checks, and monitoring alerts, are implemented to mitigate risks.
- A Mobile Device Management (MDM) solution is in place to ensure the security

of mobile and tablet devices across the Trust.
- Documented standards for end-user devices include monthly patching schedules, encryption, and user account management, enhancing security measures for provisioned devices.
- Changes to firewall rulesets require submission of detailed change requests to the service owner, ensuring planning and risk mitigation.

The DSPT assessment has evolved over the last three years and is now information security focused not simply an Information Governance exercise. It ensures the Trust moves towards not only NHS England standards but also best practice across the healthcare industry taking other frameworks as an aide to improve our assurance and compliance with the UK regulatory landscape.
In the next annual DSPT assessment this will be aligned and follow the CAF (Cyber Assessment Framework) that is provided by the NCSC (National Cyber Security Centre) who have worked with NHS England to ensure the healthcare sector can be more resilient into the future with the ever-increasing threat of cyber and security attacks.

The interim Deputy CDIO and DPO (Data Protection Officer) is attending a series of events to ensure this level of compliance is understood in granular detail. This will be relevant particularly as the Acute collaboration in the digital space moves forward. Such collaboration should be mindful of the need to manage the statutory requirements regarding data privacy and Network and Information System (NIS) security so that no single Trust is compromised.

2. ICO Incidents reported.

There have been three reports of confidentiality breach made directly to the ICO (Information Commissioners Office) which have been investigated with one concluded and no further action or involvement required from the ICO. The second continues to be investigated and relates to the loss of a patient list stolen from a staff members folder whilst in a public place. This has been reported to the police and ICO with further details on their progress awaited.

The third report relates to the ongoing cyber-attack in London and the potential for data belonging to the Trust being involved in the ransomware attack in June. (This has been covered ahead of this section).

The Board will be updated on all incidents once the ICO case manager has returned with their view of the investigation undertaken locally.

There has been a total of 164 Information Governance reported incidents during the period July 2023 – May 2024 none causing significant risk of harm to patients or staff. Learning is provided as feedback and training offered by the IG team for those areas identified as having a recurring trend of incidents. Many incidents relate to letters being sent to wrong recipient and a on closure investigation into this increasing trend has been due to staff pressures and incorrect choice of patient on the relevant clinical application.

Further training and awareness has been provided to the clinical administration leads in the Divisions and it is hoped that the incidents will reduce over the coming months.

Incident statistics are reported monthly to the ISG (Information Security Group) and it should be noted that there is a high level of awareness in relation to patient confidentiality and this is evidenced by the number of BAU queries that the IG team receive in relation to seeking advice and guidance which was approximately 1200 email queries for July 2022- June 2023 but now has reached in excess of 1600 for 2023-24 period plus general phone call queries which are managed by just two members of staff. Thie team now also respond to Information Governance matters that relate to Sulis.

3. Freedom of Information (FOI)

FOI requests have increased again as shown below:

Freedom of Information requests have increased again as shown below: There have been 354 requests received for the time frame from 1st January 2024 – 3rd May 2024 which is 57% compliance.

For reference, please see the statistics for the same reporting period for previous years below.

Numbers received = 354 to date
Numbers received = 288 - 2023
Numbers received = 223 – 2022
Numbers received = 219 – 2021
Numbers received = 211 - 2020

The level of requests is a challenge to both the FOI coordinator and to the organisation to complete beyond the normal daily tasks. Currently the Trust is well below the required 90% target set by the ICO.

The lack of an automated FOI process hinders the ability to drive increased compliance and discussions continue across the AHA to find a solution that will benefit all sites. There is a risk that not being able to meet the statutory response could result in enforcement action in the form of notices and penalties could materialise. The ICO have taken action against other public authorities recently for the lack of responding to FOI requests as can be evidenced in the following link https://ico.org.uk/action-weve-taken/information-notices/ .

The Information Security Group is committed to improving the level of compliance for FOI requests and provides monthly reports on progress in achieving this and further updates will be provided to this Committee. The following is now being put in place to improve the compliance:

- *Training programme – provide training to key staff identified as responsible leads for completing departmental FOI's*

- *Increased data analysis – identifying trends of non-compliance and areas that are falling behind in completion more promptly and provide KPI trackers to improve compliance.*
- *Review internal processes – improving internal processes and identifying blockages in the system will reduce response times.*
- *Increase proactive disclosure – by publishing more information widely on the Trust external website can lead to signposting of previously requested data thereby reducing the burden on staff and the FOI process.*
- *Improved FOI assessment – early identification of exemptions that can be applied and data previously requested that has been provided to other requestors will improve performance.*
- *Utilize technology – the new IT Service Desk system, Halo, is being scoped as to whether this can help automate or semi-automate the FOI process.*
- *Increased audits – introduction of regular auditing of FOI to be introduced and reported to ISG and via the PRM process to monitor and evaluate progress.*

3.	Recommendations (Note, Approve, Discuss etc)

- Request to note and approve the report.

4.	Care Quality Commission Outcomes (which apply)

The DSP Toolkit compliance helps demonstrate compliance with Regulation 17 – Good governance.

5.	Legal / Regulatory Implications (ICO)

UK General Data Protection Regulation (GDPR) / Data Protection Act 2018

The UK GDPR is applicable to any organisation that processes personal data – public, private and voluntary sectors. The key themes of the new legislation are more rights for individuals in relation to how their personal data is processed and more obligations for organisations that are processing personal data, whether of staff or patients / service users.

An updated Data Protection Bill was expected to have been passed earlier this year (2024) but has failed to reach the deadline prior to the call of the General Election. There were aspects of the Bill that changed some approaches to records of processing and risk assessments, as well as having a tiered approach to penalties and fines on the UK GDPR. If the Bill is resurrected at the new term of Government that may not be until the end of the summer recess this will be reported back to this Committee.

The Freedom of Information Act (FOIA)

Responding to requests under the Freedom of Information Act (2000) has been the responsibility of the Information Governance Team. The service is administered by one 1 WTE member of staff and managed by the Information Governance Manager. FOI activity is monitored by the Information Governance Group and each request has Executive sign off by

the Trust Secretary. The FOI Act states that for a request to be compliant with the legislation then the information must be provided and responded to within 20 working days.

Information Governance Data Incidents

The Trust reports all serious Information Governance incidents to the ICO by using the online NHSD DSPT incident reporting tool, which is the agreed standard in relation to data breaches and incidents. Incidents that are required to be reported to the ICO must be made within 72 hours of being discovered.

All incidents are triaged by the IG Team and any that require escalation are done so through the DSPT mechanism.

Networking and Collaboration

Internally, the Deputy CIO (interim) / DPO and IG Team are represented at various groups and committees on both ad hoc and regular basis.

Externally, these roles contribute to the West of England Strategic Information Governance Network (SIGN), the WiSC (Wiltshire information Sharing Charter), WIGF (Wessex Information Governance Forum) and the BSW ICS Cyber Technical Design Authority, providing guidance and advice as the Data Protection Officer for the ICS Local Workforce Administration Board (LWAB). The DPO has also been key to the governance structure for the N365 rollout and other regional initiatives including radiotherapy, radiology, and cancer networks agreements. The Trust DPO (Deputy CDIO) is also the IG lead and SME for the West of England Imaging Network.

6.	NHS Constitution
This report shows that the Trust is committed to maintaining patient confidentiality and patient's right to privacy, as well as complying with the Data Protection principles.	

7.	Equality and Diversity
The control of data in relation to the organisation is unbiased and non-discriminatory respecting the rights and freedoms of all staff and patients alike.	

8.	Communication
NA.	

9.	References to previous reports
DSPT update previously considered at Non Clinical Governance Committee, June 2024	

10.	Freedom of Information
Public	

Appendix 1 – DSPT status June 2024

Data Security and Protection Toolkit

NHS Digital

2023-24 (version 6)

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST

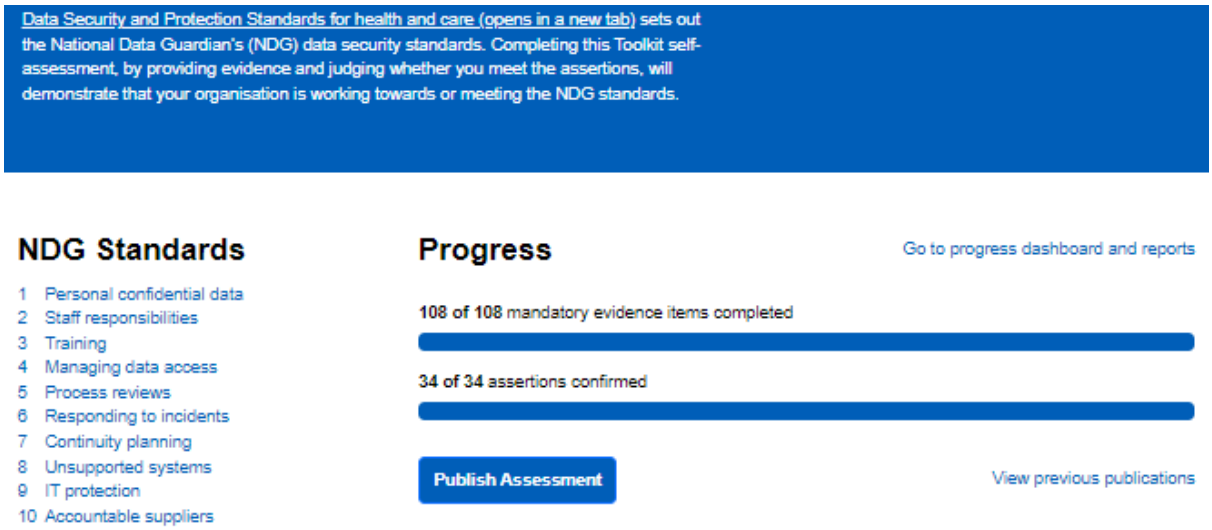
Combe Park, Bath, England, BA1 3NG

Standards met

Date of publication: **27 June 2024 (valid to: 30 June 2025)**

This organisation has completed a Data Security and Protection Toolkit self-assessment to demonstrate it is practising good data security and that personal information is handled correctly.

www.dsptoolkit.nhs.uk



Data Security and Protection Standards for health and care (opens in a new tab) sets out the National Data Guardian's (NDG) data security standards. Completing this Toolkit self-assessment, by providing evidence and judging whether you meet the assertions, will demonstrate that your organisation is working towards or meeting the NDG standards.

NDG Standards

1 Personal confidential data
2 Staff responsibilities
3 Training
4 Managing data access
5 Process reviews
6 Responding to incidents
7 Continuity planning
8 Unsupported systems
9 IT protection
10 Accountable suppliers

Progress

Go to progress dashboard and reports

108 of 108 mandatory evidence items completed

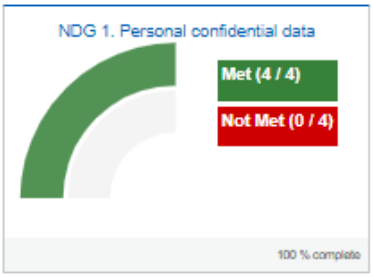
34 of 34 assertions confirmed

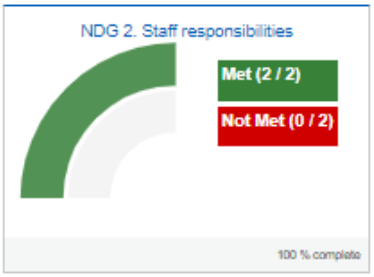
Publish Assessment

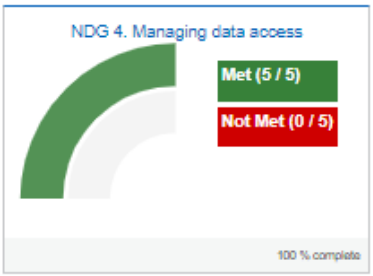
View previous publications

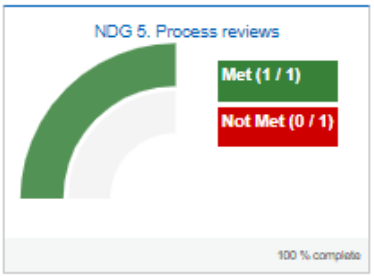
National Data Guardian Standards

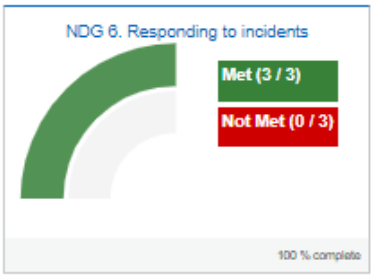
The National Data Guardian (NDG) standards have been calculated for your organisation based on the responses provided in your organisation profile.

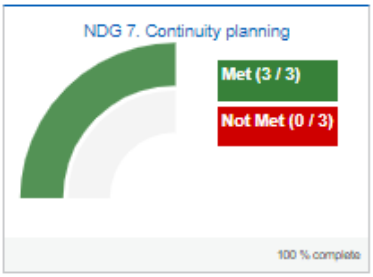


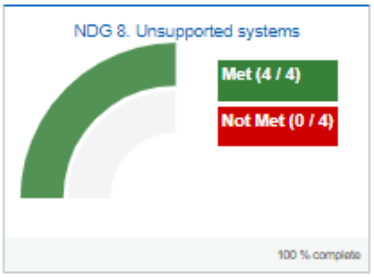


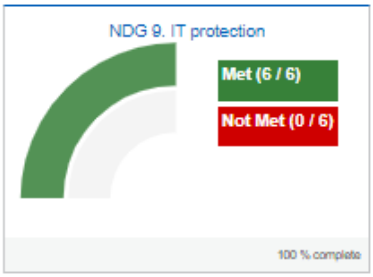












Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**18**
Date of Meeting:	**Monday 22nd July 2024**		

Title of Report:	**Strategic Priorities Q1**
Status:	**For information**
Board Sponsor:	**Joss Foster, Chief Strategic Officer**
Author:	**Ashleigh Harvey, Head of Strategy and Development** **Fi Abbey, Head of Strategic Projects**
Appendices	**Appendix 1: Q1 Review**

1. Executive Summary of the Report

This paper sets out progress made in quarter 1 towards delivery of our You Matter Trust Strategy, including new risks/context and progress against breakthrough goals. The priorities reflect the critical areas of delivery in 2024/25 and are aligned to reflect the Trust's focus on the people we work with, the people we care for and the people in our community.

Overall, good progress has been made towards delivery of the strategy in quarter 1. Activities shown on the sunrays as 'in progress' will continue into the next quarter.

Work is ongoing to develop the measures for each of our breakthrough goals for 2024/25 and this work will be completed in July and reported through the Strategy Deployment Room at Trust Management Executive (TME). Tracker measures have been included in the report, although may be subject to change - consolidated reporting will be included in the Q2 report.

There are no changes to risks as set out in the Board Assurance Framework (BAF) however it should be noted that the framework and risks are currently under review and an update will be provided in the Q2 report.

2. Recommendations (Note, Approve, Discuss)

Board of Directors is asked to note the updates against the You Matter Strategy and discuss the emergent risks/context for the three people groups.

3. Legal / Regulatory Implications

A number of the 2024/25 strategic priorities reflect the Trust's response to national planning guidance such as meeting regulatory performance targets, particularly the timeliness of urgent and emergency care and the continued delivery of our elective recovery plan to reduce waiting times for elective, cancer and diagnostic care.

The Financial Improvement Programme priority also reflects the Trust's response to the long-term need to return to financial balance and contribute to the BSW system control total for 2024/25 of £30m deficit.

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

Priorities are RAG rated to indicate delivery to date. Where relevant, key risks to future delivery have also been outlined. Board Assurance Framework (BAF) risks have been included and are unchanged, however it should be noted that these are currently under review and an update will be provided in the Q2 report.

New risks/context identified include:

- **System strategy** – Scale of system transformation requires capacity and a need for increasingly close alignment across the BSW system and Acute Hospital Alliance
- **Community services** – BSW community services contract procurement ongoing with outcome due in Q2, for mobilisation during Q3/Q4. Potential risk to service continuity during this time
- **Financial balance** – BSW system financial position at month 2 (May) was adverse to plan and requiring system-wide recovery programme
- **Political landscape** – New government leadership may result in changes to national priorities and/or expectations

5.	Resources Implications (Financial / staffing)

Scale of transformation has significant capacity implications to deliver at pace.

The Improvement Programme Steering Group is monitoring resource implications linked with delivery of the savings plan for 2024/25.

6.	Equality and Diversity

The EDI (Equality, Diversity & Inclusion) and Health Inequalities Programmes underpin the Trust's current focus on equality and diversity, for the people we care for, the people we work with and the people in our community.

Benefits delivered in Q1:

- Anti-Racism statement commitment actions underway and inclusion champions launched
- Autism cards and sunflower scheme launching for hidden disabilities
- Health inequalities steering group mobilised
- Board health inequalities self-assessment undertaken
- Health inequalities indicators included in ward/department accreditation framework
- Digital inclusion navigators recruited to support people in the community who are excluded from the digital offering at the Trust
- Health inequalities staff resources and training available on the Trust Intranet
- Recruitment of health coaches to deliver smoking cessation and lifestyle

interventions for inpatients
- Anchor organisation strategy drafted and BaNES Civic Agreement published

Risks identified in Q1:
- Risk to pace of delivery required for culture change due to operational and clinical pressures and resourcing requirements which could lead to slower progress and delayed action – Diversity and Inclusion Steering Group and Health Inequalities Steering Group exploring options for further engagement

7.	References to previous reports/Next steps

Updates will be presented to Public Board as follows:
Q1 – July 2024, Q2 – November 2024, Q3 – January 2025, Q4 – May 2025

8.	Freedom of Information

Public

9.	Sustainability

Benefits delivered in Q1:
- Trust wide sustainability day held in April 2024 to share success and build engagement with ongoing work
- Board sustainability workshops taken place
- Sustainability champions relaunched June 2024
- Sustainability working groups set up in Theatres, Endoscopy and Radiology

Risks identified in Q1:
- £3m match funding is required as part of the Trust decarbonisation project in order to access the £21.6m grant capital funding from the Government Public Sector Decarbonisation Scheme (PSDS)

10.	Digital

A number of priorities (including Paperless Inpatients Project (PIP), Single Electronic Patient Record (Single EPR) and Recruitment Transformation), aim to embed digital solutions to aid transformation in line with the Trust's Digital Strategy.

Benefits delivered in Q1:
- Single EPR leadership team have been appointed and recruitment ongoing for central and local work stream leads
- Training for Paperless Inpatients Project live for all staff with Go Live planned for Q2
- Artificial Intelligence (AI) scoping paper drafted and subgroup in development with pilot site project in clinical coding underway
- Numerous digital projects have gone live including Cardiology image archive

project and ED document capture and storage
- Migration of Trust-wide data warehouse to new high-performing resilient platform and full refresh of Trust WiFi delivered
- Badger Net Maternity Patient Record project initiated – Go Live planned for June 2025

Risks identified in Q1:

- Digital capacity for change alongside single EPR project
- Paperless inpatients – increase in training uptake required to support go live
- Single EPR – resource risk due to the large team required to deliver the system wide project.
- The speed and application of AI technology in health care is developing quickly, making it more important that the Trust can be responsive to this changing landscape and mitigate any possible risks. The AI subgroup and policy, which is in development, will support this.
- National focus on cyber security as a result of recent high profile breaches that may threaten the NHS

Trust Priorities 2024/25

Royal United Hospitals Bath NHS Foundation Trust

The people we care for

The people we work with

The people in our community

Trust goals

- Patient safety incidents
- Number of patients over 65 weeks
- Overall patient experience score
- % recommend RUH as a place to work
- % staff say the organisation acts fairly with regard to career progression
- % staff experiencing discrimination at work
- Delivery of breakeven position
- Equity of access to RUH for all
- Carbon emission reduction

Breakthrough goals 24/25

Why not home? Why not now?
Reducing inpatient length of stay top 25% of acute trusts

Discrimination
% of staff reporting they have experienced discrimination at work

Making best use of available resources
Delivery of financial plan

Enabling Breakthrough Goal: We "Improve Together" to make a difference
(measured by the adoption of tools, routines and behaviours of Improving Together via a quarterly maturity assessment)

Trust-wide projects

- Atrium Redesign
- Community Diagnostics Centre (Sulis)
- Paperless Inpatients
- Quality Governance
- Sulis Elective Orthopaedic Centre (SEOC)
- Single Intensive Care Unit (ICU)

- Basics Matter
- Compassionate Leadership
- Dignity at Work
- Equality, Diversity & Inclusion (EDI)
- Learning and Development
- Reducing Discrimination
- Staff Engagement and Experience

- Health Inequalities Programme
- Community Services Tender
- Heat Decarbonisation
- Financial Improvement Programme
- Single Electronic Patient Record (EPR)

The people we care for

2024/25 progress (Q1)

Strategic Risks (Board Assurance Framework)

- 1.1 Not meeting internally and externally set standards of quality and safety may result in harm to patients and/or experience below expected – current score 15
- 1.2 Failure to provide safe and quality care to patients attending the hospital in an emergency as a result of a mismatch between capacity and demand – current score 16

Emergent risks/context/considerations

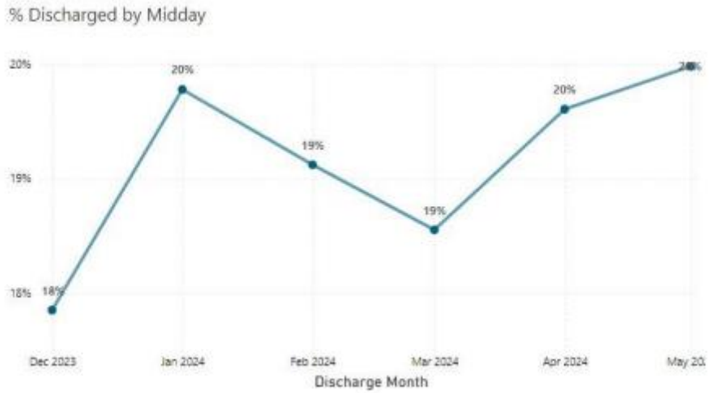
- Change to political landscape may result in differing national priorities and/or expectations
- Ongoing industrial action will continue to impact elective recovery
- Opportunities and implications of community services procurement to be mobilised in Q3/Q4
- Closer working across the BSW Acute Hospital Alliance including clinical and corporate service collaboration
- Lack of identified resources to deliver communication standards & customer care training – evolved into a patient experience quality account priority 2024/25

2024/25 deliverables – breakthrough objectives

Why not home? Why not now?
Reducing inpatient length of stay top 25% of acute trusts

A3 analysis in development, led by Associate Director of Operations to be complete July 2024

We are working with system partners to reduce the number of medically fit patients in hospital waiting to go home. We are also looking to improve processes and root cause analyses to better understand and address unnecessary lengths of stay.



2024/25 deliverables – strategic objectives (please also see sunray on next slide)

Delivered

- Dyson Cancer Centre opened in April 2024
- DrDoctor transitioning to business as usual
- AHA website proposal signed off
- Autism cards and sunflower lanyard scheme for hidden disabilities
- Maternity Outpatients environment improved
- Cath Lab Refurb complete
- New role introduced- Lead Nurse for Learning Disability
- Oliver McGowan Learning Disability and Autism training launched for all staff

In progress

- Quality Governance project initiated and steering group mobilised
- Patient Experience and Vulnerable People Strategies drafted and going through governance
- Paperless Inpatients go live Q2
- Atrium options appraisal in development
- One ICU works underway and on track
- Sulis Elective Orthopaedic Centre due to open in Q3/Q4
- Innovation and Improvement and Communication Strategies in development, to be completed Q2/Q3
- New website project underway
- Revised clinical strategy due back to Board of Directors in September

At risk

- Customer care training and communications standard project re-scoped- benefits to be delivered as a patient experience quality account priority for 2024/25
- Ward/IPC works project developed and ready to roll out when capital funding is available, however some improvement works have funding for this year including £100k investment into flooring and Infection Prevention Control (IPC) in clinical area and £50k into staff welfare facilities
- Transformation of community services is part of ongoing community services procurement discussions

The people we care for

Together, we will support you as and when you need us most

2024-25

- Quality Governance Project
- Infection control programme including estates plan – if funding is available
- Publish patient experience strategy & vulnerable person strategy
- Paperless inpatients
- Atrium options appraisal
- Improve signage to help people find their way around

2025-26

- Patient safety programme – year 3
- Integrated digital and health and social care systems
- Training and skills to work with different patient groups
- Infection control programme including estates plan
- Integrated digital and health and social care systems

- Care closer to home model established
- Alongside Midwifery Unit complete
- Collaborative relationship with primary care creating integrated models
- Integrated nursing home model with ART+
- Lower GI hub

- Patient portal with digital bookings

Connecting with you, helping you feel safe, cared about and always welcome

Clinical estate

- Dyson Cancer Centre, One ICU & DAU completion
- Sulis Elective Orthopaedic Centre
- Critical infrastructure risk reduction (fire safety)
- Outpatient & theatre transformation
- Further development of CDC
- Elective productivity
- Urgent emergency care improvement
- Innovation strategy
- Service integration with key community services

Cross-cutting strategies

- Research strategy
- Innovation strategy

- Further development of DrDoctor
- New website
- Patient representatives on all relevant forums
- Customer Care training & communication standards
- Real-time feedback phase 2
- Patient survey on discharge
- Communication strategy

Consistently delivering the highest quality healthcare and outcomes

Communicating well, listening and acting on what matters most to you

The people we work with

2024/25 progress (Q1)

Strategic Risks (Board Assurance Framework)

- 2.1 Failure to reduce levels and incidences of discrimination by managers against staff, based on race, ethnicity, religion, gender, sexuality or disability
- 2.2 The Trust could suffer significant staffing risks as a result of the limited supply of healthcare professionals in the national NHS workforce market
- 2.3 Failure to provide an open and transparent and safe culture could inhibit some staff from feeling able to 'speak up' and from highlighting concerns relating to patient care, staff safety and wellbeing
- 2.4 Failure to provide effective management and leadership development and succession planning
- 2.5 Failure to ensure strong linkages across from the People Plan to the Transformation Programme

Emergent risks/context/considerations

- Impact of Trust financial position necessitating actions such as workforce efficiencies, organisational change (including reviewing ways of working), and integrated trust models affecting staff experience and pace of delivery.
- Impact of current financial climate, in particular cost of living on the people we work with.
- Changes to the recruitment pathway for approval (vacancy panel) to control the establishment impacting on KPI outcomes for both managers and candidates.
- National rules about off framework agencies changes from July 2024 – any off framework usage requires CEO approval and external reporting.
- From April 2024, the changes to the UKV&I minimum salary means that we can only sponsor those who apply for roles who have at least 2 years of relevant experience at Band 3 and above.

2024/25 deliverables – breakthrough objectives

Discrimination
% of staff reporting they have experienced discrimination at work

This metric is measured through the percentage of staff reporting they have personally experienced discrimination at work from manager, team leader or colleague (annual measure through staff survey) This Trust result for 2023 is 8%.

The A3 is ongoing however a potential tracker measure will look at an increase in the number of staff feeling able to report abuse and harassment and could be recorded monthly or quarterly via the new report and support platform.

Making best use of available resources
Delivery of financial plan

Workforce efficiencies ahead of schedule to bring WTE used to within control total. A reduction of 59.4 WTE in April 2024 and 22.1 WTE for May 2024

Agency spend reduction: In May 2024, we spent 1.14% as a % of our pay bill on agency. This is below the national of target of 3.2% which has consistently been achieved by the Trust over the preceding quarter.

Enabling Breakthrough Goal: We "Improve Together" to make a difference

This work is measured by the adoption of tools, routines and behaviours of Improving Together via a quarterly maturity assessment

April 2024 maturity assessment for front line teams showed a 50% adoption rate of improvement huddles, with 25% of front line teams having priorities displayed on their performance board. Improving Together week took place in June 2024 to continue promotion and adoption rates. Next maturity assessment due in July 2024.

2024/25 deliverables – strategic objectives (please also see sunray on next slide)

Delivered

- Improving Together week took place 17th – 21st June 2024
- Improving Together leadership training for People Directorate, Pathology, and Divisional Directors of Nursing
- 9 additional Calderdale Facilitators trained May 2024
- 360 degree feedback now available in Learn Together appraisals
- Offering of EAP services expanded to now offer management referrals and alternative wellbeing assessment options to triage to appropriate advice
- Stress and burnout pilot completed and Trust wide roll out in action to support staff health and wellbeing
- Hidden disabilities sunflower scheme due to launch in the Trust shortly
- Inclusion champions launched

In progress

- Build of the digital people solution 'Halo' is underway with staged implementation in Q2/3.
- Training on new ways of working to enhance candidate experience and reduce pay errors ongoing and transitioning to business as usual.
- Workforce Dashboard has been deployed showing workforce information. This includes Pay and is updated and improved with plan to include forecasting.
- In July, the launch of the new preferred supplier list (PSL) for agency nursing will increase our price cap compliance.
- Two key projects – Report & Support and dignity at work will launch Summer 2024 and will support the ongoing culture work
- Anti-racism statement commitments actions underway
- Improving Together refresh training for Executive Team

At risk

- Anticipated resourcing challenges will likely have a direct impact for joy at work, dignity at work and Restorative Just and Learning Culture projects. Options being explored.
- Ongoing resourcing challenges have led to an alternative approach to leadership development programme. The People & Culture Team are working in partnership with the Coach House on a revised offering.

Demonstrating our shared values with kindness, civility and respect

2024/25

- People Plan – Programme 2 (Restorative Just and Learning Culture),
- Programme 3 (Employee Experience, incorporating Violence against Staff),
- Programme 6 – Wellbeing (incorporating burnout)
- Programme 10 – Talent Acquisition (incorporating new staff programme and employee value proposition)

2025/26

- People Plan – Programme 1 (Basics Matter year 2) Digital People Hub – easy to use, reduce pay errors, improved food offer, improved employee rest areas, residential accommodation, gym/health/wellbeing campus offer)
- Programme 5 – (Leadership development, change management training)
- Programme 7 (Learning and Development – competency frameworks and clinical skills).
- Programme 8 – Workforce Planning (apprenticeships and role definition / skill mix / career pathways, scope for growth).

- Evaluate impact of all People Plan Programmes and refresh

- Evaluate impact of all People Plan Programmes and refresh

- Evaluate impact of all People Plan Programmes and refresh

- People Plan Programme 4 – EDI
- Introduce cultural intelligence module,
- Continue positive action programme
- Race, Disability, Equality board development
- Develop and roll out ally-ship programme
- Improve reach and impact of Staff Networks
- Anti-Racist Organisation
- Flexible/Agile Working programme
- Commence Disability inclusive programme
- Race and disability pay gap analysis and actions

The people we work with

Together, we will create the conditions to perform at our best

Taking care of and investing in teams, training and facilities to maximise potential

Celebrating our diversity and passion to make a difference

The people in our community

2024/25 progress (Q1)

Strategic Risks (Board Assurance Framework)

- 3.1 Failure to deliver a viable financial plan – current score 16
- 3.2 Risk that Sulis Hospital us unable to achieve its agreed financial and operational targets – 16
- 3.3 Failure to target adequate resources to meet the health and care needs of those in the population we server who are in greatest need - 16
- 3.4 Failure to tackle the Trust maintenance backlog due to insufficient capital investment - 16
- 3.5 Failure to reduce the direct and indirect impact that the Trust's activities have on the environment – 15
- 3.6 Risk that due to a lack of funding the Trust fails to take advantage of opportunities to develop digital capabilities- 16
- 3.7 Cyber-security breaches, could result in an inability to use digital platforms - 16

Emergent risks/context/considerations

RUH contribution to system control total is deficit plan of £5.3m. This plan includes a £36.6m efficiency target. The key risks to achieving this are:

- Any QIPP delivered non-recurrently in 2023/24
- Run rates being above budgeted in 2023/24
- Ensuring fully identified and worked up schemes

- Capacity to progress partnership and strategic work at pace is limited

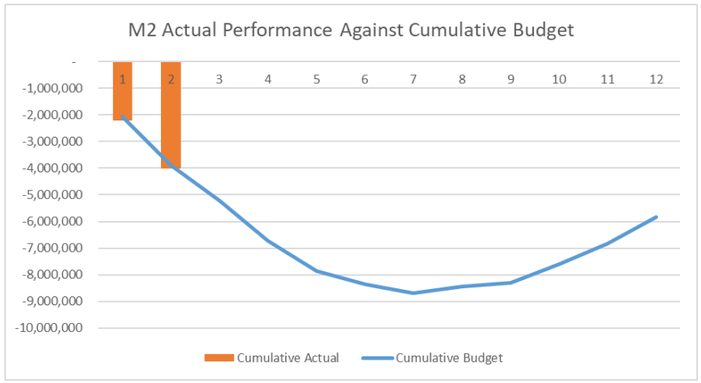
- Changes to political landscape

2024/25 deliverables – breakthrough objectives

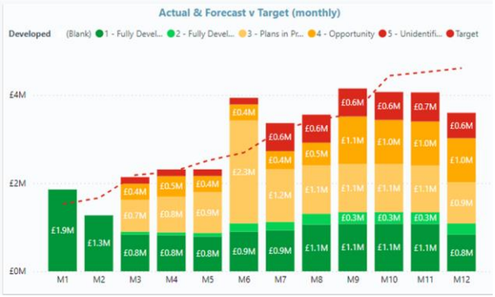
Making best use of available resources
Delivery of financial plan

Measured through delivery of financial plan (variance from plan)

At Month 2 a deficit position of £4.03 million which is £0.08 million adverse to plan.



We are working to improve our financial position through enhanced controls, transformation projects and cost saving via the improvement programme.



2024/25 deliverables – strategic objectives (please also see sunray on next slide)

Delivered

- £3.125m Improvement Programme savings delivered in by end of Month 2 2024/25
- BANES Civic Agreement published with Bath Spa University, University of Bath and BANES council
- Board Health Inequalities self-assessment undertaken
- Digital inclusion officers in place to support people in the community who are excluded from the digital offering at the Trust
- Health inequalities staff resources and training available on Trust Intranet
- Sustainability Day held April 2024 and Board level workshop
- Sustainability champions relaunched June 2024

In progress

- Ongoing work to deliver £36.6m efficiency target for 2024/25
- Health inequalities steering group mobilised
- Health inequalities Board reporting in development
- Anchor organisation strategy drafted – being socialised for feedback
- Community day planned for 21st September
- Community services procurement underway – contract award Q3
- AHA next steps model
- Sustainability Green Team Competition launching Q2
- Sustainability working groups set up in Theatres, Endoscopy and Radiology
- Sustainability Steering Group to be mobilised
- RUH Green Plan development

At risk

- Delivery of full savings programme – some schemes still to be fully detailed
- Workforce cost control forms 53% of overall improvement programme target. Good progress is being made however step change is required to meet the full target with risks around bank reduction and organisational redesign

Working with partners to make the most of shared resources to plan wisely for future needs

2024/25

- ICU plan delivered
- Innovative ideas shared
- Productivity improves further
- Clinical services plans commence
- Increased recurrent QIPP delivery
- Shared EPR
- Standard work
- Efficient Corporate services
- Maximise utilisation of community assets
- AHA transformation and joint planning
- Development of educational pathways with Wiltshire College

2025/26

- Innovative ideas shared across the Trust & TME
- Clinical services plan delivering savings
- Embedded opportunities to projects approach
- Deficit reduction

- Health inequalities programme – year 2
- Bespoke access of care
- Support vulnerable community members – Core20plus5
- Anchor organisation strategy & delivery plan

- Health inequalities programme – year 3
- Population health data integrated digital H&SC
- RUH as an anchor organisation
- Target areas for promoting careers

- De-carbonisation of buildings project – LED lighting, de-steam & fabric improvements
- Sustainability risk assessment embedded in decision-making
- Climate adaptation planning workstream established
- New provider for community services in place

- Decarbonisation of buildings project
- Carbon awareness & competency training programme & stakeholder engagement plan
- Sustainability risk assessment created
- Sustainability network established
- Community services procurement/mobilisation
- Continue to develop services off site

The people in our community

Together, we will create one of the healthiest places to live and work

Taking positive action to reduce health inequalities

Creating a community that promotes the wellbeing of our people and environment

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**22 July 2024**		
Title of Report:	**Non Clinical Governance Committee (NCGC) Upward Report – 25 June 2024**		
Status	**For Information/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 held on 25 June 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

- No items to raise this month.

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

1. The committee received a summary of the ambition set out by the Board in the seminar on 5 June but without clear plans on how progress could be made. The Chair has asked for these as it was agreed that they would come to July Board.
2. The committee received a digital upward report. The committee asked for greater detail on progress of the digital strategy and associated risks and mitigations.
3. Paperless inpatients is being rolled out on 12 August 24. Key issues identified were training, interoperability, productivity and clinical impact. As a result, the Clinical Safety Case was presented to Quality Assurance Committee in July.
4. Patien -Led Assessments of the Care Environment Summary report and score was presented. Even though scores are below the national average an action plan is being developed and the implementation of the recommendations from the external review of facilities (see below) should also have a positive impact on the score.
5. The Health and Safety report was presented. The committee requested a more strategic report to enable assurance to take place. The committee were assured that this was being progressed.
6. Annual Emergency Preparedness, Resilience and Response update was given. Good progress was made for such a small team however the committee has invited the team back to report on plans to embed best practice across the organisation (given the low uptake in training and limited business continuity plans) as a result of the increasing unstable environment (increased cyber security/ erratic weather etc.)
7. Estates Return Information Collection (ERIC) was presented however the full report will be presented at the next committee.

ASSURE: Inform the Board where positive assurance has been achieved

1. A comprehensive report was presented on Information Governance. The

committee gained assurance and in response to RUH Chair request for assurance on RUH's supply chain resilience for cyber security, a further report will be presented at the next committee on this. 2. An external peer review of facilities (undertaken by Salisbury Head of Facilities) was presented. The committee were assured by the robust review and recommendations and governance arrangements in place to oversee improvements.
RISK: Advise the Board which risks were discussed and if any new risks were identified
• Lack of capacity to progress environmental sustainability agenda.
CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding
• No items to raise this month.
APPROVALS: Decisions and Approvals made by the Committee
• No items to raise this month.

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:	**22 July 2024**		
Title of Report:	**Finance and Performance Committee – 25th June 2024**		
Status:	**For information**		
Author:	**Antony Durbacz, Chair of Finance and Performance Committee**		

Key Discussion Points and Matters to be escalated from the meeting held on 25/06/24

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

- No items to raise this month.

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

- The committee will have a joint meeting with the People Committee in July to ensure that we are consistent in our understanding of the issues and action plans.
- The Finance Team will consider creating a half year forecast.
- The Board Assurance Framework review considered the relevant risks and concluded that the reducing harm risk 1.2 should have actions identified to address the control gaps. Risk 3.1 financial risk needed to recognise that the real issue was the scale of the underlying risk.
- Both risks had a consistent theme which was the need to transform the culture to accommodate change.
- It was recognised that the Trust had gone into NHS tiering on its 28 day cancer performance. The issues around higher demand from increasing numbers of patients and the availability of diagnostic resource was discussed and the importance of the Community Diagnostic Centre.
- It was agreed that the team would sharpen up the focus on operational on trajectories for the operational performance and financial performance on variance to the run rate/budgeted cost base.

ASSURE: Inform the board where positive assurance has been achieved

- The Committee reviewed the Urgent and Emergency Care Plan, particularly the logical analysis of the problem. It was introduced to the 21 part plan which has short and long term actions to ensure ultimate compliance with best practice and national standards.
- The revised business plan was reviewed and noted.
- The committee reviewed the plan for divisional budgets which seeks to develop more ownership and accountability at the divisional level.
- The power of the underlying Business Warehouse and Patient Level Information and Costings methodology were powerfully demonstrated in identifying improvement opportunities.

RISK: Advise the board which risks where discussed and if any new risks were identified.
• No items to raise this month.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• The committee reviewed 2 “deep dives” on the urgent care plan and the use of Patient Level Information and Costings Systems to identify improvement opportunities. The presentations were of a commendable standard and provided assurance on the quality of thought supporting each initiative.
APPROVALS: Decisions and Approvals made by the Committee
• None.

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:	21
Date of Meeting:	22 July 2024		
Title of Report:	Audit & Risk Committee Upward Report – 20th June 2024		
Status:	For information		
Author:	Paul Fox		

Key Discussion Points and Matters to be escalated from the meeting held on 20th June 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

- See risk section below.

ASSURE: Inform the board where positive assurance has been achieved

- The Internal Audit Report on Corporate Risk Management achieved a rating of 'Significant Assurance with minor improvement opportunities': (Amber / Green).
- The Internal Audit Report on Budget Management achieved a rating of 'Significant Assurance with minor improvement opportunities': (Amber / Green).
- The Internal Audit review of the DSPT (Data Security and Protection Toolkit) achieved a rating of 'Significant Assurance with minor improvement opportunities': (Amber / Green).
- The Internal Audit overall opinion for 23/24 was 'Significant Assurance with minor improvement opportunities': (Amber / Green) in respect of the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

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

- The Committee received an Internal Audit Report on Risk Management, with two medium term priority findings:
  - Major risks (16+) many not always be reviewed and communicated sufficiently at TME and Divisional Governance Meetings
  - Discussion with Management identified that the risk management responsibilities at Board sub-committee level are out of date.

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

- The Committee thanked the finance team for their work in enabling the final accounts to be submitted on time, and with a satisfactory external audit opinion.

APPROVALS: Decisions and Approvals made by the Committee

- The Committee approved the Annual Report and Accounts, following delegation from the Board, subject only to the External Auditors being satisfied

that the Trust has sufficient arrangements for securing economy, efficiency and effectiveness in the use of its resources. The External Auditors subsequently (27th June) concluded that the above was the case, updated their ISA260 report, and hence the Annual Report and Accounts were approved, this being confirmed in off-line correspondence.

- The Committee approved the Letter of Representation
- The Committee agreed the statement in relation to Going Concern
- The Committee approved the 23/24 Internal Audit Annual Report
- The Committee approved the 23/24 Counter Fraud Annual Report
- The Committee approved the 24/25 Internal Audit Plan

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:**	**22**
Date of Meeting:	**22 July 2024**		
Title of Report:	**Charities Committee Upward Report – 16 May 2024**		
Status	**For Information/Discussion**		
Author	**Sumita Hutchison, Non-Executive Director and Chair of the Charities Committee**		

Key discussion points and matters to be escalated from the meeting held on 16 May 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

- No items to raise this month.

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

- No items to raise this month.

ASSURE: Inform the Board where positive assurance has been achieved

1. The charity's return on investment (ROI) was 4:1 which was above target.
2. An update was given on the completed restricted appeals which included intensive treatment unit (ITU) pendants, compassionate companions, neonatal intensive care unit (NICU) parent beds and parent shower and community wellbeing garden to name a few.
3. All costs for robotic surgery have been paid in full.
4. Recruitment for an increased senior leadership team was agreed to help the charity to deliver its objectives.
5. The League of Friends has made £200,000 available for grants and donations and has provided the Trust with 189 volunteers.
6. There are a number of events that non-executive directors can be involved with. They can be uplifting and enjoyable but also can bring in significant monies for the hospital.
7. In line with trusts strategy on sustainability, the committee is working with investors to ensure that the money is invested in line with environmental, social and governance (ESG) requirements.
8. The charitable objectives were expanded to include sustainability.
9. A PET CT fundraising campaign was approved.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- No items to raise this month.

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

1. The committee formally congratulated the RUHX team for their exception work with the Dyson Cancer Centre.
APPROVALS: Decisions and Approvals made by the Committee
• No items to raise this month.

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