Bundle Public Board of Directors 15 January 2025

0 Agenda
- 0.0 - DRAFT Public BoD Agenda Jan 25 v2.2 - 13.01.25

1 Chair's Welcome, Introductions, Apologies and Declarations of Interest
Alfredo Thompson

2 Written questions from the public

3 Minutes of the Board of Directors meeting held in Public on 6 November 2024
- 3.0 - DRAFT Public BoD Minutes Nov v1.6 - 15.01.25

4 Action Log
- 4.0 - Public BoD Action List Nov 24 v1.0 - 03.01.25

5 Governor Log of Assurance Questions and Responses (for information)
- 5.0 - Governor Log of Assurance Questions v1.0 - 09.01.25
- 5.1 - NED Assurance 2024 -v4.1 - 09.01.25

6 Items discussed at Private Board

7 Staff Story
- 7.0 - RUH_Board_cover_sheet Staff Story_

8 CEO and Chair's Report
- 8.0 - RUH CEO Public BoD Report 15.01.25 Final

9 Integrated Performance Report
- 9.0 - Public BoD IPR Cover Sheet
- 9.1 - Public BoD IPR slides
- 9.2 - Trust Scorecard November 24

10 MIS Combined Maternity and Neonates Quarterly Report Q2
- 10.0 - Combined Maternity and Neonatal Q2 report (Board)
- 10.1 - Insights mid-year review report Board
- 10.2 - TC and ATAIN Report Q2 2024 Board

11 Midwifery and Neonatal Bi-Annual Staffing Report
- 11.0 - Bi-annual staffing paper Jan-Jun 24 Board

12 Annual Nursing Establishment Review
- 12.0 - Annual Nursing Establishment review Board

13 Winter Update

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

15 Strategic Priorities Q3
- 15.0 - 202425 Q3 Quarterly Strategy Update Cover Sheet Final
- 15.1 - Q3 202425 strategy review Final (002)

16 Non-Clinical Governance Committee Upward Report

17 Charities Committee Upward Report and Terms of Reference for Ratification
- 17.0 - Charities ToR - 08.01.25

18 Audit and Risk Committee Upward Report
- 18.0 - Upward Report Audit Risk Ctte 121224

19 Board Assurance Framework Summary Report
- 19.0 - Board Assurance Framework Trust Board cover sheet
- 19.1 - Board Assurance Framework Summary January 2025

20 Any Other Business

Royal United Hospitals Bath
NHS Foundation Trust

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS OF THE ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST WEDNESDAY 15 JANUARY 2025, 13:00 – 16:00 VENUE: PAVILION FUNCTION ROOM, KINGSWOOD SCHOOL UPPER PLAYING FIELDS, BATH, BA1 9BH

Item	Item	Presenter	Enc.	For
OPENING BUSINESS				
1.	Chair's Welcome, Introductions, Apologies and Declarations of Interest: Alfredo Thompson	Alison Ryan, Chair	Verbal	-
2.	Written questions from the public		Enc.	I/D
3.	Minutes of the Board of Directors meeting held in public on 6 November 2024		Enc.	A
4.	Action Log		Enc.	A/D
5.	Governor Log of Assurance Questions and Responses (For Information)		Enc.	I
6.	Items discussed at Private Board		Verbal	I
7.	Staff Story	Toni Lynch Chief Nursing Officer	Pres.	I/D
8.	CEO and Chair's Report	Cara Charles-Barks, Chief Executive	Enc. / Verbal	I
9.	Integrated Performance Report	Andrew Hollowood, Interim Managing Director	Enc.	I/D
The People We Care For				
10.	MIS Combined Maternity and Neonates Quarterly Report Q2	Zita Martinez, Director of Midwifery / Claire Park, Obstetric Lead	Enc.	I/D
11.	Midwifery and Neonatal Bi-Annual Staffing Report	Zita Martinez, Director of Midwifery / Claire Park, Obstetric Lead	Enc.	I/D
12.	Annual Nursing Establishment Review	Toni Lynch, Chief Nursing Officer	Enc.	I/D
13.	Winter Update	Paran Govender, Chief Operating Officer	Verbal	I/D
The People We Work With				
14.	People Committee Upward Report	Paul Fairhurst, Non-Executive Director	Enc.	I/D
The People in Our Community				
15.	Strategic Priorities Q3	Joss Foster, Chief Strategic Officer	Enc.	I/D
16.	Non-Clinical Governance Committee Upward Report	Sumita Hutchison, Non-Executive Director	Verbal / Enc.	A/I

17.	Charities Committee Upward Report and Terms of Reference for Ratification	Sumita Hutchison, Non-Executive Director	Verbal / Enc.	A/I
18.	Audit and Risk Committee Upward Report	Paul Fox, Non-Executive Director	Enc.	I/D
Governance				
19.	Board Assurance Framework Summary Report	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	D
CLOSING BUSINESS				
20.	Any Other Business	Alison Ryan, Chair	Verbal	-
Date of Next Meeting: Wednesday 5 March 2025, 13:00 – 16:00 Pavilion Function Room, Kingswood School Upper Playing Fields, Bath, BA1 9BH				

Royal United Hospitals Bath
NHS Foundation Trust

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE PUBLIC BOARD OF DIRECTORS
WEDNESDAY, 6 NOVEMBER 2024, 13:00 – 16:00
VENUE: WHARF ROOM, WIDCOMBE SOCIAL CLUB, BATH, BA2 6AA

Present:

Members

Alison Ryan, Chair
Cara Charles-Barks, Chief Executive
Christopher Brooks-Daw, Chief of Staff
Paran Govender, Chief Operating Officer
Antony Durbacz, 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
Nigel Stevens, Non-Executive Director (joined via Teams until 14.45)
Alfredo Thompson, Chief People Officer
Andrew Hollowood, Managing Director
Paul Fairhurst, Non-Executive Director
Simon Harrod, Non-Executive Director

In attendance

Roxy Milbourne, Interim Head of Corporate Governance
Jason Lugg, Deputy Chief Nursing Officer (for item7)
Sharon Manhi, Lead for Patient Experience (for item 7)
Jo Baker, Associate Director for Vulnerable People (for item 7)
Sarah Thornell, Lead Nurse for Learning Disabilities and Autism (for item 7)
Zita Martinez, Director of Midwifery for Family and Specialist Services (item10)
Clare Park, Obstetric Lead (item 10)
Katie McClean, Executive Assistant *(minute taker)*
Lucy Kearney, Head of Communications
Public Governors

BD/24/11/01 Chair's Welcome, Introductions, Apologies and Declarations of Interest:

The Chair welcomed everyone to the meeting, and confirmed that no apologies had been received. Simon Harrod, Non-Executive Director was welcomed to his first Public Board meeting.

BD/24/11/02 Written questions from the public

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

BD/24/11/03 Minutes of the Board of Directors meeting held in public on 4 September 2024

The minutes of the meeting held on 4 September 2024 were approved as a true and accurate record.

BD/24/11/04 Action List and Matters Arising

The actions presented for closure were approved, the following actions were discussed further:

BD603: The Managing Director discussed the Histopathology waiting list and confirmed that demand was continuing to rise and that Biomedical Scientists were being trained to report on the less complex slides. Progress would be followed up through the Medicine Performance Review Meeting, it was agreed that the action could be closed.

BD607: It was confirmed that the Patient Experience Strategy was undergoing a review and would return to Board in due course. It was agreed that this action could be closed.

BD/24/11/05 Governor Log of Assurance Questions and Responses

The Chair noted that the log of assurance questions was on the agenda for information. She confirmed that three new questions, SEPT24.1, SEPT24.2 and OCT24.1, had been raised since the last report in September 2024. These related to the results of an independent review of facilities, specifically in relation to the Trust Security Team, the group model and the benchmarking and investigation of critical incidents. The questions had been sent to the relevant members of the Board and Nigel Stevens, Non-Executive Director had provided a response to SEPT24.2 which was detailed in appendix 1. The relevant Board members were in the process of formulating a response to the remaining questions and this would be circulated to the Council of Governors in due course. The Board of Directors noted the update.

BD/24/11/06 Item Discussed at Private Board of Directors meeting.

Th Chair provided an overview of the topics discussed at the Private Board of Directors meeting, these were highlighted as;

- The impact on the staff/patients of the contract for Community Services being awarded to HCRG.
- The Trust was working with Wiltshire Health and Care who were impacted by the Community services contract change.
- Challenges in the financial and performance situation.

BD/24/11/07 Patient Story

The Chair welcomed the Deputy Chief Nursing Officer, Lead for Patient Experience, Associate Director for Vulnerable People and Lead Nurse for Learning Disabilities and Autism to the meeting to present the patient story.

The story told the experience of Oliver and his mother Kim. Oliver was a 9 year old Autistic boy who had been behaving dramatically out of character, this was only improved with the use of paracetamol. After 5 days with no improvement Kim took Oliver to A&E, where Oliver was examined as much as possible, he was admitted and it was suggested that further examinations should take place in the morning. Blood results came back negative for infection and Doctors were unsure on where to scan Oliver as he was non-verbal. Doctors did not check in Olivers ears or mouth and Kim was left feeling like no one believed her. Oliver was discharged home and by chance Oliver yawned and his mother was able to see that he had a rotten tooth at the back of his mouth. Kim was told that the wait for treatment would be 12 weeks and nothing could be done any sooner, which felt like an incredibly long time to try and manage the pain for Oliver. Following a review Oliver was given an appointment a few days later and the tooth was removed. It was felt that reasonable

adjustments needed to be made for those patients who would find waiting that length of time too difficult.

The Deputy Chief Nursing Officer highlighted that the Trust planned to use the video in future learning and development activities to show the significant challenge that patients with disabilities faced and the difference that could be made by listening to the patients and their family/carers.

Sumita Hutchison sought clarity on whether more things could be put in place to improve the experience of patients with disabilities. The Lead Nurse for Learning Disabilities and Autism highlighted that there were a multitude of things that could help make a difference, there was a new digital flag system being implemented which would provide clinicians with more patient information. The Chief Operating Officer confirmed that this digital flag would also help prioritise these patients on the waiting list.

Paul Fairhurst referred to the reasonable adjustments in the Equality Act and questioned to what extent the obligations under the act required the Trust to change the approach to services. The Lead Nurse for Learning Disabilities and Autism highlighted that the Trust was making sure that care was accessible and that a person with a learning disability should receive the same care as someone without a disability.

The Managing Director highlighted the importance of escalating people up the waiting list, but suggested that there was a group to really discuss what conditions should be prioritised.

The Board thanked the Patient Experience Team, Oliver and his mother for such an informative and emotive story.

BD/24/11/08 CEO and Chair's Report including ICS Update

The Chief Executive presented the report and highlighted;

- The CQC had undertaken an unannounced assessment of Surgical Services, they visited three wards: Forrester Brown, Pulteney and Philip Yeoman. The overall rating for Surgical Services was good. The Trust was awaiting the publication of the final report, which would be shared once available.
- Lord Darzis review into the NHS highlighted many of the challenges being faced. The review reinforced the need to focus on recognising where parts of the system were getting things right, where they were working well, and how to spread best practice.
- Government Issues Rallying Cry to the Nation to Help Fix NHS, members of the public as well as NHS staff and experts were invited to share their experiences, views and ideas for fixing the NHS.
- Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Board publicly announced that from the 1st April 2025 community healthcare across the system would be provided by HCRG Care Group.
- Her Majesty the Queen officially opened the Dyson Cancer Centre at the Royal United Hospitals Bath (RUH) NHS Foundation Trust on the 3rd September 2024.
- Following a comprehensive process, the Royal United Hospitals Bath was successfully reaccredited as a Veteran Aware Trust.
- The Trust had received the results of the CQC Adult Inpatient Survey 2023, these showed continual improvement in inpatient experience.

- The Chief People Officer and Chief Nurse received a collective grievance on the 8th October 2024 regarding the unpaid breaks implementation and the Trust is currently considering its response.

The Chair announced that Cara Charles-Barks had been appointed as the new Joint Chief Executive Officer at Great Western Hospital, Royal United Hospitals Bath and Salisbury NHS Foundation Trust. Cara would become accountable officer at each of the three Trusts from the 1st November 2024. This appointment followed a decision by the three Trust Boards earlier this year to establish a group model, which would deliver better outcomes for the population we serve. Cara would be supported at each Trust by a Managing Director, who would be responsible for the day-to-day leadership at each site, working alongside the executive team. At the RUH, the Interim Managing Director would be Andrew Hollowood.

The Board of Directors noted the update.

BD/24/11/09 Integrated Performance Report

The Chief Operating Officer presented the report and highlighted:

- The financial position continued to be challenging, the RUH annual plan was breakeven, following allocation of £5.3m deficit support funding from NHSE. This position 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 4 hour performance for September was 63.6%.
- Further reduction was needed in length of stay and non-criteria to reside and the Trust was working with system partners to reduce these.
- 62 day cancer performance was 70.1% which was above target but below trajectory.
- 28 day cancer performance had improved but the Trust remained in NHSE tier 2.
- Appraisal rates remained a challenge at 80%.
- One fall had occurred which resulted in moderate harm.
- 11 cases of C.Diff were reported in August.

Antony Durbacz stated that the Trust needed to consider maximising capacity and utilisation of the Trust's assets when focussing on the 28 day cancer diagnostics. The Chief Operating Officer confirmed that there were capital restrictions which needed to be considered too.

The Managing Director stated that there was limited scope to modernise Dermatology with telemedicine but Marc Atkins was working across BSW on this and there was a plan to roll it out over the next 12-18 months. It was stated that there was inconsistent access to Gastroenterology across the three sites for various reasons. The Trust was struggling with faster diagnosis but were receiving support from Sulis to address this.

Paul Fairhurst highlighted that the non-criteria to reside figure seemed to have remained at the same level for some time with no progress seen in Wiltshire, he questioned whether as a result of this the assumptions made in the winter plan were still possible. The Chief Operating Officer confirmed that mapping had been completed for those patients that were within the Trust's control, but that the majority of the patients did require a system solution.

Paul Fairhurst shared his concern on staff vacancies, as within the report there were several references to staffing levels as a cause of breaches, he questioned whether there was any indication that the pay bill reduction programme would adversely impact this further. The Chief Nurse stated that there was funding committed to Paediatric Nursing but the Trust was having problems filling the posts, it was not due to the vacancy controls.

Sumita Hutchison asked whether there was any correlation between early discharges and patients being readmitted, the Managing Director confirmed data was being collected on this but early indications show that where the length of stay was reduced the readmission level had increased. The Chief Executive stated that there was a fine risk balance but there was an opportunity to improve on patients staying 7-13 days as the RUH was a current outlier. Sumita Hutchison suggested that it would be helpful to see the impact on the length of stay on readmission rates.

The Board of Directors noted the update.

BD/24/11/10 MIS Combined Maternity and Neonates Quarterly Report Q1

The Director of Midwifery and Obstetric Lead provided an overview of the Maternity and Neonates Quarterly report and highlighted:

- Vacancies were held over the summer to provide roles for the students once qualified.
- There had been no poor perinatal outcomes in month.
- Positive Maternity Incentive Scheme position.

The Obstetric lead highlighted that the Trusts average still birth rate had increased to 2.38 per 1000 births, this was still below the national average. There had been no learning outcomes from these.

The Board discussed the data for still birth rates for women of black and Asian ethnicities under RUH maternity care, but due to small values within the stillbirth cohort it was not possible to determine whether there was a link and that a bigger cohort would be required.

The Chief Executive questioned how the RUH shared its learning with the other Maternity Units in BSW, the Director of Midwifery confirmed there were safety groups where data was shared.

The Managing Director questioned whether more data was required or whether the Trust was satisfied with the information provided. The Obstetrician Lead confirmed that the robust investigations already undertaken should be enough.

The Director of Midwifery reported that 3 key priorities were part of the insights work, one was how informed consent was documented, this was currently processed through handwritten documentation but would be documented through Badgernet once this system had been implemented.

The Board of Directors noted the update.

BD/24/11/11 Safe Working Hours Guardian Annual Report

The Managing Director provided an overview of the safe working hours guardian annual report and confirmed that Mr Lukuman Gbadamoshi was relinquishing his post after 4 years, the Board expressed their thanks to him for his hard work. Mr Gbadamoshi continued to drive awareness, and as a result there had been a reduction in the number of exception reports relating to longer working hours.

The Board of Directors noted the update.

BD/24/11/13 Quality Assurance Committee Upward Report

Hannah Morley reported that the Committee had discussed non criteria to reside numbers and ambulance delays. It was noted that work was progressing in patient experience and highlighted that there were new risks to be considered around paediatrics and mental health, work was ongoing to review what additional oversight was needed. The Board of Directors noted the update.

BD/24/11/14 People Committee Upward Report

Paul Fairhurst reported that the Committee had discussed the pay cost reduction and the remarkable progress made to date. The People Directorate were under ongoing monitoring but were fit for purpose, given the scope and scale of changes approaching through the Group model, a full review of the People Plan was required. The Board of Directors noted the update.

BD/24/11/15 Emergency Preparedness, Resilience and Response Annual Report

The Chief Operating Officer reported that the EPRR report was an annual requirement and supported the Trusts compliance, the Trust had previously been unable to achieve full compliance, but had completed the annual assessment this year and were now fully compliant. A risk was identified that due to the Trust being a category 1 responder it was expected to deal with chemical, radiological and nuclear acts which required hazmat training. Training compliance on this was below target, this was challenged due to being unable to release the staff to do this. This risk was recorded on the risk register. The Board of Directors noted the update.

BD/24/11/16 Darzi Report – Independent Investigation of the NHS in England

A rapid review 'Independent Investigation of the National Health Service in England', was commissioned from Lord Ara Darzi in July by the new Secretary of State for Health and Social Care. Whilst concluding that the core principles of the NHS remained compelling, its findings were sobering regarding the changes and challenges faced over the last 10 years and the requirement for reform to address the "critical condition" the NHS currently finds itself in. The Chief Executive confirmed she had been working with the Chief Strategic Officer to identify areas for joint working. The Board of Directors noted the update.

BD/24/11/17 Strategic Priorities Q2

The Chief Strategic Officer set out progress made in quarter 2 towards the delivery of the Trusts You Matter Strategy, including risks and progress made against breakthrough goals. Overall good progress had been made towards delivery of the strategy with a number of workstreams being established to address and monitor driver measures. There had been four new shifts during quarter 2, these were identified as:

1. Darzi report
2. Reaching financial balance

3. Community services
4. Group model changes

Improvements had been seen on sustainability and a number of items were progressing in IT.

Paul Fairhurst stated that under the people we work with was a break through objective on discrimination related to disability, but stated that he had not seen any progress on this. The Chief People Officer confirmed it was on the agenda to be discussed at the next People Committee.

The Board of Directors noted the update.

BD/24/11/18 Non-Clinical Governance Committee Upward Report

Sumita Hutchison reported that the Committee had reviewed the report on the Electronic patient record and discussed that NCGC would be the correct area for governance of the EPR. The Committee received a paper on cyber security and the Trusts' supply chain. Whilst there was an audit process for procurement, there was an inherent risk with cyber and supply chain which could never be fully mitigated. Of the eight risks the NCGC held, seven related to digital. The Committee were assured that several of these risks would be downgraded, thus not being included in the risk register due to controls/ mitigation or a change in the way the risk was scored. The Board of Directors noted the update.

BD/24/11/19 Charities Committee Upward Report

Sumita Hutchison reported that the Committee had discussed the impact on RUHX from the tightening of the capital position, one area identified was the Green Heart as the Trust was due to part fund this but this was no longer looking likely, possible mitigations were being investigated.

RUHX had invited the Non-Executive Directors to attend the RUHX 25th thank you event on the 29th November. The Board of Directors noted the update.

BD/24/11/20 Finance and Performance Committee Upward Report

Antony Durbacz reported that the Committee discussed the challenging financial position, the high risk on some key operational metrics. The plan was scrutinised which identified some opportunities but also risk. The Committee had received a joint paper from the three Chief Finance Officers in BSW which was looking at 25/26 and the movement towards a breakeven position. The Committee endorsed the decision to move away from the existing financial position to another, becoming consistent across the three organisations. The Board of Directors noted the report.

BD/24/11/21 Audit and Risk Committee Upward Report and Terms of Reference for Approval

Paul Fox reported that the Committee discussed the national cost collection for 23/24 which appeared to highlight a future increase in unit cost, within the total there was significant variation, it was suggested that this was considered further by the Finance and Performance Committee.

The External Auditors recommend that the Trust review whether an overarching governance framework was needed for the deployment and operation of Artificial Intelligence. It was suggested that this would be considered by Non Clinical Governance

Committee. The Chief Finance Officer confirmed that there was a steering group that would report into Trust Management Executive and Non Clinical Governance Committee.

It was raised that the overtime calculation was not standard, and suggested that the People team reviewed this. Paul Fox suggested that steps should be taken to harmonise this. The Chief People Officer agreed to take this discussion off line.

The Chief Executive suggested that audit alignment should be considered between the three Trusts. Paul Fox confirmed it had been discussed with the auditors and they agreed that it would be possible to align some areas.

Paul Fox suggested that the Terms of Reference were not clear with regards to the membership of the Committee and which Executive Directors were members. The Interim Head of Corporate Governance confirmed that a Board's Audit Committee should be made up of independent, Non-Executive Directors only and any Executive's would not be members but "in attendance". She confirmed that there was a line within the membership section to confirm this.

Paul Fairhurst raised that the Terms of Reference still contained a reference to the Quality Governance Committee. The Interim Head of Corporate Governance confirmed that she would update this. The Board of Directors approved the terms of reference subject to this amendment.

BD/24/09/22 Subsidiary Oversight Committee Terms of Reference for Approval

The Interim Head of Corporate Governance provided an overview of the Subsidiary Oversight Committee Terms of Reference and highlighted that there had been minor changes to membership, frequency and secretariat function which had been approved by the Committee. The Board of Directors approved the Terms of Reference.

BD/24/11/23 Any Other Business

The Chief Finance Officer stated that there had been a significant uplift in the capital budget with reference to elective, diagnostics, digital, and backlog maintenance. The Chief Executive suggested a refresh on the capital requirement across BSW, to ensure that all Boards were supportive.

The Meeting closed at 15:45

DRAFT

Royal United Hospitals Bath
NHS Foundation Trust

Agenda Item: 4

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY, 6 NOVEMBER 2024

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB608	There are no open actions following the last meeting.					

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**5**
Date of Meeting:	**6 November 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 November 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.

No new questions have been raised since the last report was presented in November 2024. Three questions remained open following the last report, SEPT 24.1, SEPT24.2, and OCT24.1, and full responses have since been provided by Nigel Stevens, Non-Executive Director, Toni Lynch, Chief Nursing Officer, and Paran Govender, Chief Operating Officer. Each response is detailed in appendix 1, and all three questions were closed at the Council of Governors meeting on 10 December 2024.

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

November 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:	**20th October 2024**
Source Channel	**Email from Public Governor**
Date Sent & Responder	22nd October to Paran Govender
Question and ID	**Oct24.1** To what extent are the frequency and duration of declared Critical Incidents benchmarked against those in other Trusts? What action is being taken to fully understand most probable if not actual causes of such incidents and consequently are best practice mitigating actions used in other Trusts considered?
Process / Action	Receipt of email confirmed: 22/10/24 Deadline for final submission: 08/11/24 Response recived from Paran on the 8th November 2024. Sent to the Governors on the 8th November 2024
Answer	The full response was shared with the Governors on the 8th November 2024. The response included a definition of a Critical Incident, the dates of when criticals have occurred in the last 12 months at the RUH, National Statistics and Critical Incident for Operational Pressures. The response also included looking at lessons learned from declared critical incidents.
Closed?	Closed at the Council of Governors meeting on 10 December 2024.

Royal United Hospitals Bath
NHS Foundation Trust

Appendix 1: Governor Log of Assurance Questions

Date:	**19th September 2024**
Source Channel	**Email from Staff Governor**
Date Sent & Responder	19th September 2024 to Jamie Caulfield and Toni Lynch
Question and ID	**Sept24.1** Further to an assurance question sent in April regarding security, it was said that an independent review was going to take place and outcomes would be reviewed by NCGC. We have now had a follow up to ask what the outcomes were and if they state that we have a safe number of trained security staff on shift to cover the entirety of the hospital.
Process / Action	Receipt of email confirmed: 09/10/24 Deadline for final submission: 25/10/2024 Response received from Toni on 18/11/2024 sent to Governors 21/11/2024
Answer	The independent review has indeed taken place, and we are currently awaiting the formal output of this review, which we expect to be circulated imminently. In addition to this, we have had a proposal approved to increase the number of security officers from 10 to 15. This increase means that there will be an additional security officer on site at all times, our current minimum staffing level is two on shift, this would increase to a minimum of three on a shift, enhancing our coverage and ensuring a safer environment. We are actively recruiting for these additional 5 security officers to ensure we meet this new staffing level.
Closed?	Closed at the Council of Governors meeting on 10 December 2024.

Date:	**30th September 2024**
Source Channel	**Email from Public Governor**
Date Sent & Responder	8th October to all NEDs
Question and ID	**Sept24.2** The recent independent report into the benefits of the Group model identified both improvements to patient care and financial benefits (cost efficiencies) would result. To what extent have the non-executive Directors had clarity over the scale and financial value of the cost benefits potentially derived from synergy opportunities and what processes are in place to provide them assurance on accurately measuring these benefits?
Process / Action	Response received from Nigel Stevens on 29th October 2024. Sent to all Governors on 30th October 2024.
Answer	Throughout the discussions and process leading to the creation of a Group model, the NEDs have been closely engaged through boards, briefings from the ICS leaders and other key stakeholders. Critically, the Carnell Farrer report was commissioned to provide an independent analysis of the potential opportunities presented by a Group model approach. This report provided an unequivocal case for the approach and quantified savings possible. As the new structures are developed, an important objective is to ensure mechanisms are in place to track benefits available and delivered.
Closed?	Closed at the Council of Governors meeting on 10 December 2024.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**15 January 2024**		

Title of Report:	**Staff Story**
Status:	**For discussion**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Simon Andrews, Associate Chief Nurse Workforce and Education**
Appendices	**None**

1. Executive Summary of the Report

NHS England's Long Term Workforce Plan prioritises apprenticeships as a valuable route to developing and retaining the workforce. Evidence from the Department of Education (DfE 2022) identifies that apprentices studying through to the degree apprenticeship route are the most satisfied (91%) and 80% continue to work for the same employer on completion of their apprenticeship. The Trust has a good proven record in recruiting to apprenticeship posts and it has proved to be a value recruitment pipeline for our local community.

Student Nurse Associate Apprenticeship

The Student Nurse Associate Apprenticeship provides a career route for healthcare support workers (HCSW) to undertake a 2 year programme to become a Registered Nurse Associate, registered with the Nursing and Midwifery Council (NMC). The programme consists of clinical placements and education provider theoretical learning. The apprenticeship requires 40% supernumerary training which consists of external and internal opportunities.

Registered Nurse Degree Apprenticeship

The Registered Nurse Associates at the RUH have an option to undertake a further 18 month to 2 year Registered Nurse Degree Apprenticeship with a higher education provider. This consists of a combination of clinical and theoretical learning and successful candidates register with the Nursing and Midwifery Council as a Registered Nurse.

Both apprenticeship programmes have a robust support package focussed on clinical skills and pastoral care from the Clinical Practice Facilitators.

The purpose of presentation is to:

- Provide a personal account apprenticeship career development within the organisation
- Highlights the impact of staff development and experience
- Highlights the impact of supporting staff to achieve their career aspirations and the impact this has on our patients, teams and community.

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

3.	Legal / Regulatory Implications
CQC regulation 18: staffing.	

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

5.	Resources Implications (Financial / staffing)
The apprenticeship levy funds the cost of the training and assessment (circa £15k per apprentice). The Trust pays the full-time salary of nursing staff on the apprenticeship programmes usually as a cost pressure at band 3 (40% of hours) or band 4 (approx. 25hours)	

6.	Equality and Diversity
n/a	

7.	References to previous reports/Next steps
None.	

8.	Freedom of Information
Public	

9.	Sustainability
n/a	

10.	Digital
n/a	

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**8**
Date of Meeting:	**15 January 2025**		
Title of Report:	**Chief Executive Officer Report**		
Status:	**For Information**		
Board Sponsor:	**Cara Charles-Barks, Chief Executive Officer**		
Author:	**Helen Perkins, Senior Executive Assistant to Chair and Chief Executive / Stephanie Spottiswood, Executive Assistant**		
Appendices	**Appendix 1: CEO Report**		

1. Executive Summary of the Report

The purpose of the Chief Executive's Report is to provide a summary of key concerns and highlight these to the Board of Directors.

Updates included in this report are:

Chief Executive's Report

- Happy New Year
- Pressure on our Services
- NHS Planning Guidance:
- Group Development

Chair's Report

Local (RUH)

- Operational
- Finance
- 2024 Urgent and Emergency Care (UEC) Survey
- Intensive Care Unit (ICU)
- Dyson Cancer Centre Award Finalists
- Princess Anne Wing (PAW) Building Improvement Project
- RUH's Lead Chaplain appointed Deputy Lieutenant for Somerset
- Hospital refurbishments create a more welcoming environment for young patients
- A blooming brilliant Christmas at the RUH
- 2024 Nursing and Midwifery Awards
- Care Quality Commission (CQC) 2024 Maternity Survey
- Friends of the RUH Prepare for a Colourful Spring
- RUH Membership
- New Stakeholder Governor
- Consultant Appointments

2. Recommendations (Note, Approve, Discuss)

The Board is asked to note the report.

3. Legal / Regulatory Implications

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

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
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)
A significant amount of time is being taken by the Improvement Team to support the recovery programme.	

6.	Equality and Diversity
Recovery actions for the financial position are being overseen by the Improvement Programme Steering Group (IPSG) to ensure the impact on clinical services is considered. As part of the development of new Projects, a Quality & Equality Impact Assessment (QEIA) is completed. QEIAs undergo an Executive lead panel review prior to a project being approved to commence. The impact on health inequalities is also considered as part of this process.	

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

8.	Freedom of Information
Private	

9.	Sustainability
Further opportunities to improve sustainability should be pursued to contribute towards the Finance Improvement Programme.	

10.	Digital
Several projects within the Improvement Programme and the development of the Quality Management System will be reliant on digital solutions. There will also be elements of the Digital Strategy that will have a direct link into the Improvement Programme.	

Chief Executive Officer's Report & Chairs Report

Chief Executive's Report

1 Happy New Year

I would like to take this opportunity to wish you all a Happy New Year. I am very excited about the year ahead, knowing that we will all embrace and face the challenges ahead together.

2 Pressure on our Services

The end of 2024 represented an incredibly busy time in the NHS. As we enter 2025, we continue to face significant pressure on our services. This is linked to an increase in the flu and other winter viruses - norovirus and RSV, (Respiratory Syncytial Virus). Our primary focus has been on managing winter escalation and maintaining patient safety. I would like to thank all of our dedicated colleagues for their ongoing commitment to providing outstanding services.

3 NHS Planning Guidance:

We await the NHS Planning Guidance 2025/26 that has been delayed, with Trusts being informed that it will be released in the New Year.

We expect that the guidance will focus on the 4 key priorities of:

- Reducing waits for elective care (18 weeks)
- Improving A&E and ambulance times
- Improving access to primary care and dental
- Mental Healthcare

Our preparation for the release of the guidance is progressing, with finalised plans required end of March 2025. Plans will have Board to Board sign-off, concentrating on reducing unwarranted variation and strongly focusing on productivity.

4 Group Development

With the Christmas period since the last update on Group development, we remain in the early stages. Having said that, on my first day back after the Christmas break, I spent time with colleagues to map key things that we want to achieve over the next 12 months. This covered topics from the core basics through to overarching and guiding strategies. I look forward to updating and sharing with you over the coming months as we embrace the opportunities that working and learning together provides us.

Support to help us move to a new way of working is crucial. As such, we are presently going through a tender process to engage external support to provide additional capacity and resource. Once completed, I will update you on the outcome. Additionally, Browne Jacobson, a law firm with comprehensive experience working with healthcare organisations, are undertaking developmental work with all of our Non-Executive Directors and Governors across the Group. Non-Executive Directors and Governors have a crucial

role and we want to make sure that we support and enable them to support the ongoing decision making and development of the Group.

Chair's Report

In addition to normal duties, in particular recruiting Consultants, I had the pleasure of joining celebrations of the Nursing and Midwifery awards, RUHX annual celebration of donors, and the Volunteer Xmas party.

I took part in a one-day seminar of SW NHS Leaders looking at the 10 year plan to achieve the Governments "three shifts" for the NHS:

- Hospital to Community
- Sickness to Prevention
- Analog to Digital

I met with each of the Non-Executive Directors (NEDs) for their six month reviews and we will be looking with Group partners at a practical way of recruiting new NEDs in future so we get the benefits of overlapping working at Board level and an alignment of governance structures.

The Board and Governors shared a planning day looking at the challenges for 2025/26 and determining the key business objectives. The Council of Governors had an interesting meeting the day afterwards, in particular looking at the new Community Contract and also our plans for decarbonising the Combe Park site. We welcomed Professor Deborah Wilson as the new stakeholder Governor for Bath University.

As Chair of the Organ Donation Committee and also Regional Chair for Organ Donation I took part in the recruitment of the new Clinical Lead for Organ Donation – a post funded by NHS Blood and Transplant. Dr Sophia Henderson was appointed and will step into the very big space left by Dr Kim Gupta whose enthusiasm and efficiency over the last fifteen years has made the RUH one of the most effective hospitals in the country identifying and supporting opportunities for organ donation.

Finally, the new community contract means that Wiltshire Health and Care will no longer have a role and as Chair of the Members Board unravelling the implications for staff and patients is taking a great deal of time.

Local

1 Operational

Critical Incident

On Thursday 12 December the Trust declared Level 1 Critical Incident following sustained high patient acuity and occupancy over preceding 72 hours. Demand for ICU was exceeding the ICU footprint requiring the use of Theatre Recovery. Formal ICU escalation (CRITCON Level 2) was declared. In addition, there was a high demand for specialist capacity. All available bed capacity was full including cohort spaces for admissions to support ambulance offloading, and designated escalation capacity was all in use. There

was increased acuity in December 2024 compared to December 2023, and higher number of attendances going through Majors ED (3,964 in Dec 2024 compared with 3,514 in December 2023 – an extra 14.5 patients per day).

Despite concerted efforts, on Tuesday 17 December this was elevated to a Level 2 incident, in recognition that we needed additional support from the wider system to reduce the number of non-criteria to reside patients, thus freeing up some acute beds to support us to continue to deliver safe and effective care.
We stood down the critical incident on Thursday 19 December

Ambulance Handover

In November, the Trust lost a total of 2,872 hours in ambulance handovers, an increase from the previous month (2,667). The percentage of ambulance handovers completed within 30 minutes decreased for November to 29% compared to previous month (31%) against the national standard of 95%.

A new SWAST 'immediate release' [at 75 minutes from arrival] Timely Handover Process (THP) and Standard Operating Procedure called W75 commenced in principle across BSW on the 20th November 2024. Preparation was undertaken for implementation on 6th December, with implementation of the pathway from 16th December. This has been supported by the opening of cohort areas in order to offload ambulances in a timely way.

4 Hour Performance

There has been a steady decline in 4-hour performance over the past 3 months (~7%) across all front door areas.

RUH 4-hour performance in November was 65.2% (including MIUs) and 56.2% on the RUH footprint, a deterioration from October. Non-admitted performance was 67.6% which is a decrease from the performance for September (69.5%). Admitted performance was 28.7% which was also a deterioration from September (33.8%). Higher attendances noted in month with an increase in admissions in December.

Bed occupancy has increased over the past 3 months from 93.41% in September 2024 to 96.73% in November. Occupancy has been affected by IPC restrictions, following the trend in November. At the start of December 13.8% of beds were affected by IPC rising to 21.6% (1 in 5 beds) on the 30th of December. In addition, patients presenting to the Emergency Department are of higher acuity and complexity.

Non-Criteria to Reside

November NCTR position is 97.1 against a trajectory of 61. This has had a direct impact on flow within the hospital. Significant focus on system partner calls and support continues, with BSW ICS leading weekday calls at 15:00 to review all patients without criteria and identify blocks to discharge.

Referral to Treatment

In November 2024, the Trust had 524 patients waiting > 52 weeks, a decrease of 9% from October. For waiters > 65 weeks, the Trust also saw a decrease in November from 22 to 18 patients. There were 2 patients waiting > 78 weeks at the end of November (same as October) for Paeds T&O. For waiters > 52 weeks, the three largest specialties combined represent two thirds of the waiters. These are ENT, Gastroenterology and Trauma & Orthopaedics.

Elective Recovery

M7 delivered 110% of planned activity when compared to 2019/20 across both admitted and non-admitted settings, and 109% of the Trust income plan. This equates to an additional 380 admissions and 1700 outpatient appointments. There have been opportunities identified to ensure we are securing the income for all the procedures completed in outpatient appointments. The Trust has delivered financial performance year-to-date of 128% of 19/20 and 107% of our 24/25 plan, in ERF. This has delivered a surplus of £4.4m year-to-date.

Cancer

28 Day performance in November was 71.5%, marginally lower than October but remaining above the NHSE tiering threshold of 70%. Colorectal remains the most challenged specialty due to the waiting time for Gastroenterology appointments and the lack of clarity in endoscopy reports regarding whether the pathway has stopped. Breast and Urology both saw a drop in performance, impacting the Trust-level recovery. In Breast the long term sickness of a consultant surgeon and consultant radiographer has led to increasing waiting times for outpatient and imaging appointments. Urology continues to be impacted by the waiting time for LATP biopsy due to a nursing capacity deficit.

62 Day performance improved in November to 64.5% but remained under the national 70% target. Breast deteriorated due to the staff sickness coupled with increased diagnoses of cancer seen over summer. Colorectal is consistently challenged due to outpatient waiting times alongside patients requiring more and complex investigations.

Urology performance improved considerably although LATP capacity a consistent challenge to delivery of the target. Head & Neck had a significant, short-term deterioration in performance with a large number of patients requiring oncological treatment. Performance against both standards in December is on course to deliver above the Tiering threshold which will represent three consecutive months above threshold.
Diagnostics

In November 2024, 66.89% of patients received their diagnostic within the 6-week target against an in-month target of 63.42% and year-end target of 95% (revised trajectory October 2024). The number of patients waiting > 6 weeks decreased by 1041 breaches when compared to previous month.
Reduction in breaches for MRI, USS and Sleep Studies are driving the improved position. Performance is ahead of trajectory due to positive staff engagement with the weekend and OOH WLI lists.

2 Finance

BSW ICS Financial Performance

The BSW System has developed a financial plan with a breakeven position for the year, of which the RUH is also planning to breakeven. This plan has been accepted by NHS England and non-recurrent revenue support funding of £30m is being provided during the year, of which £5.3m is for RUH. NHS England have amended NHS business rule this year and delivery of the plan means this funding will not be repayable in future years.

At Month 8 the Integrated Care System is £13.3m adverse to plan, of which:

- RUH £4.2m
- SFT £9.3m
- GWH £3.1m
- ICB (£3.3m)

RUH Financial Performance

Delivering our Financial Plan is a Breakthrough Goal for 24/25. At Month 8 the Group is at a deficit position of £4.2 million, which is £4.2 million adverse to plan.

The key drivers of this variance are:

- £3.8m net of non pay and operating income budget overspends, of which c£1m is one off in nature. Clinical Supplies and Consumables remain a challenge to the budget. Worked WTE continues to reduce but is higher than budgeted trajectory. The overall position includes £1.5m of upside on financing charges due to interest receivable, partially offsetting unfunded high-cost drugs growth of £2.2m.
- Savings of £20.8m have been delivered to date (56.8% of annual target in 66.7% of the financial year), including £11.6m of pay savings against budget, and the benefit of Elective Recovery Fund Income and operating margin of 62%.

In order to support delivery of the system financial position; avoid regulatory intervention, including entering Investigation & Intervention (I&I) regime and the lowest Single Oversight Framework (SOF) Level 4; and avoid full repayment of NHSE deficit support funding and capital restrictions; BSW Recovery Board and NHSE SW Region team are seeking assurance that the Trust can deliver a £4.1m forecast deficit.

BSW Recovery Board have been co-ordinating actions which include detailed explanation of variances to plan and focus on key drivers of ESRF delivery, No Criteria to Reside levels and Workforce; a deep dive in to forecast assumptions and deliverability by NHSE finance adviser; assurance of grip & control measure and approach to savings delivery; escalation of workforce controls including ICS wide Vacancy Control process.

3 2024 Urgent and Emergency Care (UEC) Survey

The Emergency Department at the Trust has been singled out for praise by the Care Quality Commission (CQC), after a significant proportion of patients interviewed in a major survey answered positively to questions about their care.

Prior to publishing their report, the CQC wrote to the RUH to congratulate the Emergency Department for performing 'better than expected' for Emergency Department services in the 2024 Urgent and Emergency Care Survey, the Trust was one of 9 trusts across England to achieve this rating.

The CQC said the proportion of respondents who answered positively to questions about their care in the department was significantly above the national trust average.

The national survey targeted Trusts which had either an Emergency Department, Urgent Treatment Centre, or both. It looks at the experiences of people who visited the RUH's Emergency Department between 1st January and 29th February 2024.

Areas that patients said the Emergency Department performed well included:

- Treating patients with dignity and respect
- Having enough time to discuss their condition and treatment with medical staff
- Clearly explaining why tests might be needed, and the results of the tests
- Helping with patients' communication needs
- Doctors and nurses listening to what patients had to say
- The level of privacy provided when talking to reception staff

You can find the full survey results on the CQC's website – Urgent and emergency care survey 2024 - Care Quality Commission – https://www.cqc.org.uk/publications/surveys/urgent-emergency-care-survey

4 Intensive Care Unit (ICU)

The new 16 bedded Intensive Care Unit is now being prepared to accept the first patients this spring. This unit will replace the existing Intensive Care Units on B36 and B12, bringing the service together in one carefully designed, modern space with the latest technology and equipment. The design pays careful attention to ensuring the space supports the delivery of outstanding care whilst providing comfortable and reassuring space for relatives and areas for staff rest, recouperation and training. We would like to thank our Capital Projects Team and the Intensive Care Team for all their hard work in designing the new unit and making it a reality.

We would also like to thank RUHX and Friends of the RUH for funding the new ceiling mounted 'pendants'. The pendants house equipment that patients and staff require such as monitors, medical gases and computers at the patients bed side.

5 Dyson Cancer Centre Award Finalists

The Dyson Cancer Centre was a finalist in the recent prestigious Building Better Healthcare Awards. The awards focus on innovation within the healthcare sector, including recognising the positive impact art and design can have on the people we care for, and the people we work with.

The cancer centre featured in three award categories:

- Best Healthcare Development Between £25 – £75 Million
- Best Interior Design Project (Refurbishment or New Build)

- Best Collaborative Arts Project (Static)

6 Princess Anne Wing (PAW) Building Improvement Project

A major building programme got underway in November in the Princess Anne Wing (PAW) to update and improve some of the older buildings in that area of the hospital and bring them in line with fire safety regulations.

Several older areas within PAW need to be completely revamped to ensure they comply with fire safety standards and continue to provide a safe environment for patients and staff.

The target completion date for the works is the end of March 2025.

7 RUH's Lead Chaplain appointed Deputy Lieutenant for Somerset

The Reverend Prebendary Narinder Tegally, Lead Chaplain at the RUH, has been appointed to the prestigious position of Deputy Lieutenant for Somerset. Narinder is one of five new Deputy Lieutenants who have been appointed to support the Lord-Lieutenant, His Majesty's personal representative in Somerset.

Appointment to the office of Deputy Lieutenant is in recognition of distinguished service to the community, or to the country or county. The role of Deputy Lieutenant includes representing the Lord-Lieutenant at formal functions, award ceremonies, citizenship ceremonies or attending Remembrance Day services

8 Hospital refurbishments create a more welcoming environment for young patients

Three more departments at the RUH have been refurbished with stunning one-piece printed graphics thanks to the Time is Precious charity.

The popular graphics, alongside new fun wall-mounted activities, have been installed to relax and distract the hospital's younger patients, while helping to support parents and carers at what can be a difficult time. The vibrant and colourful jungle, wildlife and under the water scenes have been specially designed with input from hospital staff. The graphics have been installed in the waiting areas of the Orthodontics and Ear Nose and Throat departments and on the ceiling of an Anaesthesia room.

9 A blooming brilliant Christmas at the RUH

Patients at the RUH enjoyed a brighter Christmas thanks to a stunning new art installation of giant illuminated flowers that have been installed on the hospital site. The display, which is in place over Christmas and the New Year, features a number of giant Victoria amazonica flower sculptures. The flowers are in the Children's Ward garden and the two central courtyards, adjacent to the hospital's Atrium. They have been generously donated and installed by Frome-based artists' studio Jigantics, working alongside the RUH's in-house art and design team, Art at the Heart.

10 2024 Nursing and Midwifery Awards

RUH nurses and midwives were recognised for their fantastic work and outstanding contribution to the people we care for at the RUH's Nursing and Midwifery Awards 2024. There were 13 awards in total, recognising all of the hospital's nursing and midwifery groups. The ceremony coincided with the anniversary of the birth of Mary Seacole, who was a British Jamaican nurse in the 1800s and paved the way for diversity in nursing in the UK.

11 Care Quality Commission (CQC) 2024 Maternity Survey

The RUH's maternity team has been rated as 'better' or 'somewhat better' than other trusts in a number of key areas following feedback from people in the CQC's 2024 Maternity Survey. In the survey, the maternity team was praised by women and birthing people for treating them with dignity and respect during labour and birth. They also said they particularly felt confidence and trust in the staff caring for them during labour and birth. It is further good news for the RUH's maternity team, which earlier this year retained its 'outstanding' rating from the CQC – placing it in the top three per cent of maternity departments in England.

12 Friends of the RUH Prepare for a Colourful Spring

All those coming to the RUH can look forward to a bright and colourful spring, thanks to the efforts of the Friends of the RUH, who have planted thousands of Dutch tulip and crocus bulbs at the hospital site. The bulbs have been kindly donated by Bath in Bloom, in recognition of their strong relationship with Bath's twin city Alkmaar, in the Netherlands. Situated in the north-west of the country, the historic city of Alkmaar is famous for its magnificent tulip fields.

13 RUH Membership

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

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

Stakeholder Governor

The Council of Governors recently welcomed Professor Deborah Wilson who has joined the Council as a new Stakeholder Governor, representing the University of Bath. Professor Wilson is the Dean of the Faculty of Humanities and Social Sciences. We look forward to working with Professor Deborah Wilson.

14 Consultant Appointments

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

Dr David Townsend, Locum Consultant at the Trust was appointed as a Consultant Radiologist (Breast Radiology subspeciality) on 11th November 2024. Dr Townsend commenced his substantive role on the 1st December 2024.

Dr Sophie Smith, Specialty Training Year 7 at Great Western Hospital NHS Foundation Trust was appointed as a Consultant Haematologist on 19th November 2024. Dr Smith's start date is to be confirmed.

Dr Samantha Ballham and Dr Ania Barling, Consultant Geriatrician's at University Hospitals Bristol and Weston NHS Trust and Guy's and St Thomas' NHS Foundation Trust respectively, were appointed as Consultant Geriatricians on 18th November 2024. Their start dates are to be confirmed.

Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**15 January 2025**		
Title of Report:	**Integrated Performance Report (November 2024 Data)**		
Status:	**For Noting**		
Board Sponsor:	**Paran Govender, Chief Operating Officer** **Jon Lund, Interim Chief Finance Officer** **Toni Lynch, Chief Nursing Officer** **Alfredo Thompson, Chief People Officer**		
Author:	**Tom Williams, Head of Financial Management** **Rob Eliot, Lead for Quality Assurance** **Matt Foxon, Associate Director for People** **Operational Team**		
Appendices	**Appendix 1: Integrated Performance Report** **Appendix 2: Trust Scorecard September 2024**		

1. Executive Summary of the Report

The report provides an overview of the Trusts Performance for the period up to and covering November 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.

This programme drives improvement on the three nationally reported measures: price cap compliance, framework provision and our total spend on agency as a percentage of our total pay bill.

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 breakeven position for the year, of which the RUH is also planning to breakeven. This plan has been accepted by NHS England and non-recurrent revenue support funding of £5.3m is being provided during the year. NHS England have amended NHS business rule this year and delivery of the plan means this funding will not be repayable in future years.
- At Month 8 the Integrated Care System is at a deficit position of £13.3m, against a breakeven plan (see slide 14 for further details).

RUH Group Financial Plan

- The RUH breakeven plan is underpinned by £22.7m of non-recurrent revenue financial support from commissioners, £5.3m of deficit support funding from NHSE and £7.1m of NHSE funding for revenue consequences of strategic

capital investment. The financial plan for the year requires full delivery of a £36.6m Savings Programme, which has been phased to recognise progressive reduction in costs and increases in income over the year. Delivery of this plan is supported by an Improvement programme with 3 workstreams focussing on (1) Clinical Operational Service Transformation (2) Paybill Reduction and (3) Cost Control and Commercial Income. Achieving the financial plan is an RUH Breakthrough Objective for 2024/25.

- The consequence of not achieving the financial plan are significant. Deficits will need to be repaid in future periods adding minimum 0.5% to annual savings requirement; there will be less revenue investment for strategic investment priorities; there will be less capital funding; there will be less autonomy for ICS, Trust, Divisions, and Budget Holders, and increase regulatory scrutiny & intervention; Trust will have to make requests for revenue support loans to maintain cashflow.

Revenue Financial Performance – Month 8 (see slides 4-13 for further details)

- At Month 8: the Group is at a deficit position of £4.2 million, which is £4.2 million adverse to the breakeven plan.
- The key drivers of this variance are:
  - £3.8m net of non-pay and operating income budget overspends, of which c£1m is one off in nature. Clinical Supplies and Consumables remain a challenge to the budget. Worked WTE continues to reduce but is higher than budgeted trajectory. The overall position includes £1.5m of upside on financing charges due to interest receivable, partially offsetting unfunded high-cost drugs growth of £2.2m.
- Savings of £20.8m have been delivered to date (56.8% of annual target in 66.7% of the financial year), including £11.6m of pay savings against budget, and the benefit of Elective Recovery Fund Income and operating margin of 62%.

Risks and Actions required

A do-nothing different trajectory of cumulative year to date performance would lead to an £8.2m deficit, which would be £8.2m adverse to the breakeven plan. Savings achieved would be £31.2m. Actions required to improve this position include:

- Sustaining current I&E and Savings delivery.
- Increasing Elective Recovery Fund income through recovery of Theatre and Outpatient productivity and improved clinical coding.
- Further delivery of all Paybill savings through controls, improved rostering and service redesign, reducing worked wte back to March 2023 levels.
- Delivery of Non-Pay & Commercial Income Savings.
- increase in Sulis I&E due to CDC expansion.

Capital and Balance Sheet Position – Month 8 (see slides 14-16 for further details)

- Total capital expenditure is £24.1m at Month 8, which is £13.8m behind plan due to delays in both the SEOC and EPR programmes.
- The closing cash balance for the Group was £34.8m which is 41.6% higher than the plan due to the capital delays set out above and cash from the system to support the pay awards.

Operational Performance

Ambulance Handover

- In November the Trust lost a total of 2,872 hours in ambulance handovers, an increase from the previous month (2,667).
- The percentage of ambulance handovers completed within 30 minutes decreased for November to 29% compared to previous the month (31%) against the national standard of 95%.
- Most patients who are delayed are non-admitted, followed by patients who are placed admitted to the Medical Assessment Unit (MAU).
- The opening of the C16 admission lounge has not as yet had the impact that anticipated, although we are continuing to refine and update the standard operating procedure for this to support flow and to decompress MAU.
- Fit-to-Sit is now open for longer hours from November for the winter.

4 Hour Performance

- RUH 4-hour performance in November was 65.2% (including Minor Injuries Unit (MIU)) and 56.2% on the RUH footprint (unmapped), a deterioration from October. Non-admitted performance was 67.6%, which is a decrease from the performance for September (69.5%). Admitted performance was 28.7%, which was also a deterioration from September (33.8%).

Non-Criteria to Reside (NC2R)

- During October the Trust had an average of 96.3 patients waiting who had no criteria to reside, which is an increase of 2.7 on the previous month.
- Some localities saw a decrease in average numbers of NC2R.
- Bath and North-East Somerset (B&NES) has seen a decrease to 32.5, which is positive, however this still needs significant focus on system partner calls and support.

Referral to Treatment (RTT)

- In November the Trust had 524 patients waiting more than 52 weeks, a decrease of 9% from October.
- For waiters more than 65 weeks the Trust also saw a decrease in November from 22 to 18 patients.
- There were 2 patients waiting more than 78 weeks at the end of November (same as October).
- For waiters more than 52 weeks, the three largest specialties combined represent two thirds of the waiters: Ear Nose and Throat (ENT), Gastroenterology, and Trauma & Orthopaedics (T&O).
- ENT saw a decrease from 177 patients waiting more than 52 weeks in October to 140 patients waiting more than 52 weeks at the end of November.
- T&O continued to decrease in November with 73 patients waiting more than 52 weeks, down from 79 in October.
- Gastroenterology continued to decrease in November from 105 patients waiting, down to 96.

Cancer 62 Days

- Performance was below target at 62.2%, a minimal change from October.
- The deterioration in performance in Urology and Breast resulted in the drop in performance from earlier this year at Trust-level, whilst Colorectal remains the most challenged specialty.
- Local Anaesthetic Trans perineal Prostate (LATP) biopsy waiting time in Urology is the sole contributing factor to more than 50% of breaches, which is due to a deficit is nursing capacity.
- Breast service was impacted by increased demand, which coincided with long term sickness of a consultant surgeon.
- Breaches in Colorectal due to imaging (Computed Tomography Colonography (CTC)), more complex endoscopy (not suitable for Sulis), and outpatient waiting times in Gastro.
- Haematology breaches increased in month, driven by longer waiting times at North Bristol Trust (NBT) for BioMedical Admissions Test (BMAT) reporting.

Diagnostics

- In November 66.89% of patients received their diagnostic within the 6-week target against an in-month target of 63.42% and year-end target of 95% (revised trajectory October 2024).
- The number of patients waiting more than 6 weeks decreased by 1041 breaches compared to the previous month.
- Reduction in breaches for Magnetic Resonance Imaging (MRI), Ultrasound Scan (USS), and Sleep Studies, were key drivers in the improved position.
- Performance ahead of trajectory driven by above plan staff engagement with the weekend and out of hours waiting list initiatives (WLI).

Elective Recovery

- In November (Month 8) organisationally we delivered 99% of the Trust plan and 109% of 2019/20 activity.
- Additional weekend operating in theatres picked up in Month 8 and drove day case (DC) and inpatient (IP) over-delivery in M8 at 107% against plan for both point of delivery (POD) types.
- As a trust in M8 we had an overall in-month income position £1.06M.
- The Trust has delivered financial performance year-to-date of 128% of 2019/20, and 107% of our 2024/25 plan, in Elective Recovery Fund (ERF).
- This has delivered a surplus of £6.68m year-to-date.

Workforce

Overall, the key workforce performance indicators at the RUH remain positive.

- Staff-in-post in November 2024 was 5573.5 WTE, a decrease of 17 wte compared to M7.
- The vacancy rate decreased to 2.17% in M8 but remains within internal target.
- Agency spend as a proportion of the total pay bill in from 0.81% (M7) to 1.11% in (M8) keeping us within the local target of 3.5% and the national

target of 3.2%.

- Nurse Agency spend as a proportion of the Registered Nursing pay bill decreased to 0.53% in M8 (from 1.22% in M6).
- Rolling turnover decreased to 8.05% (from 8.16% in M7) a continued positive variance against a target of 11.00%.
- Rolling sickness in October 24 was 4.65%, an increase compared to the previous month (4.59%).
- The target percentage figure for Appraisal completion is 90%; Appraisal has slightly increased at 80.93%.
- Mandatory Training compliance continues to be narrowly above target at 88.60%.

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

Work is now underway to re-draft the People and Culture strategy and a final draft is expected by March 2025.

Actions are being taken to improve the key standards:

Sickness absence rate

In collaboration with IT colleagues the People Directorate is making good progress building the HALO digital system in two phases:

- Phase 1: Case management system is now live. Long term sickness cases are also now on HALO.
- Phase 2: Self-Service Portal, which has a provisional go live date of end January 25. The self-service portal will enable better access to People services for line managers, including chat bot and slicker workflows for People Processes. Work is progressing well on the integration of some employee data to facilitate the auto population of forms when they are live within the self-service portal. We are also progressing on building up our knowledge base articles within HALO which will enable the chatbot to answer HR related queries and signpost staff.

Following the work to decrease sickness absence, targeted interventions have contributed to 7 out of the 9 teams with above 3% short term sickness reducing to less than 3%. The work on interrogation of the data continues through regular meetings and the People Hub team run monthly reports from our rostering system to flag to managers both short term and long-term sickness. Divisional People Partners also continue to monitor the data for their areas and work with senior managers on interventions. As pressure increases on our clinical and operational systems, focussed brief interventions are currently being developed to support high-stress areas (e.g. ED).

Appraisal

Despite showing an improvement of 9.3% over the last 12 months, the appraisal rate remains 9% below the target. A proposal is currently being developed to explore the

feasibility of an appraisal window for the next financial year. A revised Appraisal Policy is now awaiting ratification.

Agency Spend and Bank Rate

Whilst agency spend is below national target, it is a workstream that continues to have significant focus. Current workstreams include:

- Following the success of the Southwest Regional rate cards for Nursing and Medical and Dental. The group are preparing to go live with price cap compliant rate cards for Allied Health Professionals (AHPs)/Scientific, Therapeutic and Technical (STT) to reduce agency costs from January 2025.
- Work underway to review the enhanced bank rates to understand impact and equity.

Recruitment

New workforce controls in operation from late November requires all corporate posts and any clinical post above Band 7 to be subject to additional scrutiny at ICB level to help right-size our workforce.

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 agreed performance measures and patient safety priorities.

Pressure Ulcers

- In October 2024, the RUH reported 0.4 pressure ulcers per 1,000 bed days (7 pressure ulcers).
- The RUH investigated three category 3 and four category 2 pressure ulcers on five wards.
- The improvement programme is focussed on the respiratory ward and the Older Persons ward, undertaking improvement cycles, which is monitored through the improvement group chaired by the Deputy Chief Nursing Officer.

Falls

- Analysis identified that 98% of inpatients did not fall in our care in October.
- The 4 top contributing inpatient areas are within the Medical Division and within the older persons specialty.
- The frailty and complexity of patients on older persons wards means that they have an increased vulnerability to falling whilst they are in hospital.
- The National Institute for Health and Care Excellence (NICE) guidance advises all inpatients at risk of falls should have lying and standing blood pressure recorded as part of a multifactorial risk assessment. This is used to diagnose a health condition called Orthostatic Hypotension that increases the risk of falls. Analysis reveals that one of the top contributing factors is patients not receiving

the assessment. The slides identify the improvement cycles which are being undertaken to reduce unwarranted variation.

Infection Prevention and Control Update

- There were 6 cases of Clostridioides Difficile infection (CDI) reported during October; 60 cases have been reported year to date against a threshold of 75.
- There were 6 cases of E. coli infection reported during October; 47 cases reported year to date against a threshold of 82.
- Benchmarking data shows our rate is in the middle of all Southwest Trusts.
- The 3 Infection Prevention & Control (IPC) quality improvement projects listed (under actions) are now underway and aim to improve the quality of care provided to patients, and to positively influence the health care associated infection rates longer term.
- The hydration project has commenced, and the improvement aim is being developed.

Patient Support and Complaints

- In October, the Trust received 41 new complaints. This is the highest number of complaints in a single month this year.
- The trend for complaints received each month is on an upward trajectory.
- There has also been an increase in activity over the last 12 months. The Medical and Surgical Divisions received the highest number of new complaints with both receiving 18.
- There are no clear themes or trends for the month. The number of re-opened complaints remains low. In October one new complaint was reopened.
- 85% of all contact with Patient Support and Complaints Team (PSCT) were resolved within 14 days in line with NHS Complaints standards.

Maternity/Neonatal Update

- The midwife to birth ratio remains stable with an anticipated improved position for November due to commencement of new starters.
- There were significant improvements to midwifery vacancy, from 12.5wte to 0.9wte.
- Neonatal nurse qualified in speciality (QIS) remains below national standard of 70%, currently at 69%. An action plan is in place detailing trajectories. Mitigations are in place to ensure safe staffing levels for each shift and reviewed regularly.
- Work is ongoing with the Senior Leadership Team (SLT) to better understand the Mary Ward acuity data. Reporting stratified to match Bath Birth Centre RAG to reflect overall safe staffing of the Acute Maternity Services.
- Within the reporting period there was there was one antenatal stillbirth at 36 weeks gestation. The death has been reported via MBRRACE and will receive a full PMRT review. No immediate learning was identified
- There was 1 neonatal death of a 28-week gestation baby born at the RUH and subsequently died. The death has been reported to MBRRACE and will receive a full PMRT review. Co-incidental learning identified strengthening multidisciplinary team (MDT) collaboration for patients with complex antenatal

care pathways and subsequent counselling.

- In October there was one admission to ITU following elective caesarean birth with a bowel injury of unknown cause, sepsis and subsequent stoma. An MDT review is ongoing into the cause of the bowel injury.
- The service celebrated a successful Quality Improvement (QI) project which had commenced in Q1 due to an increase in babies with low cord gases. This local QI projected is linked to the national QI to minimise separation of parents and their babies, Avoiding Term Admissions into the Neonatal Unit (ATAIN). The project outcomes were shared with Local Maternity & Neonatal System (LMNS)
- The maternity Badger net go live date has moved to 1st July 2025 due to a planned national system update.
- As part of the Maternity Incentive Scheme (MIS) Year 6 the service will commission an external audit by KPMG to review evidence compliance. The terms of reference for the KPMG audit have been agreed and the review is due to commence in December 2024.
- For MIS Safety Action 7 the service has escalated to the LMNS the lack of Maternity and Neonatal Voices infrastructure. Whilst the model of the MNVP within BSW has a funded work plan the long-term financial structure to support the MNVP sustainability has yet not been agreed. An options appraisal was reviewed and funning was agreed in December.

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

3.	Legal / Regulatory Implications
Trust Single Oversight Framework.	

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

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

6.	Equality and Diversity
NA	

7.	References to previous reports
Standing agenda item.	

8.	Freedom of Information
Public	

9.	Sustainability
None identified.	

10.	Digital
None identified.	

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report

December 2024 (November 2024 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.

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 8

The people in our community

The RUH, where you matter

Executive Scorecard

	Performance Indicator	Description	Target		Baseline	Actual 2024/25							
			Performing	Under Performing		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Sustainability Tracker Metrics	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	£0	£0m	(£0.08m)	(£1.50m)	(£0.61m)	(£0.63m)	(£1.88m)	(£2.11m)	(£4.24m)
	Forecast delivery of Group financial plan	Forecast variance from year to date plan	<=0	>0	(£5.30m)	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m
	Group delivery of Plan	Total year to date financial performance	<=0	>0	(£5.30m)	(£2.26m)	(£4.06m)	(£6.50m)	(£6.59m)	(£7.76m)	(£1.88m)	(£2.11m)	(£4.24m)
	Value of Forecast QIPP Unidentified	Forecast performance against plan	< = £5m	> £5m	£0m	£2.86m	£2.86m	£2.86m	£2.81m	£2.81m	£2.81m	£2.81m	£0.00m
	Delivery of QIPP against plan	Performance against plan	<=100%	>100%	100.0%	100.0%	98.0%	96.1%	99.2%	95.2%	89.2%	97.0%	100.5%
	Reduction in agency expenditure	Agency costs as a % of total pay costs	<= 3%	> 3%	3.0%	1.2%	1.2%	0.3%	1.0%	1.0%	1.0%	0.8%	1.1%
	Sickness against plan	Actual levels of sickness against average pre-pandemic levels	<= 4.1%	> 4.1%	4.5%	4.5%	4.5%	4.4%	4.8%	4.5%	4.4%	4.5%	4.7%
	Reducing no criteria to reside patients	No criteria to reside to reduce by 40% from December 2021	<= 90	> 90	80	73	103	73	73	70	59	67	72
	Reducing staff vacancies	Total WTE variance to plan reported each month	<=7.4%	>7.4%	4.0%	4.9%	1.7%	0.9%	2.6%	0.2%	0.8%	-0.6%	-0.4%
	Net impact of high cost drugs and devices	Total expenditure and income against plan for high cost drugs and devices (YTD)	<=0	>0	£0	(£0.1m)	(£0.6m)	(£0.8m)	(£1.2m)	(£1.1m)	(£1.7m)	(£1.5m)	(£2.2m)
	Increase productivity	Implied productivity based on financial and operational performance (Quarterly)	>=3%	3%	-7%	-23%	-23%	-23%	-23%	-23%	-13%	-13%	-13%
	Elective recovery	In Month Performance against planned levels of activity (Value based)	>= 100%	< 100%	n/a	112%	113%	109%	106%	105%	105%	114%	112%
	Non elective activity	In Month Performance against planned levels of activity (Value Based)	<= 102%	> 102%	n/a	119%	142%	116%	120%	112%	113%	112%	107%
	Delivery of capital programme	Variance from year to date planned capital expenditure (Internally Funded Schemes)	-5%	<5%	n/a	67.3%	51.9%	69.7%	65.7%	61.8%	51.8%	63.7%	66.2%
	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+ or - 5%	><5%	n/a	0	0	0	0	0	0	0	0
	Delivery of planned cash balance	Variance from year to date planned cash balance	- 10%	<10%	n/a	8.8%	25.6%	24.50%	38.7%	40.0%	17.4%	64.9%	41.6%

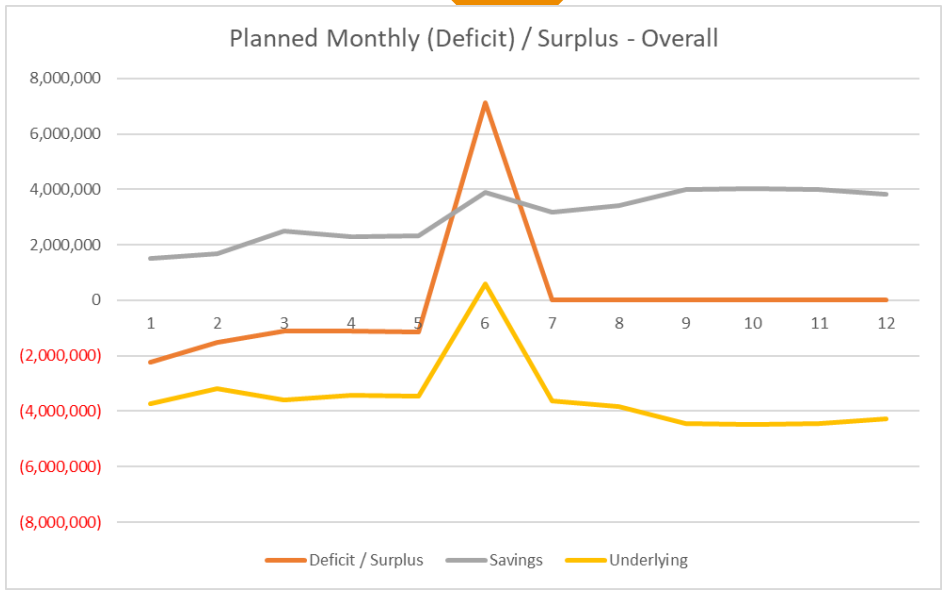
Overall Revenue Position

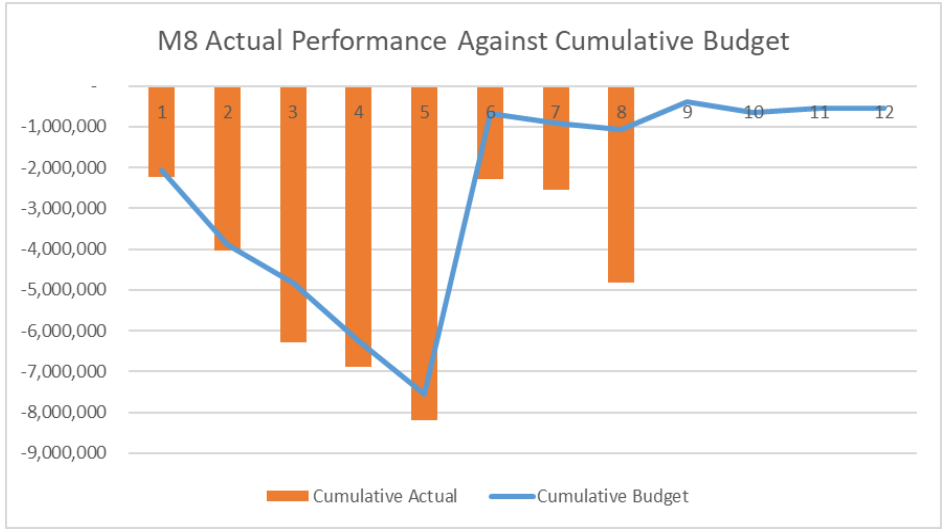
At Month 8 the Group is at a deficit position of £4.2million which is £4.2million adverse to a breakeven plan.

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. This graph has been updated to include the £5.3m system recovery funding.

The second graph shows the Cumulative Actuals and Budget. The profile highlights the I&E deficits arising up to Month 6 and highlights the step up in savings delivery in second half of the year to deliver in-month surpluses creating the improvement against the cumulative position.

A do nothing trajectory of cumulative year to date performance would lead to an £8.2m deficit, which would be £8.2m adverse to the breakeven plan. With 4 months remaining savings delivery is required to step up by approx. £2.0m per month for the remainder of the year to delivery breakeven.





True North | Breakeven position

Statement of Comprehensive Income Period to 202408	RUH						Sulis						Group Adjustment						Total Group Position					
	202408			YTD			202408			YTD			202408			YTD			202408			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	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Commissioner Income (NHSE/CCG)	41,449	38,319	(3,130)	325,795	322,654	(3,140)	2,179	2,160	(18)	18,830	17,616	(1,215)	0	0	0	0	0	0	43,627	40,479	(3,148)	344,625	340,270	(4,355)
Other Patient Care Income	604	796	192	4,888	5,600	712	1,660	1,559	(101)	11,764	10,104	(1,660)	0	0	0	0	0	0	2,264	2,355	91	16,652	15,703	(948)
Other Operating Income	3,483	5,231	1,748	31,884	35,802	3,918	12	29	17	96	231	135	(197)	(197)	0	(1,575)	(1,575)	0	3,298	5,064	1,766	30,405	34,458	4,053
Income Total	45,536	44,346	(1,189)	362,567	364,056	1,490	3,850	3,749	(101)	30,690	27,950	(2,740)	(197)	(197)	0	(1,575)	(1,575)	0	49,189	47,898	(1,291)	391,682	390,432	(1,250)
Pay	(28,621)	(29,199)	(578)	(230,396)	(231,862)	(1,466)	(1,988)	(1,951)	37	(15,945)	(14,867)	1,078	0	0	0	0	0	0	(30,609)	(31,150)	(541)	(246,340)	(246,729)	(389)
Non Pay	(12,701)	(15,303)	(2,602)	(101,541)	(112,745)	(11,205)	(1,390)	(1,040)	350	(11,134)	(9,877)	1,257	0	0	0	0	0	0	(14,091)	(16,343)	(2,252)	(112,675)	(122,622)	(9,947)
Depreciation	(2,019)	(148)	1,871	(16,154)	(14,252)	1,902	(245)	(223)	23	(1,962)	(1,787)	175	145	145	0	1,160	1,160	0	(2,120)	(226)	1,894	(16,956)	(14,879)	2,077
Impairment	(578)	(9,218)	(8,640)	(4,627)	(9,218)	(4,591)	0	0	0	0	0	0	0	0	0	0	0	0	(578)	(9,218)	(8,640)	(4,627)	(9,218)	(4,591)
Expenditure Total	(43,919)	(53,868)	(9,948)	(352,718)	(368,077)	(15,360)	(3,624)	(3,214)	409	(29,041)	(26,531)	2,510	145	145	0	1,160	1,160	0	(47,398)	(56,937)	(9,539)	(380,598)	(393,448)	(12,850)
Operating Surplus/(Deficit)	1,616	(9,522)	(11,138)	9,849	(4,021)	(13,870)	227	535	308	1,649	1,420	(230)	(52)	(52)	0	(415)	(415)	0	1,791	(9,039)	(10,830)	11,083	(3,016)	(14,100)
Other Finance Charges	(938)	(735)	203	(7,504)	(5,984)	1,520	(52)	(42)	10	(431)	(355)	76	31	31	(0)	260	260	0	(959)	(747)	212	(7,675)	(6,079)	1,596
Other Gains/Losses	0	0	0	0	29	29	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	29	29
Finance Charges	(938)	(735)	203	(7,504)	(5,955)	1,548	(52)	(42)	10	(431)	(355)	76	31	31	(0)	260	260	0	(959)	(747)	212	(7,675)	(6,051)	1,625
Surplus/(Deficit)	678	(10,257)	(10,935)	2,345	(9,976)	(12,322)	175	493	318	1,218	1,065	(153)	(21)	(21)	(0)	(155)	(155)	0	832	(9,785)	(10,618)	3,408	(9,067)	(12,475)
Adjusted Financial Performance																								
Add back all I&E impairments/ (reversals)	578	9,218	8,640	4,627	9,218	4,591	0	0	0	0	0	0	0	0	0	0	0	0	578	9,218	8,640	4,627	9,218	4,591
Retain impact of DEL I&E (impairments)/ reversals	0	(333)	(333)	0	(333)	(333)	0	0	0	0	0	0	0	0	0	0	0	0	0	(333)	(333)	0	(333)	(333)
Remove capital donations/grants I&E impact	(1,410)	(1,230)	180	(8,040)	(4,060)	3,980	0	0	0	0	0	0	0	0	0	0	0	0	(1,410)	(1,230)	180	(8,040)	(4,060)	3,980
Adjusted financial performance for the purposes of system achievement	**(153)**	**(2,602)**	**(2,449)**	**(1,068)**	**(5,151)**	**(4,083)**	**175**	**493**	**318**	**1,218**	**1,065**	**(153)**	**(21)**	**(21)**	**(0)**	**(155)**	**(155)**	**0**	**1**	**(2,130)**	**(2,131)**	**(5)**	**(4,241)**	**(4,237)**

Note. The 24/25 Financial Plan is underpinned by £22.7m of non-recurrent revenue financial support from ICB and £5.3m deficit support from NHSE (£2.3m per month); as well as £7.1m 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

Expenditure Trend Analysis

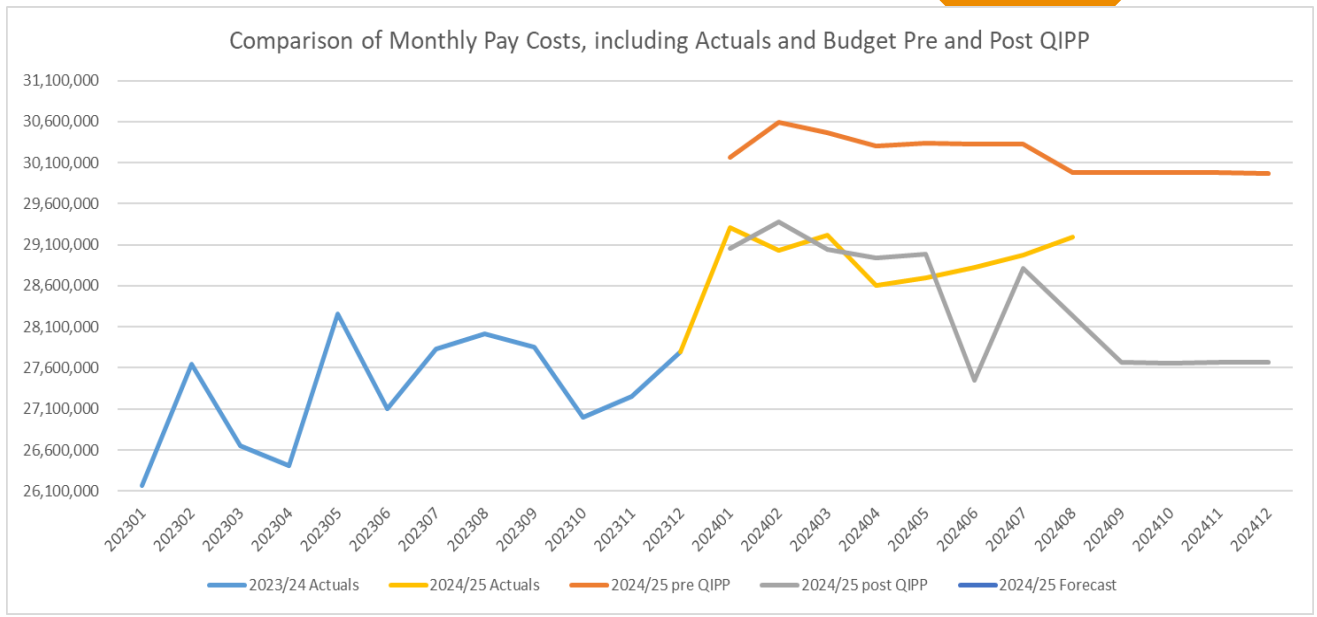
The graphs show the trend of Pay (top graph) and Non-Pay (bottom graph) by Month from April 2023 for the RUH Trust; and how these compare to operating plan assumptions before and after Savings delivery

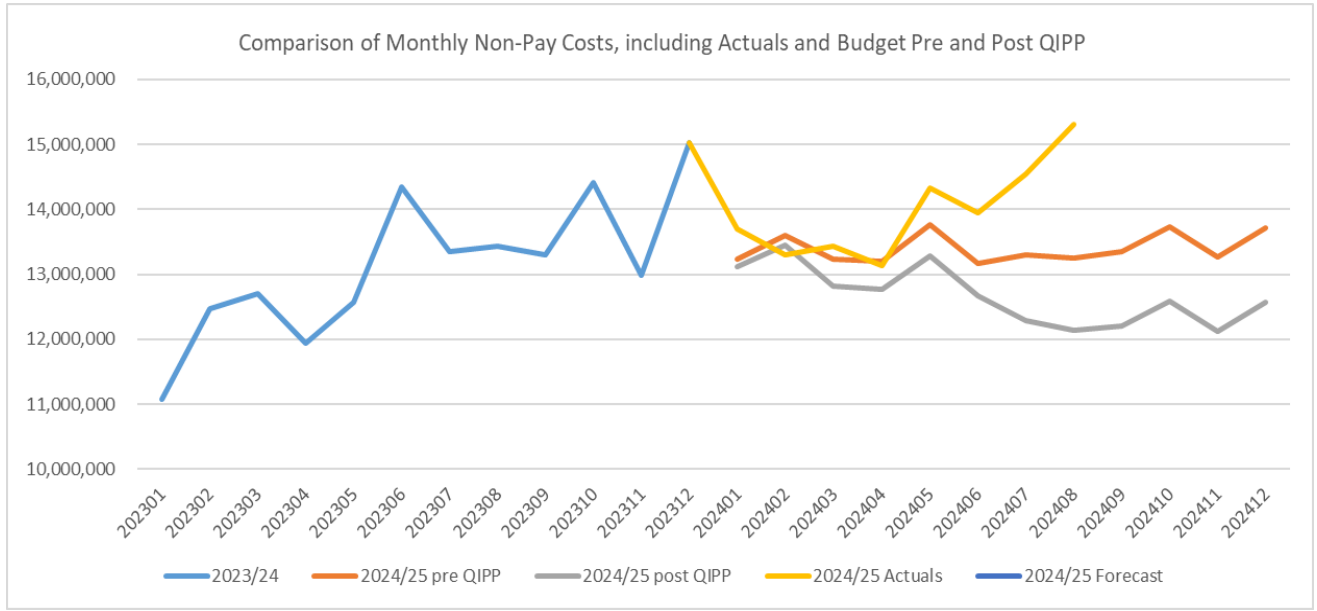
The actual Pay spend in 2023/24 has fluctuated due to backdated pay awards being funded, but there was an overall upward trend in pay costs in 2023/24.

Backdated pay awards for medical and AFC staff were funded and paid for in October 24, an increased cost in the month of £9.5m. Further pay awards for resident doctors were paid in November 24.

Non-Pay costs do vary between month, partly related to clinical activity and seasonal variation for utility costs.

Both graphs highlight the challenge of savings required. The £1.5m savings challenge is the shortfall in the delivery of QIPP to plan and is predominantly in non – pay.



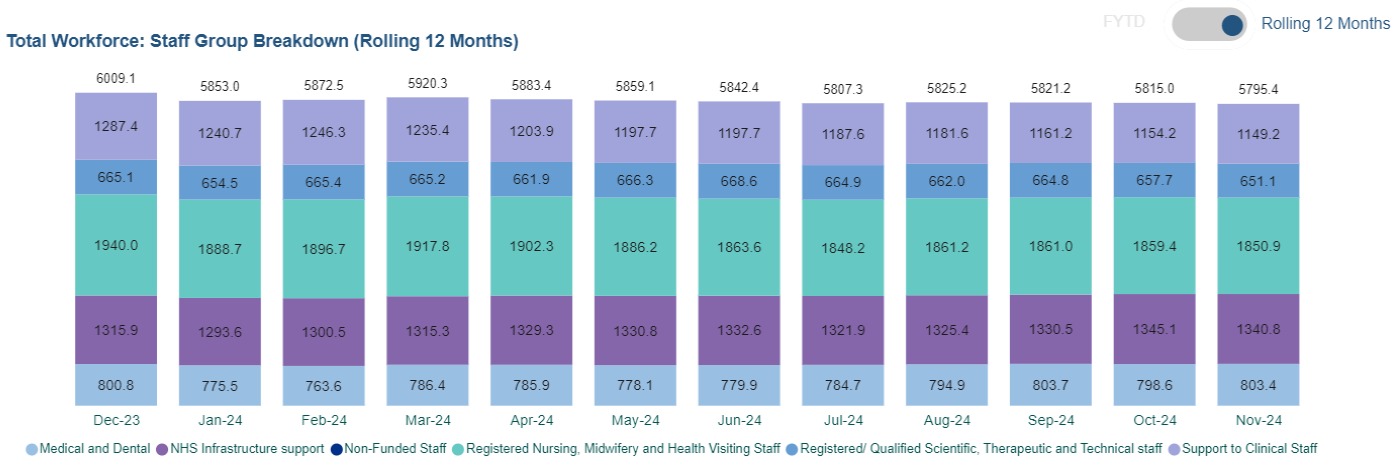


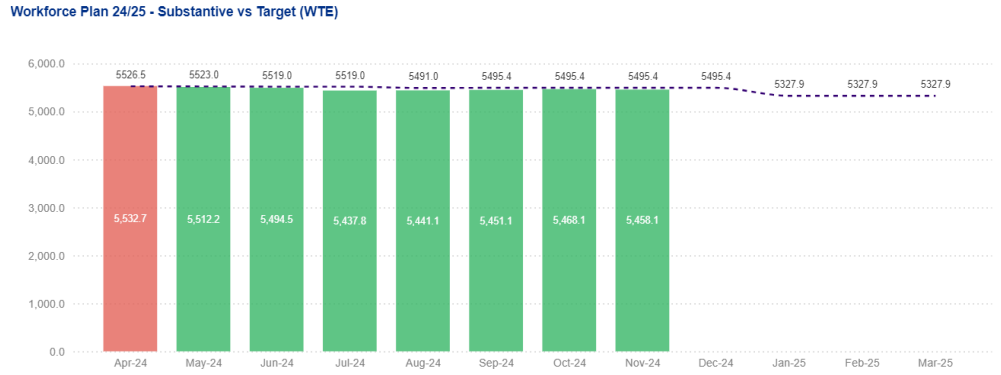
Driver Measure - Workforce Analysis

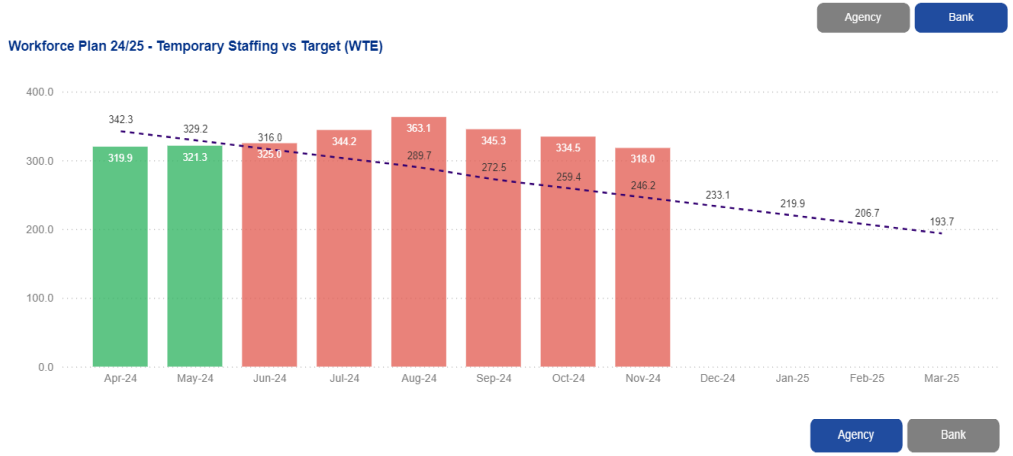
As well as tracking the overall value of Workforce Costs the Trust tracks the Whole Time Equivalent (WTE). The graphs show the Budgeted, Forecast and Actual WTE working per month.

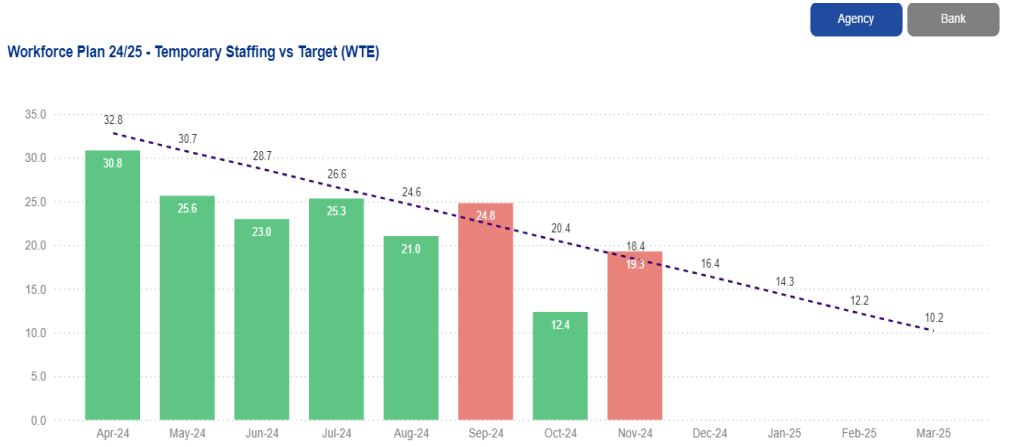
These reports show the actual worked in month. The calculation for Bank has been aligned between Workforce and Finance Reporting.

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 124.9 (2.1%) from 5,920.3 in March to 5,795.4 in November, although bank staff usage remains high and agency usage has increased in month.









QIPP | Financial Progress - overview

Delivery by Month 8 by Improvement Programme Theme

	Year to Date Plan	Year to date Actuals	Variance
	£'000	£'000	£'000
1_Clinical Operation Trans	£5,072	£5,645	£573
2_Pay Bill reduction	£9,344	£9,829	£485
3_Cost Control/Comm Income	£4,808	£3,629	-£1,179
Total	**£19,224**	**£19,103**	**-£121**
Annual Leave Accrual Release	£1,519	£1,737	£217
Total (inc A/L Release)	**£20,743**	**£20,840**	**£96**

Delivery by Month 8 by Division

DIVISION	PAY	NON-PAY	INCOME	TOTAL
CORPORATE	£1,246	£158	£21	£1,425
ED	£503	£16	£2	£521
ESTATES & FACILITIES	£1,880	£127	£106	£2,112
FASS	£1,291	£29	£55	£1,374
MEDICINE	£2,219	£647	£121	£2,988
SULIS	£0	£0	£238	£238
SURGERY	£2,682	£436	£256	£3,373
INCOME	£0	£0	£7,072	£7,072
Total	£9,821	£1,412	£7,870	£19,103
Annual Leave Accrual	£1,737	£0	£0	£1,737
Total (inc A/L Release)	£11,558	£1,412	£7,870	£20,840

Summary

QIPP as at the end of month 8 delivered £20.8 million against a £20.7 million plan. An improved delivering in meant an over delivery of plan by £0.1 million.

This was achieved predominantly due to:

- Pay Controls - Vacancy Gap savings
- Pay Controls - Reduction in bank/agency/overtime
- Pay – Service Redesign - Ward 4 pay & non pay savings
- Pay – Service Redesign - Paid break pay savings
- Pay – Service Redesign - efficiencies from paperless inpatient Project
- Release of annual leave accrual
- Procurement and medicine optimisation
- ESRF - Coding Improvement initiatives
- ESRF - Increased elective productivity incl Theatres
- Sulis profitability

NB The plan assumes an acceleration of delivery of QIPP in the later part of the year and activities are focusing on the delivery of this, particularly in non pay and productivity driven income.

QIPP | Financial Progress – by Division and Programme

	INCOME	CORPORATE	FASS	SULIS	MEDICINE	SURGERY	ED	ESTATES & FACILITIES	TRUST CENTRAL	Grand Total
3_Cost Control/Comm Income	**£1,803**	**£212**	**£25**	**£238**	**£642**	**£691**	**£18**	**£0**	**£0**	**£3,629**
Clinical Income (including coding)	£1,619									£1,619
IT improvement programme paperless inpatients		£0								£0
Commercial Opportunites	£0	£14	£55		£71	£95	£2			£236
Pharmacy Services & Medicines Management	£184		-£46		£61	£72	£10			£280
Procurement & Inventory Management		£62	£16		£361	£266	£1	£0		£707
FYE 23-24	£0	£0	£0	£0	£0	£0		£0	£0	£0
Divisional Lead		£135			£150	£258	£5			£548
Sulis				£238						£238
1_Clinical Operation Trans	**£5,269**	**£0**	**£0**		**£144**	**£0**		**£232**		**£5,645**
clinical service transformation	£1,544	£0	£0			£0				£1,544
Elective Income	£2,668									£2,668
Estates & Facilties								£232		£232
Outpatients (All Divisions)	£332									£332
Radiology					£96					£96
Theatres	£725									£725
Patient Flow					£49					£49
2_Pay Bill reduction		**£1,213**	**£1,349**		**£2,201**	**£2,682**	**£503**	**£1,880**	**£1,737**	**£11,565**
Central HR Initiatives		£1,099	£1,349		£1,162	£2,145	£435	£1,880	£1,737	£9,806
Patient Flow					£168	£412				£580
Nurse & Therapies Staffing		£115	£0		£871	£94	£69			£1,149
Medical Staffing						£31				£31
2_Pay Bill reduction										£0
Grand Total	**£7,072**	**£1,425**	**£1,374**	**£238**	**£2,988**	**£3,373**	**£521**	**£2,112**	**£1,737**	**£20,840**

QIPP | ERF – SLAM income performance

SLAM Income Performance

	April £	May £	June £	July £	August £	September £	October £	November £	Total YTD £	Total QIPP £
Productivity Performance										
Theatres/Elective Pathway	79,663	32,543	75,867	95,734	71,617	111,876	140,115	117,155	724,570	724,570
Outpatients DNA Reduction	57,018	85,859	70,083	36,548	58,181	48,536	23,643	54,591	434,459	434,459
Outpatients DNA Increases	(8,193)	(8,189)	(22,024)	(16,388)	(11,548)	(7,931)	(19,679)	(8,825)	(102,777)	(102,777)
Elective Other - balance	707,834	130,974					551,037	1,278,487	2,668,332	2,668,332
Productivity Over the Plan	(4,216)	519,128	179,062	(450,945)	(174,840)	(128,877)	(331,202)	820,151	428,261	
Total Productivity Income	832,106	760,315	302,988	(335,051)	(56,590)	23,604	363,914	2,261,559	4,152,845	3,724,584
PLICS Savings						927,960	154,667	154,667	1,082,627	1,082,627
Clinical Coding	0	0	117,522	517,888	118,958	146,558	542,184	175,667	1,443,110	1,443,110
SLAM Income Performance	**832,106**	**760,315**	**420,510**	**182,837**	**62,368**	**1,098,122**	**1,060,765**	**2,591,893**	**6,678,582**	**6,250,321**

Performance at Month 8

Developing improvement plans across all the Divisions has supported the maintenance of the increase in theatre activity seen in October and identified many opportunities to change coding to reflect the work being undertaken.

The “Other” ERF performance is the result of stretch plans identified by the Specialities, full details are being drawn out to accurately track and forecast for the rest of the year.

Outpatient DNA reductions saw an increase in performance in month following targeted work to address outliers with continuing high levels of DNAs.

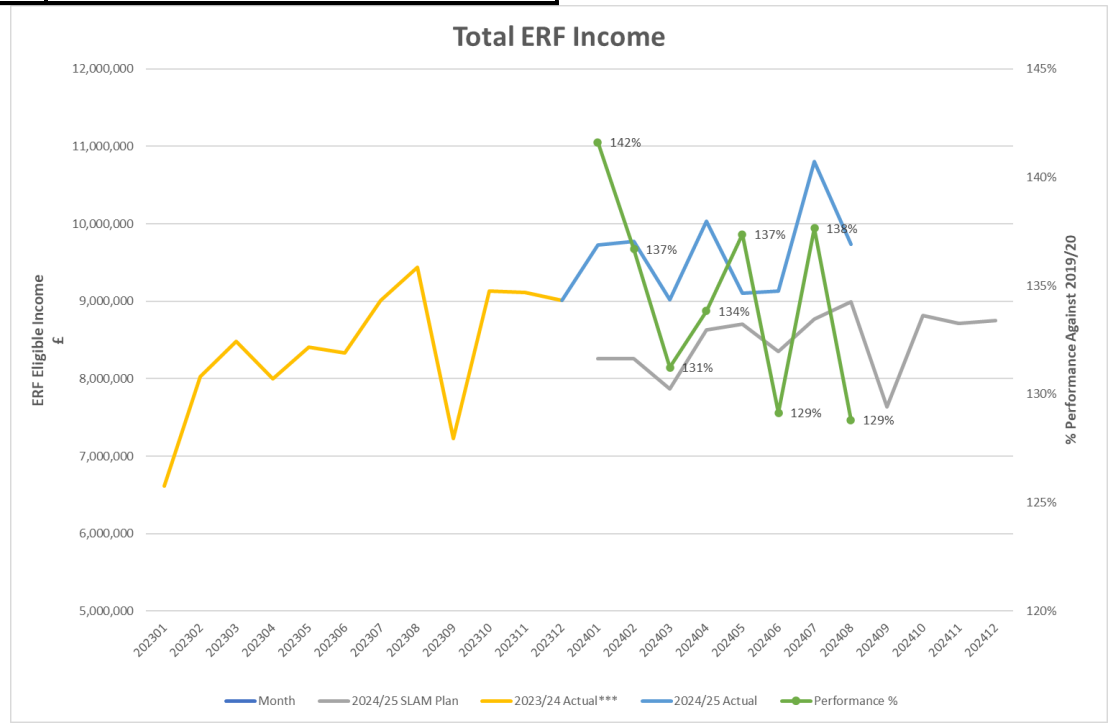
Driver Measure - RUH ESRF Performance

The total value of ERF eligible activity was £9.7 million in month. A slight reduction from October but still over £1m over plan. Backdated income drove the increased year to date performance.
Continuing increased work in theatres and improved DNA reductions and the ongoing impact of coding improvements all contributed to the delivery over plan.

	Investment Expenditure			Elective Recovery Performance			Metrics		
	Plan	Actual	Variance	Plan	Actual Performance Against 19/20	Variance	Performance Against 19/20	Performance Against Plan	Margin
Division	£'000	£'000	£'000	£'000	£'000	£'000	%	%	%
FASS	669	854	(185)	3,632	5,377	1,745	110%	112%	84%
Medicine	2,829	2,726	103	5,355	7,819	2,464	145%	108%	65%
Surgery	3,751	3,197	554	2,156	4,627	2,470	121%	107%	31%
Total	**7,249**	**6,777**	**472**	**11,144**	**17,823**	**6,679**	133%	109%	62%

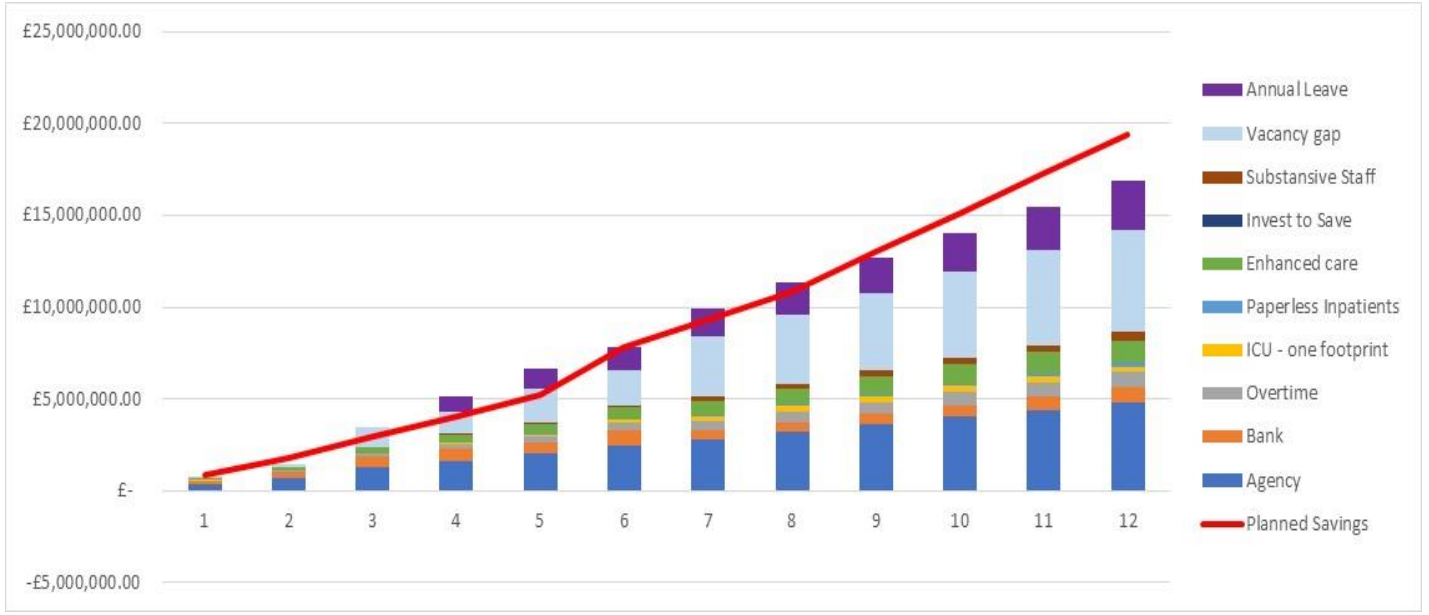
Performance year to date:

- Actual investment costs are £6.8 million, over budget by £472k. This investment generated additional income of £17.8 million, £6.7 million above target.
- The margin is 62% compared to a planned margin of 35% and this has contributed £6.2 million to the Savings Programme



QIPP – Cumulative Pay savings delivered by month (including extrapol

Month	Agency	Bank	Overtime	ICU - one footprint	Paperless Inpatients	Enhanced care	Pay breaks	Ward 4	Invest to Save	Substansive Staff	Vacancy gap	Annual Leave	Total	Planned Savings	Variance
202401	£342,357	£187,185	-£9,977	£56,000	£0	£85,400	£0	£0	£0	£0	£131,968	£0	£792,933	£853,540	-£60,607
202402	£689,041	£379,006	£27,625	£56,000	£0	£170,400	£0	£0	£0	£0	£166,017	£0	£1,488,090	£1,805,956	-£317,866
202403	£1,271,486	£626,606	£113,661	£56,000	£0	£305,400	£0	£0	£0	£0	£1,054,003	£0	£3,427,156	£2,969,413	£457,744
202404	£1,652,380	£661,586	£220,231	£56,000	£0	£452,443	£0	£0	-£29,398	£71,147	£1,150,844	£868,232	£5,103,465	£4,077,667	£1,025,798
202405	£2,043,548	£618,848	£320,918	£86,916	£26,122	£546,008	£0	£0	-£36,748	£88,934	£1,824,589	£1,085,290	£6,604,426	£5,182,833	£1,421,593
202406	£2,441,257	£855,817	£414,641	£161,916	£45,929	£639,573	£0	£0	-£44,098	£170,920	£1,792,182	£1,302,349	£7,780,486	£7,810,983	-£30,497
202407	£2,810,278	£461,623	£489,753	£316,929	£65,736	£770,041	£142,690	£88,033	-£51,448	£234,853	£3,259,328	£1,519,407	£10,107,223	£9,297,304	£809,918
202408	£3,155,217	£801,809	£552,406	£411,929	£85,543	£863,606	£285,380	£167,756	-£58,798	£301,924	£3,255,282	£1,736,465	£11,558,518	£10,863,565	£694,953
202409	£3,549,619	£902,035	£621,457	£411,929	£105,350	£957,171	£428,070	£251,393	-£66,148	£368,995	£3,845,625	£1,953,523	£13,329,018	£13,001,738	£327,280
202410	£3,944,021	£1,002,261	£690,508	£411,929	£131,580	£1,050,736	£570,760	£338,070	-£73,498	£437,692	£4,437,118	£2,170,581	£15,111,757	£15,139,911	-£28,155
202411	£4,338,423	£1,102,487	£759,559	£411,929	£157,810	£1,144,301	£713,450	£410,005	-£80,848	£506,388	£5,028,610	£2,387,639	£16,879,753	£17,274,111	-£394,358
202412	£4,732,825	£1,202,714	£828,609	£411,929	£184,040	£1,237,866	£856,140	£495,664	-£88,198	£575,085	£5,620,103	£2,604,697	£18,661,474	£19,400,000	-£738,526
Total	£4,732,825	£1,202,714	£828,609	£411,929	£184,040	£1,237,866	£856,140	£495,664	-£88,198	£575,085	£5,620,103	£2,604,697	£18,661,474	£19,400,000	-£738,526



Year to date pay savings above plan due to increased value in any WTE saving from 3.5% pay increases. Excluding this uplift the pay savings would be on plan.

As part of a review of corporate pay, £732k of budget savings from P8 to P12 were implemented this month.

Bank savings increased month on month due to an adjustment in month 7 to account for back dated pay rises. The actual trend in M8 is inline with P6 savings.

Productivity

Productivity is measured as changes in costs, compared to changes in activity levels. Productivity has deteriorated since pre-pandemic, although is now recovering. The reduction in productivity is a key driver of the Trusts' adverse finical position and why the Government is expecting higher activity and performance delivery without further uplifts in funding.

Table 1 compares productivity to 19/20 up to Month 6.
On this metric RUH productivity has deteriorated by 11.8%, however this is better than Regional and National average

	Explained change in spend				Explained activity			
System name	Inflation adj. expenditure growth	Service transfers	Non acute service change (incl GP xfers)	Unexplained expenditure growth	Cost weighted activity growth	Service transfers	Unexplained Activity Change	Implied productivity growth (unexplained)
GLOUCS	13.9%	6.6%	0.0%	20.5%	3.0%	0.0%	3.0%	(14.5%)
DEVON	29.7%	(6.1%)	0.0%	23.6%	14.2%	0.0%	14.2%	(7.6%)
BNSSG	26.5%	(1.0%)	0.0%	25.5%	9.7%	0.0%	9.7%	(12.6%)
DORSET	22.4%	0.0%	0.0%	22.4%	3.5%	0.0%	3.5%	(15.5%)
SOMERSET	26.5%	0.0%	2.1%	28.6%	6.7%	0.0%	6.7%	(17.0%)
CORNWALL	20.7%	(0.4%)	0.0%	20.3%	1.4%	0.0%	1.4%	(15.7%)
BSW	29.2%	(4.0%)	(0.6%)	24.6%	7.5%	0.0%	7.5%	(13.7%)
SW Region	25.8%	(1.9%)	0.1%	24.0%	7.6%	0.0%	7.6%	(13.3%)
Salisbury	28.1%	0.0%	0.0%	28.1%	12.0%	0.0%	12.0%	(12.6%)
GWH	25.2%	0.0%	(1.9%)	23.3%	3.5%	0.0%	3.5%	(16.1%)
RUH	33.8%	(10.4%)	0.0%	23.4%	8.8%	0.0%	8.8%	(11.8%)

Table 2 compare productivity to 23/24 up to Month 6
On this metric RUH productivity has improved by 4.5% which is equal to Regional average and better than National average

	Explained cost change			Explained activity change			
System name	Inflation adj. expenditure growth	Service transfers	Unexplained exp growth	Cost weighted activity growth	Changes to Activity	Unexplained activity change	Implied productivity growth (unexplained)
DEVON	3.1%	0.0%	3.1%	11.8%	0.0%	11.8%	8.4%
BSW	3.0%	(0.4%)	2.6%	8.2%	0.0%	8.2%	5.5%
GLOUCS	2.7%	0.0%	2.7%	7.6%	0.0%	7.6%	4.8%
SOMERSET	3.7%	0.0%	3.7%	7.5%	0.0%	7.5%	3.7%
CORNWALL	4.3%	0.0%	4.3%	7.4%	0.0%	7.4%	3.0%
DORSET	4.9%	0.0%	4.9%	6.9%	0.0%	6.9%	1.9%
BNSSG	4.5%	0.0%	4.5%	6.1%	0.0%	6.1%	1.5%
SW Region	3.7%	(0.1%)	3.6%	8.3%	0.0%	8.3%	4.5%
Salisbury	2.4%	0.0%	2.4%	11.2%	0.0%	11.2%	8.6%
GWH	3.2%	0.0%	3.2%	7.9%	0.0%	7.9%	4.5%
RUH	3.3%	(1.2%)	2.2%	6.8%	0.0%	6.8%	4.5%

Data is available 2 months in arrears and is adjusted to exclude the impact of Sulis.

System Position at M8

	GWH				RUH				SFT				ICB				System			
	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG
Financial Position (£m)*	(2.9)	(3.1)	(0.2)		(2.9)	(4.2)	(1.3)		(7.9)	(9.3)	(1.4)		1.3	3.3	2.0		(12.4)	(13.3)	(0.9)	

Month 8 Financial position vs Plan:

- The system is reporting a £13.3m deficit against a break-even plan (after the receipt of £30m deficit support funding).
- The actual deficit is therefore £43.3m.
- Based on the current run-rate, the system will exceed the full year plan by £20m (£10.2m above trajectory) without planned interventions.
- This represents an adverse movement from Month 7 of £2m (M7 YTD £11.3m).

Month 8 Variance vs Revised trajectories

- Against the YTD trajectory deficit of £12.4m, the system is £0.9m off target.
    - The above variance includes a £1m non-recurrent benefit associated with GWH: IFRS 16 £0.5m and GRNI £0.5m recognised in the ICB, and an additional £1m of ICB one-offs.

RUH:

- Included within the YTD deficit position is £1m of non-recurrent items (Redundancy £0.2m, Impairment £0.3m & Drugs/Devices £0.5m).
- Pay spend and bank remains challenged £0.6m.
- The deficit funding included within the YTD position has not been accounted for on a straight-line basis so there is a YTD benefit of £2.4m in the position.

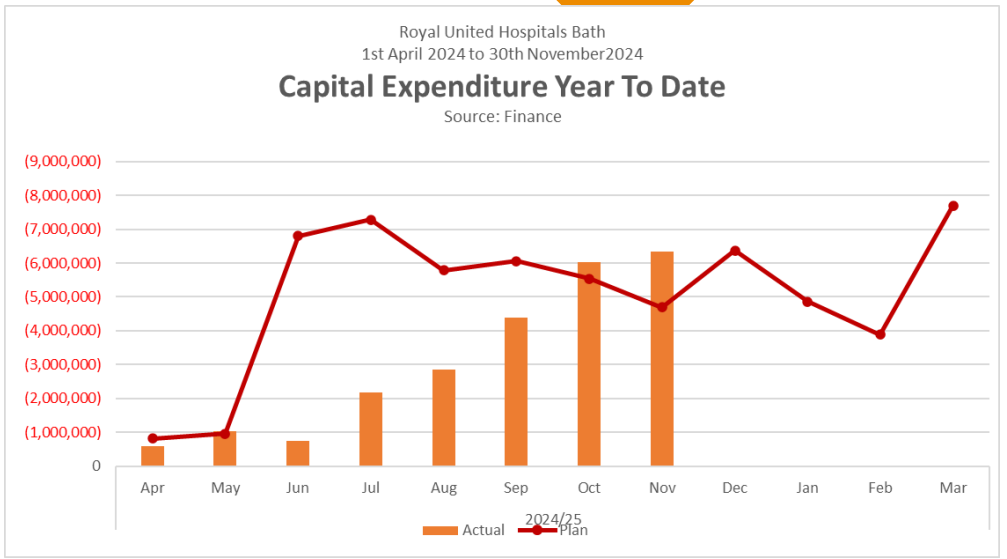
SFT:

- YTD Variance is driven by £0.9m Non-Pay, £0.4m associated with levels of escalation.

RAG Ratings	
RED	Over 15% deviation against YTD plan
AMBER	Between 5-15% deviation against YTD plan
GREEN	Between 0-5% deviation against YTD plan

Tracker Measure | Sustainability – Capital (RUH and SULIS)

Capital Position as at 30th November 2024	Annual Plan	Forecast Outturn	Year to Date Plan	Year to Date Actuals	Year to Date Variance
	£000s	£000s	£000s	£000s	£000s
Internally Funded schemes	(13,559)	(13,361)	(9,183)	(5,892)	3,291
IFRS 16 Lease Schemes	(3,700)	(3,700)	0	(189)	(189)
Disposals - NBV write off - Internally Funded & Lease		2		2	2
External Funded (PDC & Donated):					
SEOC PDC	(20,010)	(18,138)	(18,315)	(12,073)	6,242
BSW EPR PDC	(2,793)	(2,794)	(2,628)	(472)	2,156
Digital Diagnostic PDC	(367)	(367)	(71)	0	71
Community Diagnostic Centre PDC	(3,193)	(2,165)	(961)	(505)	456
Cancer Centre PDC	(422)	(422)	(422)	(107)	315
UEC PDC	(1,400)	(1,400)	(400)	(82)	318
RAAC PDC	(155)	(155)	(60)	0	60
Digital Screening PDC	(1,045)	(1,045)	0	(15)	(15)
Critical Infrastructure Risk PDC	(491)	(491)	0	0	0
Salix Decarbonisation Grant	(10,819)	(10,819)	(5,621)	(4,724)	897
Donated	(2,580)	(2,949)	(327)	(99)	228
Total	**(60,534)**	**(57,804)**	**(37,988)**	**(24,155)**	**13,833**



Is standard being delivered? No

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

The SEOC and BSW EPR schemes are behind plan.

Trust funded programme. The largest underspends remain as the BSW EPR scheme (Trust funded element), the single ITU and fire risk reduction schemes. The profile of spend for the EPR scheme has been reviewed, and £2.0 million of the assigned funding will not be spent this year. Mitigations to offset this slippage by bringing forward priority schemes from next year have been agreed by CPMG. The single ITU scheme is behind plan and is due to complete in December. The fire risk reduction scheme is now underway and is expected to come back to plan in the coming months. Within the IFRS16 lease schemes Pathology Managed Equipment Service remains a risk as it is currently out to tender, costs and timescales are not yet confirmed.

External funded schemes. The largest underspend is against the Sulis Elective Orthopaedic Centre (SEOC) scheme, this is due to delays in the planning permission. The new theatre construction is expected to complete in December, with the upgrade to laminar flow in existing theatres due to complete in March. There is a risk of a cost pressure on equipping which is currently being worked through. The BSW EPR (PDC funded element) is behind plan, full PDC funding is expected to be spent this year.

The main contractor for Heat Decarbonisation scheme has now started, grant funding for this year cannot be carried forward so any slippage will be a funding risk for the scheme.

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 CPMG to prioritise schemes to bring forward to offset BSW EPR slippage	Head of Financial Services

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

	30/11/2024 Actual £'000	31/03/2024 Actual £'000	Movement from March 24 £'000
Non Current Assets			
Intangible assets	5,594	7,105	(1,511)
Property, plant and equipment	305,534	301,392	4,142
Right of use assets - leased assets for lessee	48,463	51,035	(2,572)
Trade and other receivables	2,066	1,861	205
Total Non Current Assets	**361,657**	**361,393**	264
Current Assets			
Inventories	8,715	8,284	431
Trade and other receivables	44,140	29,887	14,253
Cash and cash equivalents	34,839	34,531	308
Total Current Assets	**87,694**	**72,702**	14,992
Total Assets	**449,350**	**434,095**	15,255
			0
Current Liabilities			0
Trade and other payables	(55,881)	(54,354)	1,527
Other liabilities	(25,748)	(13,298)	12,450
Provisions	(461)	(475)	(14)
Borrowings	(3,143)	(3,070)	73
Total Current Liabilities	**(85,232)**	**(71,197)**	14,035
			0
Total assets less current liabilities	**364,118**	**362,898**	1,220
			0
Non Current Liabilities			0
Provisions	(1,370)	(1,370)	0
Borrowings	(52,379)	(54,128)	(1,749)
Total Non-Current Liabilities	**(53,749)**	**(55,498)**	(1,749)
Total Assets Employed	**310,369**	**307,400**	2,969
Financed By:			
Public dividend capital	265,570	253,535	12,035
Income and expenditure reserve	3,237	12,303	(9,065)
Revaluation reserve	41,562	41,562	
Total Equity	**310,369**	**307,400**	2,969

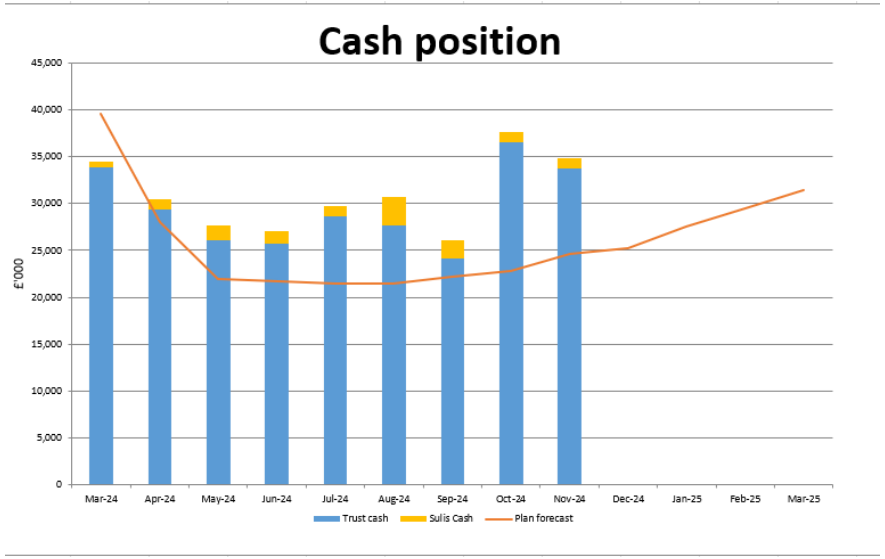
The Group Balance Sheet (RUH and Sulis)

Month 8 against 31/03/24:

- Non-current assets have decreased. The position reflects spend related to capital expenditure, which is currently behind plan as detailed in the capital slide, less depreciation.
- Trust inventories have increased, this relates to catheter stock.
- Trust receivables have increased from year end. This relates to ERF funding, secondary dental and pay award.
- Trust payables have increased. This relates to increases in capital payables and increases in expenditure.
- Trust other liabilities have increased. The key movement related to funding for the pay award.
- Cash has increased as set out in the cash slide
- Borrowings have decreased in line with expected payments. IFRS 16 leases and the corresponding borrowings are behind plan as detailed in the capital slide.
- PDC funding has increased for the drawdown of cancer centre funding, SEOC, CDC and the decarbonisation project. PDC funding is behind plan due to slippage in capital projects as detailed in the capital slide.

Tracker Measure | Sustainability – Cash (RUH and SULIS)

Group Cashflow Statement Month 8



Is standard being delivered for cash? No

The Group cash balance is £10.2 million higher than planned.

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

The variance against plan is driven by capital expenditure being behind M8 plan, interest received, donated cash for capital, pay award funding and movements in working capital.

Sulis cash position has increased by £61,000 against month 7.

Cashflow statement	
	Actual £'000
Operating Surplus/(deficit)	(3,016)
Depreciation & Amortisation	14,879
Income recognised in respect of capital donations (cash and non-cash)	(4,824)
Impairments	9,218
Working Capital movement	(11,703)
Provisions	(15)
Net cash generated from / (used in) operating activities	**4,540**
Capital Expenditure	(13,172)
Cash receipts from asset sales	29
Donated cash for capital assets	4,824
Interest received	1,373
Proceeds from sales of intangible assets	0
Net cash generated from / (used in) investing activities	**(6,946)**
Public dividend capital received	12,035
Movement in loans from the DHSC	(156)
Capital element of finance lease rental payments	(1,732)
Interest on loans	(61)
Interest element of finance lease	(1,145)
PDC dividend (paid)/refunded	(6,227)
Net cash generated from/(used in) financing activities	**2,714**
Increase/(decrease) in cash and cash equivalents	**308**
Opening Cash balance	**34,531**
Closing cash balance	**34,838**

Royal United Hospitals Bath
NHS Foundation Trust

Operational Report

December 2024 (November 2024 data)

The people in our community

The RUH, where you matter

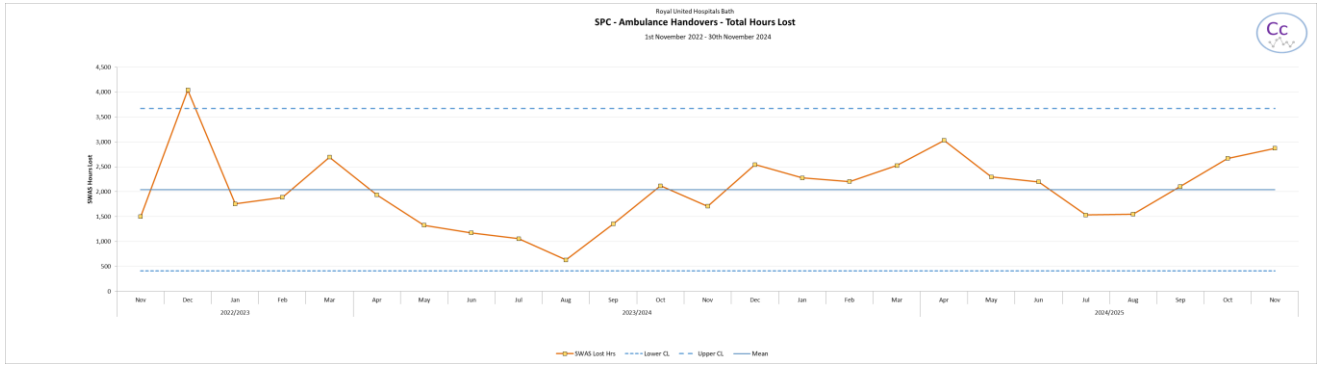
Executive Summary: Performance

Measure	Change	Executive Summary
Ambulance Handover		In November, the Trust lost a total of 2,872 hours in ambulance handovers, an increase from the previous month (2,667). The percentage of ambulance handovers completed within 30 minutes decreased for November to 29% compared to previous month (31%) against the national standard of 95%. Most patients who are delayed are non-admitted, followed by patients who are placed admitted to MAU . The opening of the C16 admission lounge has not as yet had the impact that we had hoped for, although we are continuing to refine and update the standard operating procedure for this to support flow and to decompress MAU. Fit to sit is now open for longer hours from November for the winter.
4 Hour Performance		RUH 4-hour performance in November was 65.2% (including MIUs) and 56.2% on the RUH footprint (unmapped), a deterioration from October. Non-admitted performance was 67.6% which is a decrease from the performance for September (69.5%). Admitted performance was 28.7% which was also a deterioration from September (33.8%).
Non-Criteria to Reside (NC2R)		During October, the Trust had an average of 96.3 patients waiting who had no criteria to reside, which is an increase of 2.7 than the previous month. Some localities saw a decrease in average numbers of NCTR. BaNES has seen a decrease to 32.5 which is positive, however still needs significant focus on system partner calls and support.
Referral to Treatment		In November 2024, the Trust had 524 patients waiting > 52 weeks, a decrease of 9% from October. For waiters **> 65 weeks**, the Trust also saw a decrease in November from 22 to 18 patients. There were 2 patients waiting **> 78 weeks** at the end of November (same as October). For waiters **> 52 weeks,** the three largest specialties combined represent two thirds of the waiters. These are ENT, Gastroenterology and Trauma & Orthopaedics. ENT saw a decrease from 177 patients waiting >52 weeks in October to 140 patients waiting >52 weeks at the end of November. T&O continued to decrease in November with 73 patients waiting >52 weeks, down from 79 in October. Gastroenterology continued to decrease in November, from 105 patients waiting down to 96
Cancer 62 Days		Performance was below target at 62.2%, minimal change from October. The deterioration in performance in Urology and Breast has resulted in the drop in performance from earlier this year at Trust-level, whilst Colorectal remains the most challenged specialty. LATP waiting time in Urology is the sole contributing factor to >50% of breaches, due to a deficit is nursing capacity. Breast service impacted by increased demand which coincided with long term sickness of consultant surgeon. Breaches in Colorectal due to imaging (CTC), more complex endoscopy (not suitable for Sulis) and outpatient waiting times in Gastro. Haematology breaches increased in month, driven by longer waiting times at NBT for BMAT reporting.
Diagnostics		In November 2024, 66.89% of patients received their diagnostic within the 6-week target against an in-month target of 63.42% and year-end target of 95% (revised trajectory October 2024). The number of patients waiting > 6 weeks decreased by 1041 breaches when compared to previous month. Reduction in breaches for MRI, USS and Sleep Studies driving improved position. Performance ahead of trajectory driven by above plan staff engagement with the weekend and OOH WLI lists.
Elective Recovery		In November (M8) organisationally we delivered 99% of the Trust plan and 109% of 19/20 activity. Additional weekend operating in theatres picked up in M8 and drove DC and IP over-delivery in M8, at 107% against plan for both POD types. As a trust, in M8 we had an overall in-month income position £1.06M. The Trust has delivered financial performance year-to-date of 128% of 19/20 and 107% of our 24/25 plan, in ERF. This has delivered a surplus of £6.68m year-to-date.

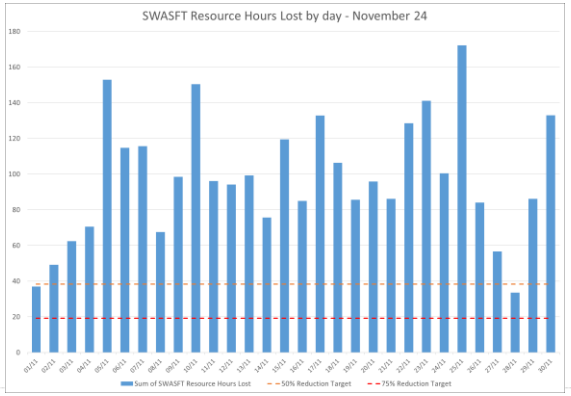
Key Standards | Ambulance Handover Delays:

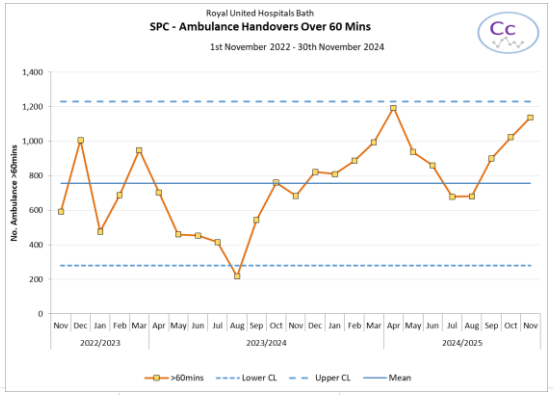
Performance Target:
Lose no more than 500 hours per month.

Historic Data: Hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

- In November, the Trust lost a total of 2,872 hours in ambulance handovers, an increase from the previous month (2,667). The percentage of ambulance handovers completed within 30 minutes decreased for November to 28.7% compared to previous month (31%) against the national standard of 95%. Most patients who are delayed are non-admitted. Fit to sit has been able to open at 08:00 and therefore supporting internal flow within ED, however, flow out of ED remains challenged.

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

The Trust reported more hours lost in November and the percentage of handovers completed within 30 minutes decreased.

The overall performance was also contributed by:

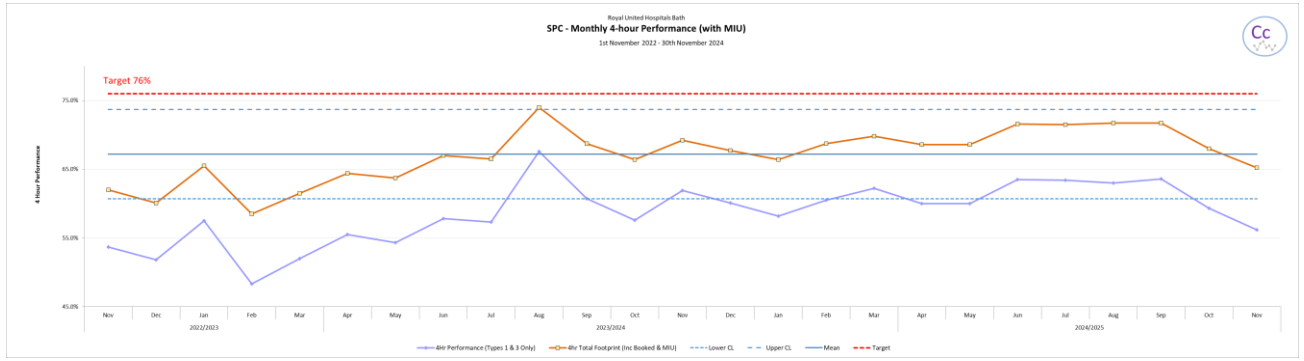
- X-CAD continues to only be utilised in ED, which is leading to data errors particularly when cohorting patients. This creates challenges with validating ambulance handover delays when a patient is placed into a Cohort Area. Daily validation is ongoing but manual validation will not override X-CAD recorded time.
- SDEC units full so expected patients arrive in ED & UTC contributing to overcrowding.
- Challenges with flow out of the ED resulting in more patients being placed in cohort areas.
- Consultant vacancies contributing to no formal RAT cover, this is covered on an ad-hoc basis
- Second registrar being pulled into CED / into ED numbers when staffing low
- SAU pathway for ENT patients not being followed resulting in congested department and patients queuing into Majors waiting area

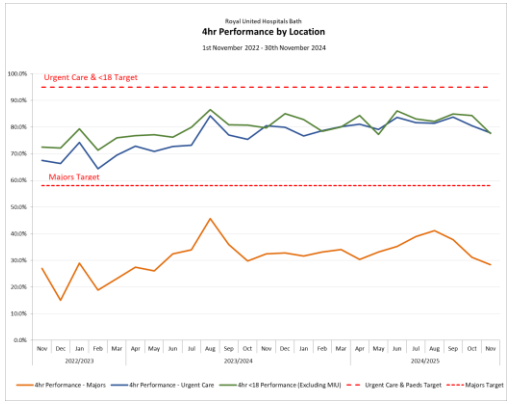
Countermeasures / Actions	Owner	Due Date
RAT working Group recommenced. SOP for Pitstop / RAT drafted, awaiting sign off by Deputy MD, then launch and embed monitoring impact.	M. Price / C. Forsyth / F. Maggs	30.10.24
Trial of a second SpR overnight to be able to undertake overnight RAT.	M. Price / C. Forsyth	01.10.24
We are looking to recruit to Consultant posts and ensure that there are 3 Consultants on to allow RAT to occur consistently.	M. Price / C. Forsyth	30.10.24
Open fit2sit 08:00 – 00:00 following PDSA.	T. Thorn/ C. Irwin-Porter	w/c 14.10.24
Review Fit to Sit protocol and maximise with patients arriving by ambulance.	M. Price & C. Irwin-Porter	31.10.24
Works to be done to increase size of SDEC waiting room Q4 2024/2025.	M.Rumble	
To have a discussion with BSW ICB / SWAST regarding role of HALO and impact on handover / XCAD issues.	C.Macgregor	31.10.24

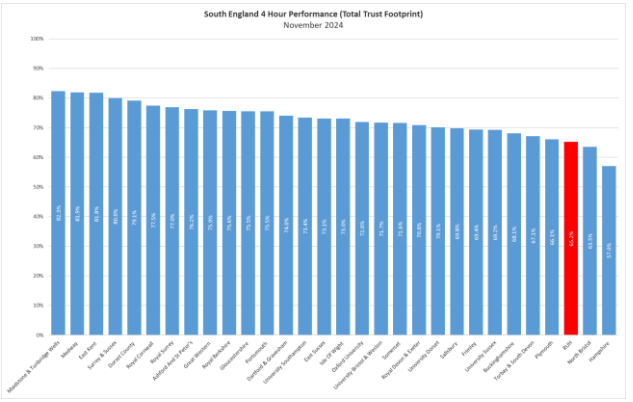
Key Standard | 4-hour Emergency Standard:

Performance Target:
76% of patients discharged or admitted from ED within 4 hours.

Historic Data:







Is the standard being delivered?

- RUH 4-hour performance in November was 65.2% and 56.2% on the RUH footprint (unmapped), a deterioration from October.
- The percentage of patients triaged within 15 minutes in Majors has decreased from 68.88% in October to 58.79% in November.

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

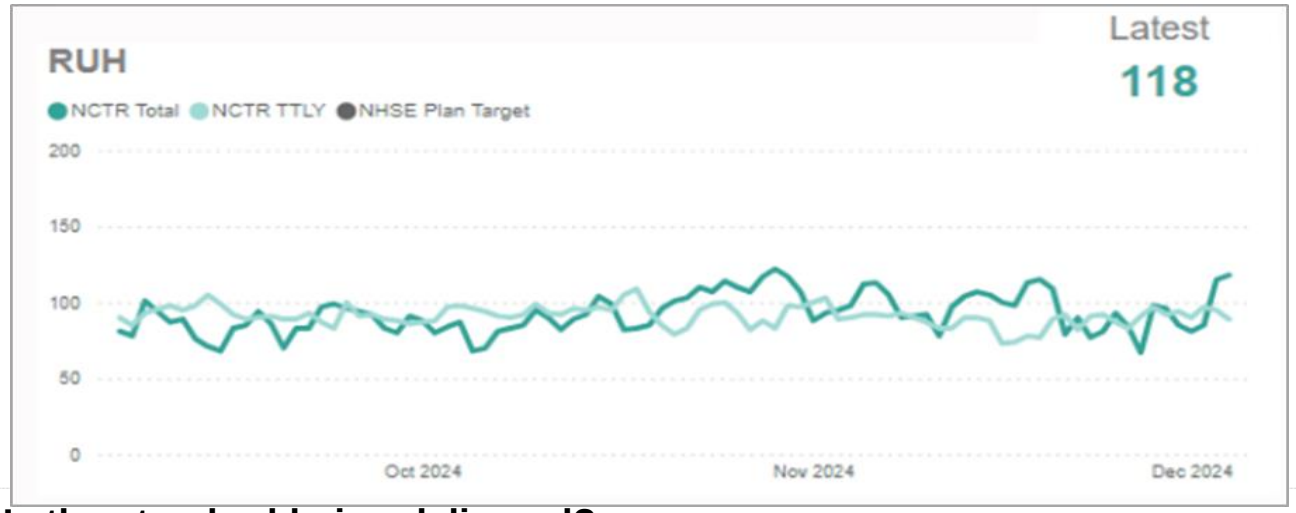
- IPC restrictions impacted on patient flow out of the ED
- Identified patients breaching in Fit2Sit (delay to first clinician)
- ACA not empty by 8am leaving us unable to open Fit2Sit earlier
- Non-criteria to reside numbers remain over trajectory.
- Ongoing long waits for mental health patients to be seen by Mental Health Liaison / AWP, particularly overnight, and in addition long waits for MH beds
- Vacancy within consultant workforce and urgent care staffing leading to gaps in rota and no consistent RAT cover
- Overcrowding in ED leading to no assessment space
- Cohort area consistently in use
- Inconsistent use of SAU and DAA waiting areas for Surgically and Medically expected patients
- Internal critical incident days within November due to poor flow both within the trust and system

Countermeasures / Actions	Owner	Due Date
Update ED safety matrix and upload to intranet page.	C. Irwin-Porter/ T. Thorn	31.10.24
Finalise draft escalation policy, ensure ratified and uploaded.	A. West/ S. Hudson/ D. Allison	31.10.24
Review new rota shifts in Urgent Care and make any amendments necessary to support demand.	T. Thorn / J. Lloyd-Rees	31.10.24
Link with the Urgent Care Directory of Services to ensure in line with GWH and the national specification.	T. Thorn / J. Rayner	31.10.24
Complete ECIST staffing review for senior decision makers in ED.	C. MacGregor	31.10.24
Open fit2sit 08:00 – 00:00 following PDSA.	T. Thorn/ C. Irwin-Porter	w/c 14.10.24
Share learning from practitioner in charge PDSA and monitor impact on 4-hour performance.	J. Rayner / T. Thorn	31.10.24

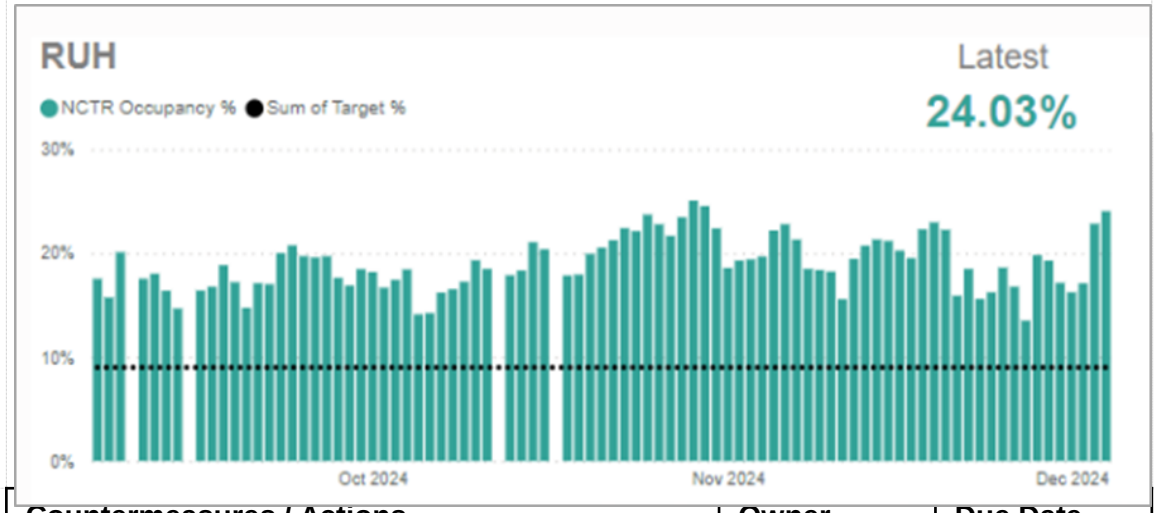
Is this a Key Standard?| Non-criteria To Reside:

Performance Target:
Agreed with commissioners for no more than 55 patients waiting who don't have criteria to reside.

Historic Data: as of 05/12/24



Supporting data



Is the standard being delivered?

The daily average target for NCTR patients at the RUH is 55 Patients per day across Community (pathways 1-3) & Hospital (majority of pathway 0 patients). During November, the Trust had an average of 97.1% patients waiting who had no criteria to reside, which is 3.0 higher than the previous month. This remains above the system refreshed target of 55.

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

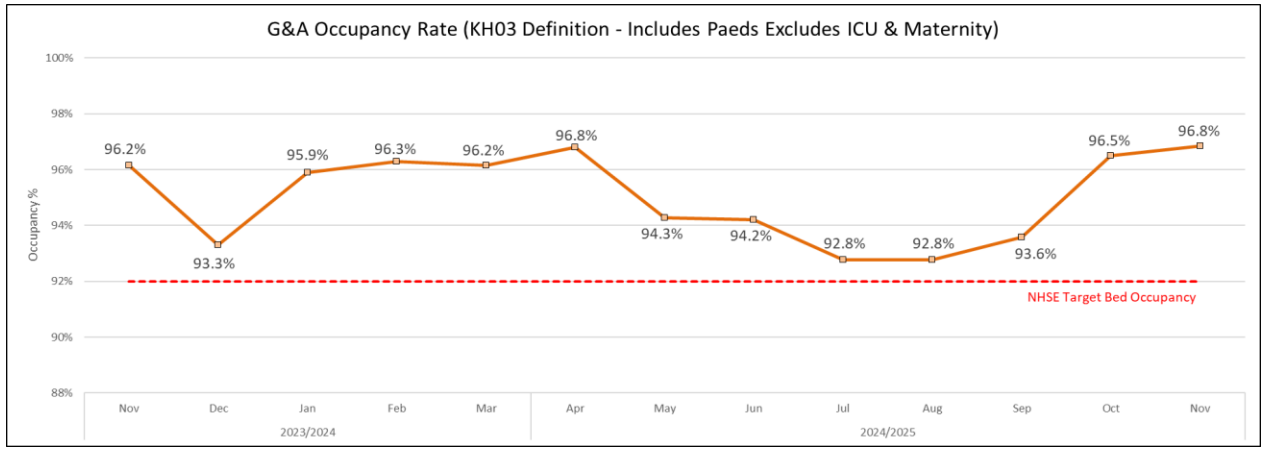
- In November 24, the daily average hit a year to date high of 97.1 patients in total, however not achieving target and remains off course to achieving the trajectory of 10.4% or below (set in April 24) by the end of March 2025 as required.
- Key challenges remain across community and hospital which are being rapidly addressed both internally and across BSW to enable meeting the target but ultimately ensure a safe and supportive discharge for people to leave hospital when it's appropriate to do so.
- Lack of required funding at system level to sufficiently fund Pathway 1 leading to capacity gaps and subsequent discharge delays.
- Ongoing workforce challenges/gaps for pathway 1 providers reducing capacity.
- Lack of required LOS reduction in pathway 2 beds reducing capacity.

Countermeasures / Actions	Owner	Due Date
Recovery plan and measures in place to support Wiltshire system. Support system with plans to address capacity gaps for pathways 1-3 to meet NCTR target of 55.	Emma Crockett	On going
Home is Best focus on admission avoidance with system colleagues.	David Allison	Q1 23/24
Implementation of electronic whiteboards to streamline discharge planning.	David Allison	Q3 24/25
Further embed P0 therapy referral guidance across all wards – aim for zero P0 therapy delays	David Allison	Q3 24/25
Deep dive P0 mapping with key wards to determine root cause and develop 2024/25 action plan.	David Allison	Q3 24/25
75% reduction in hospital-related discharge delays (pathways 1-3) and <5 pathway 0 patients 24 hours post NCTR per day	David Allison	March 2025

Key Standards | Bed Occupancy:

Performance Target:
Bed occupancy should be no greater than 92%.

Historic Data:



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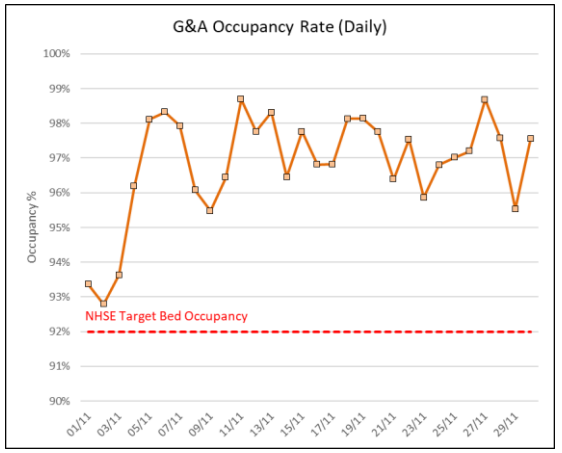
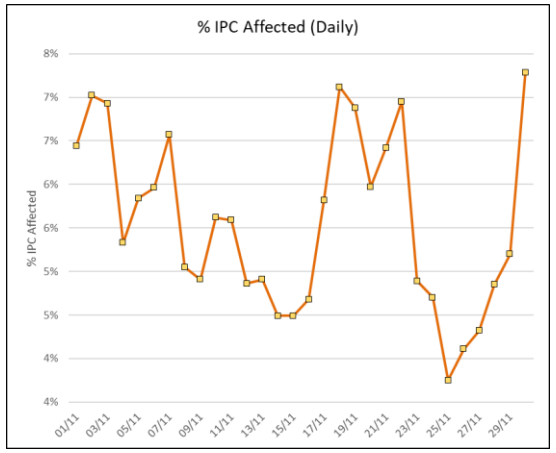




Is the standard being delivered?

NHS England target as described in the Urgent and Emergency Care Recovery Plan indicates that bed occupancy should be **92%**. For November 2024, the Trust's bed occupancy was **96.8%**, an increase of 0.3% compared to October 2024.

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

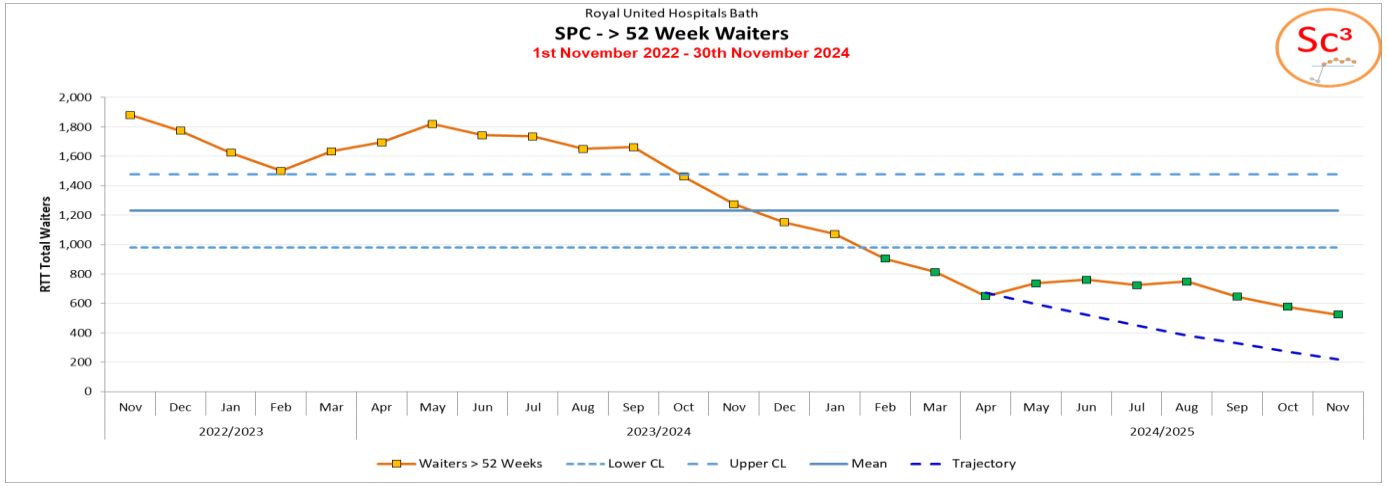
- In month up to 15% of the bed base affected with IPC restrictions.
- Discharge lounge underutilised which exacerbates the number of patients that can be discharged by midday.
- Through deployment of new ward standard work and delivery of a 'discharge sprint' (24 Oct-3 Nov) achieved:
  - 7% Increase of % Discharge by 12:00 from July-Oct.
  - 63% to 69% increase of % Discharge by 17:00 July-Oct.
  - 10% average increase Discharge Lounge occupancy from August-Nov
- 35% of patients seen through an SDEC pathway in October 2024 (1776 patients)

Countermeasures / Actions	Owner	Due Date
Embedding of Discharge lounge SOP to increase utilisation and compliance. Eligibility criteria prominent in ward areas, and compliance supported by the Discharge Lounge Senior Charge Nurse visiting all ward daily to embed the application of the criteria. Aim to sustain 42 patients discharged per day by end of March 2024	Anita West	Q1 24/25
Continued Improvement work on pre-midday discharges and utilisation of discharge lounge.	Clinical Divisions	Q1 24/25
Launching review of board rounds and comparing against the Royal College of Physicians guide on modern ward rounds.	Medicine Clinical Division	Q1 24/25
Relocation of Discharge Lounge to main block to increase both capacity and utilisation by being centrally located closer to the wards, enabling efficient transfer and removing barriers such as the incline to the lounge and transfer outside.	Sarah Hudson	Q4 24/25

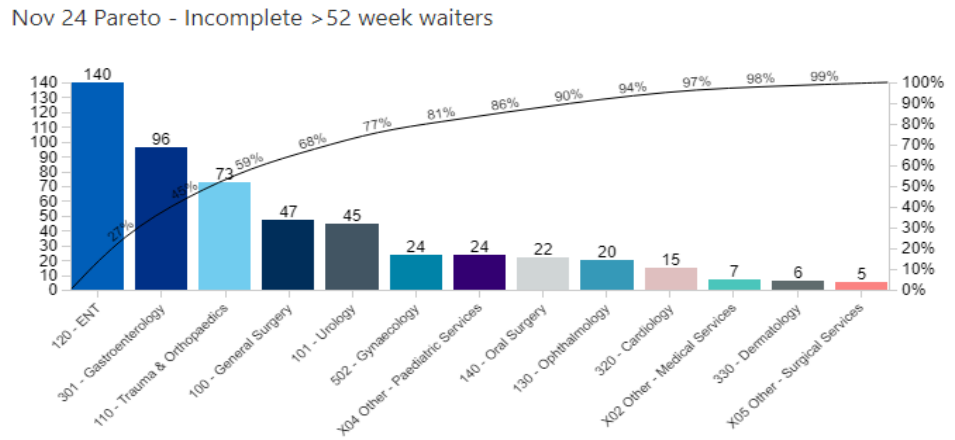
Trust Goal | Referral to Treatment:

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 November 2024, the Trust had 524 patients waiting > 52 weeks, a decrease of 9% from October.
- For waiters **> 65 weeks**, the Trust also saw a decrease in November from 22 to 18 patients.
- There were 2 patients waiting **> 78 weeks** at the end of November (same as October)
- RTT performance was 62.7% in November.
- For waiters over 52 weeks, the three largest specialties combined represent two thirds of the waiters. These are ENT, Gastroenterology and Trauma & Orthopaedics.
- ENT saw a decrease from 177 patients waiting >52 weeks in October to 140 patients waiting >52 weeks at the end of November.
- T&O continued to decrease in November with 73 patients waiting >52 weeks, down from 79 in October
- Gastroenterology continued to decrease in November, from 105 patients waiting down to 96

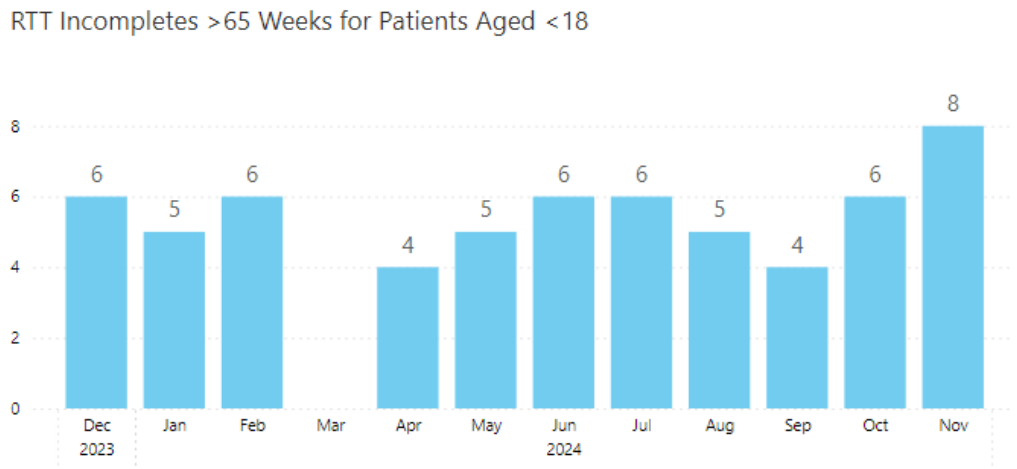
What's the top contributor for under/over achievement?

- 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. However, both the Paediatric and spinal posts have now been recruited to with a start date of 20th January 2025 for the paediatric consultant and potential start date of April 2025 for the spinal consultant.
- ENT have increased the number of referrals being sent to Sulis. 3 month locum post waiting for approval to

Countermeasures / Actions	Owner	Due Date
Review insourcing for ENT	Roberts	Nov 24
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 Q3 24/25
Continued focus on utilising BSW system wide capacity to support focused effort on reducing waiting list.	Roberts/ Macgregor	Ongoing
Validation "deep dive" into challenged specialties to obtain learning for specialties and drive process improvements.	Dando	Ongoing

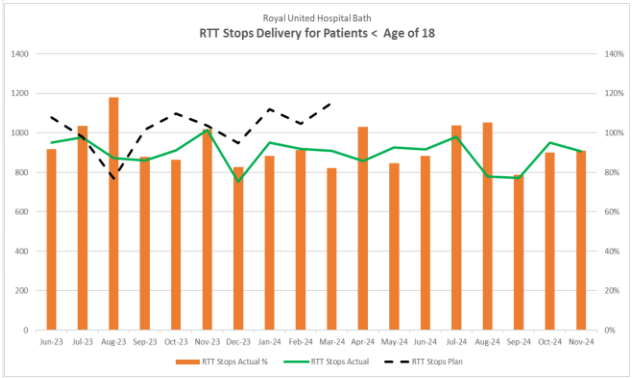
Trust Goal | Paediatrics:

Historic Data:

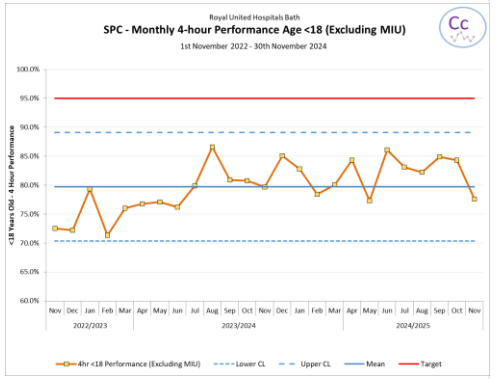


Supporting Data:

Stops v Plan



4 hr performance



Is the standard being delivered?

- RTT non-compliant – In October we reported 0 patients <age of 18 waiting **>78 weeks**. We reported 8 patients waiting over 65 weeks – these are within Trauma and Orthopaedics and due to the well documented capacity issues.

- Cancer 28 Day Diagnosis compliant – 85.7% (one breach) Patient was under the care of the Breast team with breach due to waiting time for first outpatient appointment. A locum consultant is now in post mitigating the capacity deficit caused by long term sickness of a substantive consultant. The patient was diagnosed non-cancer.

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 was approved in October. The new consultant is starting in January and will be focusing on our area of challenge, outpatient waits.

Countermeasures / Actions	Owner	Due Date
Business case for Paediatric Orthopaedic Consultant approved – Consultant starting in January	Prosser	January
CED/PAU - working together to improve 4hrs - Ambulatory paediatrics pilot – launching end of October, (increase PAU capacity). - Plan to pilot surgical electives in PAU.	Gilby / Potter/ Goodwin	End of Jan 24
CAMHS pathway – new low risk pathway to expedite CAMHS discharge process. Awaiting sign-off by consultant psychiatrist.	Goodwin	In progress

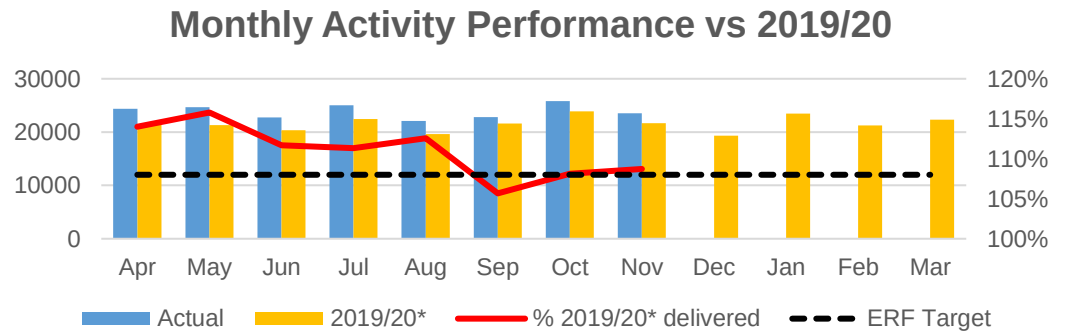
Key Standards | Elective Recovery:

Performance Target:
Deliver 109% of elective activity compared to 2019/20.

ERF Performance:

	Vs 19-20									Vs 24-25								
Division	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**YTD**	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**YTD**
FASS	152%	160%	151%	153%	144%	145%	151%	148%	**150%**	111%	115%	113%	110%	99%	108%	118%	123%	**112%**
Medicine	153%	153%	159%	149%	147%	145%	145%	140%	**149%**	108%	118%	118%	107%	109%	111%	113%	109%	**112%**
Surgery	123%	113%	104%	112%	122%	108%	121%	110%	**114%**	115%	109%	102%	103%	105%	101%	113%	110%	**107%**
Total	**136%**	**132%**	**127%**	**129%**	**133%**	**125%**	**133%**	**125%**	**130%**	**112%**	**113%**	**109%**	**106%**	**105%**	**105%**	**114%**	**112%**	**109%**

Supporting Data: - ERF Activity Delivery



Key areas of variance this month within each Division is as follows:

Month 8 ERF remains in a positive position, with an increase in income across all Divisions increasing year to date performance against plan to 109% and 130% against 2019/20 baseline.

The key variances against plan are described below and suggested actions are as follows:

FASS:

- Breast Surgery performance has fallen for the last 2 months, there has been a shift of activity from Elective Inpatients to Day Case resulting in an overall reduction in income in month. Income related to new outpatient appointments also remain below plan and 2019/20 levels too totaling £13k under plan year to date.
- Gynae income has picked up against plan from month 5, driven by higher Day Cases and outpatient activity. Whilst Elective Inpatient activity was on plan, the income was £17k lower than plan, this could be due to the scale of uncoded activity (which will be rectified once coded) or a change in acuity.
- Oncology income continues to be significantly over plan and 2019/20 levels of income, again, driven by Day Case and outpatient attendances, the specialty is now £786k over plan year to date
- Paediatric income was back up to planned levels in September, the advice and guidance correction has improved the year to date performance which is now back on plan year to date. Day Case activity has always been below 2019/20 levels of activity but higher outpatient procedures indicate a shift in treatment to outpatients.

Medicine:

- Cardiology income has been below plan since M3, mainly driven by lower new outpatient appointments. There was also a fall in Elective Inpatient activity with a reduction in income of £14k in month
- The Dermatology position benefited the most from the advice and guidance correction, however Day Case and outpatient procedure income remain below plan, £145k and £38k adverse to plan respectively.
- Endocrinology has seen a big increase in diabetes device costs driven by the NICE recommendation to closed loop systems. The outpatient activity remains slightly under plan £46k to date.
- Gastro activity remains below plan, off-set by General Surgery Income due to the split of endoscopy activity between the two specialties. However, new outpatient appointments are also below plan £34k year to date, however this saw an improvement in month delivering £35k more than plan.
- Adult Rheumatology continues to overperform against plan, £42k in month and now £326k year to date, this is

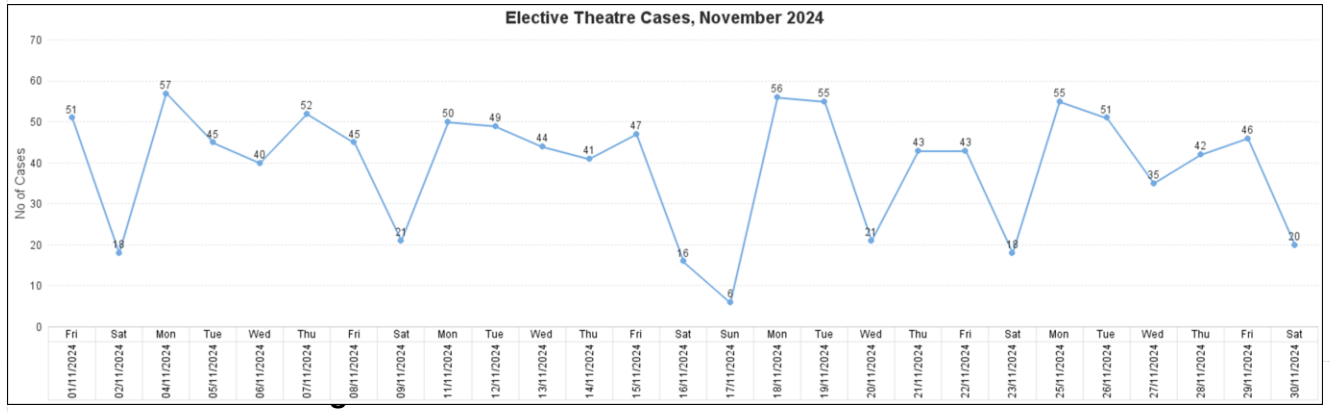
Is the standard being delivered?

In November (M8) organisationally we delivered 99% of the Trust plan and 109% of 19/20 activity. Additional weekend operating in theatres picked up in M8 and drove DC and IP over-delivery in M8, at 107% against plan for both POD types. As a trust, in M8 we had an overall in-month income position £1.06M. The Trust has delivered financial performance year-to-date of 128% of 19/20 and 107% of our 24/25 plan, in ERF. This has delivered a surplus of £6.68m year-to-date.

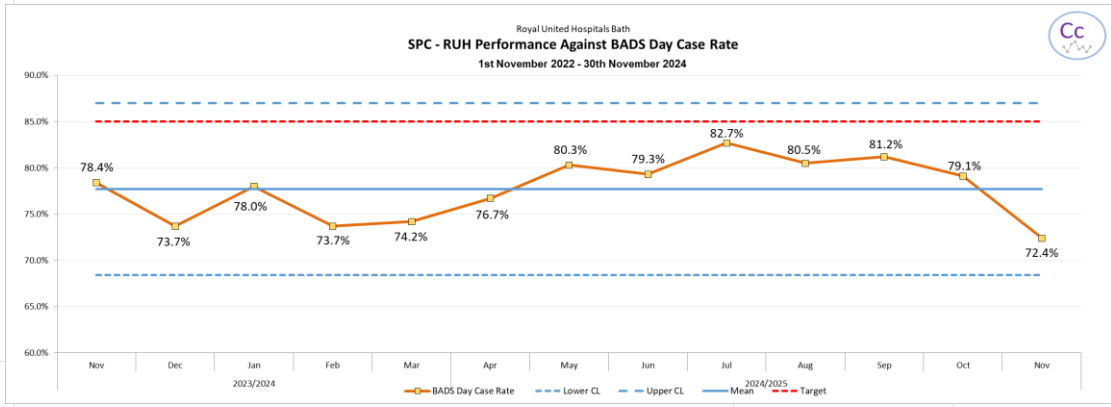
Countermeasures / Actions	Owner	Due Date
Transformation workstreams focused on supporting increased activity within Theatres and Outpatients. Extending to endoscopy/ Cath labs.	Divisions	Through Q1-Q3 24/25
Clinic Templates are being reviewed. In some specialities however there is an ongoing need to balance the NEW patient activity, for which we receive income, with any clinical risks in overdue follow-ups. Clinical	Divisions/ Improvement team	Q2-3 24/25

Key Standards | Productivity:

Historic Data:



Supporting Data:



- The RUH aims to book to 85% of lists available minutes (to allow for turnaround time), in November theatres were booked to 81.0% a from 79.1% in September; the capped utilisation was 75.6%, a decrease from 77.1% (target 85%) in September.
- The British Association of Day case Rates (BADs) was 72.4% (unvalidated), against the 85% National Target.

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

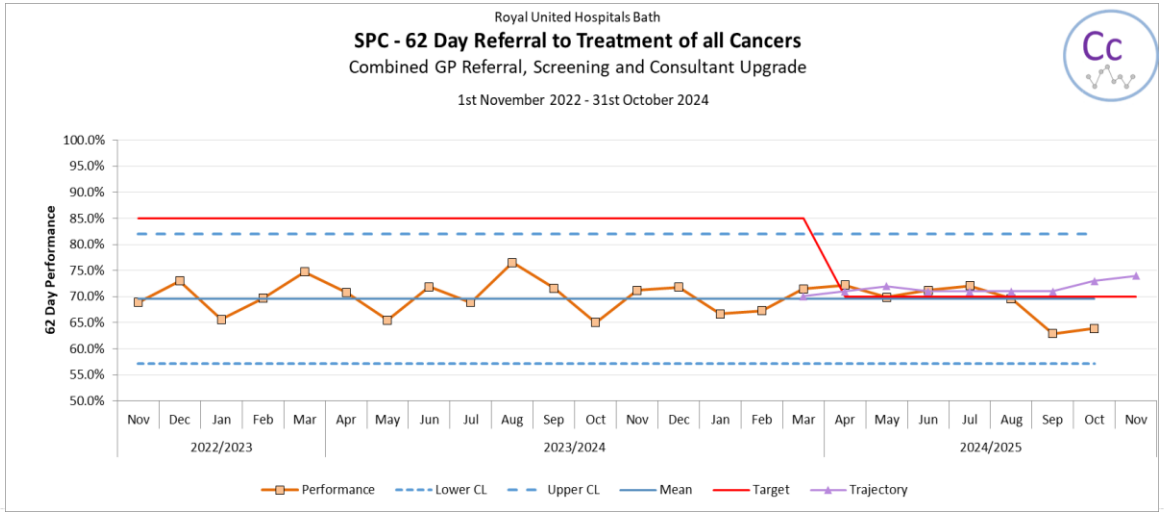
- In November, Theatre cancellations caused by sickness in anaesthetic, theatre staffing reduced and weekend theatre lists.
- The cancellations on the day increased to 105 in November, driven by an increase in sickness and patients cancelled due being unfit for surgery. Though non-elective bed pressures and ICU capacity have also been key factor in the number of on the day cancellations.
- The number of lists finishing late also decreased (27.6%), reflecting the potential overbooking of lists, case complexity or late starts/increased down-time between patients.
- The Clinical and Operational teams, with support from the improvement programme, continue to support theatre efficiency projects with focus on elective bookings and wider theatre efficiency measures, including late starts, turnaround time.
- The total number of additional High-Volume Low Complexity (HVLC) cases completed in November was 50 against a target of 35. This has brought in an additional income of £117k in month. YTD we have achieved 337 additional cases and £724k of additional income, £93k above YTD plan.

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 **Note July BADs %**
Review/refresh of booking and procedure times to ensure lists booked more accurately .	J Price	Q4 24/25
Development of speciality specific productivity dashboard to become breakthrough objective for each speciality	S Williams	Q3 24/25
NHSE Theatre Improvement lead for South West invited to attend RUH site to support / identify areas for improvement	J Price/A Dougherty	Q3 24/25

Key Standards | Cancer 62 Days:

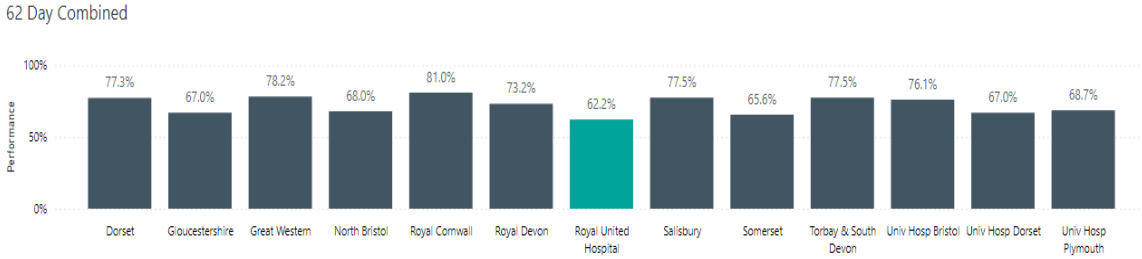
Performance Target: 70% of patients treated within 62 days of referral on a cancer pathway.

Historic Data



Supporting data

Regional 62 Day Combined RTT Comparison



Is the standard being delivered?

October was below target at 62.2%: trajectory (73.3%).

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

62 Day Treated:

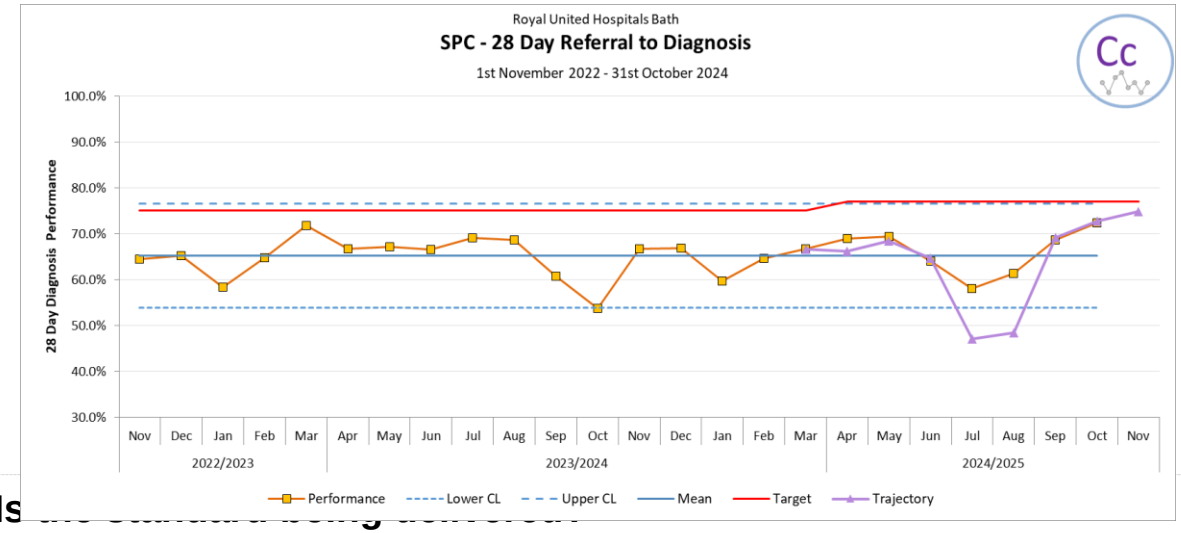
- Urology breaches increased due to increasing LATP waiting times – sole reason for >50% of breaches. Waiting time exceeded four weeks at its worst due to deficit in substantive nursing capacity and reduction in uptake of WLIs following earlier bank pay change. Now reducing through WLIs and insourcing planned.
- Prostate surgery waiting times also above timed pathway. Capacity improved from October with new consultant commencing in post and existing consultant increasing robotic procedure efficiency.
- Breast remaining challenged due to consultant surgeon long term sickness at time of peak demand for service. Above average activity levels in past four months. WLIs in place but not significant uptake leading to extended time to recover performance.
- Colorectal consistently lowest performing specialty (32.5%). Breaches due to imaging (CTC), more complex endoscopy (not suitable for Sulis) and outpatient waiting times in Gastro.
- Simple colonoscopy waiting time reduced considerably through use of Sulis.
- Haematology increased breaches in month, driven by BMAT reporting times at NBT and patients being initially referred to incorrect specialty. GP referral forms for Haematology and Head & Neck being adapted to minimise incorrect referrals.

Countermeasures / Actions	Owner	Due Date
Urology – Robotic surgery practitioner to support prostatectomy operating lists	J Prosser	Nov 2024
Urology – LATP WLIs agreed and in place from October. Waiting time reducing. Insourcing agreed but delayed until January	K Rye J Schram	Jan 2025
Haematology – Revision of Head & Neck and Haematology GP referral proformas	C Frape	Dec 2024
Haematology – One-stop myeloma pathway to mitigate BMAT reporting times at NBT	C Frape	Nov 2024
Anaesthetics – Daily drop-in pre-op clinics being commenced in November	R Leslie	Nov 2024
Pathology – Increase in outsourcing 100 extra cases per week, commencing mid-December	L Edwards	Dec 2024

Key Standards | Cancer 28 Days:

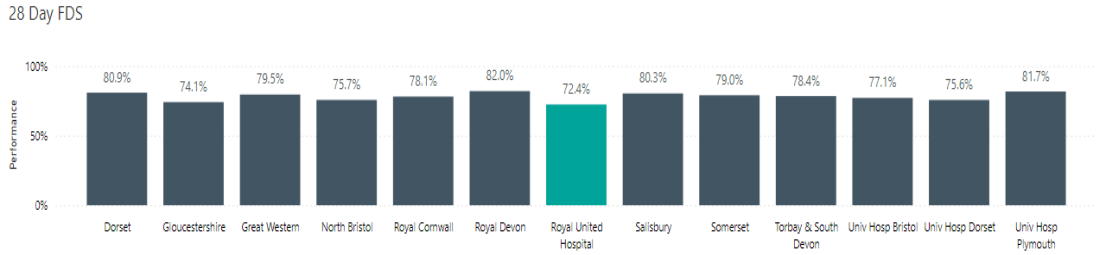
Performance Target: 77% of patients given their diagnosis within 28 days of referral.

Historic Data



Supporting data

28 Day FDS Regional Comparison



Is [illegible]

- October performance improved by 3.7% to 72.4%, delivering performance above tiering threshold (70%) for first time in 2024/25. RUH remains in NHSE tier 2 requiring three months performance above the tiering threshold to be considered for exit.

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

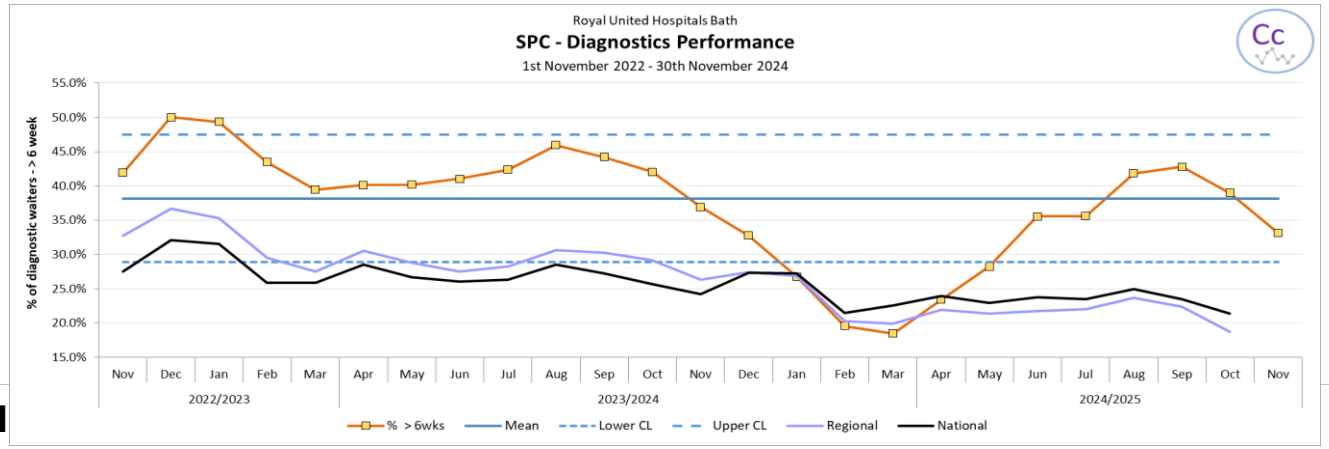
- Colorectal/Upper GI very challenged performance. Breaches due to lack of clarity in endoscopy reports over whether 28 day pathway has stopped. To be addressed with Medilogic implementation.
- Further breaches due to waiting times for Gastro OPA (circa. 4 weeks). Discussions regarding long term change to IDA pathway – meeting planned 17/12/2024.
- Urology LATP waiting time – WLIs reducing it to 3 weeks. Insourcing planned to clear backlog.
- CT IVU waiting time at circa. 2 weeks – aim to reduce to 7 days through mobile capacity.
- Haematology breaches due to BMAT reporting at NBT. Mitigated at RUH by implementation of one-stop clinic in November to reduce time to OPA/biopsy to 8 days.
- Breast performance improved in month but challenges going forward due to consultant surgeon and radiographer long term sickness. Cover being provided by locum (OPA) and WLIs (imaging).
- Histology waiting times continue to impact performance. Most impact in Colorectal, Upper GI and Gynaecology. Cancer Alliance funding agreed to extend locum consultant until mid-February.
- Full recovery of performance in Skin (97.2%), continuation of insourcing until end of January. Telederm/Cinapsis being implemented – estimates from region this could avoid 30% demand.

Countermeasures / Actions	Owner	Due Date
Breast – One-stop pilot days Q3/4. Go live delayed until March due to staff sickness/training of HCAs	H Wheeler M Jarvis	Mar 2025
Colorectal – Cancer 360 PTL system implemented to give greater visibility and timeliness of actions	E Nicolle	Nov 2024
Colorectal – Review of IDA pathway. Meeting with Gastro December	E Nicolle R Wilson	Dec 2024
Endoscopy – Implementation of Medilogic – delayed until mid-January	R Wilson	Jan 2025
Skin – Telederm/Cinapsis for suspected cancer to be implement – support from BSW and Cancer Alliance	G Lewis	Feb 2025
Pathology – SWAG funding to extend locum consultant. Request for further funding until March	L Edwards E Nicolle	Dec 2024

Key Standards | Diagnostics 6 Weeks:

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

Historic Data



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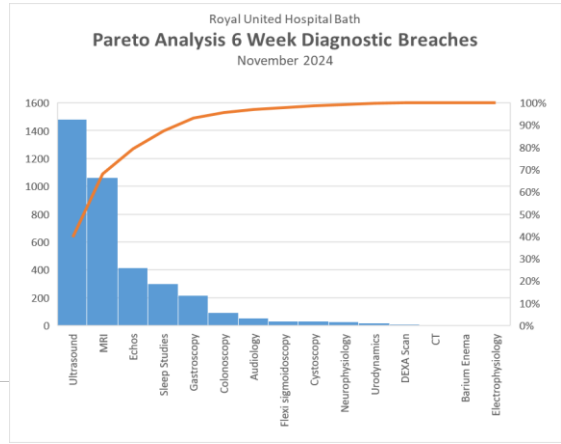
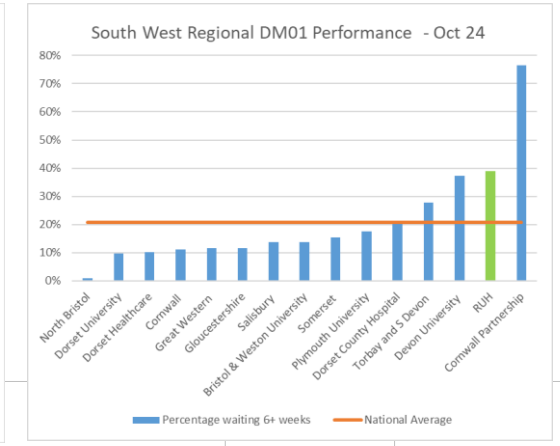




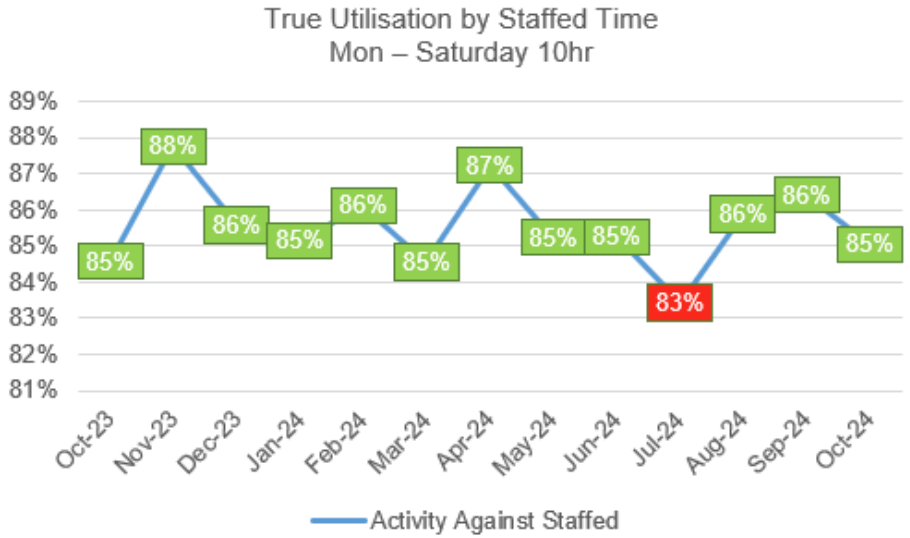
In November 2024, **66.89%** of patients received their diagnostic within the 6-week target against an in-month target of 63.42% and year-end target of 95% (revised trajectory October 2024). The number of patients waiting > 6 weeks decreased by **1041 breaches** when compared to previous month.
Reduction in breaches for MRI, USS and Sleep Studies driving improved position.
Performance ahead of trajectory driven by above plan staff engagement with the weekend and OOH WLI lists.

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

- Top contributors for breaches: MRI, USS and Echo.
- Positive impact of additional recovery actions supporting improved performance:
  - Weekend and OOH WLI's for CT, MRI and USS.
  - Mobilisation of weekend insourcing for USS.
- Demand for Radiology modalities in November in line with average for year and revised demand profile, still above national forecast.
- Endoscopy additional capacity with mobile Unit at Sulis CDC delayed to January 25.
- Sleep Studies started transferring activity to Sulis CDC (200 exams).

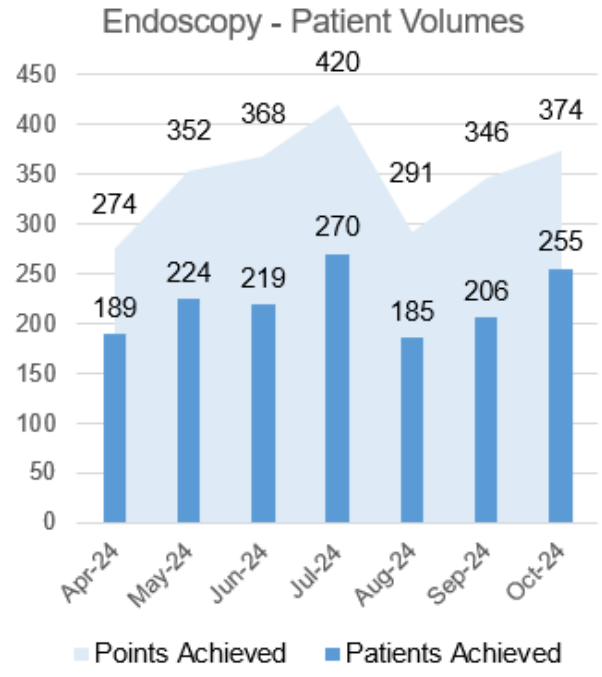
Sustain and increase radiology activity at Sulis CDC (additional 150 CT/MRI diagnostics) - monitored weekly. Review of plans for direct access to CDC for GP's and CDC reporting DM01 for activity delivered.	NA / TB / MC	Ongoing
WLI rates approved – to support increased additional activity at weekends and OOH (MRI, CT, USS, Echo). Mobilisation from 19.10.2024.	NA/JLR	Ongoing
USS insourcing at weekends approved – mobilisation from 19.10.2024.	NA/TB/RF	Ongoing
Additional Endoscopy capacity from mobile unit at Sulis CDC.	SH / VM	December-24
Transfer of Sleep Studies service to Sulis CDC from November 2024. Gradual transfer of backlog for H2 2024/2025.	Sulis CDC	Started November-24
Review of DM01 trajectories to account for increased demand profile and additional activity coming from October 2024.	NA / AA	Completed
Weekly review of each modality – performance, demand and activity against trajectory.	NA / JS	ongoing

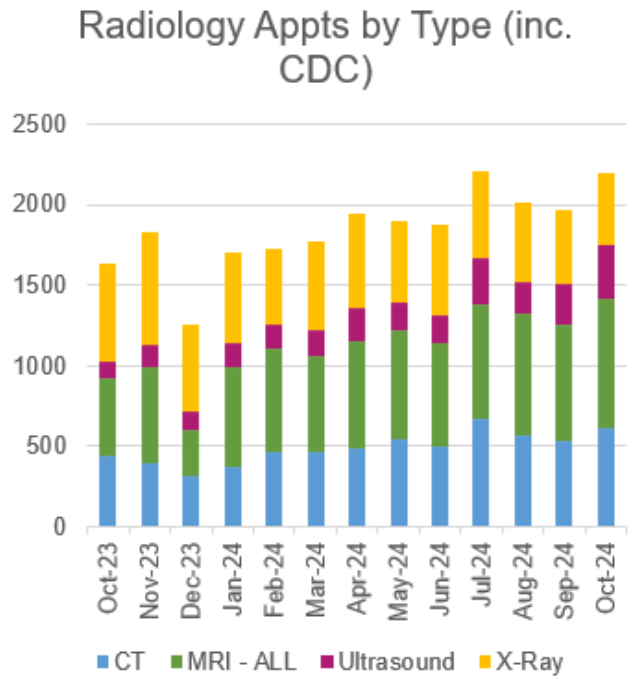
Key Standards | Sulis Hospital



RTT: **89%** - ↑ 4%

Weeks	PT QTY
78+	0
65+	15
31-65	277
19-30	507
0-18	2222





Is the standard being delivered?

- **Theatre** session up-take was good, but Laminar flow sessions were impacted by clinician availability and some challenges with volume of patient pipeline still present
- Surgical wait list is growing and in the last month we have seen it rise by 30%. This is a positive given the recent reports of lack of patient availability.
- **Radiology** volumes were the highest seen in the last two years. Extended days and weekends enabled capacity to increase for CT and MRI. CDC targets being overachieved in all modalities except XRAY. XRAY capital work will be completed mid-November to enable increased XRAY provision for CDC activity.
- **CDC –** Sleep and Respiratory services going live in November and Decembers. RTT and DM01 performance with RUH will reduce significantly over the next quarters.
- **RTT position** at 89%. Long waits are being managed to meet 65% target. Largest impact is due to IPT route to support RUH ENT. Sulis carries clock and is impacting position.

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

- Improved session up-take in Endoscopy is enabling larger capacity for work.
- Radiology extended sessions, weekend and longer days impacting positive capacity.
- Lack of patient pipeline is still of concern from both NHS and private markets

Countermeasures / Actions	Owner	Due Date
Review outreach clinic options in Yeovil and Frome to attract new referral volumes.	Milner	Ongoing
Deploy Endoscopy van to enable increased Endoscopy capacity. Review mechanism to increase volumes of referrals from RUH.	Milner	October
Commence CDC services for Sleep Studies and Respiratory at Sulis Hospital Bath.	Milner/ MacGregor	COMPLETE
Review CT volume and future sustained pipeline between RUH and Sulis CDC. Current risk is the pipeline (backlog) has been serviced.	Milner/ MacGregor	Ongoing

Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

December 2024 (November 2024 data)

The people in our community

The RUH, where you matter

Executive Summary I

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

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Key Standard	Trust Vacancy WTE (Unit 4)			104.5	91.8	56.2	80.4	290.2	94.7	50.1	150.5	11.6	139.5	145.9	123.4
Contextual Information	Trust Establishment WTE (Unit 4)			5689.9	5690.5	5700.2	5699.4	5888.3	5693.9	5639.3	5699.8	5576.2	5728.4	5737.2	5696.9
Contextual Information	Substantive WTE (Unit 4)			5585.4	5598.7	5643.9	5619.0	5598.1	5598.6	5589.2	5549.3	5564.6	5588.9	5591.3	5573.5
Key Standard	Vacancy Rate	<=4.00%	>4.50%	1.84%	1.61%	0.99%	1.41%	4.93%	1.66%	0.89%	2.64%	0.21%	2.43%	2.54%	2.17%
Contextual Information	Total Pay Bill (exc R&D)							£27.5M	£27.2M	£27.3m	£26.7m	£28.1m	£25.7m	£36.5m	£28.9m
Key Standard	In Month Turnover	<=0.92%	>1.00%	0.49%	0.53%	0.51%	0.80%	0.66%	0.92%	0.69%	0.71%	0.66%	0.87%	0.73%	0.44%
Key Standard	Rolling 12 Month Turnover	<=11.00%	>12.00%	8.98%	8.78%	8.52%	8.40%	8.12%	8.45%	8.39%	8.55%	8.22%	8.10%	8.16%	8.05%
Contextual Information	Leavers Inside 1st Year WTE (Permanent Contract Held, All Reasons)			3.2	3.3	3.6	6.0	12.8	11.4	7.5	6.3	6.4	8.9	3.2	3.6
Contextual Information	Bank Use (Staffing Solutions Data)			196.2	204.5	193.6	183.3	189.2	199.1	197.3	207.5	222.7	198.0	204.8	182.3
Contextual Information	Agency Use (Staffing Solutions Data)			28.5	20.8	18.8	20.8	19.8	17.2	17.1	13.3	14.0	16.4	11.4	15.0
Key Standard	Agency Spend as Proportion of Total Pay Bill	<=2.50%	>3.50%	2.13%	0.33%	2.22%	1.05%	1.14%	1.13%	0.27%	1.02%	0.94%	1.03%	0.81%	1.11%
Contextual Information	Agency Spend			£588k	£87k	£600k	£446k	£315k	£310k	£73k	£277k	£267k	£268k	£297k	£321k
Contextual Information	% of agency usage that are off framework			1.13%	1.58%	0.54%	3.62%	1.26%	4.89%	9.15%	5.93%	7.07%	1.42%	5.27%	0.33%
Contextual Information	% agency shifts that are above price cap			81.9%	76.9%	81.4%	82.9%	95.6%	88.5%	76.8%	55,67%	34.7%	25.3%	24.7%	24.0%
Key Standard	Nurse Agency Spend as Proportion of Registered Nursing Pay Bill	<=3.00%	>4.00%	3.62%	0.85%	2.16%	1.57%	1.62%	1.71%	-1.71%	0.60%	0.69%	1.20%	1.22%	0.53%
Key Standard	In Month Sickness Rate (Actual) - Reported 1 month behind	<=4.38%	>4.88%	4.66%	4.92%	4.83%	4.57%	4.43%	4.39%	4.87%	4.64%	4.41%	4.60%	5.12%	
Contextual Information	In Month Sickness - Estimated Cost (£m)			£807k	£860k	£812k	£791k	£758k	£781k	£861k	£876k	£819k	£830k	£988k	
Key Standard	Rolling 12 Month Sickness Rate - Reported 1 month behind	<=4.30%	>4.80%	4.46%	4.45%	4.47%	4.47%	4.48%	4.49%	4.54%	4.54%	4.55%	4.59%	4.65%	
Tracker	Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.22%	1.19%	1.20%	1.22%	1.20%	1.17%	1.19%	1.21%	1.22%	1.23%	1.25%	
Contextual Information	In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.22%	1.13%	1.25%	1.17%	1.12%	1.14%	1.34%	1.25%	1.33%	1.21%	1.26%	

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

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Vacancy	The Trust vacancy rate is below target, the aggregated figure masks some variation, with several areas demonstrating higher vacancy rates and others being over-established.	Trust led Vacancy Control and Agency Reductional Panel continues to support right-sizing our workforce against our workforce plans. The controls are supporting the Trust financial recovery plans and we anticipate vacancy rates to increase when it's safe to hold a post to support our financial position.
Sickness	In month and 12-month sickness rates are on upward trends. Anxiety, Stress and Depression sickness remains high, with Cold and Flu rising.	Earlier in the year, 9 teams were identified in the Trust with excessive short term sickness rates (defined as above 3%). In October 24 there are only 2 of these teams that remain with a short-term sickness rate of over 3%, all others have reduced significantly to well below 3%. The work on interrogation of the data continues via regular meetings and the People Hub team run monthly reports from the rostering system to identify to managers both short term and long-term sickness. Significant work has been undertaken with HALO (launched in late November 24) and currently working on a process for inputting sickness cases, allowing managers to update on each case directly through the self-service portal, which will enable more timely advice and support.

Executive Summary II

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-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	0.70	0.67	0.64	0.56	0.56	0.63	0.64	0.59	0.48	0.54	0.64	0.64
Contextual Information	% of Band 6/7 who are from Global Majority Background (WTE)			14.93%	15.25%	15.16%	15.41%	15.40%	15.39%	15.48%	15.49%	15.54%	15.66%	15.79%	15.83%
Contextual Information	% of Band8A+ who are from Global Majority Background (WTE)			6.20%	6.17%	6.14%	6.53%	6.54%	6.45%	6.39%	6.11%	6.44%	6.44%	6.43%	6.64%

				Last 12 Months											
	Performance Indicator	Latest Month Target	Outside Tolerance	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Key Standard	Appraisal Compliance Rate	>=90.00%	<85.00%	74.84%	75.82%	77.04%	77.05%	77.66%	77.69%	78.91%	78.53%	82.75%	82.84%	80.17%	80.93%
Contextual Information	Global Majority Appraisal Compliance Rate	>=90.00%	<85.00%	71.81%	73.00%	75.64%	76.74%	76.89%	78.32%	81.24%	80.07%	85.91%	86.00%	83.23%	83.29%
Key Standard	Mandatory Training Compliance (exc Bank)	>=85.00%	<80.00%	89.82%	90.29%	90.84%	90.40%	90.32%	90.03%	90.04%	88.74%	89.01%	88.16%	88.38%	88.60%
Key Standard	IG Training Compliance (exc Bank)	<=95.00%	>100.00%	86.79%	87.62%	88.40%	87.72%	88.51%	86.61%	85.92%	85.24%	87.94%	86.34%	86.23%	86.67%
Key Standard	Safeguarding Adults Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	92.10%	92.44%	92.81%	92.43%	92.79%	92.84%	92.93%	92.56%	91.76%	91.60%	91.34%	91.63%
Key Standard	Safeguarding Adults Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	91.31%	91.02%	91.84%	91.34%	91.69%	91.84%	92.08%	91.96%	92.34%	91.09%	90.81%	90.42%
Key Standard	Safeguarding Adults Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	94.55%	93.75%	89.47%	93.21%	30.43%	36.01%	37.97%	42.16%	47.36%	52.25%	59.00%	67.72%
Key Standard	Safeguarding Children Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	92.23%	92.64%	92.88%	92.22%	92.55%	92.30%	92.11%	91.68%	91.43%	91.48%	91.05%	91.01%
Key Standard	Safeguarding Children Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	91.61%	91.74%	92.46%	91.57%	9187.00%	91.51%	91.28%	91.19%	91.85%	90.44%	90.28%	90.57%
Key Standard	Safeguarding Children Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	91.24%	91.97%	90.95%	91.20%	91.32%	90.41%	88.14%	87.32%	89.34%	88.98%	87.89%	88.04%

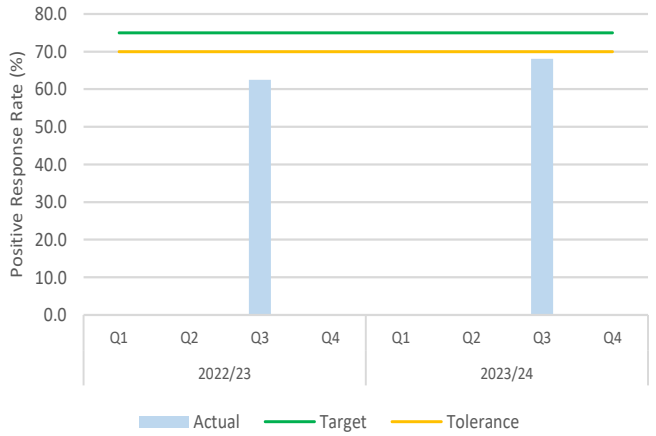
** Training data based on Learning Together from Jun-23; Appraisal and Training information re-stated due to new reporting methodology

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Appraisal	Appraisal compliance has improved but remains red against the 90% target at 80.93%.	• Focussed work with specialities with low appraisal compliance led by DPP's. • Increase uptake of appraisal training and support to prioritise (Managers and DPPs) • Developing feasibility options for implementing an appraisal window to focus efforts on quality conversations • Revised Appraisal Policy pending ratification • Forging alignment between health and wellbeing interventions and manager engagement with team colleagues.

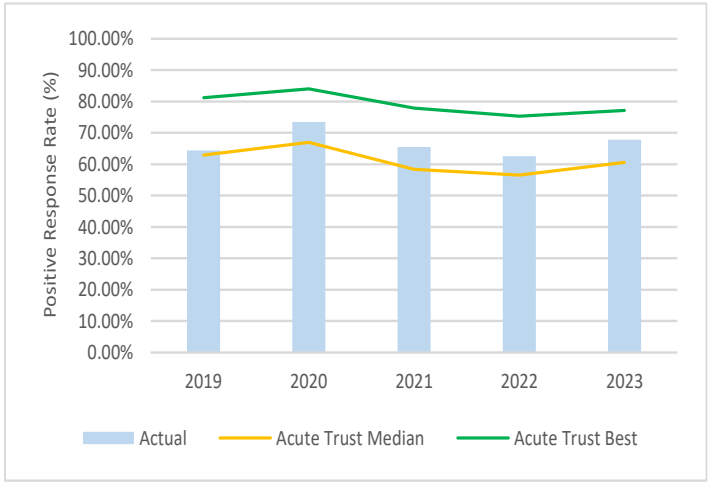
Trust Goal | Staff Recommend the Trust as a Place to Work

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%.

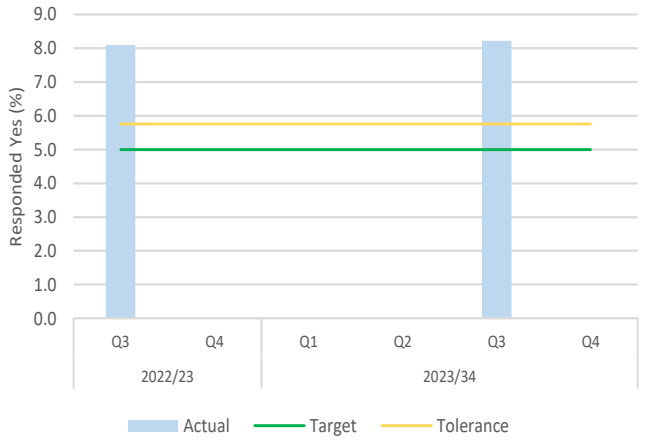
Countermeasure Summary

Countermeasure/Action	Owner
Central workstreams continue to prioritise this measure, with projects including; • Review of strategic recognition offer • Exploring new, easy to use team development options for struggling areas • EDI projects to increase engagement and provide safe, inclusive working environments. • Large-scale review of leadership and management development offer to enhance staff experience • Basics Matter programme identified priorities from staff survey to inform the content of the workstreams.	People Team for Culture Divisional People Partners/ Divisional Leadership Teams Basics Matter Team

Breakthrough Goal |

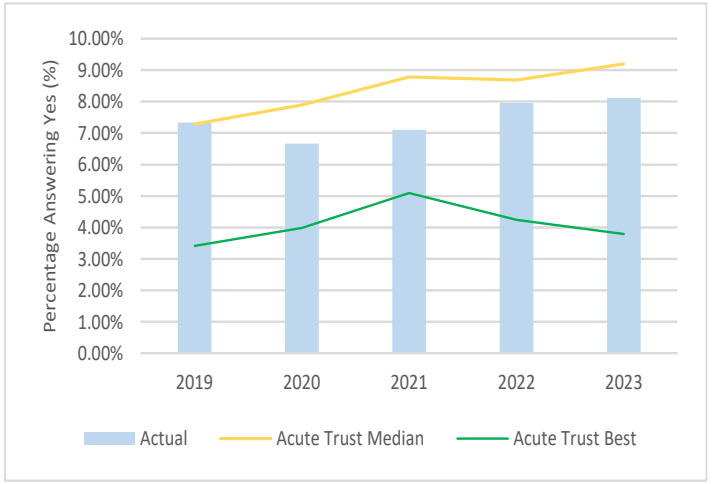
Reduce Proportion of Staff Reporting Experiencing Discrimination from Line Managers/ Colleagues

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?

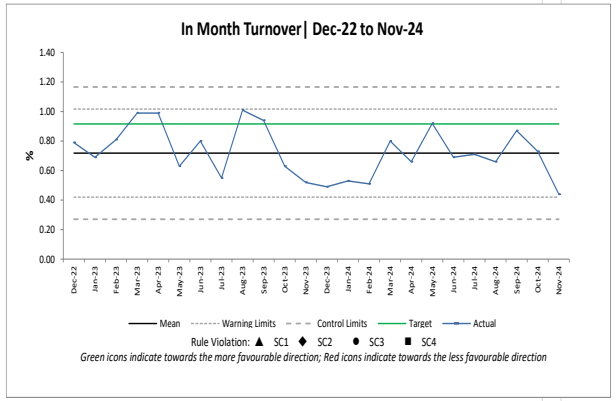
• Emergency Medicine had the lowest proportion of staff reporting that they had not experienced discrimination from a manager or colleague at 85.9%.

Countermeasure Summary

Countermeasure/Action	Owner
• Targeted team development interventions (in collaboration with People Team) to address identified issues, including emergency medicine, theatres and cleaning. • Report and Support launched in August 2024, therefore better, swifter support to areas most affected by discrimination. • Violence Management and Reduction Policy launched August 2024 • Refreshed breakthrough objective – 2024/25 focus on Disability and Long-Term Conditions, and embedding work on race (esp. Anti-Racist Statement) • Real-time outliers will be identified using reports through Datix, DPPs and Report + Support – quarterly sample is small, and survey data requires additional balancing to identify specific areas of concern.	People Hub DPPs People Team AD for Culture

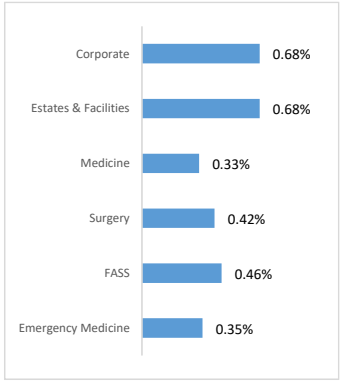
Key Standard| Turnover Rate

In Month Turnover - Trust

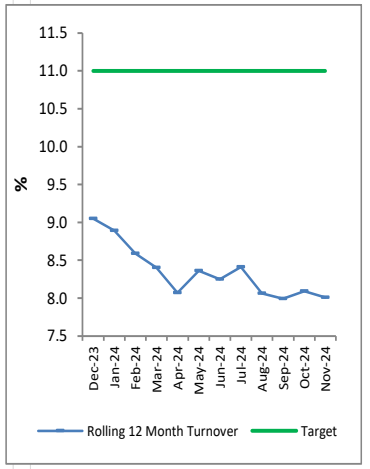


Turnover Rate	0.44%

Month Divisional Turnover



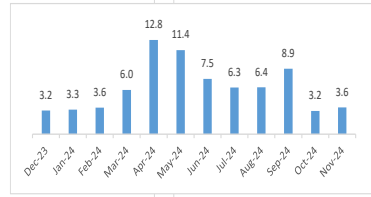
Rolling 12 Months Turnover - Trust



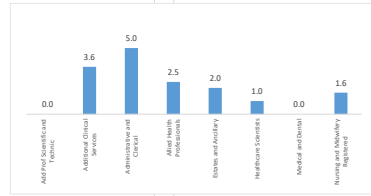
Turnover Rate	8.05%

Leavers Inside 1st Year (Permanent Contract)

Trust Trend



Staff Group - Last 3 Months



Is standard being delivered?

• As it stands, overall in month turnover for November was relatively low at 0.44%. This has in turn lowered the 12 month turnover rate to 8.05%. Although both metrics are below their respective targets, the rates may be considered as bordering on too low for the Trust to achieve other objectives.

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

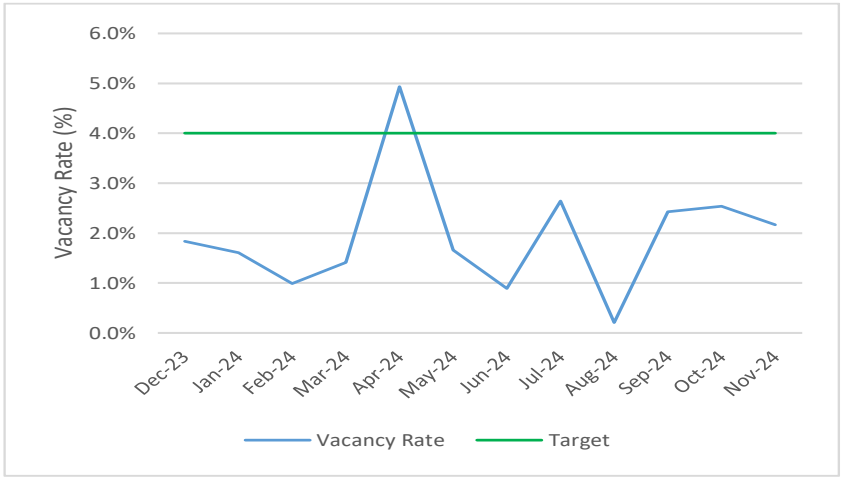
• Nursing and Midwifery continues to have a notably low - 12 month turnover rate of 4.73%. Naturally this is pulling down the overall Trust rate.

Countermeasure Summary

Countermeasure/Action	Owner
Within target, therefore no specific countermeasure.	

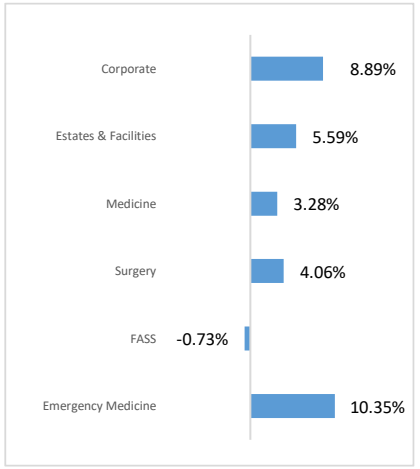
Key Standard| Vacancy Rate

Vacancy Rate - Trust

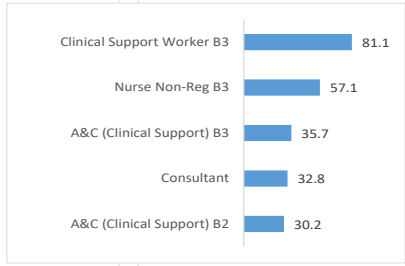


Vacancy Rate	2.17%

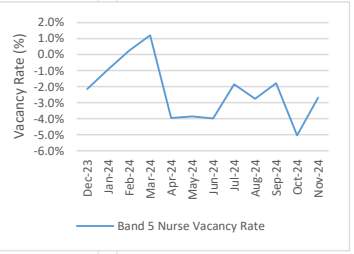
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

- The vacancy rate decreased slightly to 2.17% in M7 from 2.54% in M7 but remains within internal target of 4%
- Divisional vacancy rates may increase as we take the necessary steps to right-size our workforce and slow down the recruitment pipeline where feasibly safe to do so to support our financial position
- Leavers within the first year increased slightly from 3.2WTE in M7 to 3.6WTE in M8 indicating the new joiner experience launched summer 2023 is having a positive impact on our new joiners onboarding experience and supporting retention

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

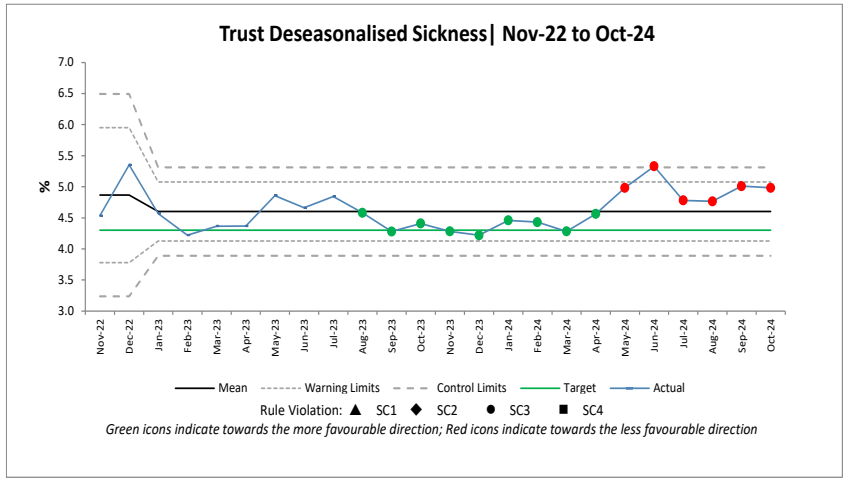
- M8 captures Emergency Medicine (10.35%) and Corporate (8.89%) holding the highest Divisional vacancy rates. Due to new ICB workforce controls we envisage the Corporate vacancy rate increasing when feasibility safe to manage the risk to support the financial position.
- At Staff group level the highest vacancy rate is within Clinical Support staff (81.1WTE)
- Support to clinical and Infrastructure support are the two NHSI groups where there is a relatively high vacancy WTE and vacancy rate.

Countermeasure Summary

Countermeasure/Action	Owner
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
International Recruitment cohorts eligible for Indefinite Leave to Remain will be supported to help the retention of this diverse workforce which includes the provision of legal workshops to assist with application process and hardship funds. First Workshop booked for December 2024	AD for People – Capacity and Talent Acquisition
Employee Value Proposition launched supporting our brand and marketing of employee experience outlining our offer to current, potential and future employees. Supports attraction, engagement and retention techniques. Work underway with our Comms team to better utilise social media channels for recruitment purposes.	AD for People – Capacity and Talent Acquisition

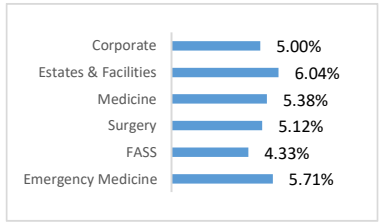
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

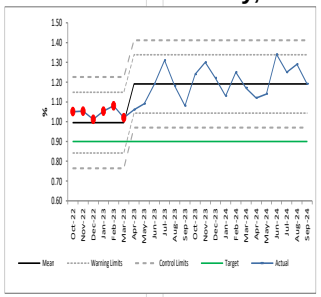


In Month Actual	In Month Deseasonalised	Rolling 12 Months
5.12%	4.98%	4.65%

In Month Divisional Sickness Rates



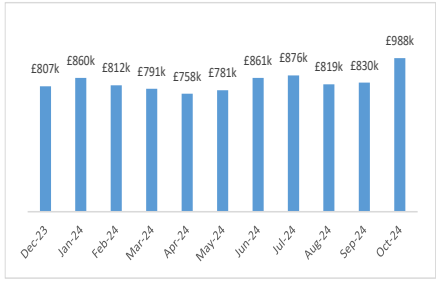
Anxiety, Stress & Depression - Trust



Absence Rate

1.26%

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	-	1	4		
Physical assault	1	-	-	-	1	-		
Slip, trip, fall same level	-	1	3	1	1	2		
Struck against	-	-	-	-	1	-		
Struck by object	1	-	-	1	-	-		
Fell from height	2	-	1	-	-	-		
Another kind of accident	-	1	1	2	-	1		

Is standard being delivered?

In month Sickness exceeds the target at 5.12%.
• When deseasonalised, the latest month doesn't trigger an SPC rule in isolation. However, when combined with other months, a shift upwards is detectable representing deteriorating sickness rates. The 12 months sickness rate is trending up. At 4.65%, it is the highest it has been since August 2023. Earlier this year we identified 9 teams in the Trust that had excessive short term sickness rates, which we defined as above 3%. In October 24 there are only 2 of these teams that remain with a short term sickness rate of over 3%, all of the others have reduced significantly to well below 3%.

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

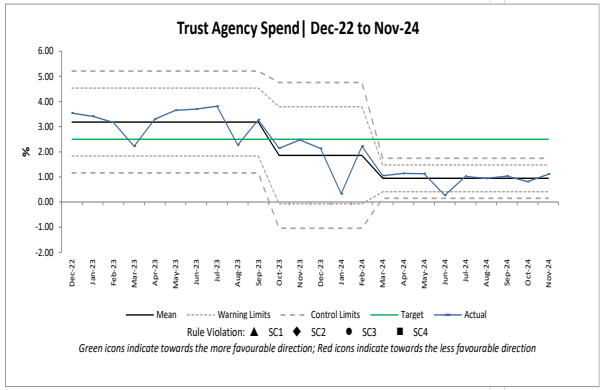
• The in month rate for Cough, Cold and Flu absence significantly rose to 0.82%. This is on par with the position last year for this reason, but unlike last year it is further compounding already high absence rates to give a much higher overall rate.
• Anxiety, Stress and Depression sickness continues to remain high with an in month rate of 1.26%. All rolling calculations are also trending up.

Countermeasure Summary

Countermeasure/Action	Owner
•**Absence management –** . Prioritising areas with high levels of short-term sickness and directing resource to support reduction initiatives. •**HALO self-service portal –** Initial role out has started via the VCARP process which is expected to be live in January 25. •**HALO case management system: –** now live and enables improved case management and increased governance. Long term sickness is also now on HALO.	Divisional People Partners/ Nursing Improvement Group/People Hub Lead
People Directorate driver (under Improving Together) to be revisited in January 2025.	DPP FASS

Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

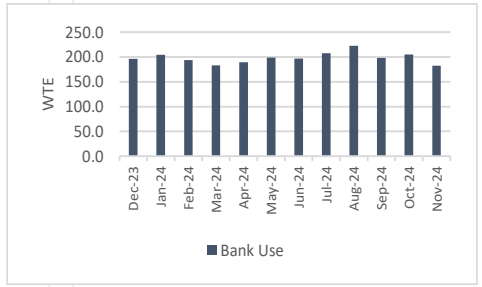


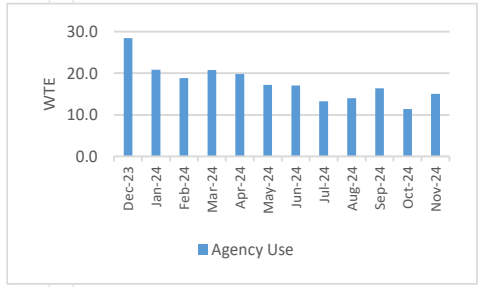
Proportion	1.11%

Agency Spend Breakdown

Agency Spend	In Month	FYTD
Consultants	£233,550	£1,265,521
Junior Medical Staff	£0	£0
Non Medical - Non-Clinical Staff	£38,465	£316,196
Registered Nurses & Midwives	£47,035	£540,077
ST&T - Allied Health Professionals	£869	£1,679
ST&T - Health Care Scientists	£0	£0
ST&T - Other	£1,269	£5,670

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

- Total agency spend recorded in November was £321k, which equates to 1.1% of the total pay bill supporting us to remain below the national target of 3.2%.
- Nurse agency spend was also below target at 0.53%.
- Overall agency usage increased from 11.41WTE in M7 to 15WTE in M8
- Price cap compliance increased to 76% of all agency shifts secured at cap. The outlier is Medical and Dental as these shifts were outside of cap rate.

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

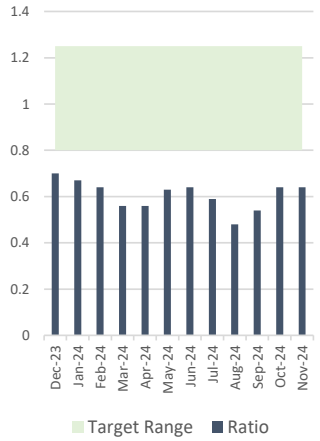
- Medical and Dental Consultants account for 70% off the agency spend this month.
- Medical and Dental remain the highest in month and FYTD spend on agency provision with Oncology and Cellular Pathology Consultants being the top contributors in M8.
- The second highest spend was Nursing with Enhanced Care Team and Theatre Scrubs being the key contributors due to vacancies within these teams.
- Bank usage decreased from 204.8WTE in M7 to 182.3WTE in M7

Countermeasure Summary

Countermeasure/Action	Owner
South West Agency rate card for Medical & Dental went live 1st September for new bookings. A longer flight path in place for existing locums to reach rate card no later than March 2025. We have 6 long-term locums of which 3 are rate card compliant already.	Associate Director for People – Capacity and Talent Acquisition
AfC Bank rates changed to align with system partners supporting collaborative work from 1st October. Work underway to review enhanced rates to assess equity and impact	Associate Director for People – Capacity and Talent Acquisition
Divisional workforce data tracked prospectively (and retrospectively) and shared with divisional teams to support management of spend	Workforce Lead
SW Regional rate card for Allied Health Professionals to Go live from January 2025	Associate Director for People – Capacity and Talent Acquisition

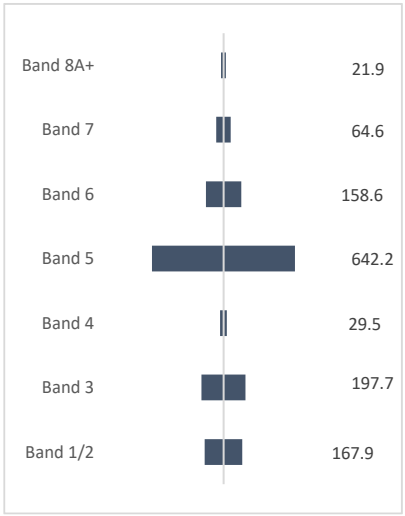
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

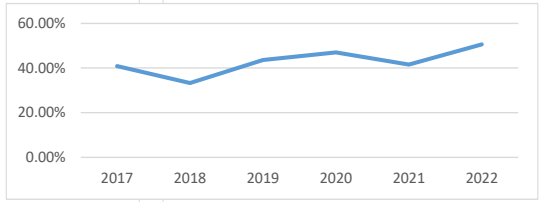


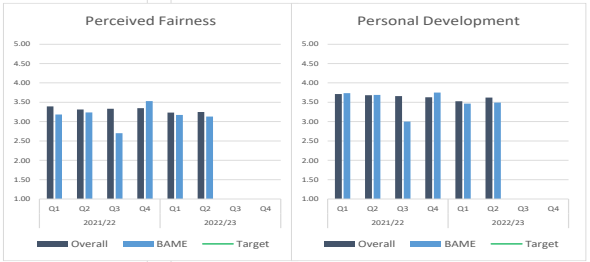
Proportion	0.64

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 Is 0.64 - below the targeted two-fifths range(0.8-1.25).

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

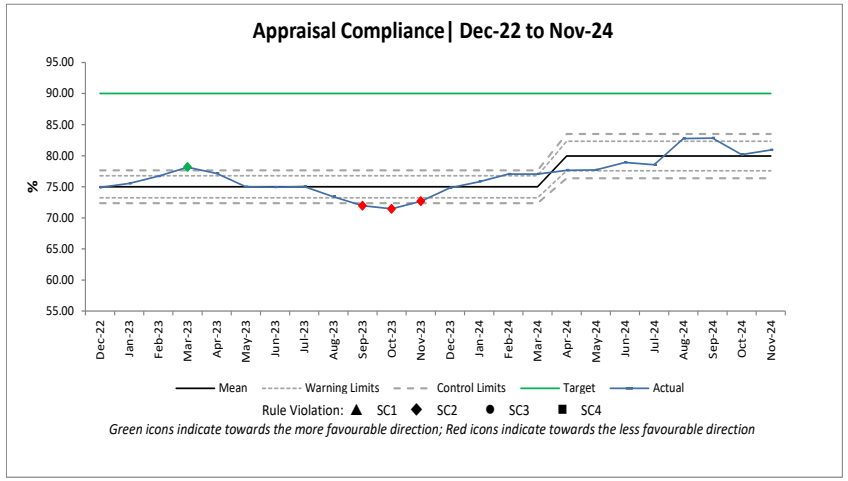
• Candidate distribution across vacancies is masked by the aggregation and this has a significant impact in determining the overall figure.

Countermeasure Summary

Countermeasure/Action	Owner
• Positive Action Programme • Independent EDI Advisors • Growth of staff networks • Growth of inclusion champions network • Divisional People Partners supporting operational colleagues to embed anti-racist statement and toolkit. • TME/Divisional PRMs – CPO request to divisions to evidence actions taken to support achievement of the breathrough objectives	ADP – Culture DPPs and Divisional SMTs

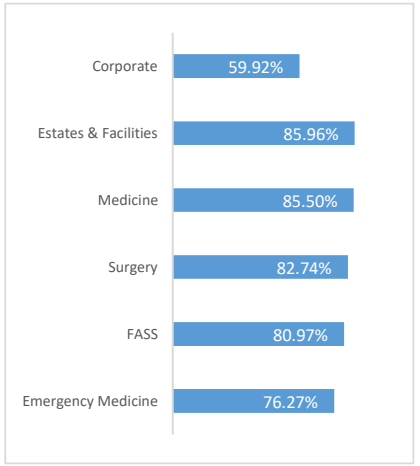
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	80.9%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff 81.6%

M&D Staff 73.9%

Consultants 91.4%

White 80.3%

BME 83.3%

Is standard being delivered?

Appraisal compliance remains below the tolerance threshold (80.9%) and 9 percentage below the Trust's target of 90%.

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

Corporate Division's compliance remains over 30% below target at 59.92%. As a Division, the compliance has not been above 70% - still some way below the target - since April 2023 and there is little evidence of sustained improvement in recent months.

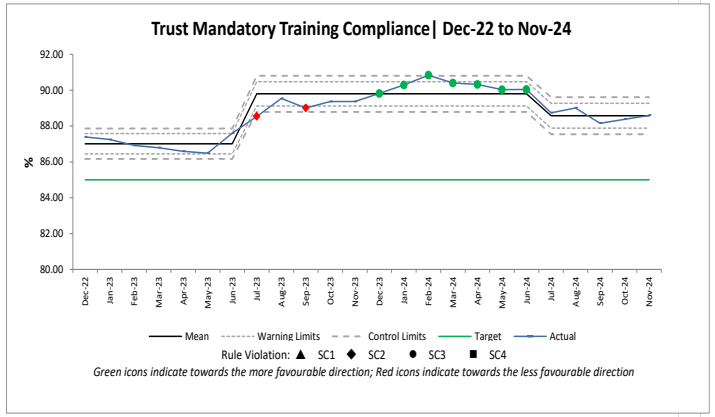
• With the exception of Estates and Facilities and Medicine, all other Divisions are below the 85% tolerance level.

Countermeasure Summary

Countermeasure/Action	Owner
• Focussed work with specialities with low appraisal compliance led by DPP's. • Increase uptake of appraisal training and support to prioritise (Managers and DPPs) • Developing feasibility options for implementing an appraisal window to focus efforts on quality conversations • Revised Appraisal Policy pending ratification • Forging alignment between health and wellbeing interventions and manager engagement with team colleagues.	Divisional People Partner's Divisional People Partners Associate Directors for People

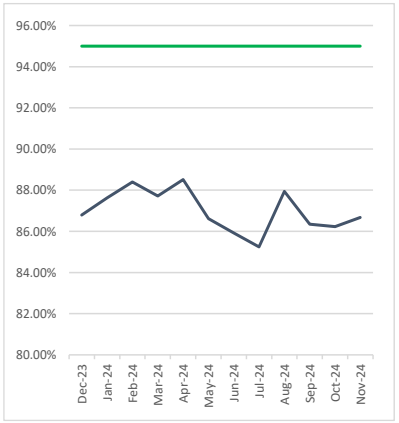
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



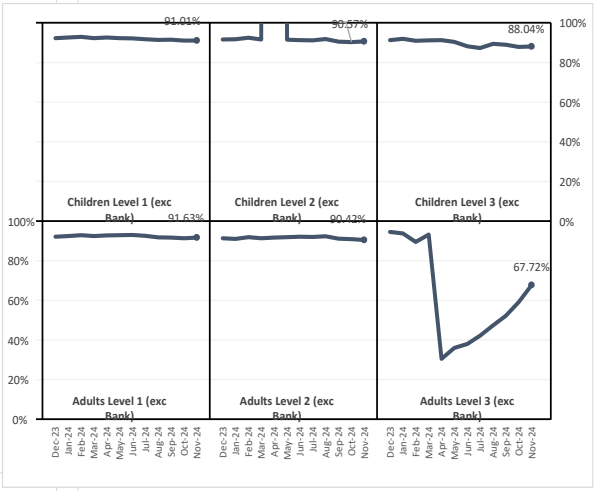
Compliance Rate	88.6%

Information Governance Training Compliance Rate - Trust



Compliance Rate	86.7%

Safeguarding Training Compliance Rates - Trust



Is standard being delivered?

- Mandatory Training compliance continues to exceed the target at 88.6%.

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

With a compliance of 77.83%, Emergency Medicines has not met the 85% target.

Countermeasure Summary

Countermeasure/Action	Owner
Continues to be pushed through Divisional PRM structure.	Deputy People Partner's
Review of all subjects based on impact not compliance	Corporate Education Lead
Focus on key subjects not at target level	Corporate Education Lead
Response to new National Stat/Man framework	Corporate education Lead

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Quality Report

December 2024 (October 2024 data)

The RUH, where you matter

Executive Summary | Quality

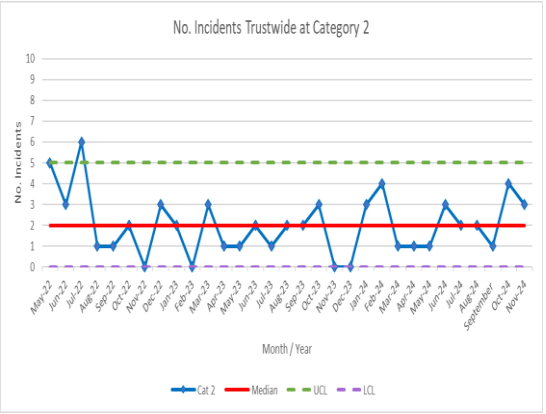
Strategic Goal		Performance Indicator	Description	Target		2023/2024						2024/2025							Trend
				Performing	Under Performing	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
Other Measures	People we care for	Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	3	6	2	2	3	3	1	0	1	1	3	1	4	
		Clostridium Difficile Hospital Onset, Healthcare Associated (counted)		<=3	>3	5	6	2	6	9	6	2	8	3	7	3	5	6	
		Clostridium Difficile Community Onset, Healthcare Associated				3	0	3	2	2	3	5	1	1	4	8	7	0	
		E.coli bacteraemia cases Hospital Onset, Healthcare Associated		<=6	>6	1	2	5	1	4	1	4	4	2	5	2	3	5	
		E.coli bacteraemia cases Community Onset, Healthcare Associated				2	6	2	5	4	4	5	6	2	4	3	0	1	
		MRSA Bacteraemias >= 48 hours post admission		0	>=1	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Klebsiella spp Hospital Onset, Healthcare Associated		<=2	>2	1	1	2	0	4	1	2	2	0	3	1	1	1	
		Klebsiella Spp Community Onset Healthcare Associated				0	0	0	1	0	2	2	2	1	1	1	1	0	
		Pseudomonas aeruginosa Hospital Onset, Healthcare Associated		<=1	>1	0	0	0	4	0	0	1	0	2	0	1	0	0	
		MSSA Post 48 Hours				1	0	1	3	6	5	2	0	1	1	2	2	3	
		Flu - Healthcare Onset (+3 days)				-	-	-	-	-	-	2	1	1	0	0	0	0	
		Norovirus Outbreaks				3	0	2	0	1	2	0	0	1	1	0	0	1	
		Number of Hospital Acquired Pressure Ulcers Category 2		<=2	>2	3	1	0	3	4	1	1	1	3	2	0	0	4	
		Number of Hospital Acquired Pressure Ulcers Category 3		<=0	>0	3	1	0	0	2	0	1	1	1	0	2	3	2	
		Hospital Acquired Category 4 Pressure Ulcer		<=0	>0	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Never events		0	>=1	0	0	0	0	0	0	0	0	0	2	1	0	0	
		Mixed Sex Accomodation Breaches				94	70	97	163	170	182	170	221	191	154	186	160	237	

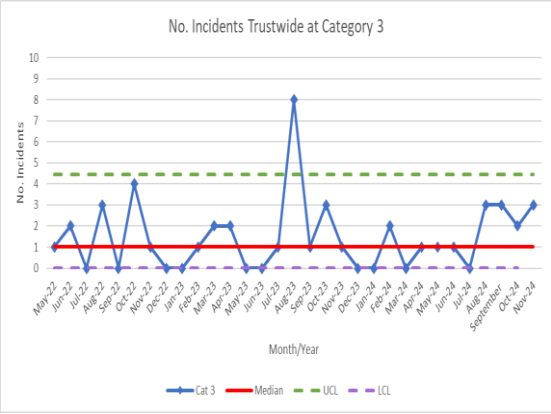
Executive Summary | Patient Experience

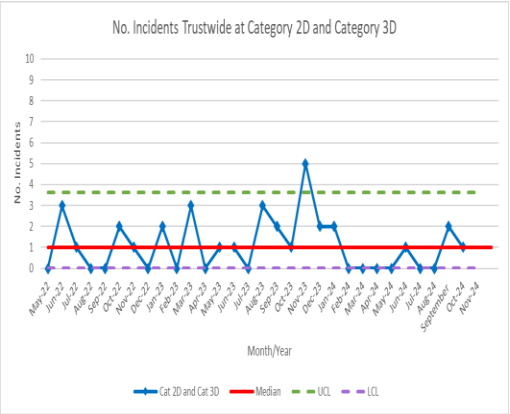
Strategic Goal		Performance Indicator	Description	Target		Baseline	2023/2024						2024/2025							Trend
				Performing	Under Performing		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
Tracker Measures	People we care for	% of positive responses to friends and family test					94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	94.2%	
		% of complaints responded to within agreed timescales with complainant		>=90%	<90%	-	60.9%	80.0%	93.3%	82.6%	90.9%	92.3%	86.7%	64.5%	73.1%	73.1%	87.5%	75.0%	69.0%	
		Number of complaints received		<30	>=30		19	33	30	21	39	33	25	25	26	38	28	31	40	
		Number of reopened complaints each month		<=3	>3	-	0	3	1	3	5	2	1	3	2	8	0	3	1	
		Concerns are acknowledged within 2 working days		>90%	<90%		-	-	-	-	-	-	100.0%	98.0%	99.0%	100.0%	99.0%	97.0%	(LAG 1)	

Pressure Ulcers

Tracker measure







We are driving this measure because…

Pressure ulcers are estimated to cost the NHS £1.4m per day. Maintaining a low incidence of pressure ulcers is a Trust priority.

The last national acquired prevalence benchmark is 9.6% (2021) and the RUH prevalence is 0.87% in 2024.

Understanding the performance

The RUH benchmarks performance against the other Acute Trusts across the ICS with both the number of pressure ulcers per 1,000 bed days and the overall number of pressure ulcers by category.

For October 2024, the RUH reported 0.4 pressure ulcers per 1,000 bed days (7 pressure ulcers). GWH reported 0.63 (12 pressure ulcers) and Salisbury data is pending per 1,000 bed days.

The RUH investigated three category 3 and four category 2 pressure ulcers on five wards.

Actions (SMART)

- An action plan has commenced for Respiratory ward led by the Division and is ongoing
- An action plan for an Older Persons Ward commenced in September and is monitored by the Division
- For skin assessment to be carried out daily and recorded on Millennium consistently by the end of December 2024
- Divisions to monitor compliance with skin assessment and report to the Tissue Viability Improvement Group in January 2025

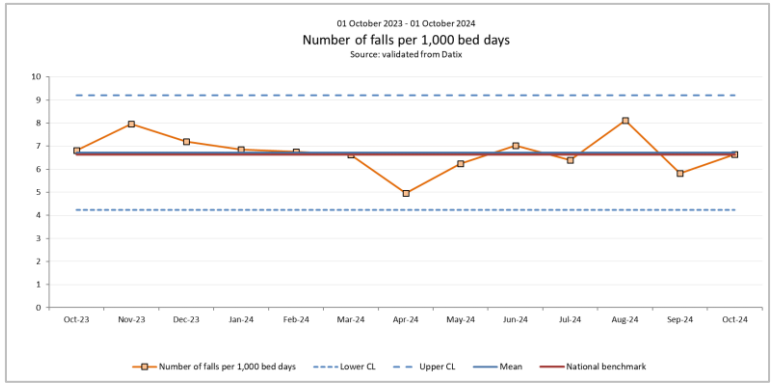
Risks and Mitigations

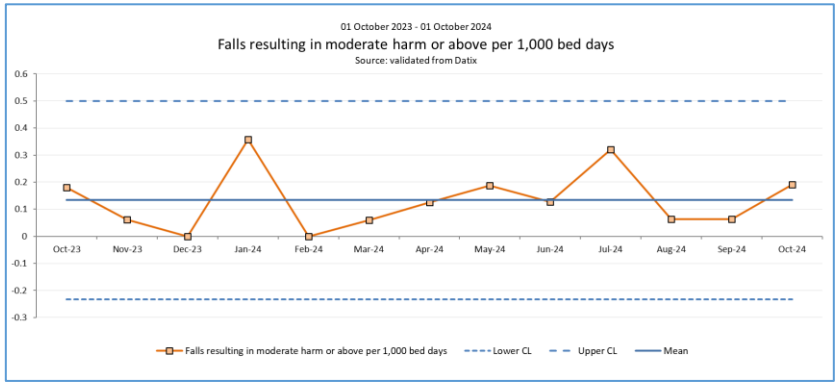
The Tissue Viability Improvement Group continues to monitor all harms related to pressure ulcers of category 2, 3 and medical device related to identify trends and opportunities for learning.

The roll out of paperless inpatients in August required training for staff and is a new way of working. Risks have been identified from incidents and the TV Team are working with the digital team to ensure those risks are reduced e.g. daily skin assessments are carried out consistently.

Falls

Tracker measure





We are driving this measure because…

Falls prevention is one of the Trust's 5 safety priorities. The national benchmark from the National Audit for Inpatient Falls is 6.63 falls per 1000 bed days (any reported falls).
The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falls also affect the family members and carers. Falls are estimated to cost the NHS more than £2.3 billion per year and have an impact on quality of life, health and healthcare costs (NICE).

Understanding the performance

Analysis identified that 98% of inpatients did not fall in our care in October. Pareto analysis identifies the 4 top contributing inpatient areas are within the Medical Division and within the older persons specialty. The frailty and complexity of patients on older persons wards means that they have an increased vulnerability to falling whilst they are in hospital.

NICE guidance advises all inpatients at risk of falls should have lying and standing blood pressure recorded as part of a multifactorial risk assessment. This is used to diagnose a health condition called Orthostatic Hypotension that increases the risk of falls. Analysis reveals that one of the top contributing factors is patients not receiving the assessment.

Actions (SMART)

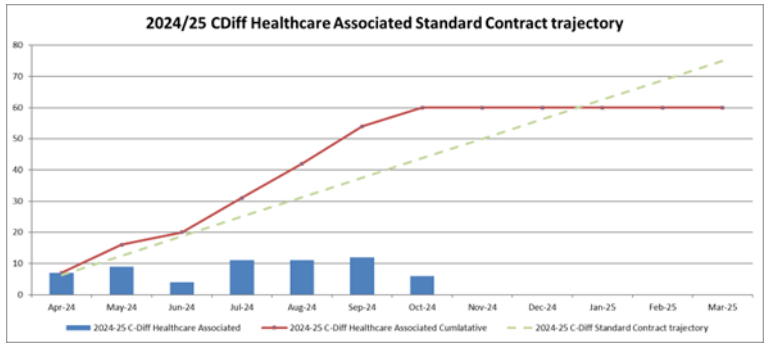
1. The Falls Prevention Improvement Group are driving a quality improvement project in 4 wards on improving lying and standing blood pressure compliance:
   - Test improvement in one ward with the aim of improving compliance to 50% by end of November 2024
   - Aim: 50% of patients in the 4 wards have a lying and standing blood pressure recorded on admission by February 2025 - progress at end of October at 42%.
   - Outcome measure: to reduce the number of falls in the 4 wards by 10% by April 2025.

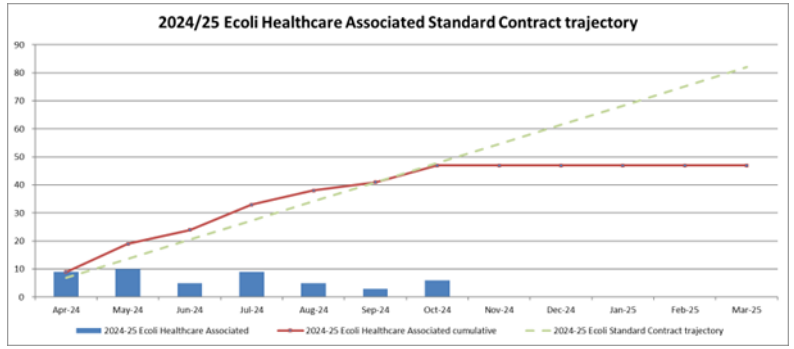
Risks and Mitigations

1. Staff are not always capturing when it is not appropriate for a patient to have a lying and standing blood pressure assessment (may not be medically stable or physically well enough to stand). This will affect the data as patients that are not appropriate will be removed. Mitigation: include how to document 'not appropriate' in training sessions.
2. There is a risk that compliance is lower than is being reported due to partial completion of the assessment not being included within the data. This can occur if a patient becomes symptomatic after the first two blood pressure recordings. Mitigation: a review of the data capture with the EPR Change lead and BIU.

Infection Prevention and Control

Tracker measure





We are driving this measure because…

Infection Prevention is one of the Trust's 5 safety priorities. Good infection prevention and control (IPC), including cleanliness, is essential to ensure that people who use health and adult social care services receive safe and effective care.
The total annual cost of Healthcare associated infections in the UK is estimated to be £774 million. The HAI cost is mainly driven by excess length of stay in hospital (HIS 2021). The impact of an infection can be devastating to both the patient and their families.

Understanding the performance

There were 6 cases of Clostridioides Difficile infection (CDI) reported during October. 60 cases have been reported year to date against a threshold of 75.

There were 6 cases of E.coli infection reported during October. There have been 47 cases reported year to date against a threshold of 82. Benchmarking data shows our rate is in the middle of all Southwest Trusts.

The 3 IPC quality improvement projects listed (under actions) are now underway and aim to improve the quality of care provided to patients and positively influence the health care associated infection rates longer term. The hydration project has commenced, and the improvement aim is being developed.

Actions (SMART)

To reduce ingestion of environmental bacteria and virus' during a hospital stay, we will enhance hand hygiene opportunities.
Aim: To increase patient hand hygiene pre and post meals within a bay on an older person's unit by 30% within 3 months.

Gloves off campaign: To ensure clinical gloves are worn appropriately. Aim: To reduce the inappropriate use of gloves by 30% within 3 months.

To develop and launch a RUH PPE App to improve the use of correct PPE for all non-high consequence infections/symptoms.
Aim: To empower clinical staff in a department to select the correct PPE, by January 2025.

Risks and Mitigations

UKHSA are monitoring influenza activity and have observed increased numbers of flu across the Southwest. Winter plans have been completed with Operational colleagues with reference to Flu/Norovirus.

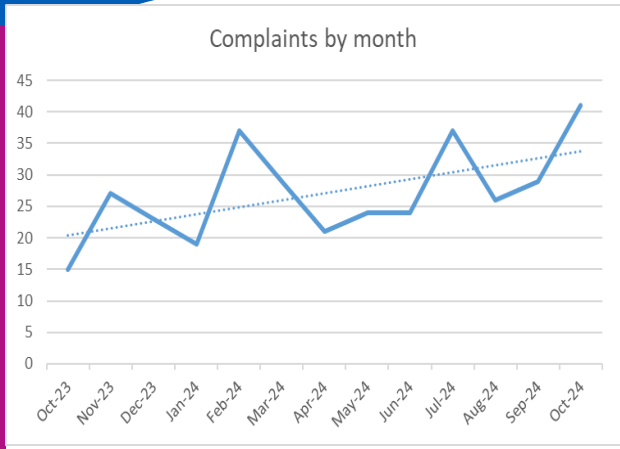
The UK Health Security Agency (UKHSA) are still managing cases of measles notification of a confirmed case, and a small number of probable cases of measles have been received from Bath and North East Somerset and Wiltshire respectively. These cases have no identified source, which suggests that measles may be circulating in the local community.

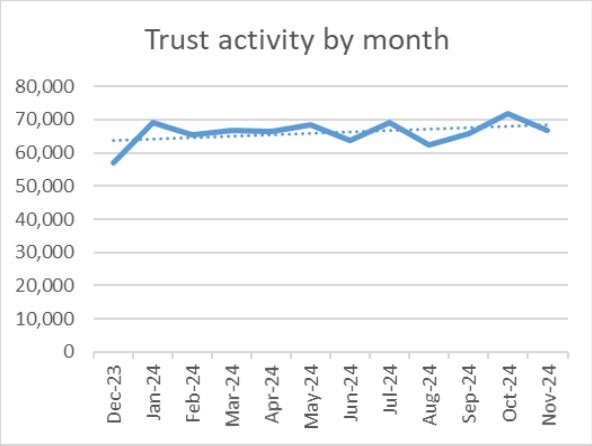
Action cards and posters are in place.

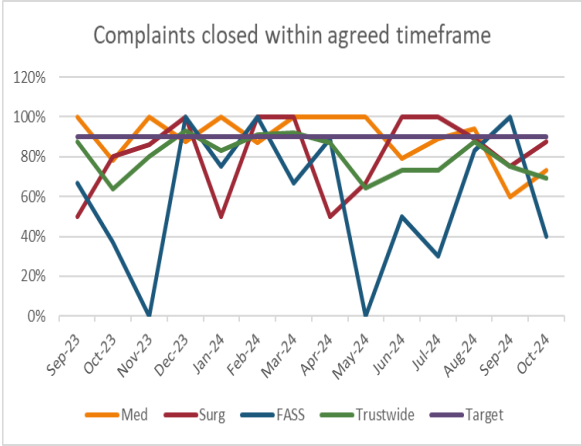
HOHA: Healthcare Onset Hospital Associated Community
COHA: Onset Healthcare Associated
PPE: Personal Protective Equipment

Patient Support & Complaints (PSCT)

Tracker measure







We are driving this measure because…

The Trust values feedback and recognises that complaints and compliments provide a valuable insight into how we can improve our services for patients and families.

The NHS Complaint Standards supports organisations to provide a quicker, simpler and more streamlined complaints handling service. The standards have a strong focus on early resolution.

Month	October 2024
% Complaints/concerns resolved with early resolution (14 days)	84.9% (target 75%)

Understanding the performance

In October, the Trust received 41 new complaints. This is the highest number of complaints in a single month this year. The trend for complaints received each month is on an upward trajectory. There has also been an increase in activity over the last 12 months. The Medical and Surgical Divisions received the highest number of new complaints with both receiving 18.

There are no clear themes or trends for the month. A high number of cases relate to clinical care concerns (n=30).

The number of re-opened complaints remains low. In October one new complaint was reopened.

85% of all contacts with PSCT were resolved within 14 days in line with NHS Complaints standards.

The RUH, where you matter

Actions (SMART)

Head of Patient Support and Complaints is working closely with the Clinical Divisions to support improvements in complaint response rates. The Patient Experience work plan includes a focus on:

- Response times - 90% within agreed timeframe with complainant; 90% acknowledged within 2 working days
- Ensure progress of actions is monitored and recorded on Datix
- Training for staff on managing concerns and complaints.

The work plan is monitored by the Patient Experience Committee.

Risks and Mitigations

1. The capacity and confidence of ward staff to respond to concerns and complaints and resolve issues at the earliest opportunity. The Head of Complaints is supporting staff with ongoing training.

2. Learning from complaints and completion of actions is not consistently embedded across the Trust together with the assurance that feedback is leading to sustained quality improvement. This is a key element of the Patient Experience priorities and focussed work has commenced.

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Perinatal Quality Surveillance

The RUH, where you matter

Safe – Maternity& Neonatal Workforce

	Target	Threshold G	Threshold A	Threshold R	Aug 24	Sep 24	Oct 24	SPC	Comment
Midwife to birth ratio	1:24	<1:24		>1:26	1:28	1:31	1:29		
Midwife to birth ratio (including bank)	1:24	<1:24		>1:26	1:25	1:28	1:26		
Consultant presence on BBC (hours/week)	98	>97			98	98	98		Meeting RCOG recommendation from Jan 23
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	1	0	0		
Daily multidisciplinary team ward round	90%	>90%		<80%	97%	93%	94%		
Band 5/6 Midwifery Vacancy rate WTEs	7.0 WTE	≤7.0		>10	12.5	0.9	0.9		
Neonatal Nurse QIS rate	70%	≥70%		≤60%	65.5%	59%	69%		Recognised Risk in neonatal services Risk Assessment completed Risk register Entry 2950 Action plan towards mitigation of risk detailed within Risk register. Action Plan presented to Trust Board in Q2 quality Report 24/25.
Neonatal Nursing vacancy rate WTES					-3.1	-0.9	lag		
Neonatal shifts staffed to BAPM standards	100%	>90		<80%	95%	74%	79%		Recent high acuity and vacancies impacted this. Vacancies now recruited to.
Maternity 12 Month Turnover rate	≤5%	≤5%		≥7%	3.31%	4.25%	4.69%		
Neonatal Unit 12 month Turnover rate	≤5%	≤5%		≤7%	6.99%	8.96%	7.66%		
Percentage of TC shifts with staff dedicated to TC care only		>90%		<80%	100%	88%	97.2%		High acuity requiring 2 NN often 1 having babies on NNU too.

Table 1.

Is the standard of care being delivered?

- Midwife to birth ratio in excess of target of 1:24 as per Birthrate + report of 2023
- Please see exception slide for operational actions taken in response to increased acuity to preserve safe staffing

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

- Increased number of births during September 2024
- Qualification of student midwives commencing their preceptorship programme in the service during Sept 24, this has reduced vacancy however due to supernumerary period during orientation to the service this does not provide improvement in midwife to birth ratios or staffing vs acuity metrics.
- Positive recruitment campaign for B5 nurses in the LNU (not QIS trained) and QIS staff re-locations resulting in drop in overall percentage of staff QIS trained compliance.

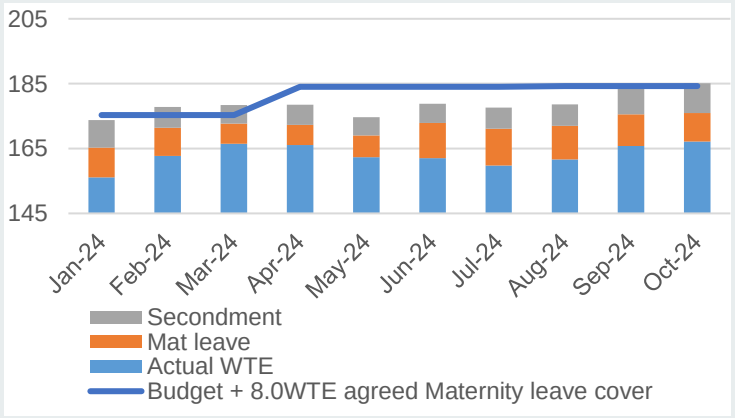


Figure 1. Band 5/6 Midwifery Vacancy rate and staffing pipeline projections

Countermeasure /Action (completed last month)	Owner
Commencement of Band 5 Midwives on their preceptorship package following completion of university courses	Retention Lead midwives
Continued work with HR and finance to ensure pipeline position is accurate and externally funded posts are visible to explain ESR variation	Acute Matron
Risk assessment completed for the risk register outlining the risk and mitigations for recovery action plan to meet BAPM standards for QIS compliance in the LNU	Neonatal Nurse Consultant

Countermeasure /Action (planned this month)	Owner
On going work with health roster team to remove unused tiles and ensure roster requirements are validated for all maternity and neonatal rota's	Acute Matron
Action Plan for QIS recovery to be shared with Trust Board.	Quality and Patient Safety Lead Midwife

Average Shift Fill Rates- planned vs actual

			Aug 24	Sept 24	Oct 24
Maternity	Midwives	Day	90%	83%	89%
		Night	89%	83%	90%
	MCA/MSWs	Day	64%	73%	69%
		Night	70%	70%	72%
Neonates	Registered nurses	Day	73%	69%	6%
		Night	97%	93%	86%
	Nursing support staffing	Day	62%	39%	38%
		Night	77%	50%	81%

Safe – Maternity& Neonatal Acuity Oct 24

	Target	Threshold G	Threshold A	Threshold R	Aug 24	Sep 24	Oct 24	SPC	Comment
Percentage of 'staff meets Acuity' BBC (intrapartum care)	100%	>90 %		<70%	67%	58%	74%		Please see countermeasures
Percentage of 'staff meets Acuity' Mary Ward (inpatient care)	100%	>90 %		<70%	23%	25%	50%		Please see countermeasures
Confidence factor in BirthRate+ recording BBC	60%	>60 %		<50%	77.42	82.78	82.26		Percentage of possible episodes for which data recorded.
Confidence factor in BirthRate+ recording Mary Ward	60%	>60 %		<50%	85.48	86.67	83.87 %		Percentage of possible episodes for which data recorded.
Maternity Absence rate	4.5%	<4%		>5%	3.61%	3.45	2.63		
Neonatal Unit Absence rate	4.5%	<4 %		>5%	1.16%	3.73	5.99		
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)	Total Red Flags				146	215	103		A midwifery 'red flag' event is a warning indicator that something may be wrong with midwifery staffing 6 NICE Red flags reported in Oct 24, all other red flags were RUH locally set red flags
(NICE 2015 red flags)	NICE 2015				8	21	6		
Birth outside of BAPM L2 place of birth standards	0	0		1	0	1	0		
Number of days in LNU outside of BAPM guidance	0	0		>2	0	1	0		

Table 1.

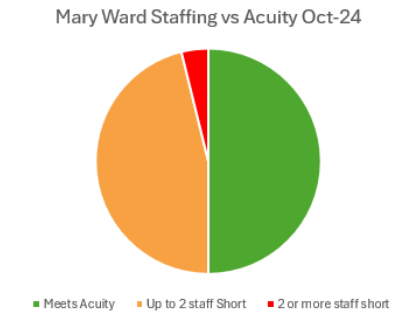


Figure 1. Acuity vs staffing by RAG Mary Ward October 2024

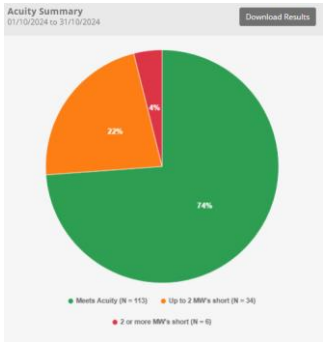


Figure 2. Acuity by RAG for BBC October 2024

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.
- RUH Red flags triggered pertained to delays to IOL
- NICE red flags pertained to delay in commencement of IOL from admission, From review of the staffing vs acuity data for Mary Ward there were 4 episodes where they were > 2 midwives short = 3.8%

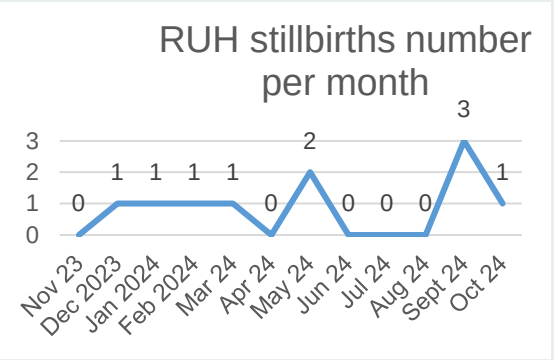
What are the top contributors for under/over-achievement?

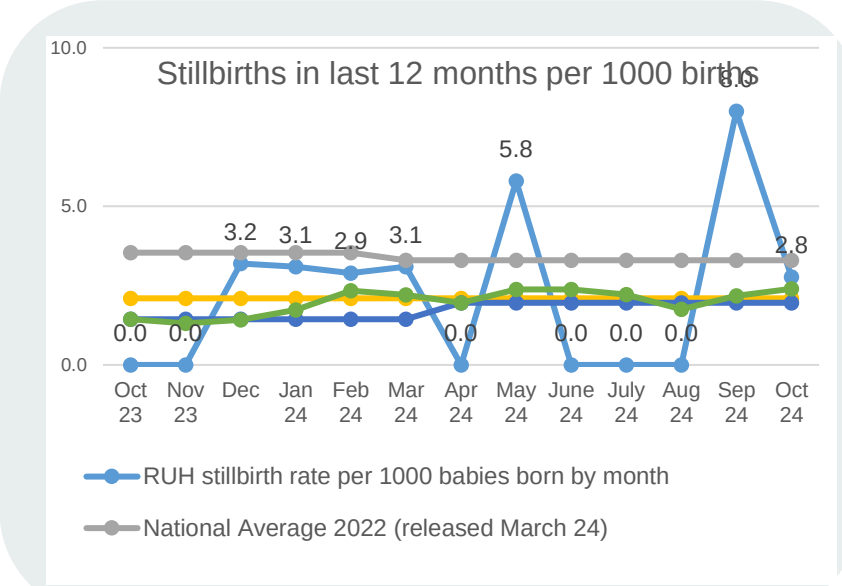
- Identification of disparity or red flag data for national 'NICE' red flags and locally set red flags.
- Improved absence rate in both Maternity and Neonates.
- Return to previously recorded babies born averages after an increased birth rate in September 24.

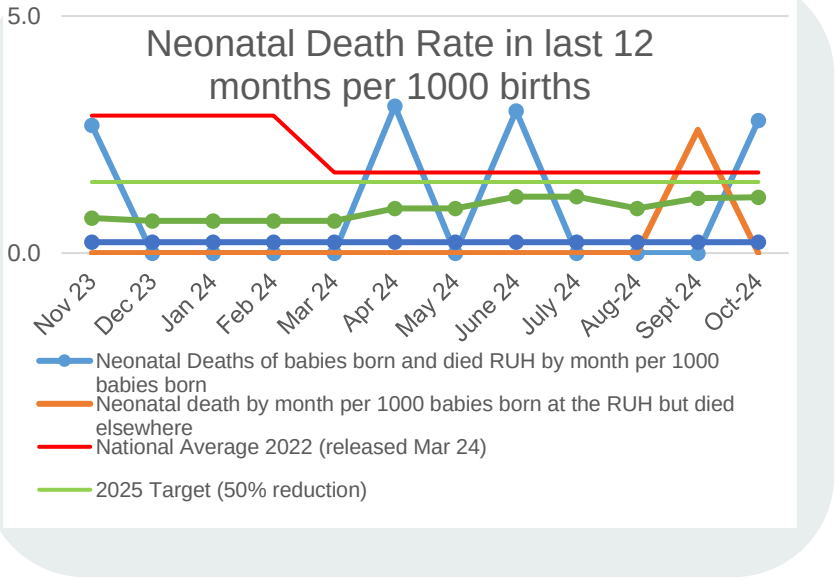
Countermeasure /Action (completed last month)	Owner
Commencement of recruitment into increased midwifery establishment as outlined within the Maternity Business case aligned to the Birth Rate + report of 2023	DOM
Commencement of Mary Ward Cultural conversations with staff as part of the national perinatal culture and leadership programme	Inpatient Matron
Approval for Mary Ward leadership re-structure pilot as part of ongoing QI work	Inpatient Matron
Recruitment to current vacancies in LNU – successful	Lead Senior Sister

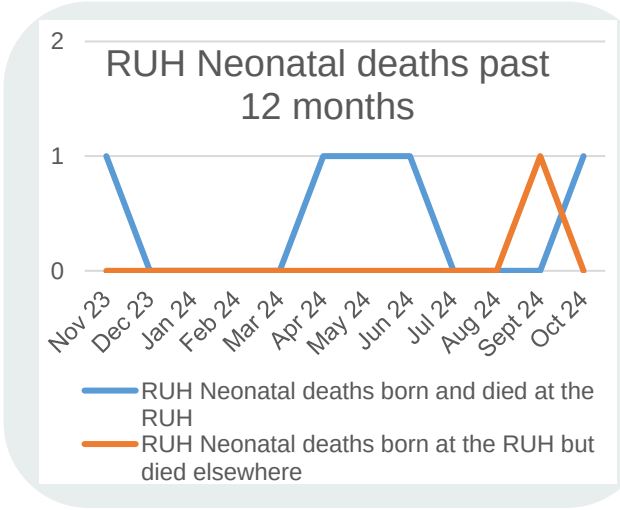
Countermeasure /Action (planned this month)	Owner
To complete the BirthRate+ guidance tool indicating the change requests required to ensure ability for national benchmarking (NICE 2015 'safe staffing red flags') and local proactive KPI measures work planned for quarter 4 24-25 to mitigate against risk of lost data during MIS reporting periods	Quality and Patient Safety Lead / Acute Services Matron
Continued Additional training and spot check audits for the newly revised Mary Ward BirthRate+ tool contemporaneously to improve data capture accuracy	Inpatient Matron/ Mary Ward Sister
For preceptee midwives to complete their supernumerary period of orientation, following which they will begin to provide care autonomously providing an anticipated improvement in staffing vs acuity metrics	Retention Lead Midwife
Staffing escalation guideline update in progress inclusive of collaboration with Trust-Wide colleagues to support periods of high acuity to preserve safe staffing within Maternity Services	Acute Maternity Sister/Matron

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 6. 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.

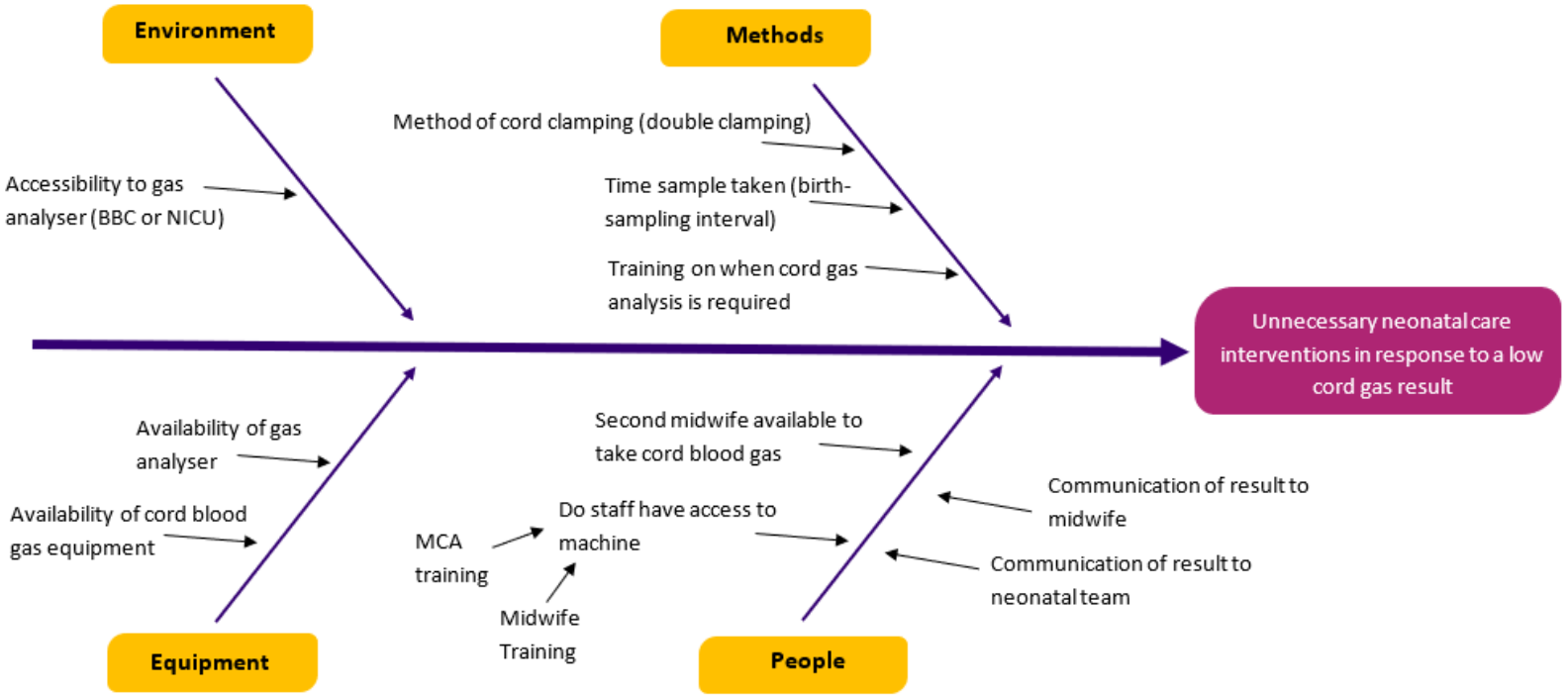
During March 24 we received the MBRRACE-UK report of 2022 deaths at the RUH. This identified new national averages for both stillbirth and neonatal deaths therefore the charts on this slide have been adjusted to reflect the new national averages for accurate benchmarking.

There was 1 antenatal stillbirth during the month of October 2024.There were no intrapartum stillbirths. please see incident slide for full details. All deaths have been reported via MBRRACE and will receive a full PMRT review.

There was 1 neonatal death of a 28 week gestation baby born at the RUH and subsequently died. Please see incident slide. The death has been reported to MBRRACE and will receive a full PMRT review

MIS Safety Action 3 Transitional Care & ATAIN QI project update

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.



What are the process measures?

1. To increase the number of cord pH samples processed within 20 minutes of the birth of the baby to >90%
2. To standardise double clamping of cords post birth to preserve the blood sample, reducing the risk of cord blood sample pH deterioration
3. To standardise the criteria for cord blood sample collection

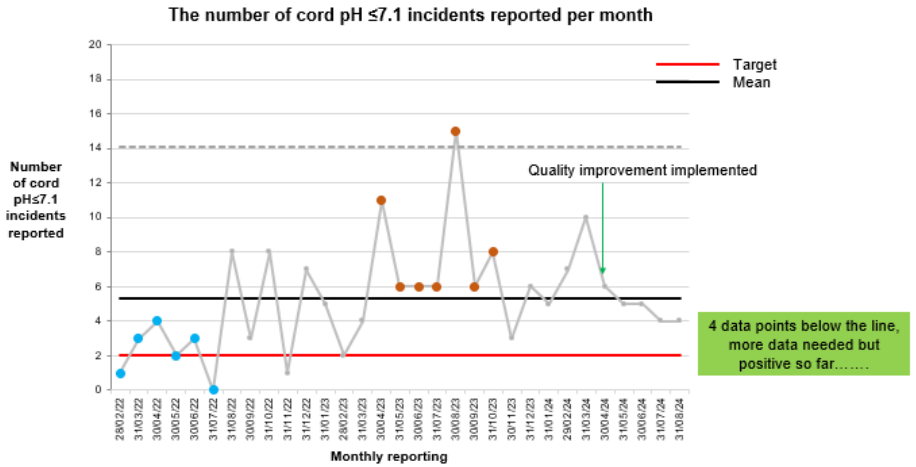
What are the outcome measures?

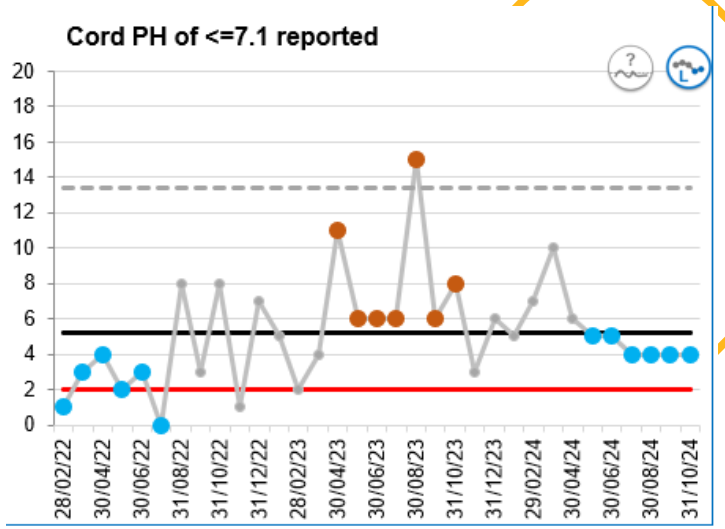
1. To reduce maternal and neonatal separation at birth by a reduction of unnecessary admissions for CFM to SW ODN guidance
2. To reduce disruption of mothers and neonates post birth by a reduction in unnecessary neonatal observations.
3. To improve neonatal care pathway planning in response to recorded pH <7.1
4. To improve maternal and neonatal care experience
5. Enhancement of Maternal and Neonatal attachment

MIS SA3 TC & ATAIN QI project update

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.

Process measure	Action	How?	Where?	Who?	When?
To increase the number of cord pH samples processed within 20 minutes of the birth of the baby to >90%	Reduce duration from birth to sampling interval	Development of traffic light system to aid optimal sampling time	Bath Birthing Centre	Neonatal Nurse Consultant Consultant Paediatrician Patient Safety Midwife	26.04.24
	Improve training on gas analyser for midwives	Ensure all mw have barcodes for machine	Acute and community areas	CSF team	01.06.24
	Improve training on gas analyser for MSW	Ensure all MSW have barcodes for machine	Acute and Community areas	CSF team	01.06.24
	Improve awareness role 2nd midwife	Updated laminates in rooms and on maternity teams channel regarding role 2nd midwife	Bath Birthing Centre	Senior Sister	27.03.24
To standardise double clamping of cords post birth to preserve the blood sample, reducing the risk of cord blood sample pH deterioration	Education and communication regarding double cord clamping	Quality boards Safety catch Safety brief	Bath Birthing Centre	Patient Safety Midwives	26.04.24
To standardise the criteria for cord blood sample collection	Criteria as to when cord gas analysis required	Displayed in table as part of care in labour guideline	Acute and community areas	Patient Safety Midwife Quality Improvement and Education Midwife Obstetric Consultant	01.05.24





Incidents

New Cases for Oct 24

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	PSII?
134092	23/10/2024	Unexpected Death	36 week antenatal stillbirth, cord detached at birth of baby.	Rapid review conducted no immediate care concerns identified will receive full PMRT review		
133790	12/10/2024	Unexpected Death	Neonatal death of a 28 week gestation post placental abruption and Prolonged Pre-Labour Rupture Of Membranes from 22 weeks of pregnancy	Rapid review conducted no care issues identified causal to the outcome for the baby- co-incidental learning identified regarding collaborative complex antenatal care pathways and counselling with neonatal colleagues		
134325	31/10/24	Moderate Harm	Maternal Intensive Care Unit admission on day 16 post Elective Caesarean section birth with suspected bowel injury	Level of harm under consistent review based upon clinical information available and anticipated long term implications for the mother. Initial rapid review undertaken – will require further review.		
133440	03/10/2024	Moderate Harm	Transfer of neonate to tertiary level NICU for active therapeutic cooling- MRI Normal – MNSI progressing at family request	Rapid review undertaken – period of 20 minutes of escalation/communication under review. MNSI progressing at family request		
134015	20/10/2024	Moderate Harm	Avoidable admission to the neonatal unit following development of subgaleal haemorrhage resulting in a 5 day stay in the neonatal unit	Rapid review undertaken, Individual learning identified for clinician conducting assisted vaginal birth – fed back by on call consultant .		
134054	21/10/2024	Moderate Harm	Possible Brachial plexus injury post forceps birth	Rapid review undertaken, no care concerns identified causal to the possible injury		

Ongoing Maternity and Neonatal Reviews

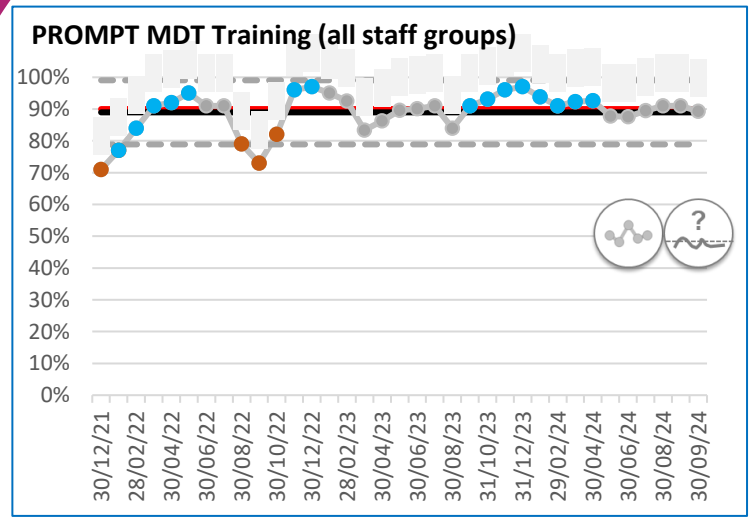
Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions/ Update of progress	MNSI Reference	PSII? Reference
127900	04/04/2024	Unexpected Death	Neonatal death following elective caesarean birth	DOC commenced by on call consultant Referred to Maternity Independent Advocacy service PMRT review – report being finalised	Discussed- did not meet criteria	
130519	29/6/2024	Moderate harm	Transfer of neonate to tertiary level NICU for active therapeutic cooling	DOC commenced. Referral to MNSI- MNSI review in progress at familial request.	MI-037619	
132682	10/09/2024	Unexpected Death	Intrauterine Death at 28 weeks of pregnancy	DOC commenced, PMRT review – report being finalised		
133266	26/09/2024	Unexpected Death	Intrauterine Death at 38 weeks of pregnancy	DOC commenced PMRT review in progress		
133232	26/09/2024	Unexpected Death	Intrauterine Death at an unknown >37 week gestation in an undiagnosed/concealed pregnancy.	DOC commenced, discussed with MNSI, discussed with coroner, rapid review undertaken, plan for Systems Engineering In Patient Safety (SEIPS) Analysis to support full exploration of learning	Discussed at MNSI regional meet 30/09/24 – does not meet criteria	
133329	28/09/2024	Catastrophic harm/ Unexpected Death	Death of 8 day old infant following call to Maternity Triage Line 12 hours prior to presentation	DOC commenced – PSII declared Terms of Reference looking at the systems and processes supporting the Maternity Triage line advice and referral pathways when contacted regarding a parental neonatal clinical concern.		Declared 07/10/24

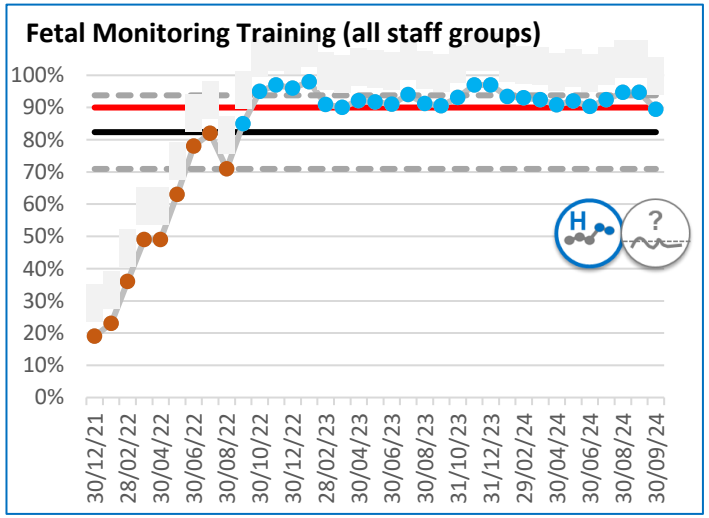
Closed Cases Oct 24

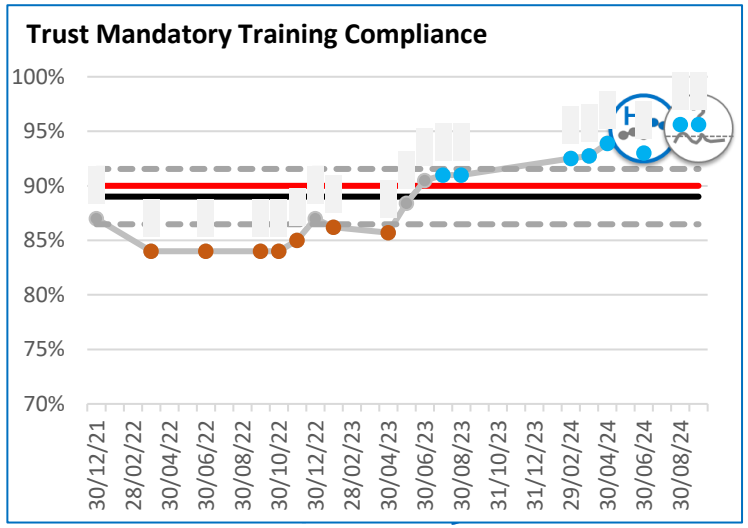
Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
126853	4/03/2024	Unexpected death/ Moderate Harm	Placental abruption - Intra-uterine death	PSII completed, PMRT report completed.		
129283	17/05/2024	Unexpected death	32+4 stillbirth	PMRT report completed- DOC closure meeting with family and bereavement lead consultant		
128985	09/05/2024	Unexpected death	36 stillbirth	DOC commenced PMRT review		

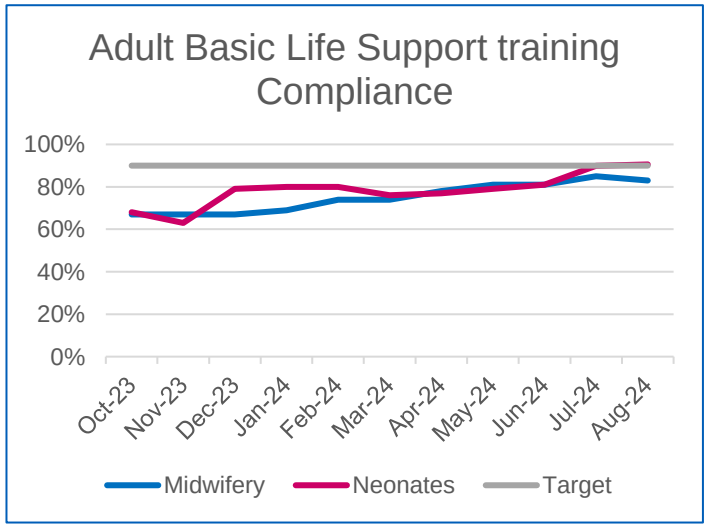
Maternity Safety Support Programme	N/A	**Coroner's regulation 28**	N/A

Well-led – Training









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

Countermeasures/action:
- Bespoke refresher skills sessions available for community staff : Skills drills and newborn life support with dates booked for the next year. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs).
- Additional skills sessions available to newly qualified staff and senior students facilitated by the Retention and Education team.
- Risk assessment for the risk register completed for mandatory training room bookings.
- PROMPT Faculty proposal completed decision to utilise CSF to reduce using establishment hours
- Agreement for ABLS to become managed in specialty moving forwards as part of the PROMPT programme.
- NNU ABLS compliance now at 90% target. Maternity on a steady increase currently at 83%.
- Additional study days to run between September to November to account for rotational medical staffing and new starters.

Risks:
- The use of our own compliance tracker as opposed to using ESR data – ESR still reflects theatre teams which impacts on our compliance. Linking in with ESR and Theatres to find a resolution to this for transparency and information sharing.
- 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)**
- ABLS compliance Risk Assessment completed for risk register
- Drop in compliance in June & July for PROMPT to 89.95% (less than target of 90%) overall compliance recovered in august across all staff groups to 91%- informed of emerging risk of vacancy within trust-wide resus team
- Rotation of obstetric doctors during august – knock on compliance within this staff group to below 90% for both fetal monitoring and PROMPT (66% and 75% respectively)
- New MIS Y6 standard for all anaesthetists who contribute to the on-call rota to be accounted for in PROMPT compliance,
- See MIS exceptional training compliance and trajectory slide.

Compliance to National Guidance

	Maternity Incentive Scheme Y6 - Safety Action Detail	Current positon	Anticipated submission position March 25
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?		

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	11	5	1	0	17	64.7
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	**99**	**21**	**12**	**0**	**130**	76.2

Maternity Incentive Scheme (CNST) Year 6

- **Key Achievements:**
- Continued 100% compliance with PMRT- 1 administration error on PMRT during Feb 24 discussed with MIS – evidence in place to demonstrate 100% compliance- now excluded from MIS external verification process
- DOC/MNSI/ENS referrals remain 100%
- Continued non requirement for use of Locum obstetricians
- Planning and agreements in place with LMNS to progress/demonstrate compliance with SA6.
- Q2 SBLv3 evidence submission in progress
- MSDS submission data for July 24 –compliant with SA2
- MIS change of standards for anaesthetics – compliance not monitored in year 6 for non obstetric anaesthetists- local target to ensure training compliance maintained.

Next Steps for Progressions:

- Bi-monthly Quad leadership meets at safety champions
- Bi-monthly culture slide to continue in safety champions PQST
- Training compliance oversight and assurance meeting in Nov to ensure on target for completion
- KPMG external audit of evidence due to commence Dec 24- TOR received
- Whilst the model of the MNVP within BSW has a funded work plan the long term financial structure to support the MNVP sustainability has not been agreed.

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 noncompliance no work in progress currently

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.

- Succession planning strategy
- Mentorship for band 7s and 8s
- Specialist workforce gap Analysis
- Manual Audit of maternal readmissions to assess timeliness of consultant review (target <14 hours)

Education (Training) MIS update

Staff Group	Training programme			
	PROMPT (NBLS inclusive)		Fetal Wellbeing Study day	
	Oct compliance	Projected compliance 30/11/24	Oct compliance	Projected compliance 30/11/24
Midwives (N=260)	**95.4%**	**97.3%**	**94.7% / 94.7/89.3%**	**98.8%**
Maternity Support Workers (N=75)	**97.4%**	**97.3%**	Not Applicable	
Consultant Obstetricians (N=11)	**83.3%**	**100%**	**91.7% /75%**	**100%**
Obstetric Registrars (N=13)	**73.3%**	**100%**	**66.7%**	**100%**
Other obstetric doctors (N=12)	**69.7%**	**100%**	Non applicable	
Other obstetric doctors on the specialty trainee programme for obstetrics (N=4)			**75%%**	**100%**
Anaesthetists (N=40)	**82.5%**	**97.6%**	Not Applicable	
Overall across all staff groups	**93.3%**	**98.6**	**92.4%**	**99.2%**

PROMPT:

2 x Consultants booked for 20th Nov

2 x Reg booked for 20th Nov

3 x SHO booked 20th Nov

5 x Anesthetists booked 20th Nov

Provisional Space booked as contingency plan.

Fetal Wellbeing/SBL:

K2 compliance overall 88.4%

2 x consultants booked 26th Nov

5 x Reg booked on 26th Nov

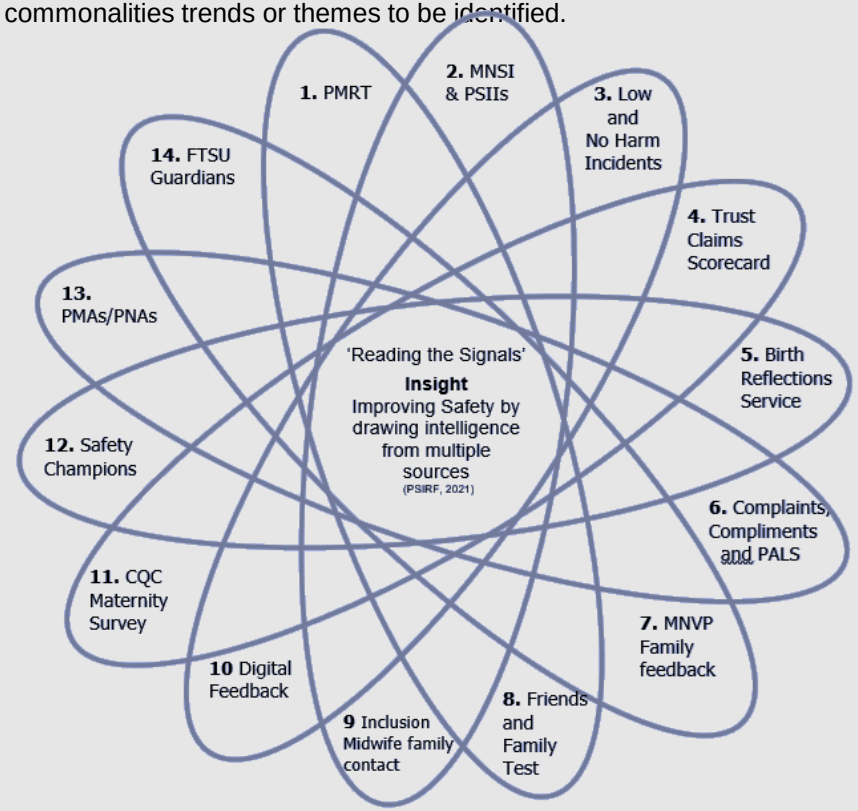
2 x SHO booked on 26th Nov

Provisional space booked for 29th Nov as contingency plan.

Responsive

Family Feedback 'Insights' Triangulation Group 24

The Maternity and Neonatal 'Insights' Family Feedback triangulation group meet every month to discuss the 'in month' feedback which has been 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.



October 24 Themes

- Medication and discharge delays on Mary ward
- Cramped and noisy environment on Mary ward
- Positive support and culture experience from NNU and midwifery students

Safety Champions Staff Feedback

Safety champion feedback –walk around 21st October 2024 (LNU, BBC), walk around with new NED 28/10/24 (Triage BBC and Mary Ward)

Maternity:

- Unpaid breaks continued additional pressure on management staff to facilitate breaks to ensure morale of staff – awareness of current union advertisements
- Reports of satisfied staff on BBC
- Fire compartmentalisation and operational system planning to facilitate vital estates work to be completed- concerns escalated regarding security.
- Areas requiring re-decoration/updating
- **Next steps**
- Continued work post-paid breaks consultation in maternity to operationally support leaders in break facilitation and escalation
- Operational planning in place by Inpatient Matron in collaboration with estates and FASS to plan for essential building works to limit impact on patient care and experience
- Planned Baby Abduction drill during Q3 of 24/25

Neonates:

- Positive reports of care and experience from family
- Positive feedback from student nurse enjoying her placement and the support
- Positive feedback from student regarding the culture at the RUH reporting 'warm, friendly and supportive' with a focus on providing 'holistic care'
- Shared information of staffing pressures over summer months but seem to be improved following recruitment of new band 5s which is 'refreshing' and welcomed
- Pressure on ANNP roster following re-locations
- **Next steps:**
- To advertise for tier 2 ANNP post to attract applications following failed recruitment at tier 1.

Maternity and Neonatal Voices Partnership (MNVP)

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

- **Key points raised** Focus on nutritional aspect of infant feeding and not enough about bonding and attachment

Next Steps: IF team to review training

Compliments & Complaints

Formal Compliments	**5**	**PALS Contacts**	**4**
Online Compliments	**--**	**Formal Complaints**	**0**

- 1 x commonality identified across PALS contacts pertaining to communication delivery feeling impatient
- Compliments of care received across Mary Ward and BBC.

Friends & Family Survey

Key Achievements: Continue to receive positive feedback re: culture and kind/caring staff

Identified Areas of Improvements:

Mary ward culture work ongoing. MDT culture conversations undertaken by external coach and action plan being drafted

Trust Integrated Balanced Scorecard - November 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

Strategic Goal		Goal Description	Performance Indicator	Measure description	Target: Performing	Target: Under Performing	Baseline	2023/2024 Nov	Dec	Jan	Feb	Mar	2024/2025 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
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%	-	50.1%	-	-	-	-
	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	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			318	253	256	193	39	33	41	56	36	42	26	22	18
		Communicating well, listening and active on what matters to you	% of positive responses to friends and family test					95.1%	93.9%	93.9%	94.0%	93.6%	93.9%	93.7%	93.2%	94.7%	93.9%	93.8%	93.6%	92.9%
	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%	-	50.1%	-	-	-	-
		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%	-	50.1%	-	-	-	-
	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		-2618	-4570	-5545	-6130	1665	527	192	-1086	-817	976	1744	1380	-6901
		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%	-	16.7%	-	-	-	-
			We improve together	Number of teams that are regularly holding improvement huddles (out of 128 frontline teams)	>=115 (90%)	<115 (90%)		-	-	69	-	-	57	-	-	72	-	-	84	-
	People we care for		Why not home, why not today	Average Length of Stay for Emergency Admissions (days)	<=8.4	>8.4		9.5	9.0	8.7	9.1	8.6	9.5	9.1	9.2	8.9	9.2	8.9	9.1	9.0
	People in our community		Delivery of financial plan'	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	(£3.17m)	(£5.03m)	(£5.03m)	(£6.70m)	£0.01m	£0m	(£0.08m)	(£1.50m)	(£0.61m)	(£0.63m)	(£1.88m)	(£2.11m)	(£4.24m)

Key Standards

Strategic Goal			Description	Performance Indicator		Target: Performing	Target: Under Performing	Baseline	2023/2024 Nov	Dec	Jan	Feb	Mar	2024/2025 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Key Standards	People in our community			Deliver 109% of 19/20 Elective Activity		>=109%	<109%		112.0%	112.0%	112.0%	114.0%	115.0%	130.0%	125.0%	122.0%	122.0%	123.0%	124.0%	128.0%	130.0%
	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%		69.2%	67.7%	66.4%	68.7%	69.8%	68.6%	68.6%	71.6%	71.5%	71.7%	71.7%	68.0%	65.2%
		L	C Diff Total Healthcare Associated (Hospital & Community) tolerance = 59	Clostridium Difficile Hospital Onset, Healthcare Associated				-	6	2	6	9	6	2	8	3	7	3	5	6	3
		SOF	RTT - Incomplete Pathways in 18 weeks	RTT - Incomplete Pathways in 18 weeks		>=92%	<92%	87.1%	60.1%	60.2%	60.4%	62.3%	63.6%	65.4%	66.4%	66.2%	65.5%	64.3%	63.7%	62.8%	62.7%
		NT	28 day referral to informed of diagnosis of all cancers	28 day referral to informed of diagnosis of all cancers		>=70%	<70%	-	66.7%	66.9%	59.7%	64.6%	66.7%	69.0%	69.4%	64.0%	58.0%	61.4%	68.5%	72.6%	(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%		94.9%	92.2%	90.8%	94.4%	95.8%	91.6%	95.0%	90.6%	94.5%	95.2%	94.2%	92.9%	(LAG 1)
		SOF	Combined 62 Day Cancer Targets	Combined 62 day cancer targets for GP referral, screening and consultant upgrade		>=75%	<75%		71.2%	71.8%	66.5%	67.3%	71.5%	72.2%	70.1%	71.2%	72.1%	69.6%	62.9%	62.6%	(LAG 1)
		SOF	Diagnostic tests maximum wait of 6 weeks	Diagnostic tests maximum wait of 6 weeks		<=1%	>1%		36.9%	32.7%	26.8%	19.6%	18.5%	23.4%	28.2%	35.5%	35.6%	41.8%	42.8%	39.0%	33.1%

Trust Integrated Balanced Scorecard - November 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

Strategic Goal			Performance Indicator	Description	Target		Baseline	2023/2024					2024/2025								Trend
					Performing	Under Performing		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	
Tracker Measures	People we care for	IT	% of complaints responded to within agreed timescales with complainant		>=90%	<90%	-	80.0%	93.3%	82.6%	90.9%	92.3%	86.7%	64.5%	73.1%	73.1%	87.5%	75.0%	69.0%	85.7%	
			Number of complaints received		<30	>=30		33	30	21	39	33	25	25	26	38	29	31	42	30	
		IT	Number of reopened complaints each month		<=3	>3	-	3	1	3	5	2	1	3	2	8	0	3	1	3	
			Concerns are acknowledged within 2 working days		>90%	<90%	-	-	-	-	-	-	100.0%	98.0%	99.0%	100.0%	99.0%	97.0%	98.0%	99.0%	
			Complaints acknowledged within 2 working days (target 90%)					-	-	-	-	-	-	-	-	-	-	-	-	-	
			Number of cases referred to the PHSO					-	-	-	-	-	-	-	-	-	-	-	-	-	
		IT	Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	-	6	2	2	3	3	1	0	1	1	4	2	5	6	
		IT	ED time to triage	Percentage of ED attendances triaged within 15 minutes			-	52.6%	54.1%	53.1%	48.8%	49.2%	47.1%	44.7%	55.0%	56.3%	62.1%	61.4%	57.4%	55.2%	
		IT	Medication Incidents per 1000 bed days	All Incidents			-	8.9	6.4	7.4	7.3	7.2	8.4	6.0	6.5	6.8	5.7	6.1	7.5	8.7	
		IT	Number of Patients given medication by scanning device					33.0%	35.7%	39.5%	40.6%	41.2%	42.1%	46.3%	46.6%	45.9%	47.0%	46.0%	47.1%	49.1%	
			Early Identification of Deteriorating Patient					24.4%	21.2%	24.5%	25.3%	23.5%	22.4%	26.2%	24.6%	23.8%	24.7%	24.4%	20.6%	21.4%	
			COVID 8+ Days					13	15	45	22	11	37	9	13	32	10	31	31	10	
		IT	Same Day Emergency Care (SDEC)	Non-elective adult admissions with 0 day LOS, Medicine only.	>=30%	<30%	-	31.5%	30.9%	32.5%	32.7%	33.0%	35.4%	34.0%	33.2%	34.2%	30.3%	33.4%	34.8%	32.7%	
			Ambulance Handover Delays	minutes (below 39 is upper quartile)				684	822	810	887	995	1194	938	860	679	681	899	1023	1138	
		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%	-	56.5%	53.8%	52.7%	52.8%	48.0%	51.6%	49.9%	53.4%	52.1%	50.6%	49.4%	50.6%	47.9%	
		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%	-	23.8%	23.4%	24.8%	26.0%	25.8%	22.8%	24.5%	23.7%	29.2%	29.2%	25.6%	21.7%	21.2%	
			% with Discharge Summaries Completed within 24 Hours					83.5%	82.9%	84.3%	84.2%	84.6%	84.3%	83.7%	84.0%	83.2%	84.0%	84.8%	82.4%	84.6%	
			Non Criteria to Reside (Average per day)					89.3	83.0	81.9	80.7	86.2	88.0	92.8	93.3	86.9	90.2	85.6	94.6	96.3	
			HSMR - Total					98.0	95.9	99.8	100.4	99.5	97.6	99.0	101.9	100.4	101.6	(LAG 3)	(LAG 3)	(LAG 3)	
			HSMR -Weekday					97.2	96.3	100.4	101.5	99.7	97.4	98.5	102.0	99.3	101.4	(LAG 3)	(LAG 3)	(LAG 3)	
			HSMR -Weekend					100.7	94.4	97.7	96.9	99.0	98.4	100.7	101.6	104.3	102.5	(LAG 3)	(LAG 3)	(LAG 3)	
	People we work with	IT	Turnover - Rolling 12 months	Voluntary turnover only	<=11%	>12%		9.2%	9.0%	8.8%	8.5%	8.4%	8.1%	8.5%	8.4%	8.6%	8.2%	8.1%	8.2%	8.1%	
		IT	Vacancy Rate		<=4%	>5%		3.1%	1.8%	1.6%	1.0%	1.4%	5.6%	5.2%	2.9%	6.1%	4.1%	5.0%	2.9%	3.8%	
		IT	Sickness Rate	Rolling 12 months	<=3.5%	>4.5%		4.4%	4.7%	4.9%	4.8%	4.6%	4.4%	4.4%	4.9%	4.6%	4.4%	4.6%	5.1%	(LAG 1)	
		IT	Mandatory Training Compliance		>=90%	<80%		89.4%	89.8%	90.3%	90.8%	90.4%	90.3%	90.1%	90.0%	88.7%	89.0%	88.2%	88.4%	88.6%	
			% Staff with annual appraisal		>=80%	<80%		72.7	74.8	75.8	77.0	77.1	77.7	77.7	78.9	78.5	82.8	82.8	80.2	80.9	
	People in our community		Health Inequalities 1	% Difference in DNA rates between IMD1-2 and IMD 9-10				5.0%	4.7%	4.0%	5.4%	4.3%	4.3%	3.7%	3.0%	3.5%	3.8%	3.6%	3.6%	3.4%	
			Health Inequalities 2	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD9-10				-5.1%	-2.0%	7.6%	0.6%	12.3%	5.8%	3.9%	12.3%	-0.2%	5.3%	2.1%	6.7%	8.8%	
		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	-	-3154	-5094	-6438	-6807	3986	308	526	-537	-185	1086	579	835	-7565	
		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 %	-	3.1%	3.0%	2.7%	2.7%	2.5%	1.2%	1.2%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	
			% activity delivered off site (virtual and community)					21.6%	21.8%	22.7%	21.8%	22.1%	22.1%	22.3%	22.0%	21.6%	21.4%	21.3%	21.0%	20.8%	

Strategic Goal			Performance Indicator	Description	Target		Baseline	2023/2024					2024/2025								Trend
					Performing	Under Performing		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	
Other Measures	People We Work With		Total monthly fill rate, day hours, RN	Average per ward	>=90%	<90%		83.8%	80.2%	79.9%	75.0%	82.3%	84.4%	86.3%	85.9%	87.7%	88.0%	87.1%	88.1%	90.6%	
			Total monthly fill rate, day hours, HCA	Average per ward	>=90%	<90%		75.9%	72.5%	75.1%	78.4%	77.3%	77.3%	84.2%	84.7%	84.1%	83.2%	82.8%	86.3%	85.3%	
			Total monthly fill rate, night hours, RN	Average per ward	>=90%	<90%		94.4%	94.6%	92.7%	92.0%	93.5%	93.4%	93.1%	94.7%	95.9%	94.5%	93.9%	95.4%	94.5%	
			Total monthly fill rate, night hours, HCA	Average per ward	>=90%	<90%		87.3%	82.7%	83.8%	85.6%	85.4%	87.9%	88.8%	92.5%	92.5%	92.0%	103.6%	96.4%	97.6%	
			Information Governance Training Compliance		>=80%	<80%		86.2%	86.8%	87.6%	88.4%	87.7%	88.5%	86.8%	86.0%	85.2%	87.9%	86.3%	86.2%	86.7%	
	People we care for	NR	Hip fractures operated on within 36 hours		>=80%	<=70%		60%	62.3%	66.7%	53.2%	46.9%	66.0%	39.6%	69.2%	51.4%	66.7%	72.7%	81.0%	74.5%	
		NR	Time to Initial Assessment - 95th Percentile					103	124	104	102	106	154	120	79	42	34	28	29	33	
		NR	% of mothers booked within 12 completed weeks		>=90%	<=85%		88.5%	87.6%	84.5%	88.8%	87.4%	86.5%	86.3%	85.3%	84.3%	81.0%	84.4%	81.7%	80.2%	
		NR	% Women identified as smokers referred to specialist stop smoking service		>=90%	<=80%		94.3%	97.0%	100.0%	100.0%	93.1%	89.3%	94.7%	95.0%	100.0%	100.0%	90.5%	95.2%	95.8%	
		NR	Midwife to Birth Ratio		<=1:27	>1:32		1:31	1:26	1:27	1:29	1:27	1:27	1:29	1:28	1:28	1:28	1:31	1:30	1:27	
		NT	TIA Treated within 24 hours		>=60%	<=55%		28.2%	29.0%	44.2%	41.7%	21.2%	19.0%	20.8%	49.0%	28.3%	42.9%	37.0%	41.0%	41.9%	
		NT	12 Hour Breaches		0	>0		11	27	21	24	16	39	4	19	5	15	54	123	131	
		LC	Number of medical outliers - median		<=25	>=30		9	12	9	16	11	10.5	6	3	4	9	9	13	14	
		L	Readmissions - Total		<=10.5%	>12.5%		7.4%	8.4%	7.4%	7.6%	7.9%	7.9%	8.0%	7.7%	8.7%	7.7%	7.9%	7.9%	7.9%	
		L	Discharges by Midday (excluding Maternity)	Includes transfers to the Discharge Hub	>=45%	<45%		21.4%	19.7%	22.6%	21.9%	22.6%	23.3%	22.5%	22.5%	23.6%	21.6%	22.5%	25.6%	26.6%	
		NT	Number of 52 Week Waiters Incomplete Pathways					1274	1151	1072	905	813	650	737	760	725	748	645	576	524	
		L	GP Direct Admits to SAU		>=168	<168		229	229	237	243	249	218	259	211	256	228	205	233	264	
		L	GP Direct Admits to MAU (including DAA)		>=84	<84		295	314	328	269	353	289	305	286	329	323	277	281	293	
		NR	Bed occupancy (Adult)		<=93%	>97%		96.5%	93.8%	96.6%	96.9%	96.7%	97.5%	95.0%	95.0%	93.8%	94.1%	94.6%	96.9%	97.2%	
		NR	% Cancelled Operations non-clinical (number of cancelled patients) Surgical		<=1%	>1%		1.1% (38)	1.0% (29)	1.2% (43)	1.3% (46)	0.6% (24)	0.9% (33)	1.2% (44)	1.1% (37)	0.9% (33)	1.6% (53)	1.1% (36)	0.9% (33)	1.2% (43)	
		NT	Urgent Operations cancelled for the second time		0	>0		0	0	1	1	2	0	0	0	1	1	0	0	0	
		NT	Cancelled operations not rebooked within 28 days - Surgical		0	>0		0	1	0	0	0	0	0	1	0	0	0	0	2	
		SOF	Clostridium Difficile Community Onset, Healthcare Associated					0	3	2	2	3	5	1	1	4	8	7	0	3	
		SOF	E.coli bacteraemia cases Hospital Onset, Healthcare Associated		<=6	>6		2	5	1	4	1	4	4	2	5	2	3	5	5	
		SOF	E.coli bacteraemia cases Community Onset, Healthcare Associated					6	2	5	4	4	5	6	2	4	3	0	1	2	
		SOF	MRSA Bacteraemias >= 48 hours post admission		0	>=1		0	0	0	0	0	0	0	0	0	0	0	0	0	
		L	Klebsiella spp Hospital Onset, Healthcare Associated		<=2	>2		1	2	0	4	1	2	2	0	3	1	1	1	0	
			Klebsiella Spp Community Onset Healthcare Associated					0	0	1	0	2	2	2	1	1	1	1	0	1	
		L	Pseudomonas aeruginosa Hospital Onset, Healthcare Associated		<=1	>1		0	0	4	0	0	1	0	2	0	1	0	0	0	
			Pseudomonas aeruginosa, Community Onset Healthcare Associated					-	-	-	-	-	0	1	2	1	0	0	0	2	
			MSSA Post 48 Hours					0	1	3	6	5	2	0	1	1	2	2	3	1	
			Flu - Healthcare Onset (+3 days)					-	-	-	-	-	2	1	1	0	0	0	0	1	
			Norovirus Outbreaks					0	2	0	1	2	0	0	1	1	0	0	1	0	
			Number of Hospital Acquired Pressure Ulcers Category 2	Includes Medical Device Related	<=2	>2		1	0	3	4	1	1	1	3	2	0	0	4	4	
			Hospital Acquired Category 3 Pressure Ulcer	Includes Medical Device Related	<=0	>0		1	0	0	2	0	1	1	1	0	2	3	3	3	
			Hospital Acquired Category 4 Pressure Ulcer					0	0	0	0	0	0	0	0	0	0	0	0	0	
		SOF	Never events		0	>=1		0	0	0	0	0	0	0	0	2	1	0	0	0	
		SOF	SHMI		<=Expected	> Expected		0.9784	0.95	0.95	0.94	0.93	0.93	0.93	0.94	0.95	(LAG 4)	(LAG 4)	(LAG 4)	(LAG 4)	
			Mixed Sex Accomodation Breaches					70	97	163	170	182	170	221	191	154	186	160	237	244	
	People In Our Community	L	Delivery of Group financial plan	Variance from year to date plan	<=0	>0		(£3.17m)	(£5.03m)	(£5.03m)	(£6.70m)	£0.01m	£0m	(£0.08m)	(£1.50m)	(£0.61m)	(£0.63m)	(£1.88m)	(£2.11m)	(£4.24m)	
		L	Delivery of capital programme	Variance from year to date planned capital expenditure (Internally Funded Schemes)	-5%	<5%		-68.2%	-67.0%	-57.9%	-33.1%	-0.5%	67.3%	51.9%	69.7%	65.7%	61.8%	51.8%	63.7%	66.2%	
		L	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+/-5%	><5%		0.0%	0.0%	0.0%	0.0%	-0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
		L	Delivery of planned cash balance	Variance from year to date planned cash balance	+/-10%	><10%		13.4%	14.0%	-5.1%	-8.6%	-12.8%	8.8%	25.6%	24.5%	38.7%	40.0%	17.4%	64.9%	41.6%	

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**	**Agenda item No:**	**10**
Date of Meeting:	**15 January 2025**		

Title of Report:	**Maternity and Neonatal Safety Quarter 2 Report**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Author(s):	**Zita Martinez, Director of Midwifery**
Appendices	**Appendix 1: Insights report of 23/24 Mid-Year QI review** **Appendix 2: Transitional Care Pathway and ATAIN Audit Q2 2024/2025**

1. Executive Summary of the Report

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

This RUH Maternity and Neonatal Safety report identifies at the end of Q2, the Royal United Hospitals Bath NHS Foundation Trust (RUH) rolling 12-month average stillbirth rate is 2.18 per 1000 births; this remains 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 23/24 of 1.42 per 1000 (MBRRACE reporting timeframe).

The RUH neonatal mortality 12 month rolling average at the end of Q2 is 1.16 per 1000 births, this remains below the reported national average for 2022 of 1.7 per 1000 births. All stillbirths and neonatal deaths, during Q2 have been reported to Mothers and Babies Reducing Risk through Audit and Confidential Enquiries-UK (MBRRACE-UK), and where applicable, excluding Medical Terminations of Pregnancy (MTOPs), a Perinatal Mortality Review Tool (PMRT) process will be undertaken.

No births met the criteria for referral to the Maternity and Neonatal Safety Investigations (MNSI) team hosted by the Care Quality Commission (CQC) in Q2. The service currently has 1 ongoing review with MNSI. The service received 1 finalised report from MNSI during Q2, this report contained no safety recommendations to the service, all findings have been analysed for co-incidental learning and improvement and any identified actions will be monitored through governance. 1 new internal Patient Safety Incident Investigations (PSII) was initiated in Q2 in response to the death of an 8-day old baby. Terms of reference for declaration of a PSII are detailed within this report.

On 31 March 2024, the service received Year 6 safety standards for the Maternity Incentive Scheme (MIS), the current and projected position at submission is detailed within this report (section 7.0). It is identified that the current compliance of neonatal nurses holding a recognised qualification in the specialty (QIS) has decreased following staffing re-locations and retirements, to below the British Association of Perinatal Medicine (BAPM) standard of 70%. This is presented as a new risk on the risk register and the full action plan towards recovery and mitigation is detailed within this report.

This report outlines the current service responses to insights from service users including the Maternity and Neonatal Voices Partnership and Safety Intelligence data. The Insights report of 23/24 sought to identify key areas for improvement and learning for the service during 24/25. Appendix 1 provides a mid-year review summary of the current quality improvement work the service has undertaken in response. This report seeks to provide assurance of the service's ongoing commitment to continuous improvement.

The Avoiding Term Admissions into the Neonatal Unit (ATAIN) working group identified during Q2 the transitional care (TC) pathway remained open for 100% of the time, with staffing meeting the

identified transitional care pathway model on average 89% of the time. On no occasion were there identified missed opportunities to have provided TC care or identified 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. No babies were admitted to or remained on Neonatal Unit (NNU) because of their need for nasogastric tube feeding, which could have been cared for on a TC if nasogastric feeding was supported there. Two avoidable admissions were identified in Q2 into the Neonatal Unit, the same as in Q1, there have been no identifiable commonalities between the avoidable admissions reviewed at the ATAIN multi-disciplinary group.

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 Q2 Maternity and Neonatal, services presented 4 new risk assessments, which were approved for the risk register:

Risk No	Domain of Risk	The Risk	
2950	Patient Safety Quality Complaints and Audit	There is a risk that due to the current compliance of percentage of staff QIS trained in the LNU below BAPM standards, the quality of care being delivered to the babies at risk of being compromised	12
2949	Patient Safety	There is a risk that due to the current estates footprint, and estates availability of Princess Anne Wing (PAW) Maternity services are unable to run optimally.'	8
2948	Statutory Duty/Inspections Finance including claims	There is a risk that due to a gap between demand and capacity to process the increasing volume of Maternity Subject Access request the service will be unable to meet the mandated 30-day delivery target	8
2785	Patient Safety Quality Complaints and Audit	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards.	12

Current Open Risks in Maternity and Neonates Q2 24/5:

2784	Maternity and Neonatal Services Adult Basic Life Support Compliance	6
1948	Obstetric ultra sound scan capacity	8
2359	Maternity Information System IT support/capacity	8
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	4

	as a female gender	
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
2681	Mandatory Training room booking availability	9
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
2950	There is a risk that due to the current compliance of percentage of staff QIS trained in the LNU below BAPM standards, the quality of care being delivered to the babies at risk of being compromised	12
2949	There is a risk that due to the current estates footprint, and estates availability of Princess Anne Wing (PAW) Maternity services are unable to run optimally.'	8
2948	There is a risk that due to a gap between demand and capacity to process the increasing volume of Maternity Subject Access request the service will be unable to meet the mandated 30-day delivery target	8
2785	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards.	12

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 report – Quality Assurance committee and Board of Directors
Q2 report – Quality Assurance Committee (cancelled)

8. Publication

Public.

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 the RUH Maternity Single Delivery Improvement plan encompassing of Ockenden 2022 Immediate and Essential Actions (IEAs) aligned to the three-year delivery plan for Maternity and Neonatal Services of 2023. This report also outlines the current position of compliance with 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 revised National averages.

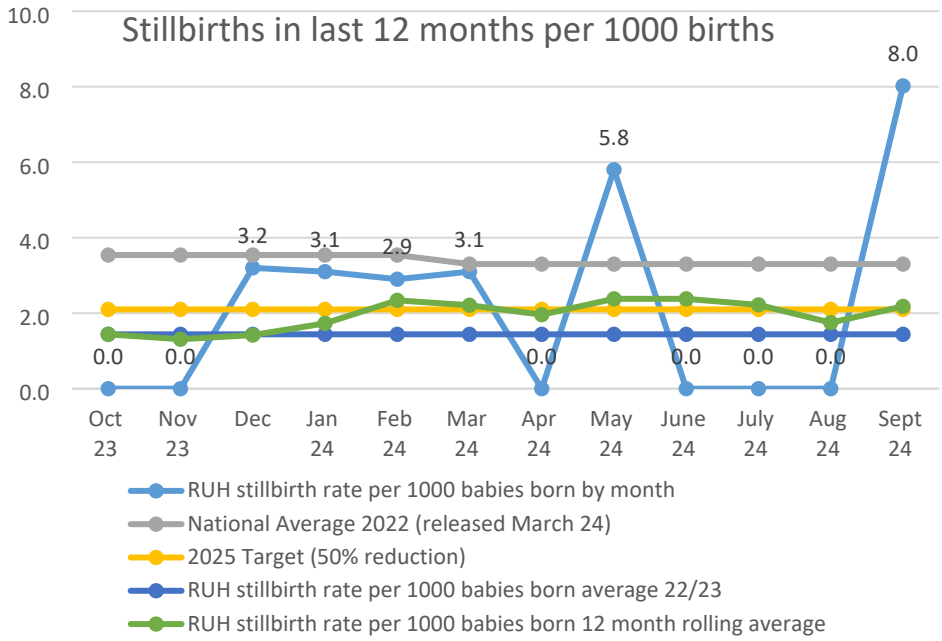


Figure 1: RUH NHS Trust stillbirth rate per 1000 births over last 12 months

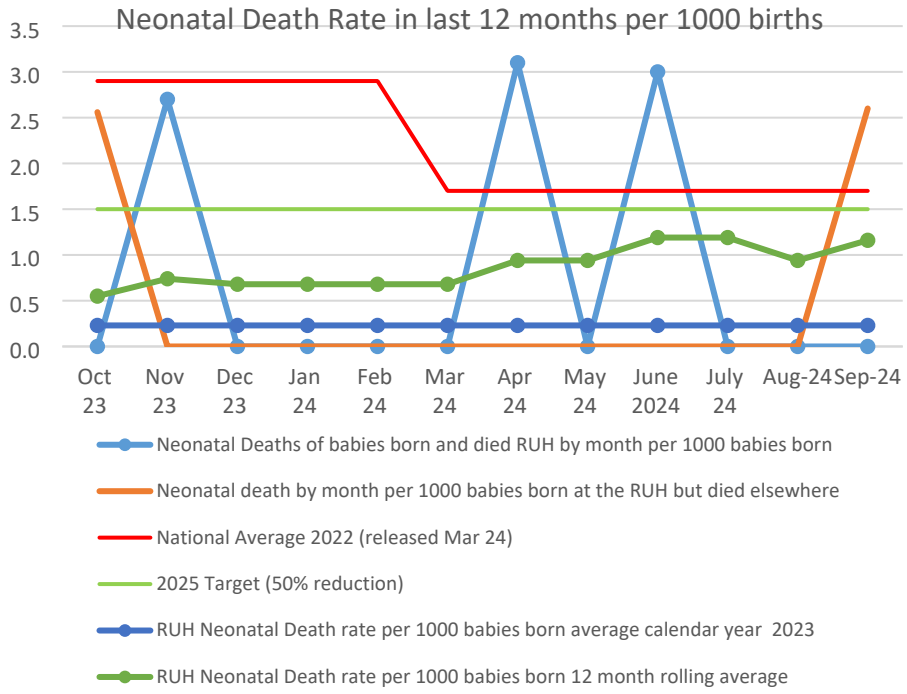


Figure 2: RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

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. Neonatal deaths of pre-viability infants (less than 22 weeks gestation) born with signs of life, and births between 22-24 weeks are identified 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 if the RUH statistics were representative of the national socioeconomic demographics. Therefore, MBRRACE crude, and stabilised and adjusted rates for the RUH will be different. 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.

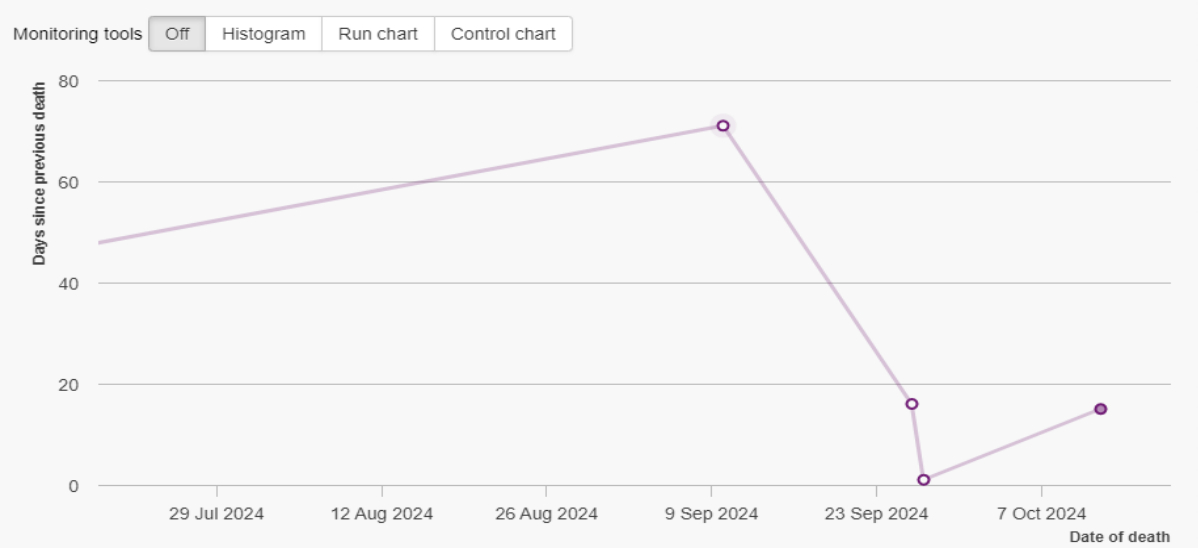
Four perinatal deaths (excluding Medical Termination of Pregnancies (MTOP)) were reported in Q2. This consisted of 3 stillbirths: 1 at 28 weeks of pregnancy, 1 at 38 weeks of pregnancy and 1 at an unknown term gestation in an undiagnosed/concealed pregnancy and a Neonatal Death of a baby at day 8 of age. The Neonatal death has been declared as a Patient Safety Incident Investigation see section 3.4.

2024/25 (excluding terminations for abnormalities)	Q2 24/25	Annual total 24/25	Annual total 2024 (calendar year)
Stillbirths (>37 weeks)	2	2	4
Stillbirths(>24weeks-36+6weeks)	1	3	4
Late miscarriage (22+weeks-23+6weeks)	0	1	1
Neonatal death at the RUH	0	2	2
Neonatal death elsewhere following birth at the RUH	1	1	1
Total	**4**	**8**	**12**

Table 1: Perinatal Mortality summary by number of cases, quarter 2 2024/25

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 Q2 cases have been reported to MBRRACE-UK via PMRT. See Figure 3 as confirmation of reporting as per table 1.



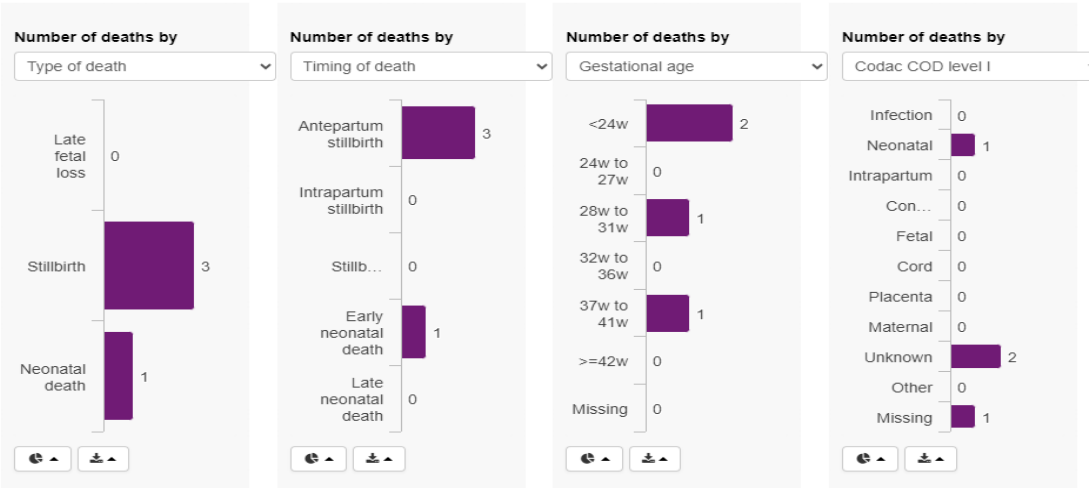


Figure 3: Reporting of RUH NHS Trust Deaths within Organisation for Q2 24/25

2.1 PMRT PROCESS MEASURES

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Q2 24/25	Annual 24/25	Standard
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within 7 working days	**100%**	**100%**	**95%**
Surveillance of all perinatal death information must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter	**100%**	**100%**	**95%**
A PMRT review must be commenced within two months following the death of a baby	**100%**	**100%** 1x administrative error in Dec 2023	**50%**
Percentage of PMRT review meetings which have met quoracy as outlined within the PMRT recommended composition	**100%**	**100%**	**100%**
A draft PMRT report must be completed within four months of a baby's death	**75%**	**75%** 1x excluded case as subject to MNSI	**50%**
A PMRT must be completed within six months of the baby's death	**75%**	**75%** 1 x excluded case as subject to MNSI	**50%**
All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**100%**	**100%**	**95%**
Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**	**100%**	**100%**

Table 2: PMRT Process Measures Quarter 2 24/25.

2.2 LEARNING FROM PMRT REVIEWS

In Q2, 4 PMRT reviews were completed and shared with the families. In all cases the PMRT review group concluded that there were no issues with care identified for the mother which would have impacted upon the outcome for the baby.
The review group identified co-incidental learning actions to support service quality improvements outlined below identified at Rapid Review:

Issue/area for improvement	Review Response/Action plan	Action target date
1. Symphysis Fundal Height (SFH) measurement was not plotted onto the inter-growth chart, when retrospectively plotted would not have impacted upon care pathway.	Compliance with plotting of SFH into growth charts is subject to regular audit; compliance is monitored via quarterly audit meetings reporting into specialty governance to address any areas of low compliance. As part of digital transformation and service movement to badger.net scheduled for June 2025 the plotting of SFH will be automated and will mitigate against the risk of transcription errors/missed plots	Badger.net implementation anticipated June 25

Table 3: PMRT Action plan Q2 24/25

3. MATERNITY AND NEONATAL SAFETY INVESTIGATIONS (FORMERLY THE HEALTHCARE SAFETY INVESTIGATION BRANCH) AND MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS

3.1 BACKGROUND

Maternity and Neonatal Safety Investigations (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

No new referrals were made in Q2. Table 4 summarises the ongoing MNSI reviews into Q2. The findings and recommendations of these reviews, and the actions taken in response, will feature in future quarterly Trust Board reports. No cases in 24/25 have met the criterion for Early Notification Scheme referral to NHS-Resolution.

Ref	Details of Event	Confirmed Investigation	External Notifications and Other Investigations	Duty Of Candour commenced inclusive of information sharing pertaining to MNSI and NHS-R.
Completed in Q2				
MI-036771	Stillbirth of baby en route to hospital for labour assessment.	February 2024	MBRRACE/PMRT. Discussed with coroner.	Yes 30/01/2024
Ongoing				
MI-037619	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling, Normal MRI post cooling.	June 24 progressing at family request		Yes 04/07/2024
New Referrals				
No new referrals were made during Q2				

Table 4. MNSI referrals and ongoing investigations Q2 2024/2025

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY PATIENT SAFETY INCIDENT INVESITGATIONS (PSII)

One Patient Safety Incident Investigation reached completion in Q2. The learning and improvement findings, recommendations and actions are detailed in section 3.5. One new Patient Safety Incident Investigation was initiated as described in table 5.

Ref	Details of Event	Review Response	External Notifications and Other Investigations	Duty Of Candour commenced
Completed reviews				
	Placental abruption, stillbirth and maternal Intensive Care Unit (ICU) admission at 34 weeks of pregnancy	PSII ongoing with terms of reference looking at the use of computerised cardiotocography (CTG) and holistic risk assessments	PMRT/MBRRACE.	Yes 03/04/2024
New review(s)				
	Neonatal Death on day 8 of life	PSII initiated with terms of reference: • To review the current service education provision to parents regarding routes of escalation in response to the signs of an unwell newborn in the early postnatal period	PMRT/MBRRACE/ Coroners/CDOP	Yes 15/10/2024

		• To review the current Maternity Telephone Triage line 'signs of an unwell newborn' 'action cards' 'red flags'. • To review the supporting systems and structures in place in managing escalations of clinical concerns from parents regarding signs of an unwell newborn via the Maternity Telephone Triage line • To review the referral pathways following contact from parents via the Maternity Triage line for neonatal clinical concern.		

Table 5. Maternity and Neonatal Patient Safety Incident Investigations Q2

There were 3 moderate harm events reported during Q2, in response to 4th degree tears. Obstetric Anal Sphincter Injuries (OASI) are subject to ongoing review via audit looking for areas of improvement with an ambition to reduce OASI rates. All 3rd and 4th degree tears have received a local rapid review, the multidisciplinary review team (MDT) did not identify any care concerns causal to the event. 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 was received in Q2 2024/25. No safety recommendations were made to the Trust within the report. A safety recommendation is made where alterations in care may have changed the outcome for either the mother or the baby. An MDT review has taken place to consider incidental learning identified within the final report to inform ongoing and future improvement work. Where applicable, action plans have been derived and progress will be monitored via Maternity and Neonatal Specialty Governance, feeding into the 'triangulation of feedback' data base to allow for assessment of wider commonalities or trends across the service 'insights'.

When reviewing Q2 incidents, received reports and opportunities for learning and improvement alongside the claims scorecard for 2023 one commonality can be seen. During Q2 the service identified an increase in the number of moderate harm events pertaining to OASI, and one of the leading clinical events resulting in damages paid by the trust within the claims scorecard of 2013- 2023 (n=4) was for OASI. The cause for claim in response the clinical event varied from: unnecessary pain, fail/delay treatment, unnecessary operation, and psychological damage. It is difficult to ascertain from the scorecard the aspects of care identified as being sub optimal which led to the determination of causation. Each case of 4th degree tear has received an individual multidisciplinary team review; no identified care issues causal to the outcome has been identified.

In one case the perineal repair was not supervised by a consultant Obstetrician in line with the Royal College of Obstetrics and Gynaecology 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' (RCOG , 2021). This was due to mobile telephone connectivity issues which has since been rectified. Additional communication has

been distributed to all obstetric specialist trainees; should there be an inability to contact the on-call consultant then another consultant is to be called outside of their on-call hours and agreed by the obstetric consultant body. Follow up via the Perinatal Pelvic Health Service has been ensured; no concerns have been identified with the repair, should any concerns be identified the event is to be re-reviewed and harm level amended as appropriate.

Learning and Improvement drivers from service insights are fed back to staff in a variety of formats including: the 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 from co-incidental learning through service insights such as themes of low and no harm incidents, audit and, or family feedback. Furthermore, local insights for learning are fed into the mandatory training programme for midwives as per the Core Competency Framework version 2 (CcFv2).

4. RUH SINGLE MATERNITY AND NEONATAL IMPROVEMENT PLAN

4.1 THREE YEAR DELIVERY PLAN UPDATE- Q2 2024-2025

RUH Single Improvement plan compliance categorised under the 4 pillars of the 3 year Delivery plan 2023						
Domain	**Blue**	**Green**	**Amber**	**Red**	**Total Actions**	**% of Compliance**
1- Listening to Women	10	3	5	0	18	55.6
2- Workforce	48	11	13	0	72	66.7
3- Culture and Leadership	39	5	5	0	49	79.6
4- Standards	19	7	3	0	29	65.5
Total	**116**	**19**	**26**	**0**	**159**	73.0

Table 6. RUH compliance with open actions towards the 3-year delivery Plan Q2 24/25

The Maternity and Neonatal service has developed a single Maternity and Neonatal Improvement Plan for 24/25 in response to the NHSE 3-year delivery Plan, Ockenden report (2022) and the NHSE visit (2022). The plan encompasses all actions associated with the reports, listed under the 4 Domains of the 3 year plan. Next steps include the incorporation of the CQC action plan into the single delivery plan to ensure concurrent review and delivery.

The compliance for the individual report action plans can be extracted from within the plan.

Progress towards full implementation are outlined within tables 6 and 7; percentage of compliance is only attributed to those actions within the action plan which have been completed.

- Blue actions - Evidence of implementation assurance can be obtained if required
- Green actions - Improvement work is on target for completion, and/or the service is developing assurance processes
- Amber actions - Improvement work in progress however continued work is required, or no assurance of compliance is available at present
- Red actions - Current non-compliance with no work in progress to address currently.

4.2 OCKENDEN FINAL REPORT UPDATE – Q2 2024-2025

The Trust is no longer required to submit evidence of compliance with the 15 Immediate and Essential Actions outlined within the Ockenden report (2022). Any remaining open actions have been incorporated into the RUH Single Maternity and Neonatal Improvement Plan and

progress monitored at Specialty Governance, Maternity and Neonatal safety champions via the Internal Performance Review (IPR) presentation every month.

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	11	5	1	0	17	64.7
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	99	21	12	0	130	76.2

Table 7. RUH compliance with open actions towards the Ockenden 2022 actions Q2 24/25

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

5.1 Q2 POSITION

The report provides an update on the local training and development that is ongoing within the maternity and neonatal service, including a response to year 6 of the Maternity (and Perinatal) Incentive Scheme (MIS), Safety Action 8. The Core Competency Framework version 2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment for midwifery staffing across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service.

Compliance with attendance and demonstrated competence for fetal monitoring, neonatal resuscitation and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) across all staffing groups is required to be above 90% to fulfil the requirements set out within the MIS. The service is also committed to working towards 'stretch targets' as outlined within the CCFv2 which is considered a measure of high functioning organisations

During the latest 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% resulting in a 'should do' recommendation. In response the specialty has liaised with the trust-wide resuscitation team to manage compliance 'in specialty' as part of the scheduled mandatory 'PROMPT' agenda. Since its implementation during Q2, the service has seen a steady increase in compliance currently at 86% for September 2024.

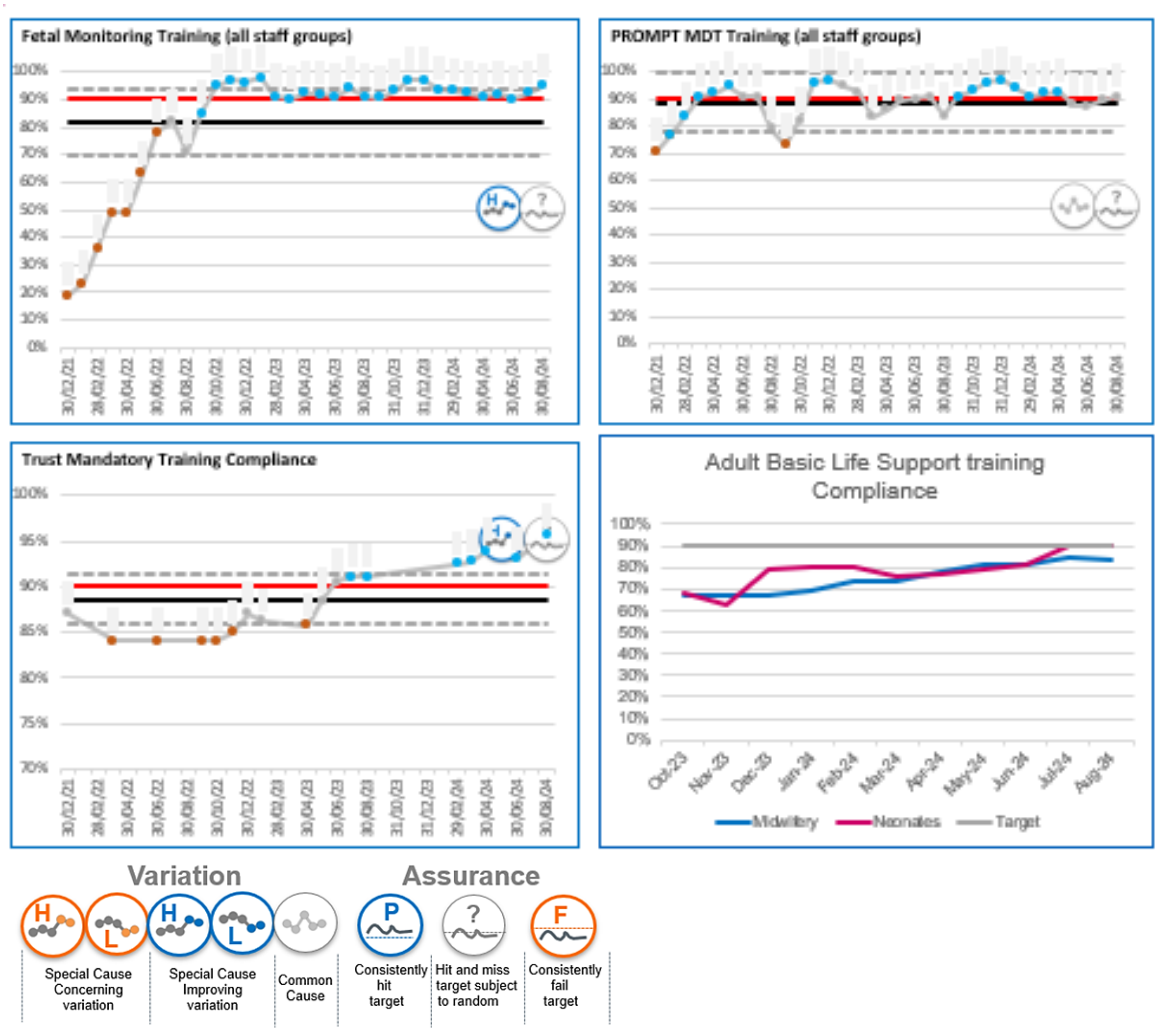


Figure 4. Maternity Training Statistical Process Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance, as of 30/09/2024

Specific training standards for all staffing identified within the Saving Babies Lives version 3 are externally assessed by the Integrated Care Board (ICB), Local Maternity and Neonatal System (LMNS) for both content and compliance (section 8).

During Q2, the service saw a marginal drop in overall compliance for PROMPT and Fetal Wellbeing to 89% (target 90%). This was attributable to annual leave impacting on both training attendance and ability to release from clinical shifts to maintain safe staffing levels and the rotation of medical staffing in training reducing the number of medical staff members holding locally delivered training compliances. Additional study days are in place for September through to November to support compliance recovery within the MIS reporting.

As of 30/09/24 training across staff groups is detailed as per table 8 with projected compliance to meet 90% across all staff groups as of the 30/11/24 (MIS reporting deadline).

Staff Group	Training programme			
	PROMPT (NBLS inclusive)		Fetal Wellbeing Study Day	
	Q2 compliance	Projected compliance 30/11/24	Q2 compliance	Projected compliance 30/11/24
Midwives (N=260)	**95.4%**	**96.9%**	**90.2%**	**96.8%**
Maternity Support Workers (N=75)	**94.7%**	**97.3%**	Not Applicable	
Consultant Obstetricians (N=11)	**83.3%**	**100%**	**91.7%**	**100%**
Obstetric Registrars (N=13)	**69.2%**	**100%**	**53.8%**	**100%**
Other obstetric doctors (N=12)	**42%**	**100%**	Non applicable	
Other obstetric doctors on the specialty trainee programme for obstetrics (N=4)			**60%**	**100%**
Anaesthetists (N=40)	**65%**	**97.6%**	Not Applicable	
Overall, across all staff groups	**89.3%**	**98.6**	**89.4%**	**99.2%**

Table 8. RUH compliance with mandatory training requirements and projection for MIS reporting period deadline of 30/11/2024

To achieve the projected compliance for 'other obstetric doctors on the speciality training programme for obstetrics' within the fetal wellbeing study day, following the rotation of medical trainees in August 24, in line with MIS standards, the service has accepted the certified attendance on fetal monitoring training in another NHS Maternity provider within the last 12 months for 1 trainee. The service will be unable to facilitate local training for this individual by the MIS deadline of the 30/11/24 without impacting upon clinical service provision. Local training has been booked to be completed in Q4; within 1 year of previous certified training, within 6 months of joining the service.

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.

Themes raised to the Safety Champions during Q2 were:

- Concerns regarding the trust-wide paid breaks consultation and outcome, both regarding breaks facilitation on shift, and the impact the unpaid breaks will have on work-life balance due to an increased requirements for 'make-up shifts' if not reducing hours.
- Summer Staffing pressures in response to increased annual leave uptake and held vacancy rates to honour pre-agreed job offers to midwifery students post their qualification in September 24.
- Concerns regarding the confidence of new senior/specialist midwives in their contribution and clinical expectations of the Maternity Manager on Call (MOC) out of hours cover provision.

Current work to address the concerns raised:

- Maternity services developed 'breaks working party' looking at developing tools, systems and techniques to support staff to effectively take their unpaid breaks particularly pertaining to work on Mary Ward.
- Development of a Maternity Standard Operating Procedure for the escalation of an inability to facilitate staff breaks.
- See appendix 2 for full report on Quality Improvement work update for Mary Ward
- Recruitment into held vacancies during September 24 as of 30/09/24 the substantive vacancy within Maternity is 0.49WTE (section 9).
- To provide operational sustainability and equity to all employed midwives, there is an identified need and expectation to provide a form of out of hours service cover provision; this is in the form of night shift working, or in an on-call capacity. The Retention lead midwife has reviewed the current Manager on-Call guidance, with a planned re-launch and buddy system in place for new starters on the rota. It is anticipated that following stabilisation of the acute staffing following the period of held vacancy that the MOC will be in place to provide a managerial/operational oversight role of support only and not utilised for clinical care provision.

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

7. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q2 2024/25

The Clinical Negligence Scheme for Trusts released the Maternity (and perinatal) Incentive Scheme Year 6 on 31 March 2024. 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 on a monthly basis.
Areas of current non-compliance are in response to the reporting time scales set within MIS not yet reached to be able to achieve the set standards.

	Maternity Incentive Scheme Y6 - Safety Action Detail	Current position 30/09/24	Anticipated submission position March 25
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 9: Position of compliance with MIS Year 6.

Next Steps for Progression towards full compliance:

- Provisional MSDS submission data from July indicates provisional compliance with Safety Action 2, the service will receive confirmation on the 28 October 2024,
- Submission of evidence towards implementation of the Saving Babies' Lives Care Bundle Version 3 has continued in Q2 with assurance provided by the LMNS as per MIS standards (section 8).
- For progress towards compliance within Safety Action 8, refer to section 5 of this report.
- Compliance is anticipated within Safety Action 9, however this remains 'amber' at present due to reporting time frames, this is anticipated to be compliant as of December 2024.
- Risk Assessment complete and action plan in progress for recovery of neonatal staffing holding Qualified In Speciality qualification to >70% to meet British Association of Perinatal Medicine (BAPM) standards (sections 9.3 and 12.0).

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

Saving Babies Lives Care Bundle Version 3 implementation is subject to ongoing continuous improvement work assessed externally by the LMNS as per MIS Safety Action 6 standards using the national implementation tool on NHS Futures Platform. The RUH evidenced position in Q2 is reported in table 10 demonstrating progression of implementation from 73% in January 2024 to 79% in July 2024.

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	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	75%	Partially implemented	65%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	81%	Partially implemented	78%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	84%	Partially implemented	79%	CNST Met

Table 10. RUH Maternity position for implementation of Saving Babies Lives Care Bundle v3.

Ongoing quality improvement work continues towards full implementation of all elements of Saving Babies Lives Care Bundle Version 3, progress towards implementation is monitored via specialty and divisional governance and shared with the Local Maternity and Neonatal System (LMNS) for collaborative working as outlined within the safety standards of the Maternity Incentive Scheme.

9.0 SAFE MATERNITY AND NEONATAL STAFFING

9.1 MIDWIFERY STAFFING

As of September 2024, the Band 5/6 Midwifery establishment vacancy rate has a gap of 0.49 WTE. Of which 9.16WTE are on secondment, and 9.76WTE are on Maternity leave. Due to the consistent rates of maternity leave cover required within the service, the RUH has agreed an additional 8.0 substantive WTE into the budget to minimise impact on clinically available workforce and maintenance of safe staffing.

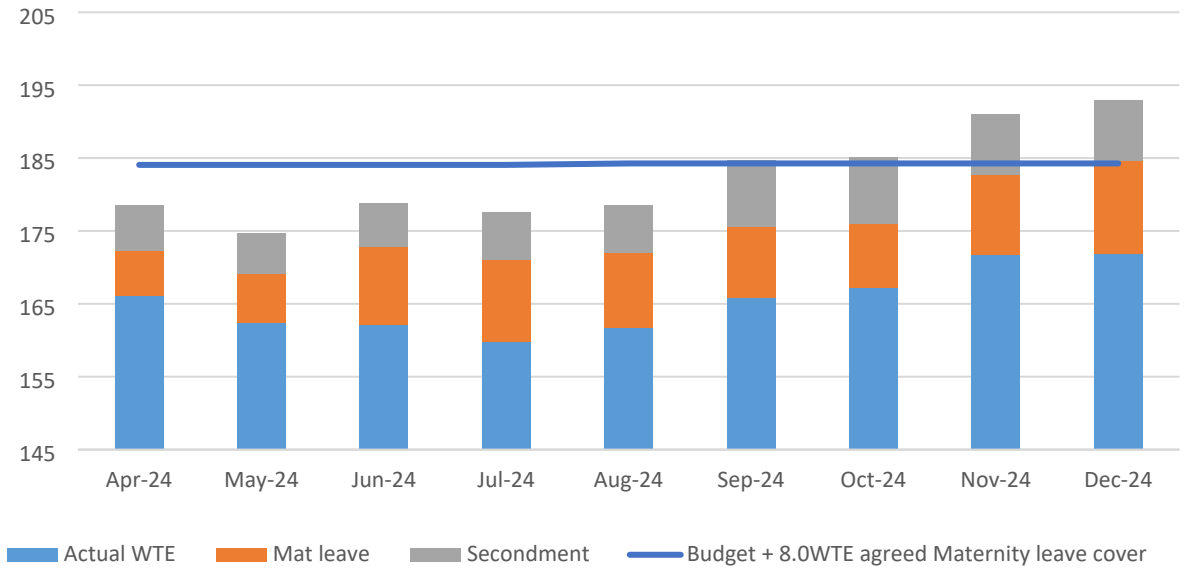


Figure 5. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness)

Table 11 outlines some of the key process and outcome measures during Q2 for the provision of safe staffing levels.

Measure	Aim	July	August	September
Midwife to birth ratio	1:24	1:28	1:28	1:31
Midwife to birth ratio including bank	1:24	1:25	1:25	1:28
Episodes of inability to maintain Supernumerary labour ward coordinator status	0	0	0	0
1:1 care not provided	0	0	0	0
Confidence factor in Birth-rate+ recording	60%	78.49	77.42	82.78

Table 11. Midwifery staffing safety measures

9.2 OBSTETRIC STAFFING

Measure	Aim	July	August	September
Consultant presence on BBC (hours/week)	≥90 hours	98	98	98
Consultant non-attendance (in line with RCOG guidance)	0	0	1	0
Twice daily MDT ward round	90%	94%	97%	93%

Table 12. Obstetric staffing safety measures

Q1 and Q2 has seen a return to the previously stable position for compliance with twice daily MDT ward round >90%, following a period of instability due to a trial of digital data capture which was unsuccessful. The service is now confident that the data capture is reflective of 'work as done achieving' consistence of ≥90% compliance.

9.3 NEONATAL NURSING STAFFING

Measure	Aim	July	August	September
Percentage of nursing establishment who hold Qualified In Speciality (QIS) qualification.	>70%	65.5%	65.5%	59%
Percentage of Transitional care (TC) shifts with staff dedicated to TC care only	>90%	100%	100%	100%
Neonatal Nursing Vacancy rate (WTE)		1.7	3.1	0.9

Table 13. Neonatal Nursing staffing percentage

MIS Safety Action 4 outlines the requirement to demonstrate compliance with meeting BAPM neonatal nursing standards. During 24/25 the service has seen a decrease in the number of staff members within the LNU holding the QIS qualification in Neonatal nursing due to staff re-locations and retirements. The substantive vacancies have been filled with new starters, however due to the new starters not holding the QIS qualification this has resulted in a drop below BAPM target standard of 70%.

The high demand for academic QIS training programmes is compounded by the lack of locally available academic courses in the Southwest Region. This has been escalated at Local Maternity & Neonatal System safety level. The South West Neonatal Operational Delivery Network (SWNODN) are in the process of developing a network led QIS course in association with Plymouth University. There is a projected pilot course commencing in January 2025 with plans for cohort intakes each year following this. There is no fee for the 2025 pilot course however as QIS is a Continued Professional Development in addition to Bachelor of Science Paediatric nursing there is no identified funding stream for continued QIS training programmes, resulting in a risk to recurrent funding and pipelines.

Due to the duration of the training programme and the limited availability of courses the projection to recovery of >70% of staff holding QIS will exceed 6 months therefore this has been raised as a risk on the Maternity and Neonatal Risk Register, Risk 2950 (section 12.0).

Actions towards mitigation of the risk, and reduction in the likelihood of quality of care being impacted will be monitored via Maternity and Neonatal Specialty Governance and Maternity and Neonatal Performance Review Meetings for financial planning.

	Action Plan towards Risk Mitigation:	Target Completion date
1.	Shifts allocations/rostering overseen by senior sister to ensure stability in the number of QIS members of staff on each shift to meet service need	ongoing
2.	Shift swap requests/allocations made in response to short-term sickness to preserve QIS staff on each shift	ongoing
3.	Monthly monitoring of percentage of neonatal shifts staffed to BAPM standards shared at board level as part of monthly internal performance review Perinatal Quality Surveillance Tool to provide assurance of effectiveness of actions 1 and 2	Complete
4.	4 nurses are enrolled on QIS course in Birmingham for 2024/2025 funded via Trust-Wide CPD funding	April 2025
5.	1 nurse allocated to funded place on pilot course on behalf of SWODN to commence Jan 25	January 2025
6.	Identification of risk on Maternity and Neonatal Risk Register to ensure progression of actions towards mitigation	complete
7.	All new starters to the Neonatal Unit to complete the South West Neonatal Foundation programme	Complete/ongoing
8.	Additional skills and simulation training for existing staff	Ongoing

Table 14. Mitigations to reduce the impact of <70% QIS trained nursing staff

9.4 NEONATAL MEDICAL STAFFING

The service has maintained compliance with the BAPM standards for neonatal medical workforce across Q2 of 24/25 in line with Safety Action 4 of the Maternity Incentive scheme.

Measure	Aim	July	August	September
Tier 1 separate rota compliance 24/7 'At least one resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated the providing emergency care for the neonatal service 24/7'	100%	100%	100%	100%
Tier 2 Separate rota compliance 12h per day 'Resident Tier 2 (ANNP or junior doctor ST4-8) practitioner dedicated solely to the neonatal service 12 hours a day during the busiest times of the day'	100%	100%	100%	100%
Tier 2 compliance: significant geographical separation between neonatal and paediatric units	100%	100%	100%	100%

'The Tier 2 (ANNP or junior doctor ST4-8) practitioner should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required'				
Tier 3 daytime compliance All consultants on-call for the unit have regular weekday commitments to the neonatal service only (ideally with a 'consultant of the week' system) and all consultants do a minimum of four 'consultant of the week' service weeks per year	100%	100%	100%	100%
Tier 3 compliance No on-call rota should be more onerous than one in six		compliant		

Table 15. Neonatal Medical staffing compliance for BAPM standards

10.0 INSIGHTS FROM SERVICE USERS AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

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

	July	August	September
Number of formal compliments	2	0	4
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	4	6	3
Complaints	0	0	1

Table 16. Complaints and compliments Q2 24/25

Compliments to the service were received across all areas of Maternity and Neonatal care including Bath Birthing Centre, The Birth Reflections Service 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.

During Q2, 1 formal complaint was received, all complaints, PALS contacts and informal feedback are assessed for commonalities, trends or themes within the monthly Maternity and Neonatal 'Insights' Family feedback Triangulation group.

1 commonality was identified within the service feedback received across Q2 pertaining to care experiences on Mary ward and perception of short staffing impacting upon patient experience. This was identified across MNVP feedback, Friends and Family Test forms, PALS contacts, a complaint, and staff feedback to Maternity and Neonatal Safety champions.

The service identified improving patient experience in the immediate postnatal care period as a safety priority for 2024/2025 (section 10.2).

Next steps:

- The strong link between workforce satisfaction and the improvement in quality-of-care provision is well evidenced. A workstream is focussed on improving staff and patient experience on Mary Ward.
- As part of the national Perinatal Culture and Leadership programme the Trust has identified Mary Ward as the service's area of focus to take through the programme.
- During Q2, the service has trained 4 'culture coaches' to support the perinatal culture and leadership/ Quality Improvement work in this area.
- Multi-disciplinary Team culture sessions pertaining to work on Mary Ward are scheduled to commence throughout Q3, the first sessions will be facilitated by an external culture coach from 'Korn Ferry' with future sessions being chaired by local culture coaches, to confirm/clarify the current identified workstreams.

10.2 SERVICE 'INSIGHTS' SAFETY PRIORITIES UPDATE

All service feedback 'insights' received 'in month' are reported into a cumulative tracker to allow for thematic assessment of trends or commonalities seeking identification of areas for improvement. Any identified 'in month' themes or trends requiring action are shared via the Perinatal Quality Surveillance Tool (PQST) shared with board level safety champions and Trust Quality and Safety Group.

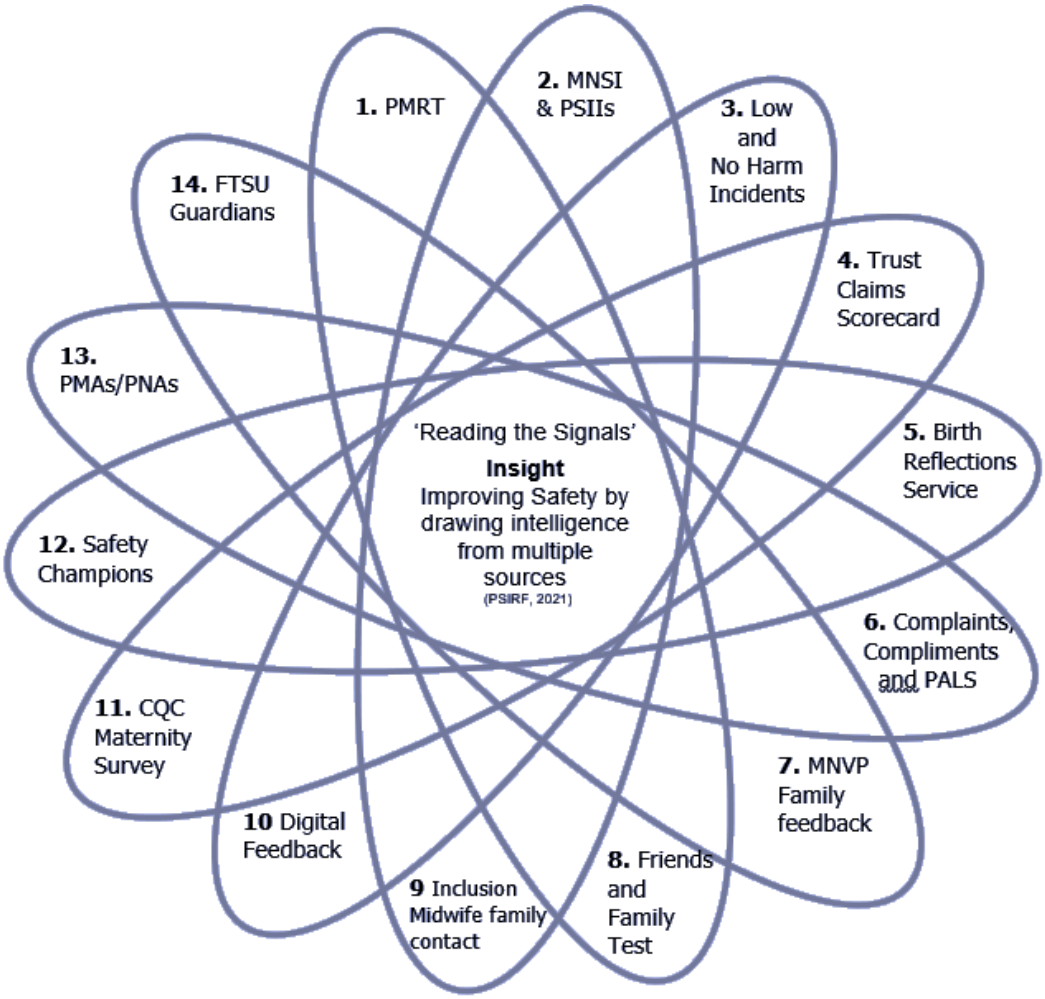


Figure 6. Sources of service 'Insight' analysed on a monthly basis via the Maternity and Neonatal Triangulation of feedback group.

Annually the service conducts a thematic review of the service 'insights' to generate identified safety priorities to inform Quality Improvement focus for the upcoming year. There were 3 identified areas for improvement as 'safety priorities' for 2024/2025. These were:

- Fetal Monitoring – Intermittent Auscultation
- Information provision to ensure Informed Consent
- Improving patient experience in the immediate postnatal care provision

A mid-year progress report is provided to give assurance of the commitment to continuous improvement and ongoing work to improve upon the systems and processes underpinning the delivery of care within the identified safety priorities, appendix 1.

This report outlines the quality improvement work, driver diagrams and measurables which have ensued across Q1 and 2 of 24/25.

10.3 MATERNITY AND NEONATAL VOICES PARTNERSHIP PLUS (MNVPP)

The Maternity and Neonatal Voices Partnership Plus (MNVPP) will hold a key stakeholder membership in the 'Insights' Family Feedback 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 Northeast Somerset, Swindon and Wiltshire (BSW) system. This will support delivery of the key priorities:

- To review outcome of the inclusion midwife pilot and embed recommendations
- To promote the care to translate app and undertake review of the current translation services to assess
- To Increase voice of the bereaved and/or NICU parent/family within MNVP communications
- Complete '15 steps' to drive environmental improvements in the clinical areas
- To champion co-production between the clinical teams and the MNVP ensuring service user voice is at the centre of projects.

11.0 RISK REGISTER

In Q2 Maternity and Neonatal, services presented four new risk assessments, which were approved for the risk register:

Risk No	Domain of Risk	The Risk	
2950	Patient Safety Quality Complaints and Audit	There is a risk that due to the current compliance of percentage of staff QIS trained in the LNU below BAPM standards, the quality of care being delivered	12

		to the babies at risk of being compromised	
2949	Patient Safety	There is a risk that due to the current estates footprint, and estates availability of Princess Anne Wing (PAW) Maternity services are unable to run optimally.'	8
2948	Statutory Duty/Inspections Finance including claims	There is a risk that due to a gap between demand and capacity to process the increasing volume of Maternity Subject Access request the service will be unable to meet the mandated 30-day delivery target	8
2785	Patient Safety Quality Complaints and Audit	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards.	12

Table 17. New Risks for the Maternity and Neonatal risk register Q2 2024/25

During Q2 1 risk was closed,

Risk No	Title of Risk	Rationale for closure	
2648	There is a risk that birthing people will miss haemaglobinopothopy screening in pregnancy for due to the current process of multiple manual data inputs including manual transcription of information.	New digital process implemented during Q2 resulting in mitigation of risk for human transcription errors	9

Table 18. Closed Risks for the Maternity and Neonatal risk register Q2 2024/25

A full summary of the Maternity risk register is detailed in table 19. 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.

2784	Maternity and Neonatal Services Adult Basic Life Support Compliance	6
1948	Obstetric ultra sound scan capacity	8
2359	Maternity Information System IT support/capacity	8
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	9

	Network.	
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
2681	Mandatory Training room booking availability	9
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
2950	There is a risk that due to the current compliance of percentage of staff QIS trained in the LNU below BAPM standards, the quality of care being delivered to the babies at risk of being compromised	12
2949	There is a risk that due to the current estates footprint, and estates availability of Princess Anne Wing (PAW) Maternity services are unable to run optimally.'	8
2948	There is a risk that due to a gap between demand and capacity to process the increasing volume of Maternity Subject Access request the service will be unable to meet the mandated 30-day delivery target	8
2785	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards.	12

Table 19. Maternity and Neonatal Risk Register September 2024

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

During Q2 the transitional care pathway remained open for 100% of the time, with staffing meeting the identified transitional care pathway model on average 89% of the time. On no occasion were there identified missed opportunities to have provided TC care or identified 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. No babies were admitted to or remained on NNU because of their need for nasogastric tube feeding, which could have been cared for on a TC if nasogastric feeding was supported there.

The Avoiding Term Admissions into the Neonatal Unit (ATAIN) working group identified 2 avoidable admissions into the Local Neonatal Unit (LNU) in Q2. There have been no identifiable commonalities between the avoidable admissions reviewed at the ATAIN MDT. The learning from these cases has been actioned by the Obstetric Consultant and the Quality and Education Midwife with an identified quality hot spot focus on the Safety Catch and quality boards.

13.0 RECOMMENDATION

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

Appendix 1 'Insights Report Mid-Year review'
Appendix 2 Transitional Care Pathway and ATAIN Audit Q2 2024/2025

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item No:	10.1
Date of Meeting:	15 January 2024		

Title of Report:	Maternity and Neonatal Service Insights Safety priority mid-year review
Board Sponsor:	Antonia Lynch, Chief Nursing Officer
Author(s):	Zita Martinez, Director of Midwifery
Appendices	Nil

1. Executive Summary of the Report

This report seeks to provide assurance outlining a situation report for the continued Quality Improvement work in maternity services, 6 months on from the local 'Insights Report of 23/24' where 3 key area for improvement were identified from thematic analysis of the service 'Insights'. The three areas were:

- To improve the provision of information to ensure informed consent is obtained in all clinical care planning.
- To ensure Fetal Monitoring with specific focus on Intermittent Auscultation is conducted efficiently in line with local and national standards.
- To improve the experience of women/birthing people and families within immediate postnatal care and recovery.

For each identified project throughout Q1 and Q2 the service has developed a working group consisting of key stakeholders across the multidisciplinary team to provide leadership and direction for improvements. Where applicable, the service has sought co-production with the people we care for and people we work with the ensure the proposed change ideas will meet the needs of the service, are realistic, and will ensure progress towards the identified deliverable process, and outcome, measures the service hopes to achieve, aiming for delivery of the statements above.

This report provides background and context to the identified ongoing improvement workstreams, the current identified barriers and challenges to the delivery of the overall aims in each project, and the service's current driver diagrams for change. The driver diagrams within this report outline the primary drivers, secondary drivers and current change ideas for delivery of change and improvement and a progress update as of the 30/09/2024.

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)

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 – 2024/25 Maternity and Neonatal Insights Report 23-24 Quarter 4 2023- May 2024 Patient Safety Incident Response Plan (PSIRP) 2024 Patient Safety Incident Response Framework 2021 Maternity and Newborn Safety investigations – 'factors affecting the delivery of safe care in midwifery units' 2024	

8.	Publication
Public	

REPORT OVERVIEW

This report follows the 'Safety Priorities for 24/25' identified within the 'Insights report of 23/24'; where thematic analysis of all the clinical insights, identified key areas of focus for improvement work to undertake in 2024/25. This report seeks to provide assurance and outline the improvement activity, work completed, ongoing workstreams, and planned future actions to drive continuous improvement and risk mitigation, aligned to the Trust's identified 5 safety priorities under the PSIRF (2021) and Trust Patient Safety Incident Response Plan (PSIRP, 2024).

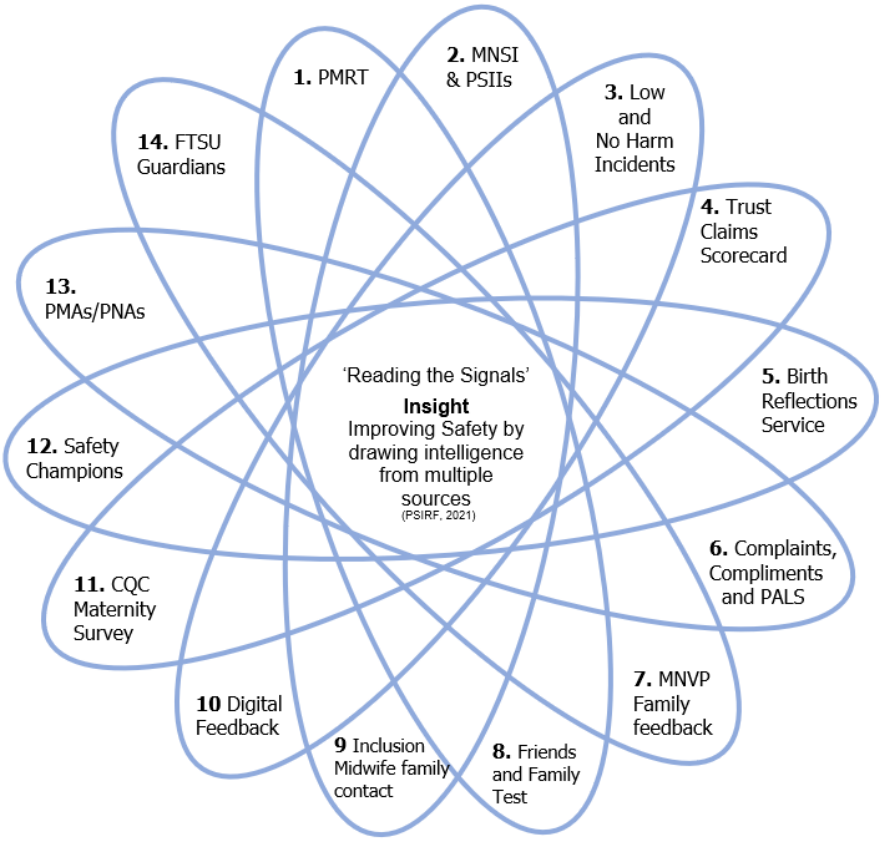
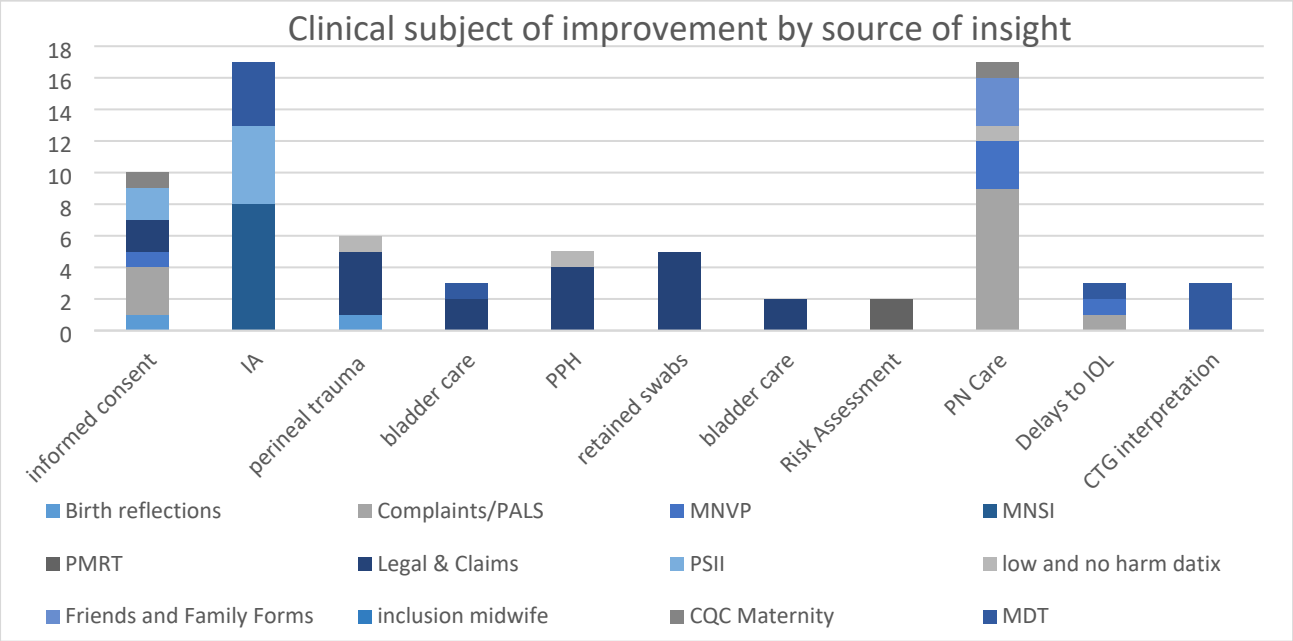


Figure 1. RUH Maternity 'Insights' diagram of 23/24.

1.0 IDENTIFIED AREAS FOR IMPROVEMENT 23/24 – MATERNITY AND NEONATAL SAFETY PRIORITIES FOR 2024/25



Graph 1. Category of Clinical Subject for improvement by service insight during 23/24.

Following analysis of all the service insights received during 2023/2024 the 'Insights report of 23/24' identified three key areas for focus 'Safety Priorities' for quality improvement specific to Maternity during 2024/25:

- **To improve the provision of information to ensure Informed consent is obtained in all clinical care planning.**
  Trust-Wide Safety Priority: Management and recognition of the deteriorating patient.
  Trust Values: Everyone Matters

- **To ensure Fetal Monitoring with specific focus on Intermittent Auscultation is conducted efficiently in line with local and national standards.**
  Trust-Wide Safety Priority: Management and recognition of the deteriorating patient.
  Trust Values: Working Together

- **To improve the experience of women and families within immediate postnatal care and recovery.**
  Trust-Wide Safety Priority: Indirect links to: Management and recognition of the deteriorating patient and Safe Discharge.
  Trust Values: Making a Difference

2.0 To improve information provision to ensure Informed consent is obtained in all clinical care planning.

Problem Statement: Informed consent equated to 5 of the 16 insights within the sub-category of negative communication and was identified as a theme within the birth reflections service, complaints/PALS contacts, Patient Safety Incident Investigations (PSII) findings and recommendations, Maternity and Neonatal Voices Partnership (MNVP) feedback, and the legal and claims scorecard of 2023 during 2023/24.
Vision: To ensure the RUH provides all women/birthing people and families with the required information for them to make informed, individualised, choices regarding their care throughout their pregnancy and postnatal care pathway.
Goal: To reduce service insights pertaining to negative feedback regarding a lack of information provision to support informed consent.

2.1 Q2 24/25 position update

During Q1 and Q2 of 24/25 the service has set up an informed consent working group consisting of a multidisciplinary team across: Obstetrics, acute midwifery, community midwifery, specialist midwives and service user voice representatives to begin developing aims and change ideas to improve information provision for informed consent across maternity services.

The group has reviewed each of the service insights identified within the 'insights report of May 24' with the commonality of informed consent and following analysis has proposed 2 designated workstreams (figure 2).

- Antenatal Education - specifically information provision of modes of birth and emergency scenarios
- Intrapartum consent – specifically what communication considerations need to be made when seeking consent during intrapartum care with the competing/influencing human factors such as contraction pain.

During June-July 24 a social media campaign was launched across RUH maternity services social media accounts, seeking service user voice and experiences of information provision for informed consent within our services. This survey subsequently sought to invite participants to take part in focus groups to identify both the content, and format of information provision currently utilised, and what would best practice look like to the families we provide for. The facilitation of the focus groups in conjunction with our Maternity and Neonatal Voices Partnership aims to co-produce the direction for change ideas of 'what does better look like?'

The survey received a response rate from 50 families, with a preference for focus groups to be held over Microsoft Teams during evening hours. Focus groups are scheduled for October 24.

The service is currently working with the trust-wide Vulnerable People's Committee to support the development of an educational package for senior midwives working in intrapartum care settings regarding the Mental Capacity Act in recognition of the impact physiological effects of labour, such as pain, can have on a cognitive ability to process information. This programme looks to support staff in raising awareness and utilising effective tools of communication and

assessments to assure them that information being provided is understood; hence supporting women and families in informed decision making and consent.

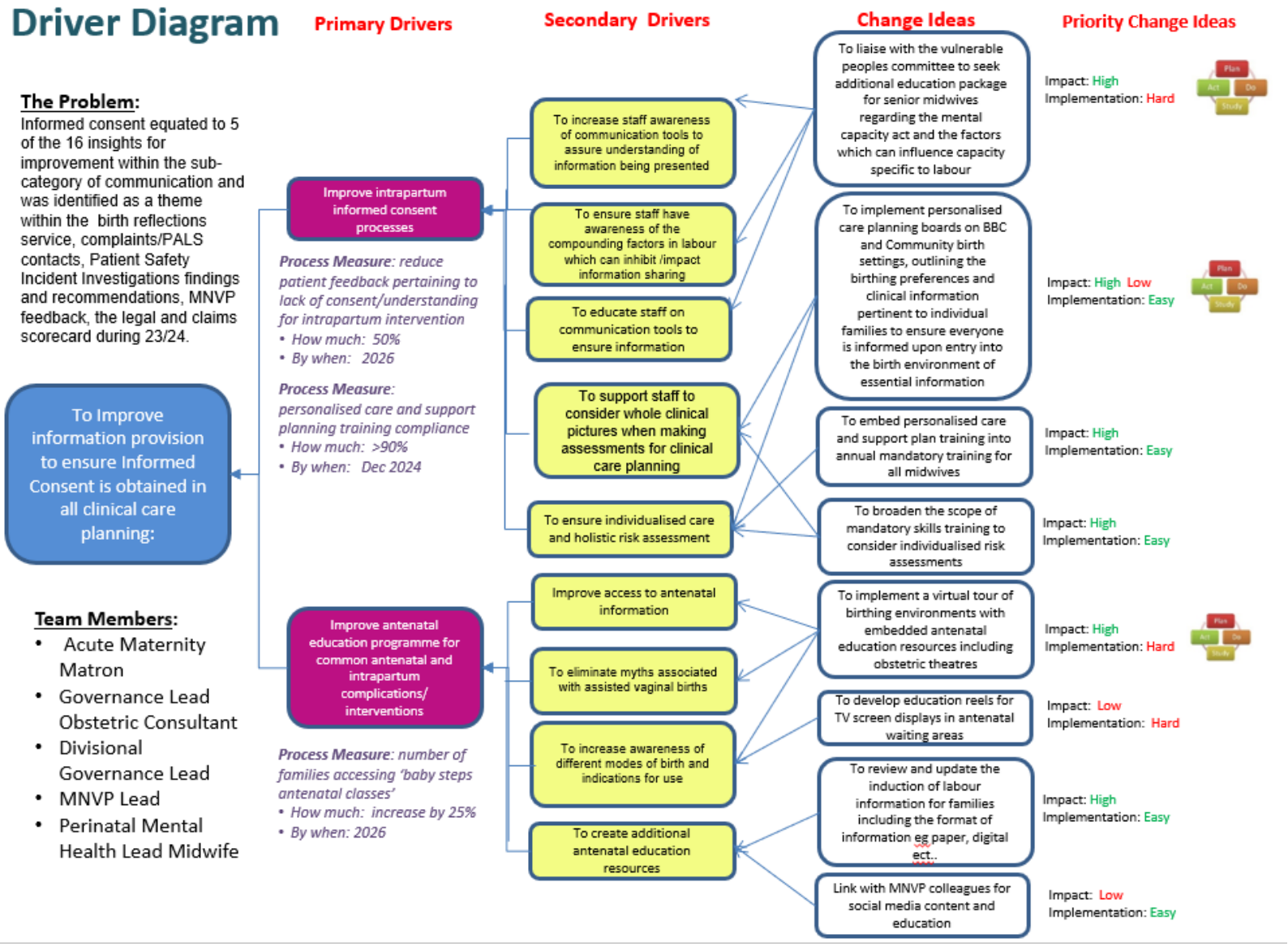


Figure 2. Driver diagram for Information provision for informed consent RUH maternity 24/25

Next Steps:

- Conduction of focus groups are scheduled for October 2024
- Re-evaluation of change ideas following service user feedback to ensure clarity of direction and change ideas
- Consider sourcing and resource for funding in order to facilitate development of educational resources as desired within the driver diagram.

3.0 To ensure fetal monitoring with a specific focus on Intermittent Auscultation (IA) is conducted efficiently in line with local and national standards.

Problem Statement: 'To ensure fetal monitoring with a 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 during 23/24.
Vision: To ensure all midwifery and obstetric staff working at the RUH are competent and efficient in the conduction of Intermittent auscultation supporting holistic risk assessment, early detection and escalation of fetal distress.
Goal: To mitigate against the risk of harm from inadequate intrapartum IA monitoring.
During Q1 and Q2 of 24/25 the service sought to understand the identified local barriers to the provision and monitoring of effective Intermittent Auscultation.

3.1 Q2 24/25 position update

Local learning has informed the Saving Babies' Lives Study Day programme and learning outcomes. The service also set up an anonymous feedback drop box on Bath Birthing Centre for staff to feedback on challenges and barriers to intrapartum IA monitoring.

A review of national evidence based best practice and collaboration within the Local Maternity and Neonatal System to review neighbouring unit clinical audits further identified variances in clinical practices pertaining to IA provision and methodologies across Bath Swindon and Wiltshire

During Q1 the Maternity and Newborn Safety Investigations (MNSI) team published a national learning report following identification of increased cases of Hypoxic Ischaemic Encephalopathy (HIE) from births in Midwifery Led Units where the only provision of fetal monitoring available is IA. A theme identified within the report of clinical care issues/provision for improvement, was the delivery of optimal intrapartum IA and its subsequent efficacy. This report outlined the compounding variables, challenges, barriers, and limitations of IA provision.

Below is a summarised list of barriers and challenges the service has identified from both local and national insights to the delivery of optimal IA :

- Staff knowledge and familiarity with the national and local standards pertaining to intrapartum IA
- Pre-December 2023 there was no formal local guidance for the conduction of IA at the RUH, historically staff were referenced to NICE guidance
- Holistic risk assessments to ensure suitability for IA provision (MNSI, 2024)
- Support for recognition of developing risks requiring escalation and indications that IA is no longer recommended (MNSI, 2024)
- Awareness of the subtle clinical indicators, which must be assessed concurrently, to deliver IA efficiently
- Competing demands resulting in task overload during the provision of IA effecting efficiency and standards, particularly pertaining to the second stage of labour.
- Attention and vigilance, 'IA demands paying attention to, and processing information from multiple sources' (MNSI, 2024)
- Accurate documentation of IA (MNSI, 2024)
- Timing of IA (MNSI, 2024)
- Physical constraints (MNSI, 2024)
- Environmental Noise (MNSI, 2024)

- Inaccuracies in counting (MNSI, 2024)
- The conduction of IA is difficult to process measure robustly without observational audit
- Privacy of birthing people, and staff cultural challenges when considering observational audit for assurance of process measures for the conduction of IA
- Heavily focused on neonatal outcome measures to indicate proficiency of IA
- Birthing people awareness of requirement for completeness in the methodologies of recommended IA processes to ensure safety and efficacy of practice
- Lack of evidence base to support the best method of IA (MNSI, 2024)
- Varied approaches to IA nationally and regionally (IA as per NICE vs Intelligent IA) (MNSI, 2024)

The service has identified primary, and secondary change drivers and change ideas in place or in progress as of Q2 24/25 with an aim to deliver the vision and goal identified.
See Figure 3.

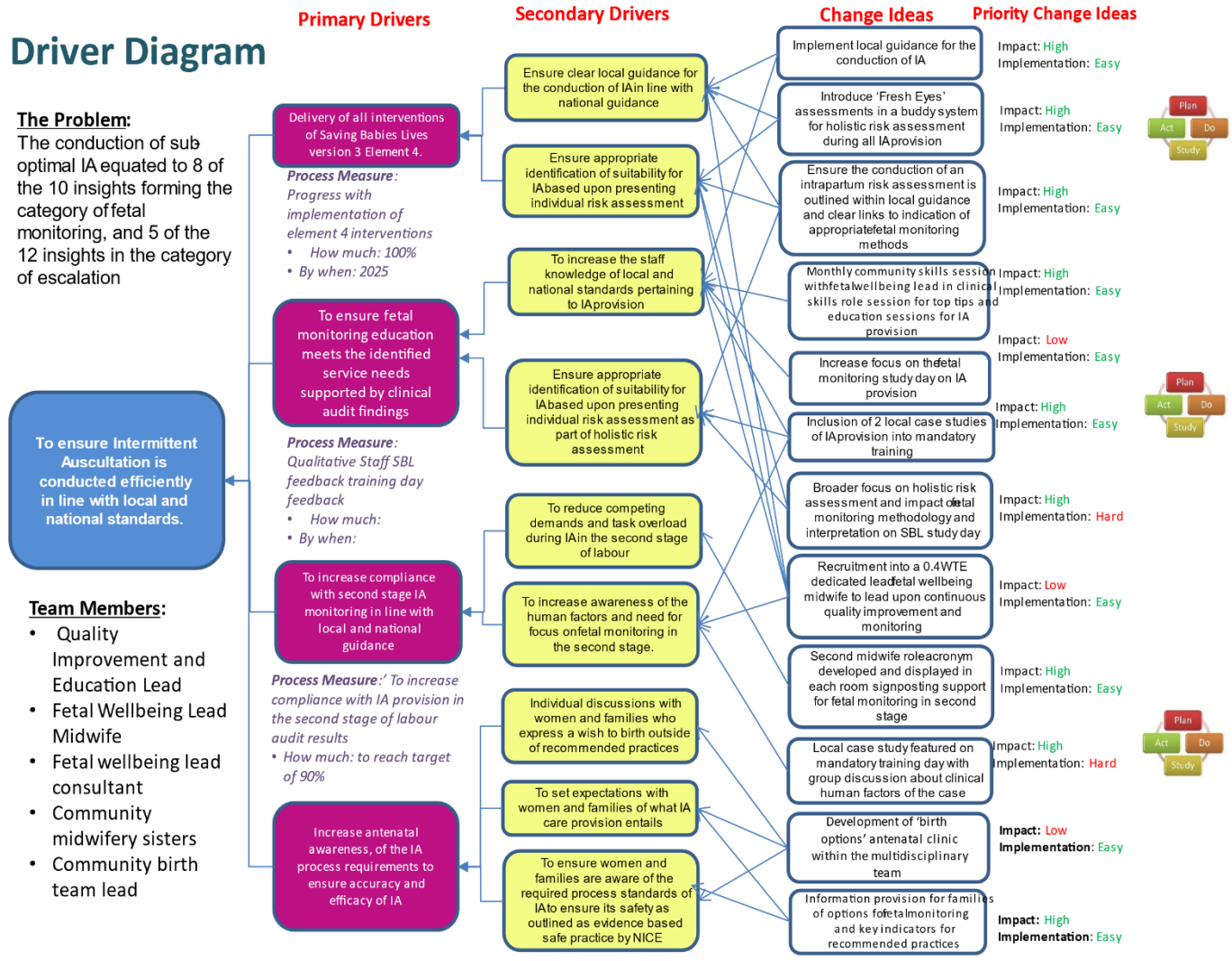


Figure 3. Driver diagram for Information provision for informed consent RUH maternity 24/25.

The service successfully recruited into a 0.4WTE Band 7 Lead midwife for fetal wellbeing during Q2 of 24/25, in line with national recommendations, to lead, support, and drive continuous improvement in standards of fetal monitoring.

3.2 Current Measures as of Q2 24/25:

Process Measures as of Q2 24/25:

Compliance with attendance on the mandatory Saving Babies Lives study day featuring the mandated annual training update for the provision of fetal monitoring is outlined in figure 4; this shows strong compliance across all staff groups maintained at greater than 90%, as per Maternity Incentive Scheme Safety Actions.

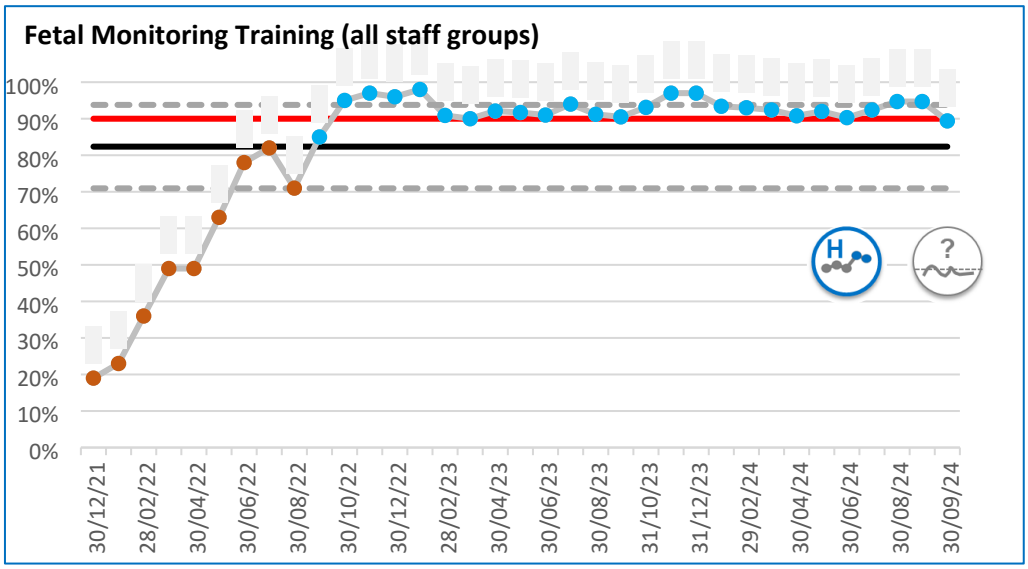


Figure 4. Compliance as of 30/09/2023 for attendance on saving Babies Lives Study Day across all staff groups.

The specific assessment of clinical documentation pertaining to IA in line with local standards is subject to regular clinical audit in line with the Maternity and Neonatal Audit plan of 2024/25. However, it is recognised there are limitations to process measuring IA via clinical audit – see challenges and barriers.
The most recent results for Q2 are outlined in figure 5.

Standard	**Quarter 1 2024** X19 sets of birth notes for standards 1-13 X39 standards 14,15	**Quarter 2 2024** X17 sets of birth notes for standards X37standards 14,15
Perform Initial Assessment of Antenatal risk factors for fetal compromise at the onset of labour via use of the "intrapartum risk assessment tool"	58% (11/19)	**76% ↑ (13/17)**
The intrapartum risk assessment tool is correctly populated to identify whether IA or CTG is offered as initial method of fetal monitoring.	58% (11/19)	**76%↑ (13/17)**
IA carried out after a palpated contraction for at least 1 minute and recorded as a single figure	58% (11/19)	**94%↑ (16/17)**
Measuring Fetal Heart Rate 1.10.2 First Stage of Labour		
Intermittent auscultation should be carried out in women with a low risk of complications in established first stage of labour. It should be noted that the fetal heart rate is being auscultated immediately after a contraction for at least 1 minute every 15 minutes and recorded as a single rate NICE CG 190 1.10.2	84% (16/19)	**76% ↓ (13/17)**
If rising baseline of fetal heart rate or decelerations has CTG been commenced NICE CG 190 1.10.2	N/A	**100% (3/3)**

If labouring in the community is transfer to obstetric unit discussed	N/A	**100% (1/1)**
The CTG should be removed if normal after 20 minutes NICE CG 190 1.10.2	N/A	**100% (1/1)**
Measuring Fetal Heart Rate in the Second Stage of Labour		
The fetal heart should be auscultated as a minimum every 5 minutes, this must be Immediately following a contraction, for at least 60 seconds	36% (5/14)	**46% ↑ (6/13)** 4 N/A 2nd stage <5 mins
Has the IA sticker been used hourly during labour	73% (151/208)	**74% ↑ (153/207)**
4 hourly IA fresh eyes should be carried out?	**75% (26/35)**	**65%↓ (24/37)**

Figure 5. Clinical Audit results for IA provision in line with local and national standards as of Q2 24/25.

Although the audit results identify the need for continued improvement, with compliance below locally agreed targets, a positive trend is seen with improving metrics from Q1 into Q2 24/25.

Clinical Outcome Measures as of Q2 24/25:

No cases have been referred to MNSI with concerns of HIE following birth with a primary intrapartum fetal monitoring provision of IA as of 30/09/24 .

Intrapartum fetal monitoring has not been identified as an 'issue' in any of the care reviews undertaken within the Perinatal Mortality Review Tool (PMRT) which reviews all stillbirths and neonatal deaths within the service.

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

Problem Statement: To improve the experience of women and families within postnatal care and recovery'.
Vision: To ensure all families are provided with the highest quality of care during the immediate postnatal period.
Goal: To reduce service insights of negative feedback regarding care provision on Mary Ward.

4.1 Q2 24/25 position update

Following analysis of the various service insights, Mary Ward has been identified as an area for improvement; this is in response to a combination of staff and service user feedback. Due to the strongly evidenced links between the quality of care provision and positive workforce culture and wellbeing, the service has decided to apply the use the National Perinatal Culture and Leadership programme to undertake improvements on Mary Ward.

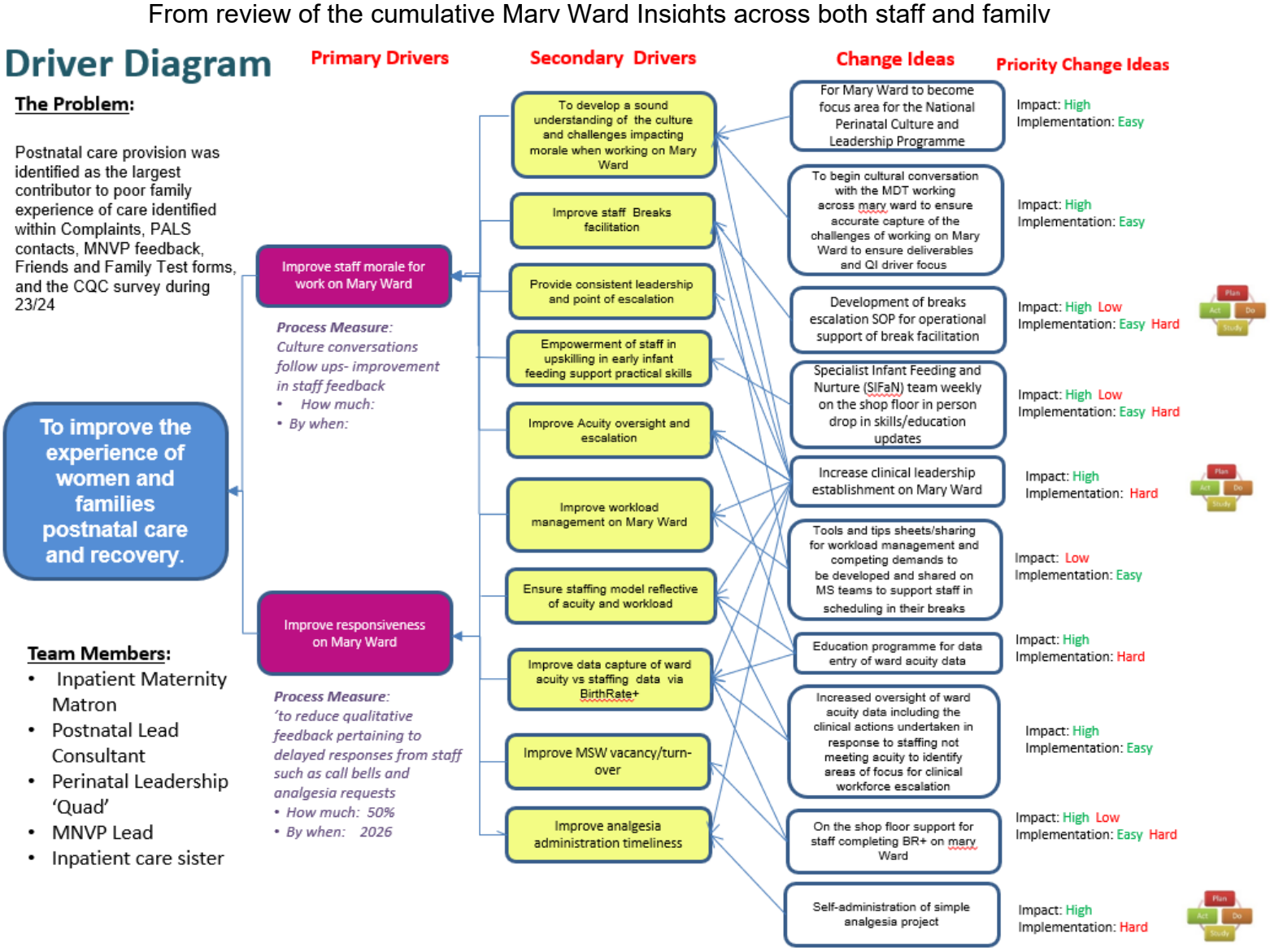
During Q1 and Q2 the service has supported the training of four 'culture coaches' as part of the perinatal culture and leadership program facilitated by 'Korn Ferry'. The 'Culture coaches' will begin facilitating culture conversations with staff to gain a deeper understanding of the challenges and barriers to a positive working experience on Mary Ward.

The service has four cultural conversations scheduled throughout Q3, the first sessions will be facilitated by an external culture coach provided by Korn Ferry, with subsequent sessions facilitated by our newly trained 'in house' culture coaches.

From review of staff feedback we have available to us at this point, the service had identified the following challenges/barriers to the provision of the highest quality of care:

- Staff workload
- Ward acuity
- Internal staff re-deployment to areas of highest risk reducing staffing vs acuity measures
- Staff morale
- Trust-wide paid breaks consultation impact on morale on Mary ward as identified area of challenge for staff breaks
- High turn-over of patients

From review of the cumulative Marv Ward Insights across both staff and family



- Culture conversations as part of national perinatal culture and leadership programme to commence in October 2024 to ensure current vision and change ideas meet the needs.
- Re-evaluation of change ideas following culture conversations to ensure clarity of directions and change ideas.

The service is committed to making improvements in the identified areas, progress with the change ideas, and the ongoing monitoring of process and outcome measures identified within the report is provided through the maternity and neonatal governance structure. Improvement updates in identified each area are received on a rotational monthly basis to the quadrumvirate, resulting in a quarterly update on each safety priority, reporting into Trust Quality and Safety Group ensuring ongoing accountability towards progression.

10. RECOMMENDATION

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

Clinical Audit Report

Transitional Care Pathway and ATAIN Audit Q2 2024/2025

Speciality: Local Neonatal Unit

Division: Family & Specialist Services Division

Project team				
Kirstie Flood	Title/grade:	Lead Nurse	Data period:	Q2 July 2024- Sept 2024
Sarah Goodwin	Title/grade:	Neonatal Governance Lead	Report completion:	Nov 2024

Transitional Care Pathway and ATAIN Audit Q2 2024-Sept 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 Local Neonatal Units (LNU) programme.*

Objectives

- To assess compliance with the pathways of care into transitional care which have been jointly approved by maternity and neonatal teams focusing on minimising the separation of mothers and babies. Please 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 Board (ICB) 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 due to capacity or staffing issues.
- To evaluate the number of babies that were admitted to or remained on LNU because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. 34+0 - 36+6.
- To provide a data record of existing transitional care activity, (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery, nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.
- 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 Champion.
- To provide evidence and assurance of progression with the action plan for sharing with the neonatal maternity safety champion, and Board Level Champion, LMNS and ICB quality surveillance meeting each quarter.
- To provide an audit trail of evidence that reviews of all term babies transferred or admitted to the LNU, irrespective of their length of stay.

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

Key findings

Standard	Compliance July 2024	Compliance August 2024	Compliance September 2024	Quarter 1 and 2 24/25 Totals
Audit findings shared with neonatal safety champion	**Complete**	**Complete**	**Complete**	**Complete**
The % of babies who received all their care on the TCP pathway	**51%**	**55%**	**46%**	**51%**
The % of babies who received care on the TC Pathway (TCP) for part of their admission	**56%**	**63%**	**68%**	**62%**
The number of admissions to the neonatal unit that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues	**0**	**0**	**0**	**0**
The number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. 34+0 -36+6	**0**	**0**	**0**	**0**
% of shifts TCP nurse provided as per TCP staffing model	**86%**	**92%**	**88%**	**89%**
TCP open	**100%**	**100%**	**100%**	**100%**
Number of babies readmitted to neonatal unit from TCP	**0%**	**0%**	**0%**	**0%**

The number of avoidable term admissions 37+0 weeks gestation and above admitted to the neonatal unit	**0**	**0**	**2**	**2**
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	**4**	**1**	**5**	**10**

Clinical Audit Report

Project title

Transitional Care and ATAIN Audit Q2 2024/2025 July - Sept 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 Neonatal Governance Lead

Standards

Maternity Incentive Scheme - year Six. Safety action 3.

Sample

- All admissions to LNU and TCP from 01/07/2024-30/09/2024 to determine if the correct location of care was achieved.

- All babies born at 37+0 weeks gestation and above from 01/07/2024-30/09/2024 who were admitted to the LNU.

Data source

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

Audit type

Retrospective and live data collection.

Transitional Care Audit Findings Q2.

Staffing:

During Q2 the transitional care pathway remained open for 100% of the time, with staffing levels meeting the identified transitional care pathway model on average 89% of the time. On no occasion were there identified missed opportunities to provide TC or identified admissions that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues. No babies were admitted to or remained on NNU because of their need for nasogastric tube feeding, which could have been cared for on a TC if nasogastric feeding was supported there. Staffing levels were challenging during Q2 due to increased staff turnover and vacancy rate in conjunction with summer period increased annual leave uptake. The service has subsequently successfully recruited into vacancies, with an improved vacancy of 0.9WTE as of 30 September 24.

Admissions:

When reviewing the leading causes of admission to the TCP (figure 1), the leading causes for admission remains consistent from Q1 into Q2 as:

- Requirement for intravenous antibiotics
- Requirement for 'Kaiser' observations for a risk of sepsis

The inclusion of the 2 new categories of babies that are recommended to be cared for on the TCP as per the BAPM (British and Perinatal Medicine) recommendations, account for 26% of the total admissions. (34-35+6 above 1.8kg; and below 2nd weight centile). This has, on occassions contributed to up to 8 babies being cared for on the TCP. Capacity and provision for 8 TC babies is supported and recommneded by the Getting It Right Frst Time (GIRFT) report for our birth rate.

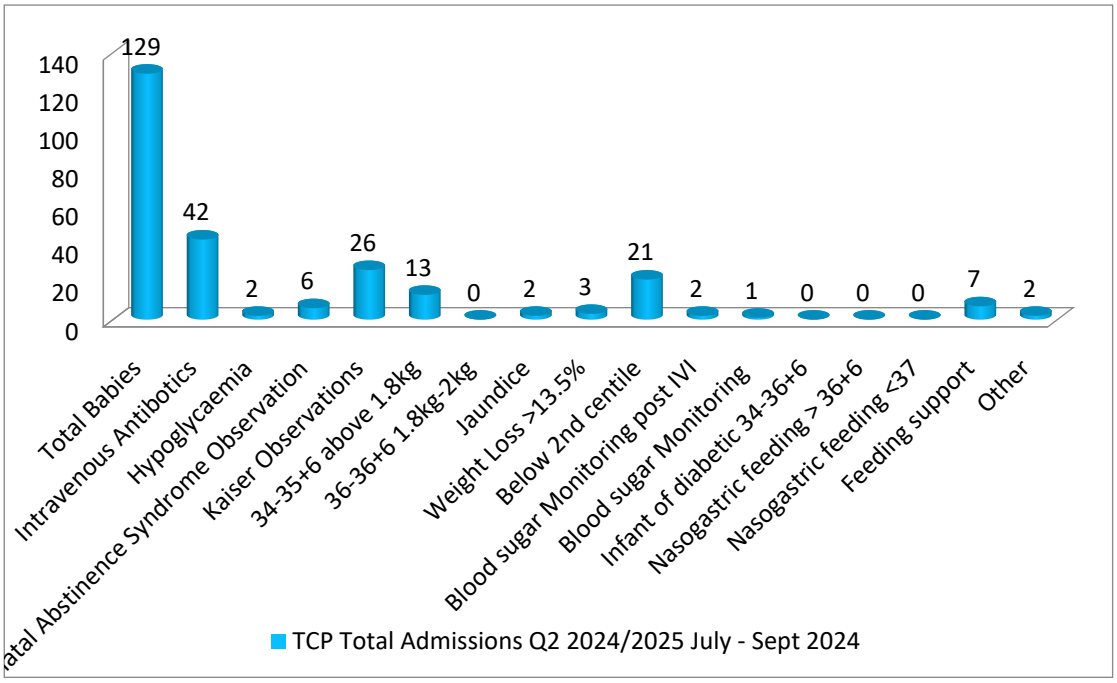


Figure 1: values of admissions to the RUH Transitional Care Pathway (TCP) by causation Q2 24/25

1.1 Parental TCP feedback

The transitional care pathway seeks parental feedback via an optional patient/parent survey sent to all families who received TC care via a QR code which is collated by the Trust-wide Patient Experience team. The results are provided to service providers for analysis to identify service improvements.

During Q2 14 responses were received to the TCP patient experience survey:

- 100% of people responded identifying that the reason for their baby being on a TCP was clear and easy to understand
- 100% of people responded identifying that the staff caring for their baby were available when needed
- 93% of people responded identifying they felt supported by the neonatal nurse caring for their baby whilst under the TCP
- 100% of people responded identifying they felt their baby was safe
- 100% of people responded identifying they felt their baby was well cared for
- 7% (1 response) felt they would have liked more time with their neonatal nurse.

Within the 14 responses one family felt the communication between the midwifery and neonatal staff could have improved. This was due to the baby being fit for discharge and the family told they would be going home soon. But the mother wasn't fit for discharge. All other feedback was positive.

From review of the written comments left by parents and families within the survey a commonality regarding positive feedback for the level of care and support provided by the TC team was identified within 8 of the 14 responses, the other 6 responses left the optional comments box blank.

ATAIN Audit Findings Q2

The ATAIN working group meets fortnightly to undertake a Multi-Disciplinary Team (MDT) review of all admissions and transfers into the neonatal unit, assessing if alterations in care may have provided opportunities to have avoided the admission into the Local Neonatal Unit therefore providing insight into areas of potential service improvements. Q2 identified 2 possible avoidable admissions to the LNU, this is the same as recorded across Q1.

In Q2 there has been no identifiable commonalities between the causation of avoidable admissions reviewed at the ATAIN MDT. There were no avoidable term admissions for July and August. In September, there were 2 avoidable term admissions identified.

On review of the first case, it was identified that uterine hyperstimulation and the subsequent impact on intrapartum fetal wellbeing in-utero was not identified. The group identified that more likely than not this impacted on the neonatal condition at birth. This was a low harm event with the baby requiring admission to the neonatal unit for 2 days following birth, baby subsequently returned to their mother's care and is currently at home with no anticipated long-term impact.

The second case identified there was an opportunity to commence intravenous antibiotics for the mother during labour in response to signs of developing infection in labour, subsequently chorioamnionitis was noted on placental histology. The baby required initial respiratory support on the neonatal unit and was relocated to the transitional care pathway on day 1.

Admissions to the neonatal unit from other areas in the hospital –

In line with standard 3, neonatal unit transfers or admissions regardless of their length of stay, of all term babies transferred or admitted to the neonatal unit from other areas within the RUH, are reviewed. This includes Emergency Department and the Children's ward. In Q2 2024 there were 10 babies that were admitted, an increase from Q1 (n=7). Admissions are assessed against current admission guidance seeking to ascertain if the LNU was the appropriate care setting. The review looks for common themes within the source and cause of admission. Of the 10 admissions over Q2, 6 were identified as the neonatal unit being the most appropriate care location and in 4 cases, the Children's ward was deemed a more appropriate location.

There is a current working party within the LNU to explore current pathways of care for all babies that are readmitted from home into the RUH. This is to improve the efficiency of the service and protect the vulnerable and immunosuppressed babies being cared for in the LNU from a potential risk of introducing community acquired infections into the LNU via re-admissions. It is also imperative to recognise the potential impact on patient experience, with families often appreciating the holistic aspects of the current referral pathways back into care via maternity and neonatal services. A draft guideline, "Care of community infants less than 3 months admitted to paediatrics needing intensive care" has been completed and is out for consultation prior to ratification.

Where cases have highlighted learning, information is cascaded to the teams on vignette Safety Catches, shift Safety Briefs, Local newsletters, Quality Board displays and is shared at the Maternity Neonatal Governance meeting.

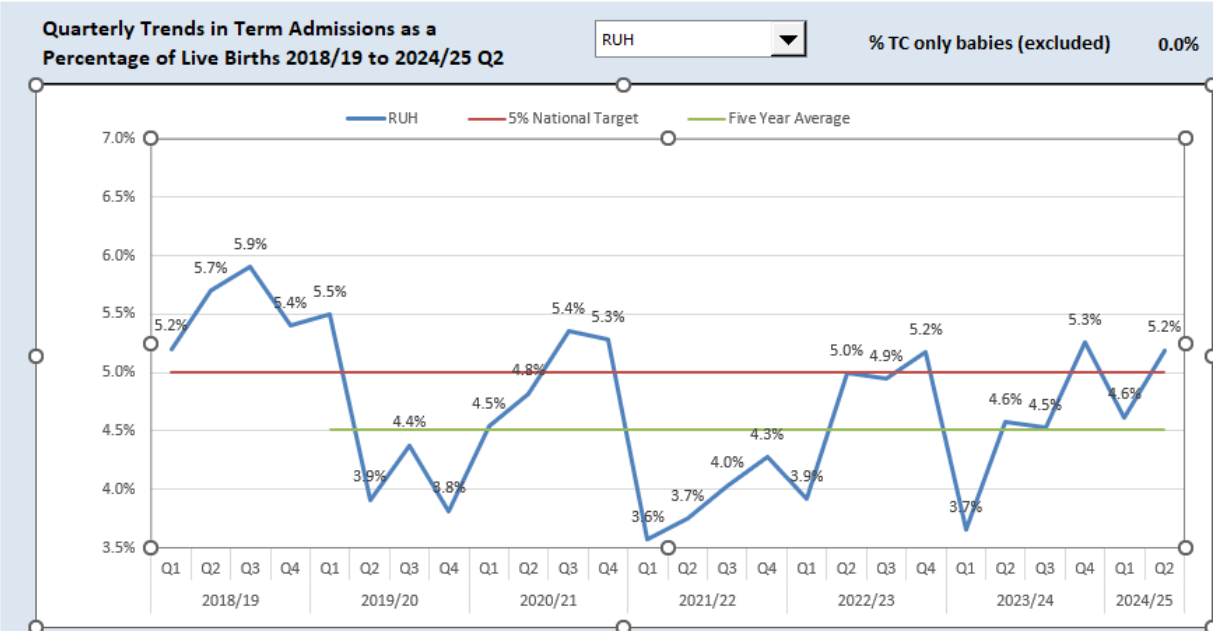


Figure 2: Data caption for the RUH ATAIN

It is recognised that September had a much higher birth rate than previous months – the average number of term admissions to the neonatal unit is 17 and there were 26 in September, however of these cases it was deemed the number of avoidable admissions was stable from Q1.

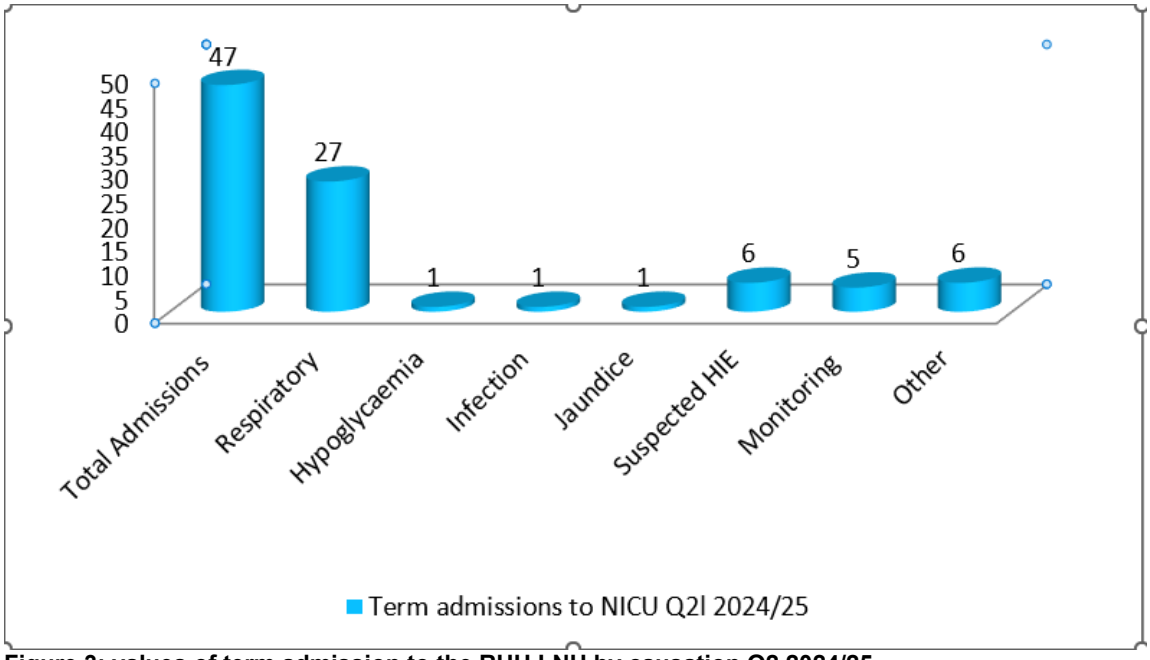


Figure 3: values of term admission to the RUH LNU by causation Q2 2024/25

When reviewing the leading causes for admission to the Neonatal Unit during Q2, respiratory symptoms remain the leading cause of term admissions into the LNU, this is in line with national data. No commonalities or cause for concerns in respiratory management was identified within the MDT review of care, all admissions were deemed as appropriate based on the clinical presentation of the babies.

Quality Improvement Projects

- TCP guideline has been updated BAPM recommendations to include criteria for admission for 35/40 babies; babies less than 2nd centile, and clinically stable ≥34 week babies whom previously may have been admitted to midwifery care. During Q2 we have seen increased overall numbers of babies being cared for on the TCP 26% due to the new recommendations.

- Room G project to offer further facilities for parents to sleep beside their baby and further reduce family separation is nearing completion. Furniture has been ordered and the shower room is complete. Communication between the donor family and RUHX and neonatal unit continues.

- Collaborative meeting with NNU lead and nurse consultant with 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.

  During Q1 in line with Safety Action 3 of the maternity incentive scheme, a quality improvement project aiming '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 was launched collaboratively across Maternity and Neonates supported by the National and Trust QSIR training programme. Following the implementation of actions identified in response, the service has preliminarily seen a positive impact.

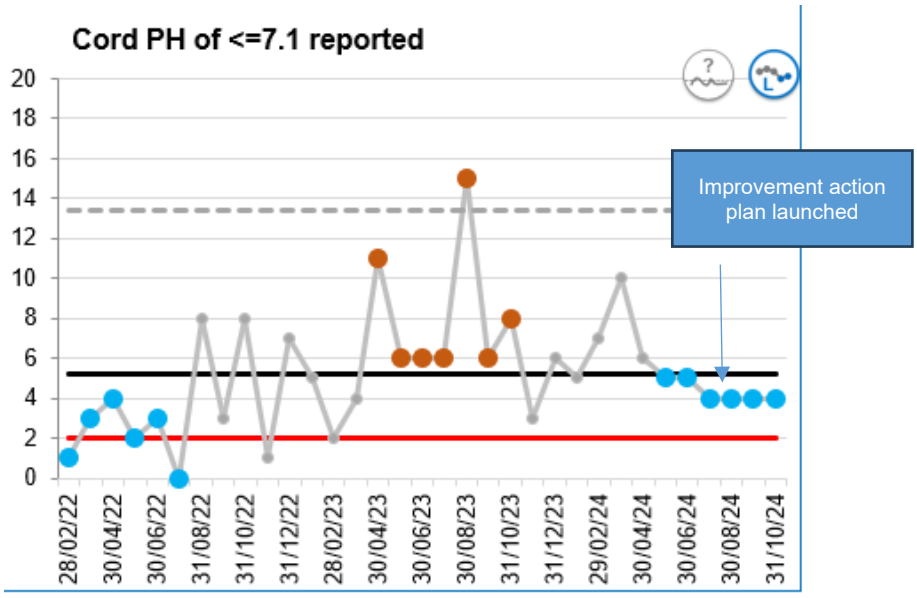


Figure 4: Accuracy of cord gas samples

Ongoing work streams.

- Exploration of Data caption concerning 37+ week gestation babies being readmitted into neonatal services and included within the neonatal ATAIN rates. Benchmarking against other neonatal units within the Southwest Neonatal Network

- Implementation of the guideline - Care of community infants less than 3 months admitted to paediatrics needing intensive care.

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 deteriorating 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	January 2025		
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 34/40 week 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	January 2025		

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	To be established	Neonatal transitional care lead and Senior Midwife			
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.	Business case being compiled	Consultant ANNP	March 2025		

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	Consultant ANNP and Quality and Education Neonatal Sister	January 2025		

Report to:	**Public Board of Directors**	**Agenda item:**	**11**
Date of Meeting:	**15 January 2025**		

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	**None**

1. Executive Summary of the Report

This report provides cover for the period January to June 2024 inclusive.

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 establishments, to maintain continuity of maternity and neonatal services, and to always provide safe care to women/birthing people and babies across all settings.

This report provides a summary of the measures in place to ensure safe midwifery and neonatal 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).

The vacancy in June 2024 (inclusive of maternity leave) was 16.36 whole time equivalent (wte), there have been 12wte new starters in this reporting period. The rolling turnover rate at the end of June is 7.34%. Rolling sickness rate is 4.11%.

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 work towards compliance with BAPM safe staffing for the LNU. The Southwest ODN conducted an annual review in Q3 2023 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 June 2024 in the LNU for band 5 and 6 nurses was 5.09wte following recruitment of 2.64wte during the reporting period. LNU rolling turnover rate has decreased from 5.56% to 4.54%. Rolling sickness rate is 4.34%.

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.
Maternity Incentive Scheme Year 6 standards.

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

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

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

Maternity Incentive Scheme combined Maternity and Neonatal Safety Quality report Q1, 22024
Birthrate Plus® (BR+) report data from 2022, presented to Trust Board 2023.
Perinatal Quality Surveillance Tools (PQST) presented monthly.

8. Freedom of Information

Public

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

2.1 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 Local Neonatal Unit (LNU) to include an annual workforce review, including a mid-year review and collaborative working with the Operational Delivery Networks (ODN) to ensure recruitment and retention, skill mix and flexible working.

3.0 Birth rate Plus® Workforce Planning for 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 Board funded the midwifery staffing budget to reflect establishment as calculated in the BR+ 2023 report. It is recommended that BR+ assessment is undertaken every three years to ensure planned staffing establishment is in line with changing activity and acuity within Trusts.

3.2 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 and Neonatal Delivery Plan. This will need to be considered within Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System workforce planning. We continue to explore service needs and long-term funding to make care safer, personalised and equitable.

4.0 Recruitment and retention

4.1 Maternity leave and secondment figures remain relatively stable with a notable increase in maternity leave in June 2024. The increase in substantive vacancy in Q4 and Q1 24/25 was a result of planned investment into the maternity service with a strategy for all

midwifery students after fulfilling set criteria to be offered substantive posts. This has resulted in successful recruitment to substantive posts.

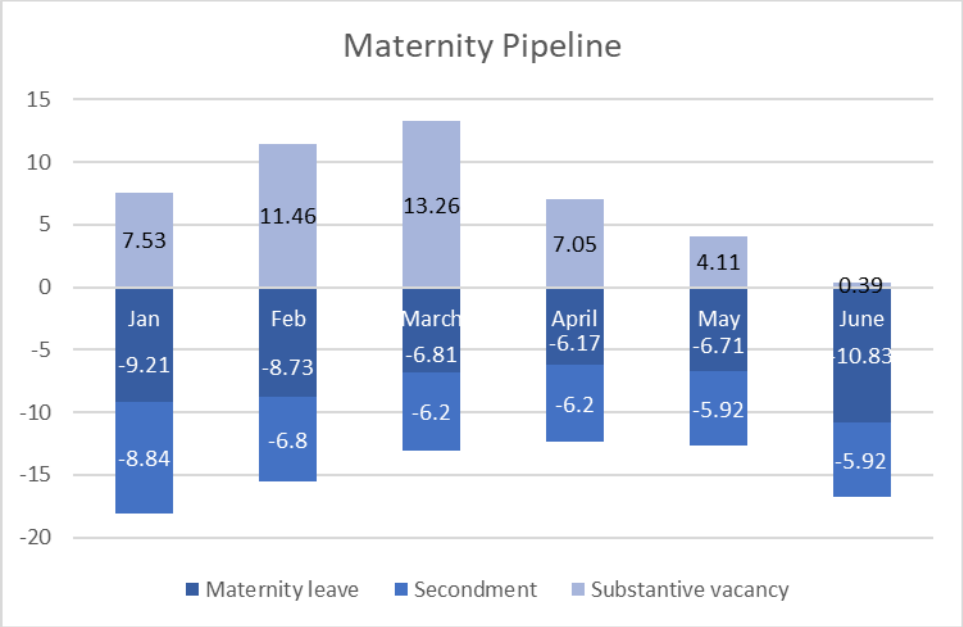


Figure 1.Midwifery pipeline

4.2 Retention of newly qualified midwives remains at 100% since May 2022. A total of six band 5 midwives have achieved their band 6 within this period.

4.3 Rolling turnover rate saw a slight increase from 5.96% in December 2023 to 7.39% in June 2024. Flexible working and adjustments are offered to all staff members prior to them leaving along with a conversation with the retention lead midwife. In this reporting period 6 band 6 midwives left the service with no commonalities identified from exit interviews.

5.0 Sickness rates

5.1 Midwifery sickness rates remain stable with an equal split for long-term and short-term sickness. The top contributor for episodes at 76 is cold, cough, flu – influenza, but 646 sickness days were lost for anxiety/stress/depression/other psychiatric illness. Supporting attendance is managed in line with guidelines with a focus on staff health and wellbeing.

Month	sickness %
Jan 2024	4.32%
Feb 2024	5.41%
March 2024	5.22%
April 2024	4.32%
May 2024	3.73%
June 2024	3.71%

Table 1. Sickness % for midwives

Reason	Episodes	Sickness days
Cold, cough, flu – influenza	76	233
Gastrointestinal problems	57	136
Anxiety/stress/depression/other psychiatric	37	646

Table 2. Top three reasons for sickness (over reporting period)

6.0 Planned vs Actual

6.1 Table 3 highlights the stabilised position for midwifery shift fill rates over the past 6 months. This shows an overall improvement from the previous report.

Month	Day qualified %	Night qualified %
Jan 24	95%	93%
Feb 24	94%	90%
March 24	91%	93%
April 24	92%	96%
May 24	93%	93%
June 24	94%	93%

Table 3. Shift fill rates

6.2 Mitigation and Escalation

Mitigations and escalation processes are implemented to manage any shortfalls in planned versus actual midwifery staffing. Staffing and Operational Pressures Escalation Level Midwifery Framework (OPELMF) status is reviewed daily by the senior operational leadership team and mitigated where redeployment is considered based on acuity to ensure safe staffing is maintained. When midwifery staffing does not meet acuity, 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 (BBC)
- Request additional support from the on-call midwifery manager
- Consult closely with maternity services at other sites to manage and move capacity as required (mutual aid)

The improved staffing position has also shown a decrease in the number of times/hours community midwives were called out of hours in escalation (figure 2) from 514.85 in the previous reporting period to 39.25. This can be directly attributed to successful recruitment, transformation of community birth provision and subsequent shift fill rates.

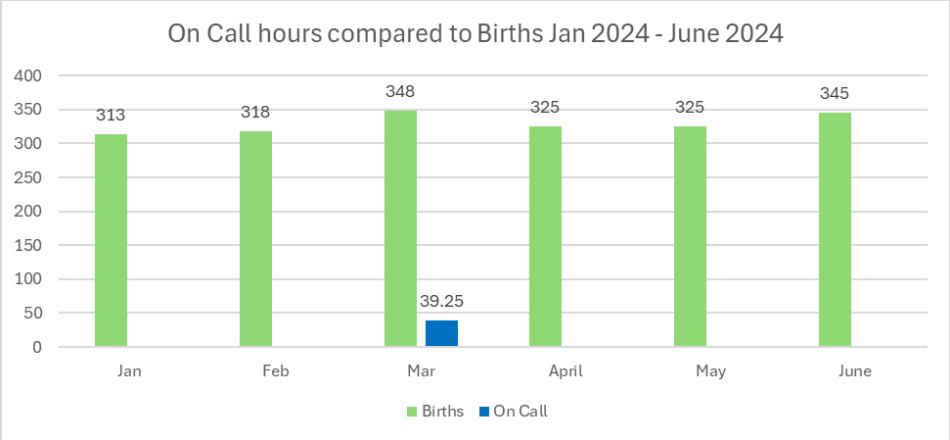


Figure 2: On-call hours and birth number comparison per month

6.3 Midwife to birth ratio

The midwife to birth ratio is calculated monthly using BR+ methodology. The BR+ Midwife to birth ratio 1:24 target was introduced in July 2023 to align with the outcome RUH BR+ Report 2023. The midwife to birth ratio was maintained throughout the reporting period with an exception in June when there was a rise in women with complex care needs.

Midwife to birth ratio	Target	Jan 2024	Feb 2024	March 2024	April 2024	May 2024	June 2024
Substantive only	1.24	1.26	1.27	1.25	1.25	1.27	1.27
Including bank	1.24	1.23	1.24	1.23	1.23	1.24	1.25

Table 4. Midwife to birth ratio

6.4 Supernumerary status

As part of Maternity Incentive Scheme Safety Action 5, Trusts are required to demonstrate supernumerary status of the midwifery coordinator in charge of labour ward. This is to oversee safety on the labour ward and oversight of all birth activity within the service. An internal performance review is conducted monthly to monitor compliance and reported via speciality governance. Table 5 outlines the compliance for the past 6 months.

Month	Days per month	Shifts per month	Compliance
Jan 2024	31	62	100%
February 2024	28	56	100%
March 2024	31	62	100%
April 2024	30	60	100%
May 2024	31	62	100%
June 2024	30	60	100%

Table 5. Supernumerary status of LWC

6.5 1:1 care in Labour

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. As part of Maternity Incentive Scheme, Safety Action 5, Trusts are required to demonstrate to provision of 1:1 Care in active labour. An internal performance review is conducted monthly to monitor compliance and reported via speciality governance. Table 6 outlines the compliance for the past 6 months.

	Jan 2024	Feb 2024	March 2024	April 2024	May 2024	June 2024
1:1 care in established labour	100%	100%	100%	100%	100%	100%

Table 6. 1:1 care in labour – source BR+ live acuity tool

6.6 Inpatient ward acuity

The inpatient ward-based acuity tool data is entered prospectively for the upcoming 6 hours. Acuity scoring criteria was changed prior to the reporting function been turned on in March 2024 and allowed access to retrospective compliance data from January 24.

Compliance data has evidenced that staffing has consistently not met the acuity, with a data entry compliance of 82.52%. It is recognised that the return of the reporting function was delayed and meant oversight and spot audit of acuity scoring was not possible. It has since been identified that further training is needed to ensure midwives are confident in allocating acuity scoring, with spot checks by ward manager to ensure robust data. The data will be monitored by the Quality & Patient Safety team and any issues or concerns raised with the ward manager/matron.

Escalation to the ward manager and LWC ensures that ward safety is maintained in periods of high acuity and actions detailed in section 6.2 are initiated.

6.7 Specialist Midwives

At the time of BR+ there were 11.30wte Specialist Midwives in substantive funded posts.

BR+ recommends 18.37wte specialist midwives including management and non-clinical element of specialist roles.

There are currently 18.56wte specialist midwives including those in management positions available to be deployed to mitigate in times of escalation. A number of these roles are external funded but form part of requirements of Ockenden, MIS and the 3-year Maternity and Neonatal Delivery Plan. These roles are being discussed within BSW and will need to be considered within BSW workforce planning. We continue to explore service needs and long-term funding to make care safer, personalised and equitable.

7.0 NICE Red Flag Events (NG14, published 27/02/2015)

7.1 A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. Actions to reduce red flag events includes operational management

actions such as initiation of the Operational Pressures Escalation Level Midwifery Framework (OPELMF). NICE Red Flag events are all recorded on BR+ acuity tool, the reliability of this data is also analysed on the tool via the confidence factor which should be maintained above 75%.

7.2 There are 9 national red flags agreed by NICE. Other midwifery red flags may be agreed locally. The service has agreed 2 local red flags pertaining to induction of labour and patient flow which has been identified as a quality and patient safety risk, (Risk Register Entry 2649) and monitored through the risk register processes. The highest number of red flag events recorded by the service are the locally set red flags for delay in admission to commence and continuation of induction of labour. Actions towards mitigation of the risk are detailed within the risk register and monitored for progress by internal governance processes.

8.0 Neonatal Nurse Staffing

8.1 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 a headroom of 25%, this tool should be used for direct patient care in the LNU only. Headroom is currently built into budget at 23%.

8.2 As recommended by NHSE, Transitional Care and Community Outreach should be delineated from the inpatient neonatal budget. Based on service cot occupancy and activity calculations in 2022/23, safe staffing levels were maintained from the inpatient establishment and budget. Consdieration for redefining the inpatient budget is being explored by service leads.

8.3 Overall vacancy in June is 5.09wte. There is a national shortage of paediatric and neonatal nurses which has caused challenges in recruitment. Promotion of the neonatal unit as a place to work was actioned, including a new joint paediatric/neonatal role was created to mitigate this and create more desirable options for newly qualified nurses to work at RUH.

8.4 Nurse rolling turnover rate remains stable and well below the Trust rolling KPI of 11% at 4.54%.

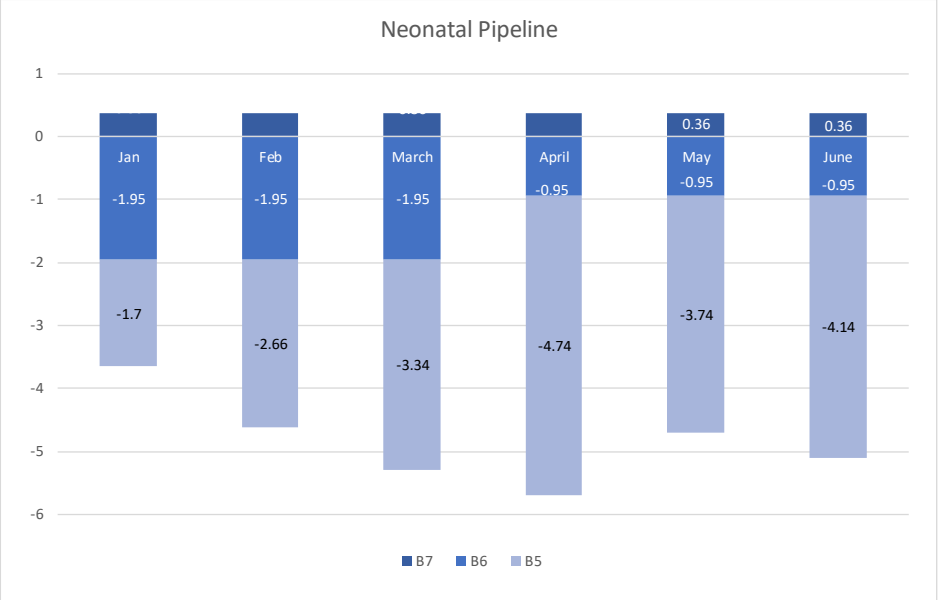


Figure 3. Nurse vacancy pipeline

9.0 Sickness

9.1 In May there was a reduction in sickness due to staff returning from long term sickness, June sickness figures are below the Trust target. The top episode reason for NNU absence is cold, cough, flu – influenza at 13, however days lost top contributor remains anxiety/stress/depression/other psychiatric illness at 125 days. Supporting attendance is a priority for line manager as per trust guidelines with a focus on staff health and wellbeing. Healthcare professionals working in emergency and intensive care units are often confronted with death, suffering which can lead to higher incidence of anxiety and stress (Deger 2024). To mitigate this, the neonatal team have invested in improving facilitates for staff breaks and have a counselling psychologist who provides education, offers focused debriefs in addition to 1:1 staff support for the team within her role.

Month	sickness %
Jan 24	5.62%
Feb 24	7.84%
March 24	6.83%
April 24	4.71%
May 24	4.17%
June 24	3.92%

Table 7. Sickness % for registered nurses

Reason	Episodes	Sickness days
Cold, cough, flu – influenza	13	30
Anxiety/Stress/Depression/other psychiatric	9	125
Gastrointestinal problems	6	9

Table 8. Top three reasons for sickness (over reporting period)

10.0 Transitional Care

10.1 All LNUs should offer a transitional care service (BAPM, 2017). Our TC is staffed from the LNU patient facing budget, with 99.5% shifts covered in the reporting period. The Trust currently provide a 4-bed service with ratio of 1:4 nurse to patient care. Getting it Right First Time (GIRFT) report recommends we should increase our TC service to at least 8-beds based on the current birth rate. The neonatal service is often caring for more than 4 babies within TC, a review of current staffing is in progress to consider expansion of TC bed provision. All eligible babies received transitional care in the given time period. Quarterly reports are maintained.

11.0 Neonatal Community Outreach Workforce

11.1 Neonatal Community Outreach has been expanded from within patient facing budget with 1.8 WTE offering a 6-day service for families, and as per GIRFT recommendations (2022) are in progress of expanding their offer of care for babies in the community, this will reduce length of stay for the preterm population.

12.0 Qualified in Speciality (QIS)

12.1 The British Association of Perinatal Medicine (BAPM) recommends all ITU and HDU patients should be cared for by a nurse who is qualified in specialty (QIS) trained. QIS is a post registration education pathway, combined with clinical competency which allows registered nurses working in neonatal units to become equipped with the specific knowledge and skills to practice safely and effectively in neonatal critical care. It is best practice for special care babies to also be cared for by a QIS trained nurse although national standards can still be met if they are supervised by a QIS nurse. The supervisory nurse in charge and nurse overseeing TC must also be QIS trained. The compliance level for the neonatal establishment in QIS training is 70% with our aspiration to exceed this to 85% to ensure a robust compliance un-wavered by small workforce changes.

12.2 There are national, regional and local challenges in achieving the 70% QIS compliance rate. Currently RUH QIS is 65.5% of the qualified workforce. The anticipated trajectory to 70% in 2024 has not been achieved due to retirement of QIS nurses, small number of QIS leaving the service and a recent large intake of Band 5 nurses without QIS. The lack of recurrent funding for QIS training, along with the lack of education provider is being discussed at Operational Delivery Network level and is a national issue. Figure 4 represents QIS trained neonatal nursing staffing provision over the review period. During the reporting period 91.69% of shifts were staff to BAPM recommendations, with 87.53% of shifts QIS to toolkit. QIS compliance is monitored via the Maternity and Neonatal Specialty Governance and a risk assessment will be conducted if QIS is consistently below the national BAPM recommendation of 70%.

12.3 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. There is mitigation in place as all nurses complete the Southwest Neonatal Foundation programme and local induction programme, and all are supported with gaining experience in intensive and high dependency care.

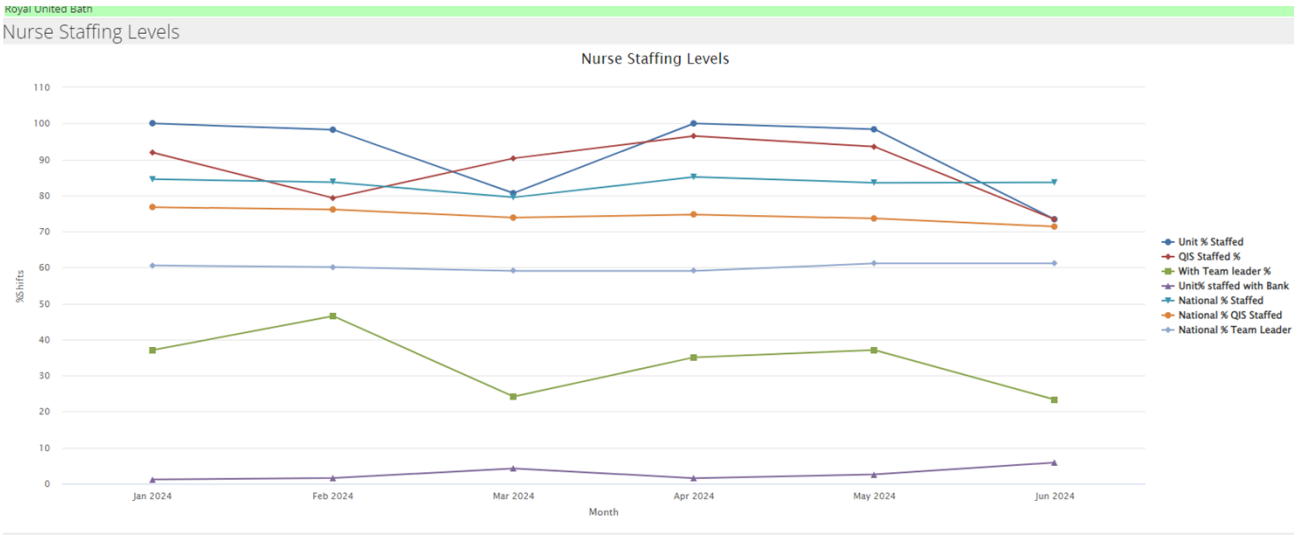


Figure 4. QIS shift fill rates

13.0 AHP staffing

13.1 In addition to nursing staff, neonatal services 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. National Standards for AHP provision are based upon number of ITU, HDU, SC, TC with 0.15 for half day clinic. The service recognises this is a gap and is reflected in the Risk Register entry 2591 and is monitored via Maternity and Neonatal Safety Governance.

13.2 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 9. Focussed work for AHPs is on inpatient babies with support provided by a named Consultant and Advanced Neonatal Nurse Practitioner (ANNP). To mitigate this, MDT specialist interest groups have also been implemented such as a Family Integrated (FI) care and nutrition group. Further AHP provision would allow for TC and Outreach babies to receive care, increased service improvement and the provision of further training for staff.

AHP	Current provision (WTE)	Deficit against BAPM (WTE)
Physio	0.2	0.6
OT	0.35	0.5
SALT	0.2	0.6
Dietician	0.2	0.7
Psychologist	0.3	0.6

Table 9. AHP wte comparison

14.0 Specialist roles

14.1 BAPM Service specification 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 include provision for a designated lead nurse, clinical nurse educator, supernumerary shift co-ordinator, discharge planning / outreach co-ordinator, bereavement lead, 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).

14.2 We continue to have four such roles in place; 0.4wte Neonatal Education and Quality Lead, 0.4 wte Safety Governance lead and 0.5 wte Family Integrated Care Lead. Remaining specialist roles, in line with BAPM recommendations, are allocated to individuals from the clinical nurse budget and subject to being redeployed during times of staffing escalation.

15.0 Recommendations

1. Review the need to increase headroom required to support the BR+ 2023 report and findings from BSW Academy review for maternity staff, including new mandated training
2. Undertake review of externally funded posts and agree workforce planning strategy to mitigate risk of removal of national funding
3. Review of inpatient acuity and staffing model to support expansion of TC and outreach service
4. Work with SWODN to ensure access to funding/education for QIS training.

16.0 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 impact if not provided in line with National standards. Having a baby in neonatal care has a significant impact to parental mental health which is long standing if they do not receive the care and support as per national requirements.

The Trust Board is asked to discuss the report and note the position of staffing in maternity and neonatal services.

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**15 January 2024**		

Title of Report:	**Annual Nursing and Allied Health Professional Establishment Review**
Status:	**For discussion and approval**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Authors:	**Olivia Ratcliffe, Deputy Chief Nursing Officer** **Simon Andrews, Associate Chief Nurse for Workforce and Education**
Appendices	**Appendix 1: National Quality Board Expectations for Safe Staffing** **Appendix 2: Inpatient Nursing Safe Staffing Establishment Overview** **Appendix 3: National Quality Board Recommendations self-assessment**

1. Executive Summary of the Report

Background:

This report provides an in-depth analysis of the Nursing staffing levels and for the first time, includes Allied Health Professionals (AHP). The assessment evaluates Nursing staffing compliance underpinned by the principles described in Developing Workforce Safeguards (NHSI 2018) and measures against National Quality Board (NQB) standards and National Institute for Health and Care Excellence (NICE) guidance.

There is clear national evidence of a direct correlation between staffing levels and patient outcomes, including the incidence of adverse events and inpatient mortality. The review aimed to assess current staffing establishments across various inpatient areas, including the Intensive Care Unit (ICU) and the Emergency Department, to assure the Trust Board that departmental establishments meet service demand with high quality care, and achieve safe staffing standards.

This is the first time that AHP workforce has been included in this paper at the Trust. However, there is no validated workforce tool to Allied Health Professionals on which to benchmark. The ambition is to develop more robust workforce insights and tools to better support the assurance and validation of a high-quality service in the future.

A comprehensive staffing review was conducted using multiple methodologies, including:

- The Shelford Safer Nursing Care Tool
- Care Hours Per Patient Day (CHPPD)
- Workforce data including vacancy, turnover, sickness, and appraisals
- Patient quality and outcome data
- Patient and staff experience metrics

The report identifies key findings:

- Enhanced Care Needs: The increasing complexity of patient care, particularly for people experiencing a mental health crisis and people living with dementia who require additional staffing and specialised training.
- Temporary staffing: There has been a reduction in the reliance on high-cost agency staffing due to successful recruitment, however some specialist areas such as Paediatrics and Theatres still require agency support due to national specialist skill shortages.
- Staff experience: Feedback from staff surveys highlights issues related to discrimination and the need for better support for staff from diverse backgrounds. The Trust is working to address these through various initiatives aimed at improving equality, diversity, and inclusion.
- Student and learner support: The hospital has successfully supported a considerable number of students and learners in clinical practice, which has had a positive impact on the workforce and underlines the need for sufficient supervisory support, especially for Allied Health Professionals.

The report recommends:

- Continued recruitment to the Enhanced Care Team and training in mental health and patients presenting with enhanced care needs: Continue to support the recruitment of additional Mental Health Care Support Workers and Mental Health Specialists to improve the safety and quality of care provision.
- Development of an AHP staffing dashboard: Focus on developing workforce and quality key performance indicators for AHPs to improve workforce planning and ensure patient safety.
- Improved training and support: Increase capacity to provide adequate training and support for staff, particularly in areas with high learning acuity and complex care needs.
- Enhancing workforce diversity: Strengthen initiatives aimed at improving workforce diversity and reducing discrimination, ensuring that staff from all backgrounds feel supported and valued.

The cycle of biannual reviews continues to assess staffing levels support safe care, the next round of reviews has commenced and will be presented to the Board of Directors in 2025.

2. Recommendations (Note, Approve, Discuss)

The Board is asked to **discuss** and **approve** the recommendations detailed in the report, outlining the current context and statement of need.

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). Regulation 18 (staffing) sets out the requirement for sufficient numbers of suitably qualified, competent, skilled, and experienced staff.

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

This report outlines identified gaps in workforce establishment which present risks identified on the risk register as below:

2075	Urgent Treatment Centre vacancy	**16**
2748	Reduced capacity of Occupational Therapist provision for Acute Stroke Unit	**12**
2725	Reduced capacity of Physiotherapists with respiratory skills to provide on-call service	**12**
2473	Impact of Theatre staff vacancy causing cancellations or delays	**12**
2631	Inability to recruit adequate staffing for paediatric assessment unit 24/7 when full capacity in High Dependency Unit	**9**
2290	Training provision within the Emergency Department to meet the learning demand of the team.	**9**

5. Resources Implications (Financial / staffing)

This proposal outlines no further increase to budgeted Nursing or AHP establishments.

6. Equality and Diversity

Compliant with the Equality and Diversity Policy.

7. References to previous reports

- Annual Establishment Review – Quality Assurance Committee, December 2024 (deferred)
- Mid-year review of Nurse staffing levels – January 2024

- Mid-year review of Nurse staffing levels – Quality Governance Committee 2023
- Safer Staffing Report – May 2022
- Safer Staffing Report – March 2021
- Safer Staffing Report – September 2020

8.	Freedom of Information
Not Applicable	

Introduction

The purpose of this paper is to provide the Board of Directors with an assessment of Nursing staffing levels and an overview of the Allied Health Professionals (AHP) workforce and challenges at Royal United Hospitals, Bath. It measures the Trusts compliance with the Developing Workforce Safeguards (NHSI 2018) standards, which builds on National Quality Board (NQB) standards and National Institute of Health and Care Excellence Guidance (NICE, 2014).

This paper focuses specifically on a review of nursing workforce levels for inpatient areas including the Intensive Care Unit (ICU), Theatres, and the Emergency Department (ED) undertaken from December 2023 to June 2024. The graphs and data contained in the paper cover the period from June 2023 to June 2024 to enable the observation of trends.

The workforce requirements for safe Maternity services and the Neonatal Unit (NNU) have been reviewed separately, and the paper was reported to the Board of Directors in July 2024 and January 2025.

It is important to recognise that there is not a validated staffing tool on which to calculate the Allied Health Professional workforce requirements and guidance is only provided at a speciality level such as in Intensive Care (e.g. GPICS). This paper is introducing the AHP workforce data, considerations, and challenges, with an ambition to build on this by developing greater workforce insights and tools.

Background

Evidence has shown there is a direct correlation between the registered nurse-to-patient ratio and the incidence of adverse events (Murphy et al 2021) which includes an increased risk of inpatient mortality (Musy et al 2021). Furthermore, economic modelling demonstrated that increasing the number of registered Nurses (RNs) delivered better outcomes with a net decrease in cost due to reduced length of hospital stays (Griffiths et al, 2018). A later study found for every additional hour of RN care available during the first 5 days of a patient's hospital stay, the risk of death was reduced by 3% (Griffiths 2019).

Reducing mortality is not the only benefit of increasing nurse staffing; studies have also shown a direct correlation between nurse staffing levels and patient outcomes. Shang et al (2019) found the risk of health care acquired infections increased by 15% when patients were exposed to low staffing levels. The research concluded that while healthcare support workers have an important part to play in maintaining the safety of patients, they cannot act as substitute for registered nurses.

The primary aim for the establishment review was to assess the hospital current establishments against the principles of Safe Staffing across inpatient wards, Theatres, and the Emergency Department, and to determine if investment was required to deliver Safe Staffing. The National Quality Board (NQB, 2016) guidance, 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing'. which provides a set of expectations (Appendix 1) for nursing and midwifery care staff, and an expectation that the RUH measures and improve patient outcomes, people productivity and financial sustainability all together.

Ward staffing review methodology

A full review is undertaken annually, with a 'light touch' review at six months which was last presented at RUH Trust Board in March 2024. The RUH has a systematic, evidence-based, and triangulated approach which aims to provide safe, competent, and fit for purpose staffing levels to deliver efficient, effective, and high-quality care.

The twice-yearly reviews are led by the Associate Chief Nurse for Workforce and Education, supported by the Divisional Finance Manager for Medicine, Divisional Human Resources Business Partner and took place throughout November – December 2023. The comprehensive data set is comprised of;

- Shelford Safer Nursing Care Tool Acuity/Dependency staffing multiplier (A nationally validated tool reviewed in 2013 - previously AUKUH acuity tool)
- Care Hours Per Patient Day (CHPPD)
- Workforce data including vacancy, turnover, sickness, appraisals, and ethnicity.
- Professional judgement
- Peer group validation
- Benchmarking and review of national guidance including Model Health System data
- Review of eRostering Key performance Indicators
- Patient quality and outcome data including falls, pressures ulcers & other harms
- Patient experience including Friends and Family Test, Patient Advice and Liaison Service (PALS) and Complaints
- Staff experience including survey results and Freedom to speak up information.

Each ward was represented by their Ward Senior Sister / Charge Nurse, Matron, and the relevant Divisional Director of Nursing. Clinical Leads, Speciality Managers and Human Resource (HR) Business Partners were also invited to attend. The outputs of the establishment reviews were then analysed by the Chief Nursing Officer and are discussed later in this report.

National guidance and research underpinning the Annual Nursing and AHP workforce review:

<u>The National Quality Board (2017)</u>

The expectations are fulfilled partly by this review, and the detailed action plan (Appendix 3) has been updated with progress towards compliance with the 37 recommendations that make up the three over-arching expectations. The latest full review of the action plan (August 2024) shows the RUH is compliant with 19 of the 37 recommendations. The following outstanding recommendations have an action plan and are reviewed monthly at the Nursing, AHP and Midwifery Workforce Group.

<u>Developing Workforce Safeguards (NHSE, 2018)</u>

The guidance echoes many of the actions identified in both the NICE guidance and the NQB recommendations to broaden to all staff groups, which informs the RUH to have closer oversight and assurance of AHP workforce. A recent key research study was published (Zaranko et al., 2022)

which highlights the link between higher registered nurse numbers and their seniority, and improved patient outcomes.

Allocated time for the supervision of students and learners

The set of national guidance that informs safe staffing for pre-registration learning supervision includes the RCN (2021) Nursing and Workforce Standards, which state that each student requires 6.45 to 7.45 hours per placement for assessment, with more time needed if they require. The Nursing and Midwifery Council (2023) Standards for Student Supervision and Assessment also recommends dedicated time for supervision, but this amount is not quantified. Similarly, the Safe Learning Environment Charter recommends setting aside time and space for learning. For student nurse apprenticeships (SNA) NMC (2024) guidance requires 40% off-ward time, with 20% in protected clinical areas, and their learning acuity is extremely high.

Equality, Diversity and Inclusion

The main reports and guidance informing Equality, Diversity, and Inclusion (EDI) includes the Marmot Review (2010), which highlights the scale and persistence of discrimination and racism affecting patient outcomes, The Workforce Race Equality Standard (WRES) established in 2014 consistently reports disparities in the experiences of Black, Asian and Minority Ethnic (BAME) staff compared to white staff, and as an acute provider the RUH is expected to show progress against a number of indicators. The NHS Equality, Diversity, and Inclusion Improvement Plan, and additionally, the NHS Long Term Plan (2019) focuses on retention and progression. For AHPs this include AHPs Deliver strategy (2022), and the NHS Long Term Workforce (2023) also contributes to EDI initiatives. The principles of anti-racism and co-production in this strategy reinforces this commitment, ensuring inclusive actions across the AHP community.

The other principles underpinning this report are recommendations from the following resources:

- National Institute for Clinical Excellence (NICE)
- The Royal College of Nursing (2021) Nursing Workforce Standards
- Safer Nursing Care Tool for inpatient wards and the Emergency Department
- The Royal College of Emergency Medicine (for the Emergency Department)
- Safer Nursing Care Tool for the Paediatric RSV inpatient wards
- British Thoracic Society (for respiratory services)
- Guidelines for the provision of Intensive Care Services
- Association for Perioperative Practice, Staffing for Patients in the Perioperative Setting (for Theatres and recovery)
- British Cardiovascular Society (for the Acute Cardiac Unit)
- Get It Right First Time (for the Acute Stroke Unit)

Considerations over the last 6 months since the previous twice-yearly safer staffing review

Escalation beds

When the RUH is in significant operational pressures (OPEL level 3 & 4) 13 beds are allocated across the Surgical and Medical inpatient footprint, and then a further 6 beds are allocated for inpatient for next day discharges in the discharge lounge. The number of escalation beds is likely to change as we approach winter.

The Day Surgery Unit

The Surgical Short Stay Unit was redesigned from 22 beds to 38 trolleys, to accommodate a new surgical pathway for adults, in the last 12 months the pathway has extended to treat children requiring the skill mix to change by employing Registered Children's Nurses. Along with this bed-base and pathway change was the renaming of the unit.

William-Budd ward

On 18 April 2024 the Oncology and Haematology ward transferred to the newly built Dyson Cancer Centre. On 26 April 2024, the inpatient bed-base increased from 16 beds to 22 (original pre-COVID position) with a full complement of staff.

B36 Intensive Care Unit and B12

In April, the B36 unit closed and relocated to the original ICU footprint on B12 to accommodate estate work on B36, with the aim to create a modernised single footprint ICU. With this move, the bed-base went from a maximum of 22 beds to 13 beds. The workforce was transferred, and vacancies were no longer an issue. Therefore, a reduction in temporary staffing was observed.

Ward B41 and Ward 4

Ward B41 was created to provide 20 additional inpatient beds, namely for Older People, this ward closed on 22 April 2024 to support the extension of B36 to enable the ICU single footprint works. Therefore, all B41 staff were re-located to Ward 4, St Martins Hospital, Bath which had a maximum bed-base of 23. As B41 was an additional capacity inpatient area, the current Ward 4 workforce had no assigned funded establishment and therefore is a cost-pressure to the medicine Division. Ward 4 closed on 27 September 2024 and the staff have been redeployed to other wards across the Trust.

Reduced dependency on high-cost temporary staffing (Agency)

Due to the successful recruitment and retention across the Nursing workforce, high-cost temporary staffing (specifically Tier-4 Agency Staffing) was stopped in January 2024. To uphold safety in the difficult to recruit and retain areas such as paediatric and theatre specialties, high- cost agency staff are still used, although there is robust oversight by the Chief Nursing Officer (CNO) and Divisional Directors of Nursing (DDON). Both specialties have an agency exit plan reviewed fortnightly through the improvement group (Nursing, AHP & Maternity improvement program).

24/7 Clinical leaders (Sister/charge Nurse band 6) for inpatient wards

Due to safety considerations following the occurrence of safety events, Haygarth and Older Persons Unit Short Stay (OPUSS) had 24/7 clinical leaders (band 6) appointed at financial risk with no allocated funding. The medium-term plan is to repurpose safer staffing funds to support this change fully financially.

Industrial action

Nursing industrial action supported by the Royal College of Nursing took place before November 2023 and did not impact this time-period of this report. However, the Junior Doctor's Industrial action has continued from 3 January – 9 January 24–28 February, and 27 June – 2 July 2024. This impact necessitated the rostering of Enhanced and Advanced Nurse and AHP practitioners to support services and pathways to maintain patient safety. Some teams were offered enhanced rates benchmarked across the Integrated Care Board (ICB) to fill bank shifts and provide this support.

Workforce overview

Registered Nursing

Figure 1 highlights the vacancy rates for Band 5-7 registered nurses which identifies from the graph that there are zero Registered Nurse vacancies. There is some caution with this data – the data is finance information and there is no triangulation between workforce (Electronic Staff Register) and finance data. The Trust has Registered Nurse vacancies in its Children's services. Turnover rates for Registered Nursing Band 5 are extremely low and far less that was forecasted for the financial year. Sickness rates for the same group remained stable, hovering between 4-6%, however this is more than is accounted for in the headroom and therefore has a financial cost to the Trust. Appraisal compliance showed a downward trend from 85% to around 75%, with a slight recovery in mid-2024.

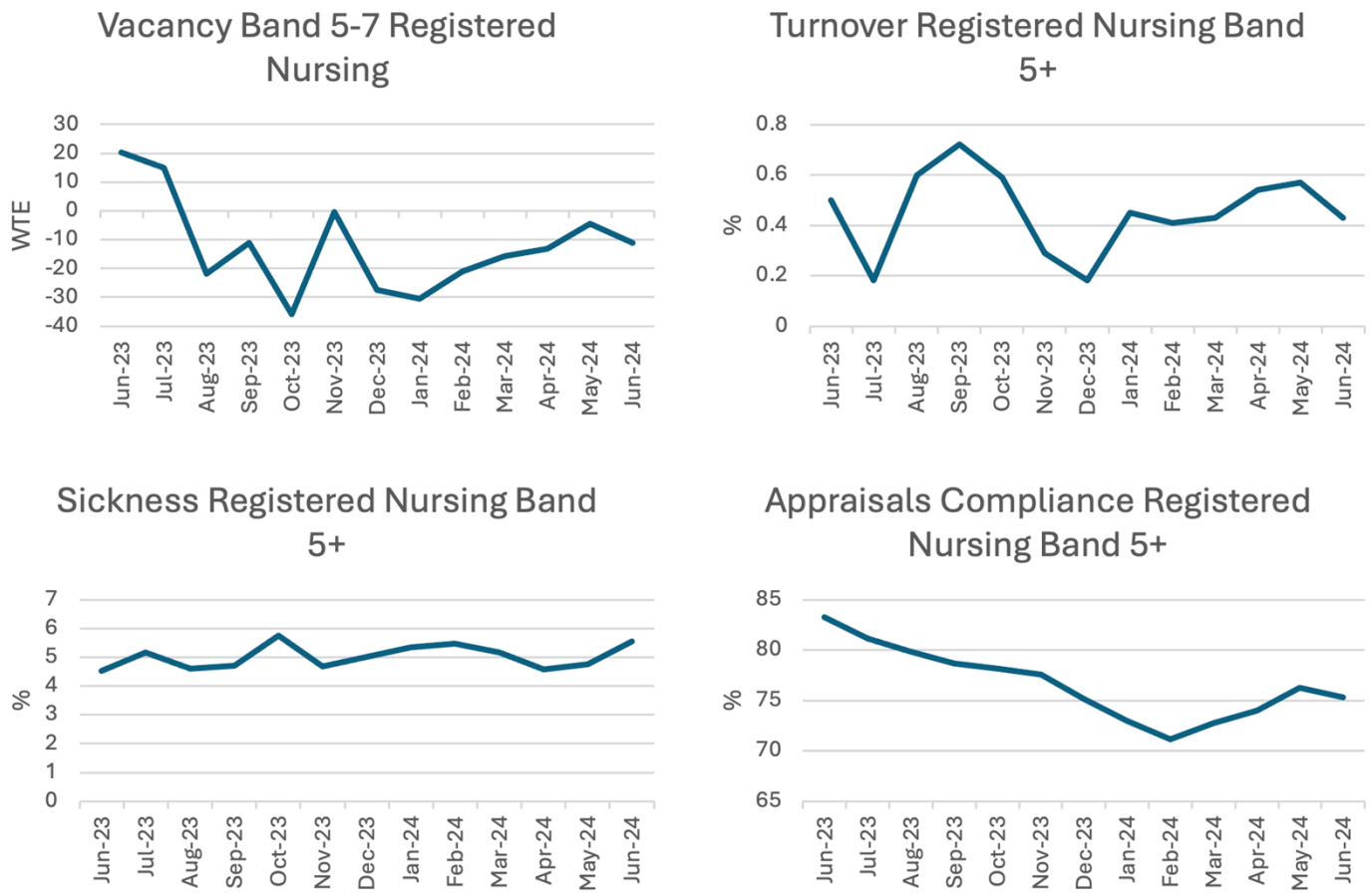


Figure 1: Registered Nurse workforce dashboard

Health Care Support Workers (HCSWs)

Further data cleansing is required to separate HCSWs from other professional roles. Therefore, Figure 2 represent numerous professions including porters. The graphs show vacancies for Bands 2-4 experienced a significant decrease towards the end of 2023 but showed improvement in early 2024, stabilising at approximately 150 WTE. Through manual analysis of the rosters, there were 48 WTE vacancies in June 2024 for HCSW across wards and departments.

Turnover rates fluctuated, peaking at around 1.5% in late 2023 before reaching circa 1%. Appraisal compliance for Bands 2-4 showed a steady increase from circa 70% to 78% over the year. Sickness rates for Bands 2-4 remained stable, fluctuating between 5% and 7% throughout the period.

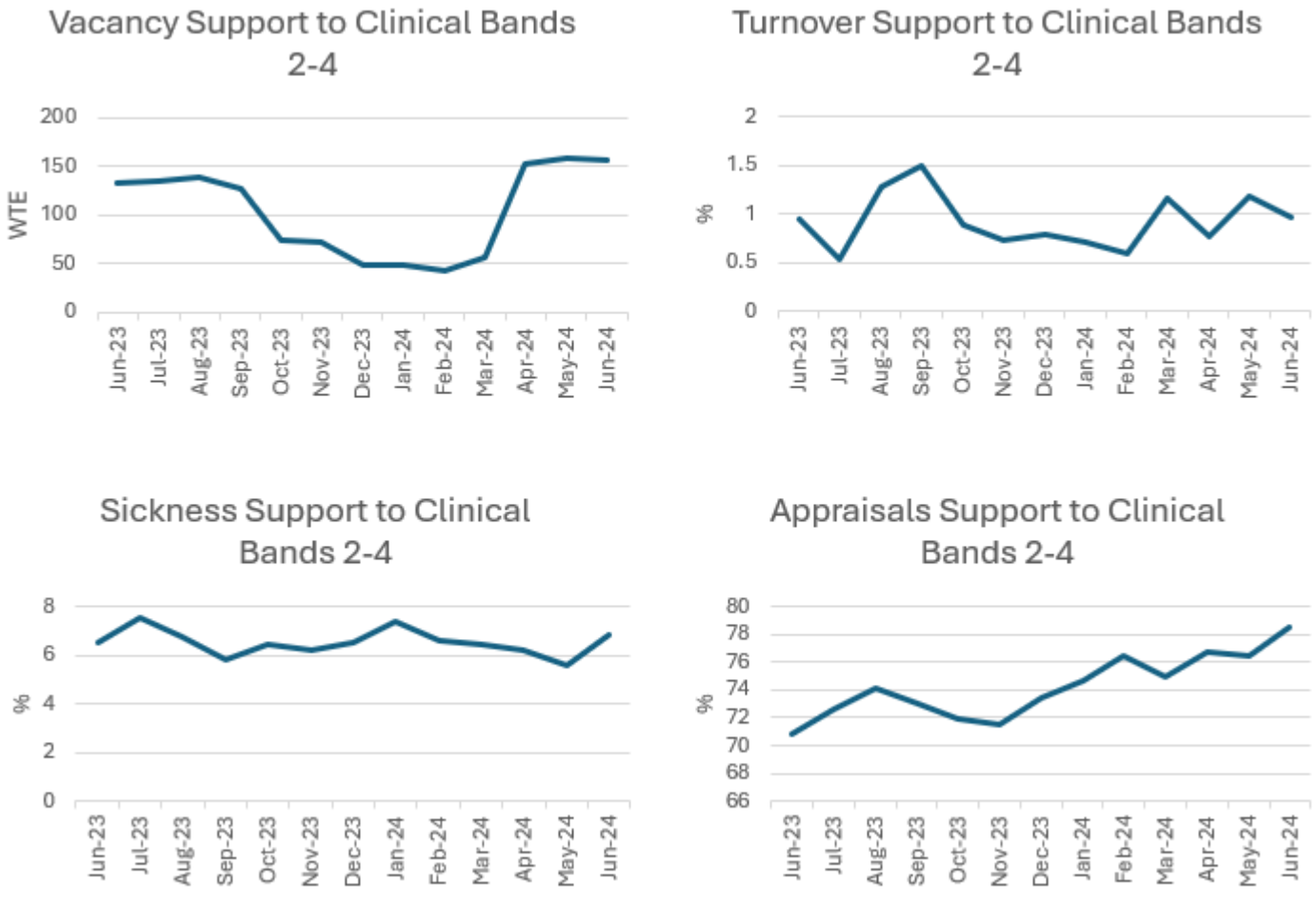


Figure 2: Health Care Support Workers workforce dashboard

Allied Health Professionals

Vacancy rates for the total AHP workforce showed a significant decline, with a brief increase in April 2024 before dropping again. Turnover rates for AHP Band 5/6 fluctuated, peaking at around 1.5% multiple times throughout the year. Sickness rates for AHP Band 5/6 have shown a decreasing trend since late 2023 however since May 2024 sickness rates have shown an upward trend returning to late 2023 levels but remaining less than 3.5%. Appraisal compliance for AHP Band 5/6 remained stable, with a slight upward trend, reaching around 80% by June 2024.

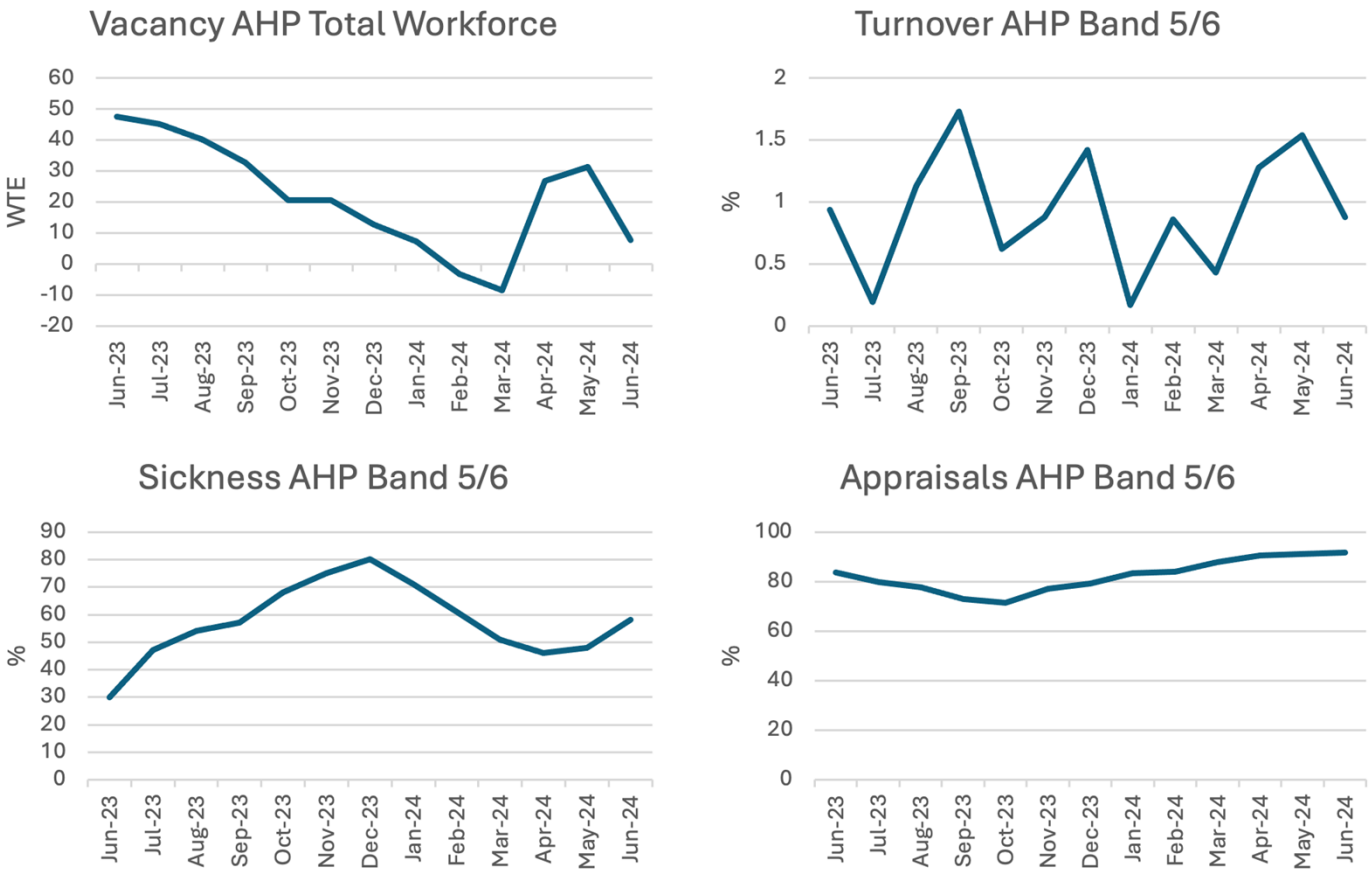


Figure 3: Allied Health Professionals workforce dashboard

Temporary staffing

Figure 4 represents the bank spend across vacancies in HCSW across all three clinical divisions. Monthly spend increased by circa £80,000 from October to December 2023, before returning to pre-summer levels in October 2023. The drive of this spend is due to the number of HCSW vacancies across all clinical divisions and increased demand in 1:1 enhanced patient care need, in addition to up-take of bank shifts in holiday periods. The reduction in spend was due to a Health Care Support Worker recruitment open day in September 2023 whereby 30 new starters arrived in January 2024.

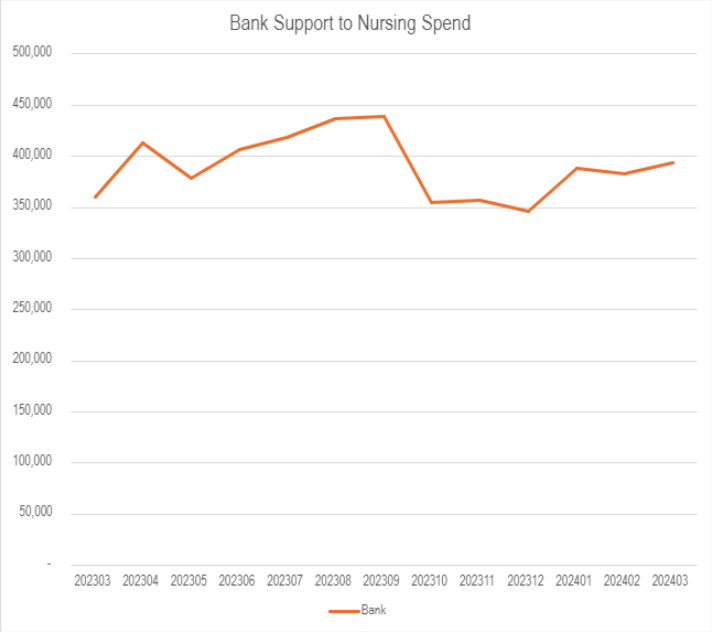


Figure 4: Bank Nursing spend June 2023 - June 2024

The significant Nursing agency reduction is observed throughout the year with the remaining agency reliance on occasional paediatric inpatient Nursing and the registered mental health nurses allocated on arrival (x4 per 24hrs equating to £50,000pm). The agency spend will continue to fall with paediatric Nursing recruitment and the substantive appointment of the Enhanced Care Team. There was an expected peak within the winter period of September 2023 to January 2024 in both bank and agency spend. There has since been a rapid reduction in agency spend, however bank spend has returned to pre-winter levels. The demand is driven by multiple factors; a high incidence of sickness (both short and long-term); study leave and apprenticeships above the funded establishment; and locally agreed specialist rates applied to difficult to recruit roles.

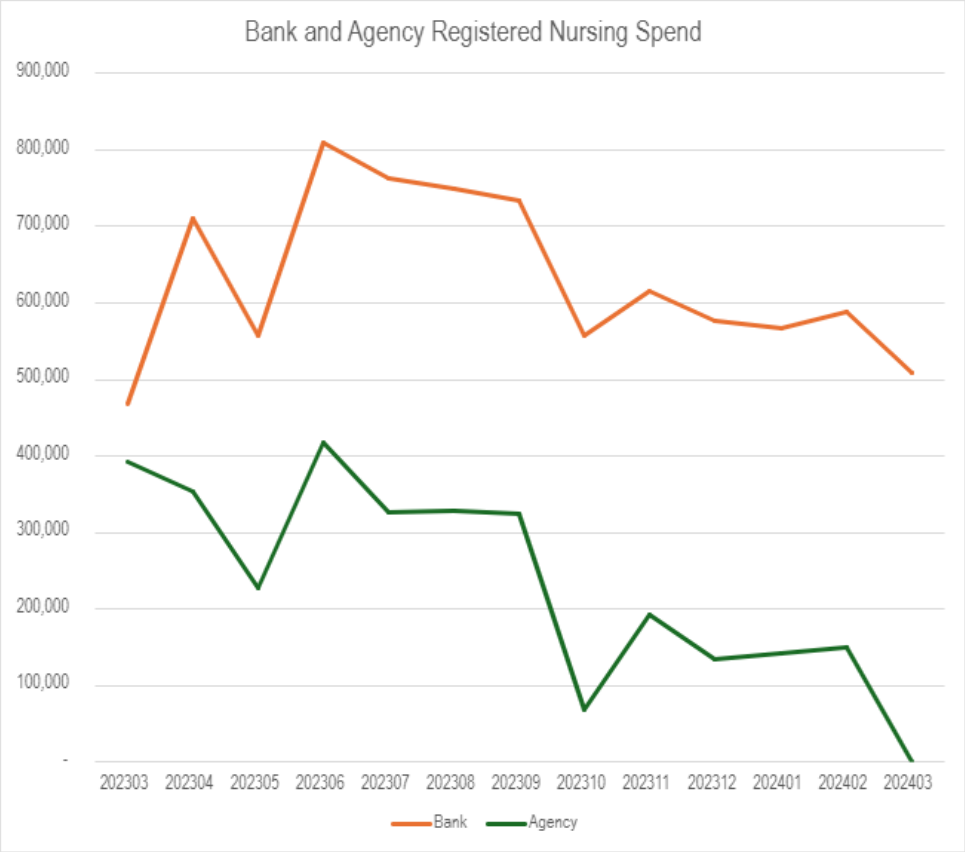


Figure 5: Bank and Agency Nursing spend June 2023- June 2024

The significant AHP agency reduction throughout the year represents the increased recruitment, reduced attrition rates, greater oversight, and senior controls along with minimal dependency in Theatres. The peak in bank work represents the Therapies team's transition from weekend and on-call working from paid over-time rates to bank.

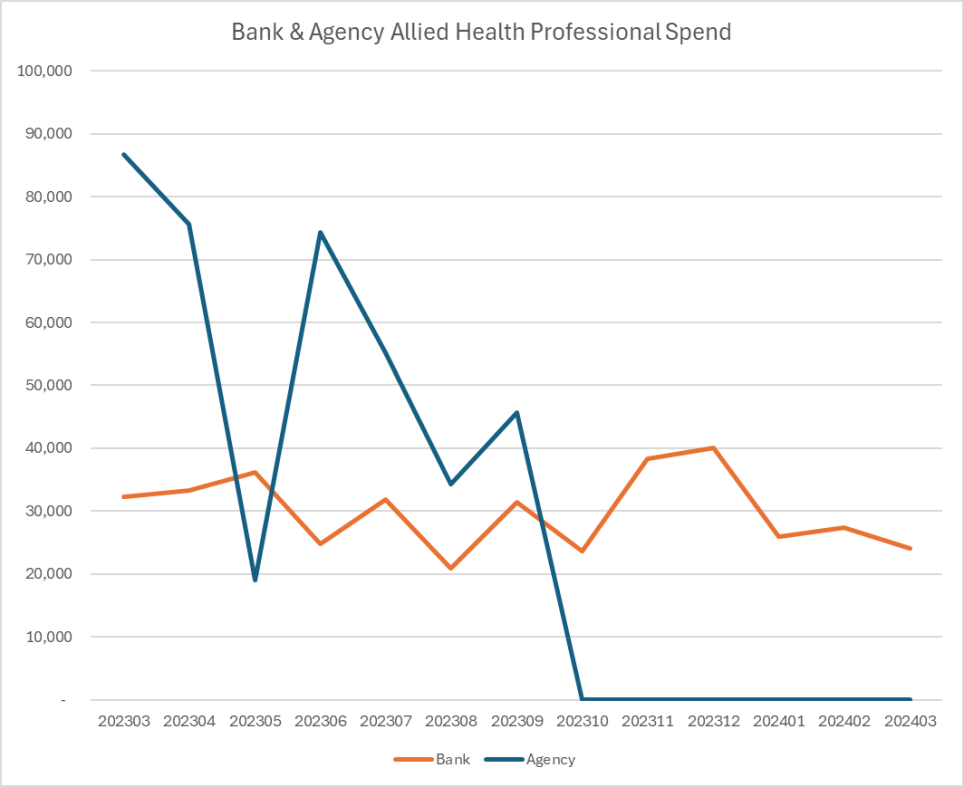


Figure 6: Bank and Agency AHP spend June 2023- June 2024

Students and Learners in Clinical Practice

From June 2023 to June 2024 the RUH has supported a substantial number of students and learners in clinical practice:

- 111 internationally educated Nurses have been recruited and 110 have successfully passed the training and requirements to receive a NMC registration.
- 1 internationally educated Operating Department Practitioner (ODP) has been recruited and now has registration.
- 12 HCSWs who were registered nurses previously overseas have successfully passed the Registered Nurse conversion programme, and all have gained NMC registration.
- 151 staff have commenced the New to Care Programme for HCSW competency and 71 successfully completed in this time-period.
- 11 Student Nurse Associates started, 35 are currently in training and 9 qualified successfully as Registered Nursing Associates.
- 5 registered Nurse Degree Apprentices have been recruited; 11 apprenticeships are ongoing. 13 RDNA qualified in this period all successfully qualified as registered Nurses
- Pre-registration student Nursing hours was 302
- Pre-registration student AHP hours was 175

Staff Experience

148 Freedom to Speak up escalations were captured from April 2023 to March 2024. 37 of these were from Nursing and Midwifery and 8 were from AHPs. These escalations were equally spread across the year and evenly balanced throughout all divisions. The main themes were (in order of prevalence): staff safety and wellbeing, inappropriate attitudes, and behaviours, bullying and harassment, and patient safety and quality.

The National Education Training Survey (NETS) was conducted from September 2022 to September 2023, reflecting the academic year and completed by all clinical professions. Responses from undergraduates, postgraduate students, and trainees in Nursing and AHP specialties have been extracted below.

The results are positive, and all scores are significantly above the national average, which is a testament to the learning environment and culture. Within the BSW ICB, the RUH scores above Great Western Hospitals (GWH) which also uses UWE/University of Bristol as their main Higher Education Institute provider. Salisbury's students in contrast are provided by Southampton University and show a much higher curriculum and assessment delivery satisfaction score.

	Responses (AHP and Nursing only)	Learning environment and culture	Education governance and leadership	Supporting and empowering learners	Delivering curriculum and assessment
Royal United Hospitals Bath	61	81.97%	85.04%	77.04%	66.27%
Great Western Hospitals	48	76.06%	77.09%	70.6%	63.90%
Salisbury Foundation Trust	8	81.47%	87.58%	78.57%	82.03%
National Average		77.41%	79.52%	74.07%	63.65%
Benchmark Service Type		76.41%	78.63%	73.12%	62.29%

Table 1: RUH NETS Survey 2022 Benchmarking

The breakdown in table 2 from Nursing and AHPs shows that both cohorts had a highly positive experience, with AHPS satisfaction reaching 100%. The results reflect the AHP four elective undergraduate clinical placements, as well as 6-week leadership placements for Physiotherapists which both had especially positive feedback.

	Have you felt you have received appropriate help in the placement	Does your education institution provide access to learning support?
Nursing Workforce	87% agree	93% agree
AHP	100% agree	100% agree

Table 2: RUH NETS Survey 2022 Professions Benchmarking

The RUH published their NHS annual staff survey results in September 2023. For AHPs, the perceived strength was Compassion and Inclusivity, which was the highest scoring metric, although this was slightly below the national average. Of note, although morale scores were low nationally, RUH scored slightly higher than the average. However, in the safe and healthy category, RUH scored slightly below average. In all other domains RUH had no significant statistical deviation to other NHS organisations.

The issues underlying these lower scores relate to AHP resources and equipment to do the job which have not always been perceived to be adequate. One key example is that radiographers have been using heavy and difficult to manoeuvre portable x-ray machines and x-ray boards. This concern is recognised at a regional level and being addressed at a regional steering group.

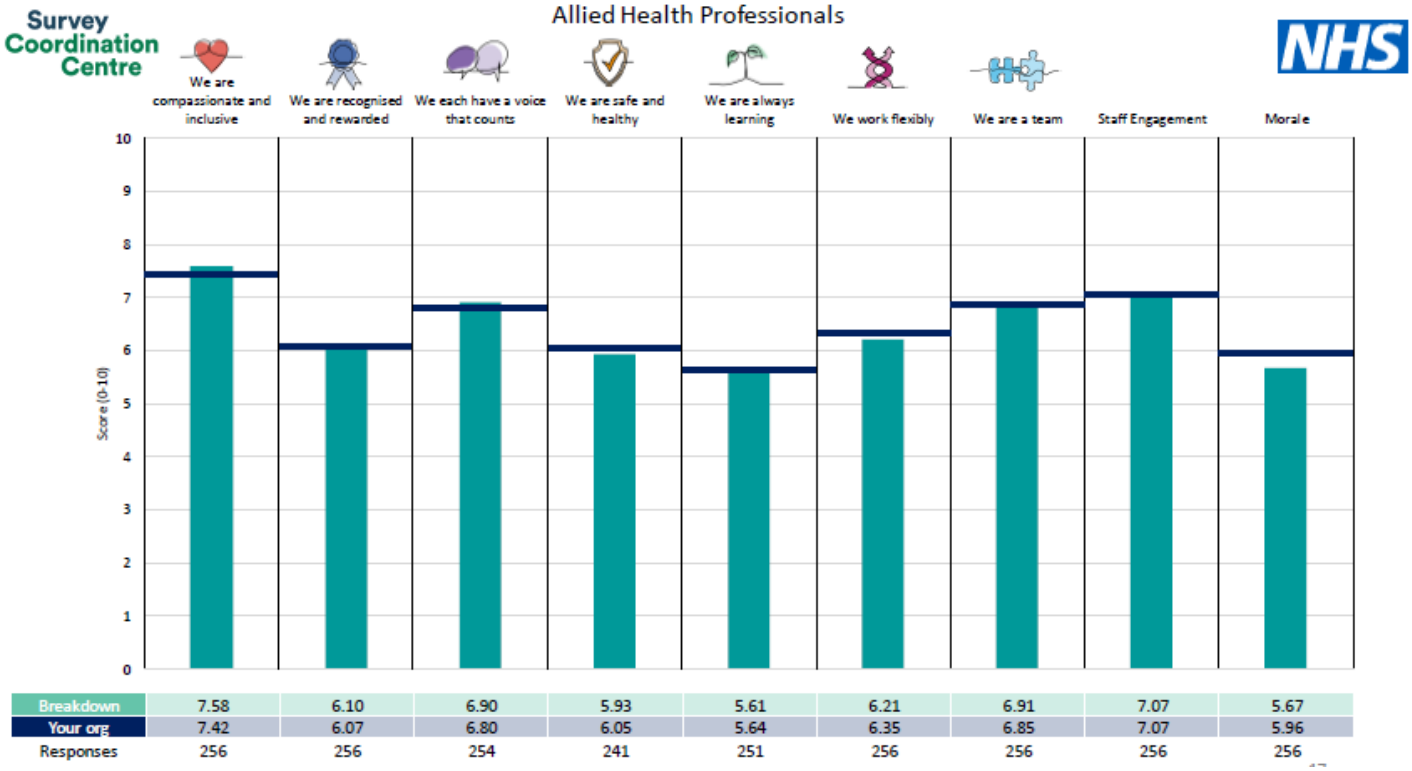


Figure 7: RUH AHP NHS annual staff survey results 2023.

In Nursing, Compassion and Inclusivity was the highest scoring metric equal to the national average score. Safe and Healthy scored significantly above the national average, however, Always Learning was significantly below that of other organisations. Clinical skills workshops were set up in May 2024 to mitigate this, as well as the use of local leadership development programmes. Clinical Practice Educators are now integrated within the clinical divisions to embed learning and development in the clinical environment. it is hoped that these interventions will deliver an improvement to learning over the coming year.

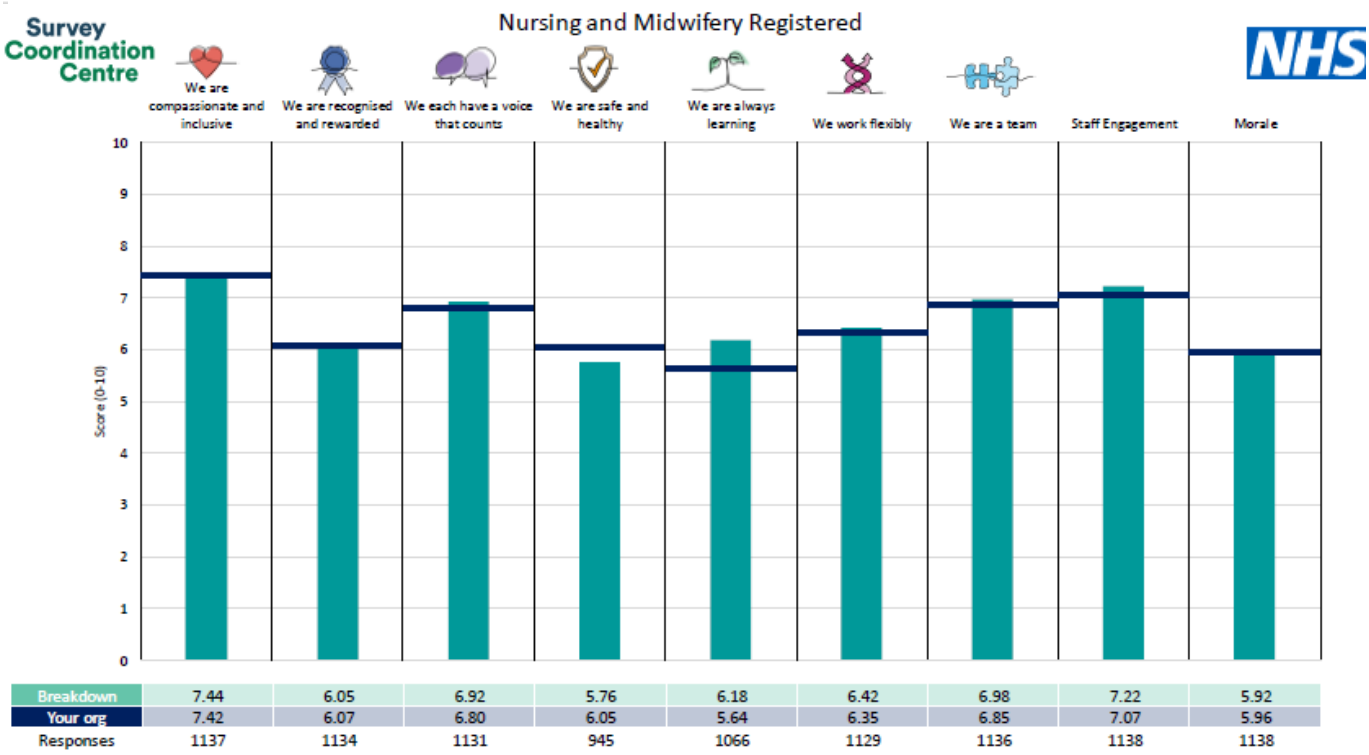


Figure 8: RUH Nursing and Midwifery NHS annual staff survey results 2023.

Key Quality indicators for Safer staffing

Falls

The falls rate has remained within the expected variance, having reduced consistently since December 2023. Key factors contributing to falls include orthostatic hypotension. There were high vacancies among Healthcare Support Workers (HCSWs), and low fill rates for HCSW bank shifts, meaning ad-hoc support is often unavailable. As HCSWs provide the 1:1 enhanced care support to those at high risk of falls. However, analysis reveals that 98% of inpatients do not fall, and the highest fall rates are in the Medicine division, and especially Older People's departments due to their patient's frailties and complexity

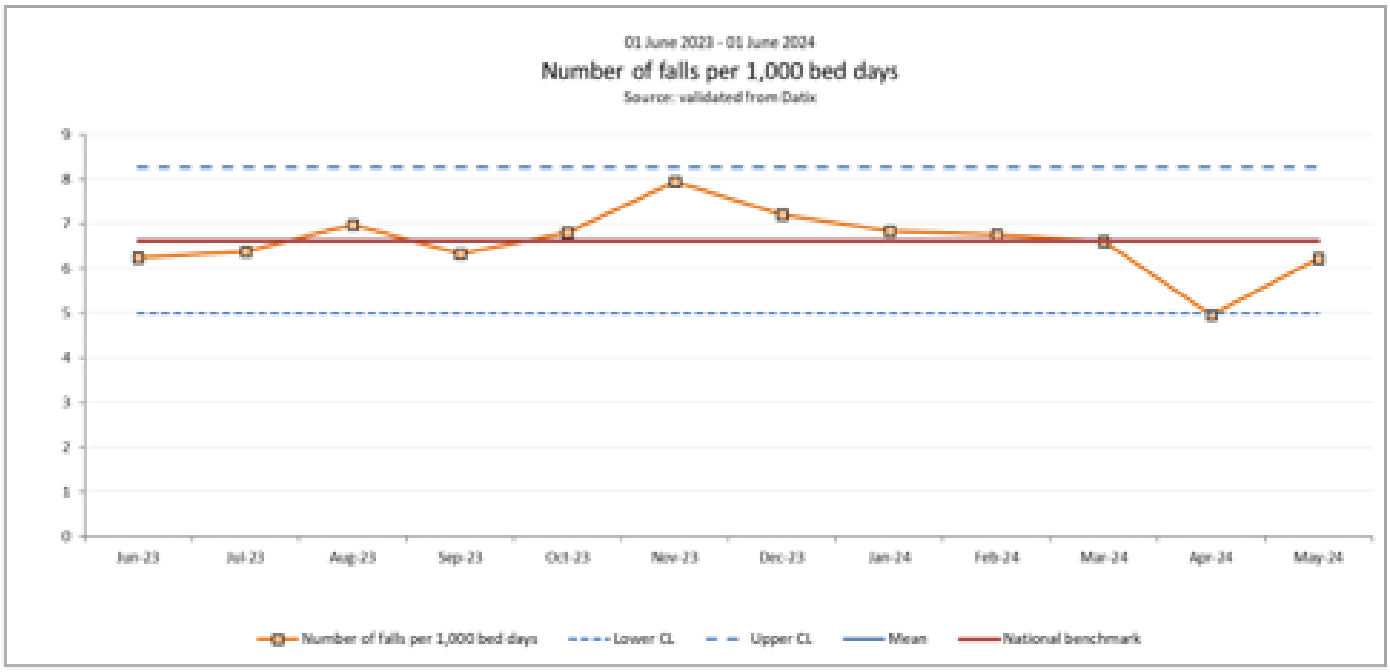


Figure 9: RUH's Number of falls per 1,000 bed days June 2023 – June 2024

Pressure Ulcers

There were 61 pressure ulcer cases reported from June to June 2024, with Pierce Ward having the highest incidence at 14 cases. All pressure ulcers were investigated which identified gaps in knowledge for some ward staff. After changes in senior leadership, including a new sister, leadership programs, and support from Clinical Practice Educators and the Tissue Viability Nurse (TVN) team, no pressure ulcers have been reported on Pierce Ward since October 2023. This mirrors the progress on Haygarth Ward, where similar interventions reduced cases to six.

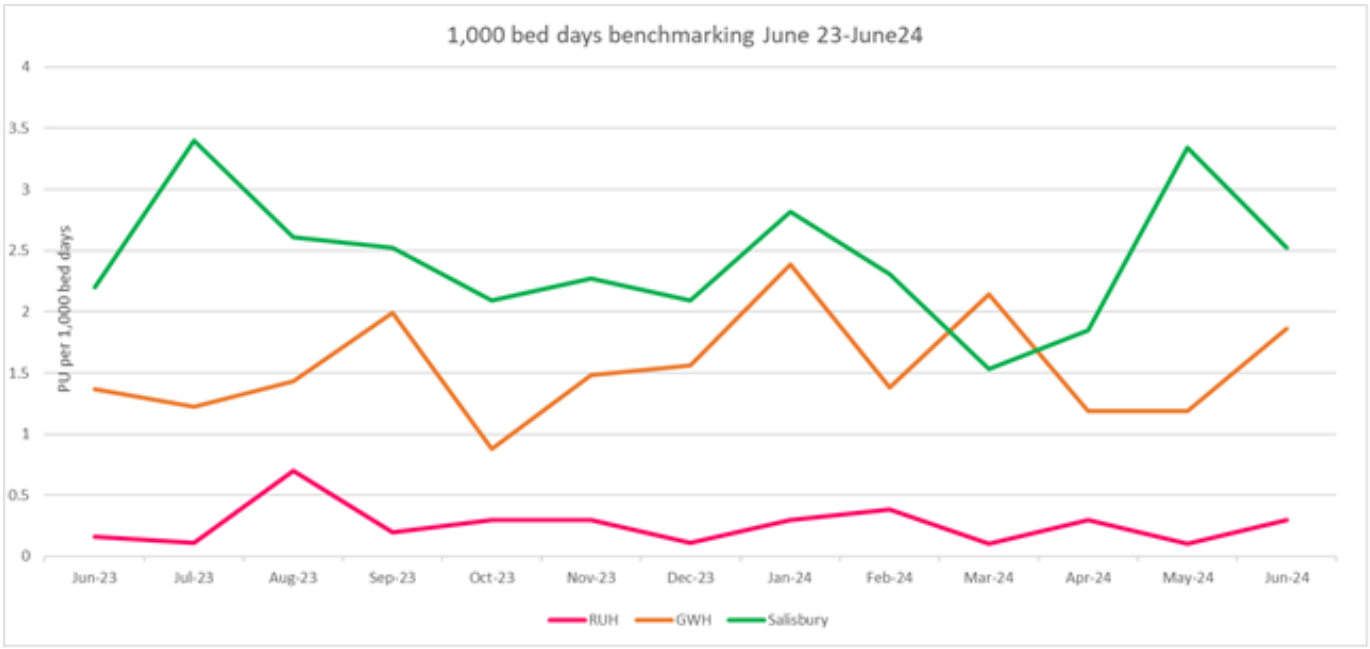


Figure 10: RUHs pressure ulcers benchmarking against BSW acute providers

Medication Incidents

The graph depicting medication incidents shows some fluctuation throughout the year. The highest number of incidents occurred around October and November 2023, peaking above 140 a month. This is nationally recognised as the most critical time for medication incidents and represents the intake of newly qualified nurses on the wards. The lowest numbers were recorded in December 2023 and May 2024, reducing to approximately 90.

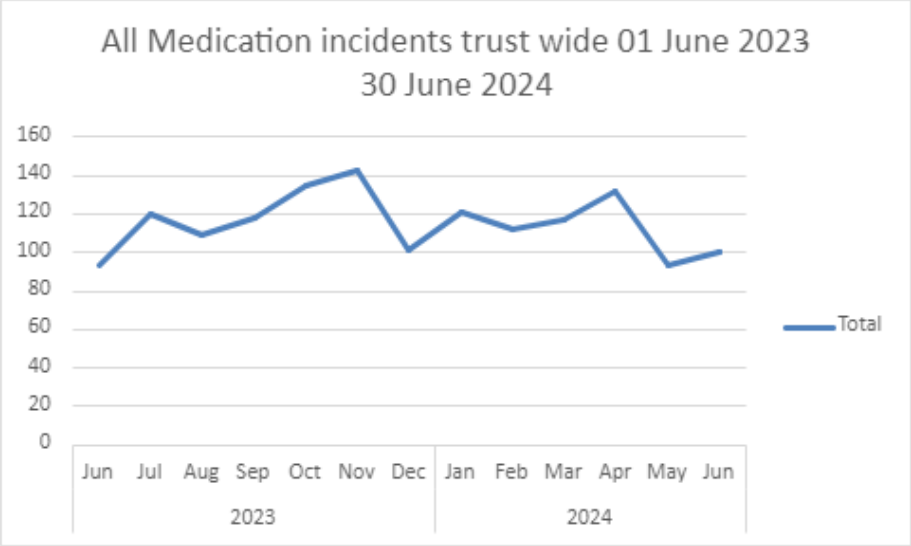


Figure 11: RUHs medication incidents (trust wide) June 2023 – June 2024

Infection prevention and control

The data includes monthly figures for influenza, Norovirus, and COVID-19 infections. Despite very few full ward closures, some were recorded in Cheselden (n=3), Parry (n=2), Combe (n=2), Acute Stroke Unit (n=1), Helena (n=1), and B41 (n=1). Most outbreaks are associated with medical wards, though a small number of surgical bay closures occurred, and the William Budd oncology ward was occasionally affected. Importantly, the wards listed did not have concerns about staffing levels. The observed peaks reflect expected seasonal variations. in infection rates.

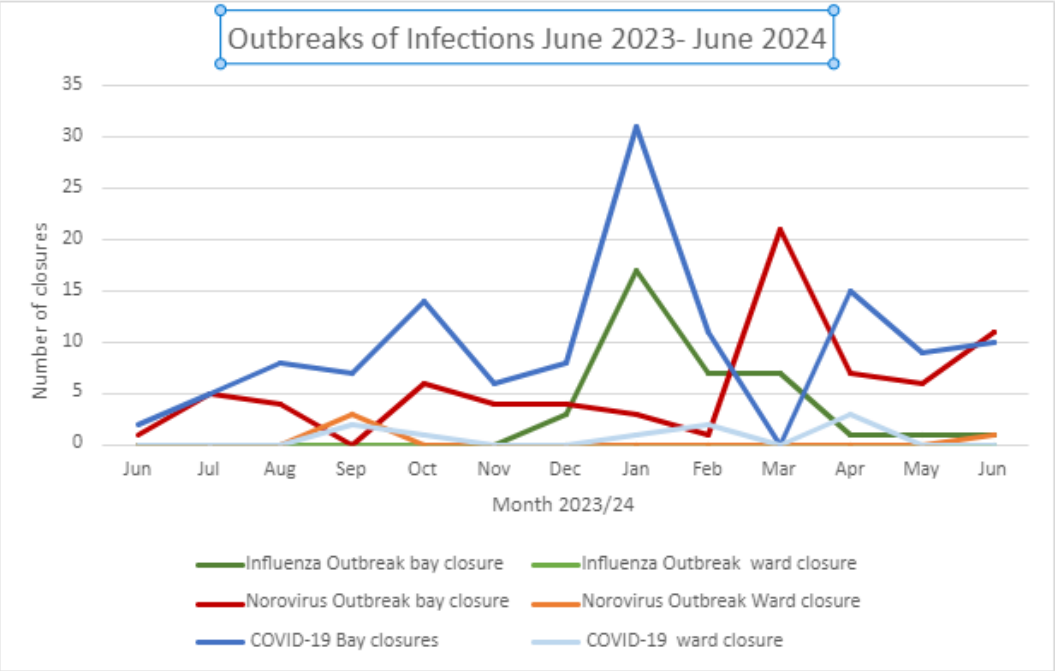


Figure 12: RUHs infection outbreaks June 2023 – June 2024

Reported incidents

Figure 13 represents Datix incidents related to the Nursing and AHP workforce from June 2023 to June 2024. There is a clear downward trend in reported incidents through the year, this correlates with the recruitment of Nursing and AHPs and minimising vacancies.

Figure 13: RUHs workforce incidents reported through Datix, June 2023 – June 2024

The most prevalent incident themes relating to both Nursing and AHP Workforce is the lack of suitably trained staff (top contributors in order of incidence; Emergency Department, Combe, Pulteney), low levels of staff due to sickness/leave (top contributors; Plaster Technicians, Pierce,

Combe). Followed by low levels of staff due to unexpected staff transfers (top contributors; Emergency Department, Combe, Acute Stroke ward).

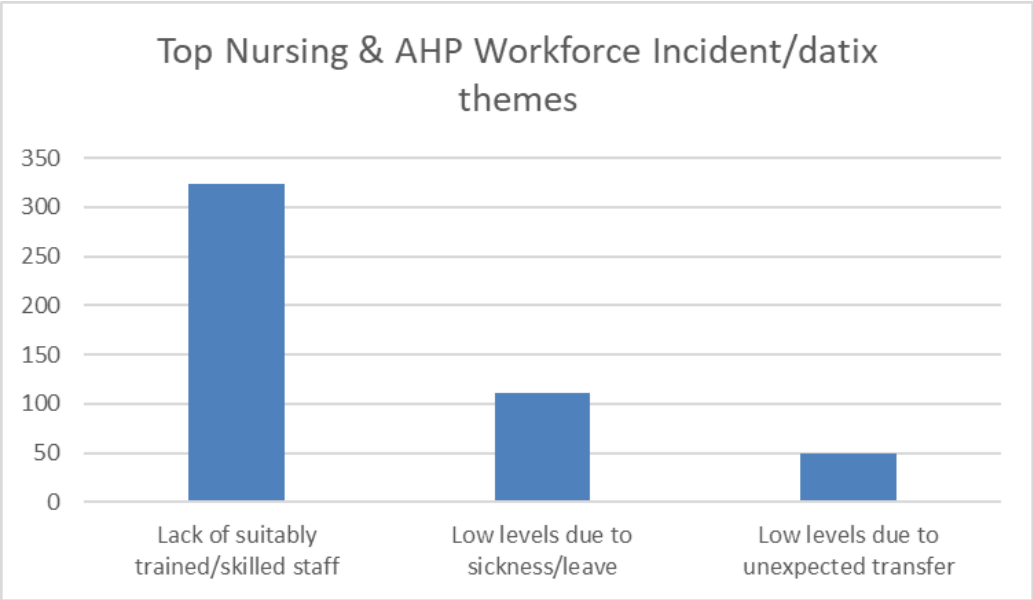


Figure 14: RUHs workforce incidents Datix themes, June 2023 – June 2024

Roster Red Flags

The nurse in charge can raise a red flag on the roster if, in their assessment, the nursing staffing levels are unable to meet care requirements. This notifies the Matron, and the red flag requires action to close the escalation. Nursing teams are encouraged to raise a red flag, it does not mean there is variance between the number of nurses expected to work the shift and the numbers on duty. Professional judgement is an important assessment of staffing levels. The significant decrease in Nursing vacancy aligns with the consistent downtrend in the number of roster red flags. The significant reduction in reporting has matched the progression of recruitment and development of newly appointed staff. The main reason was a shortfall of registered Nurses by 25%, followed by omission of comfort Rounds. There is no national guidance for AHP roster red flags and therefore is not adopted at the RUH.

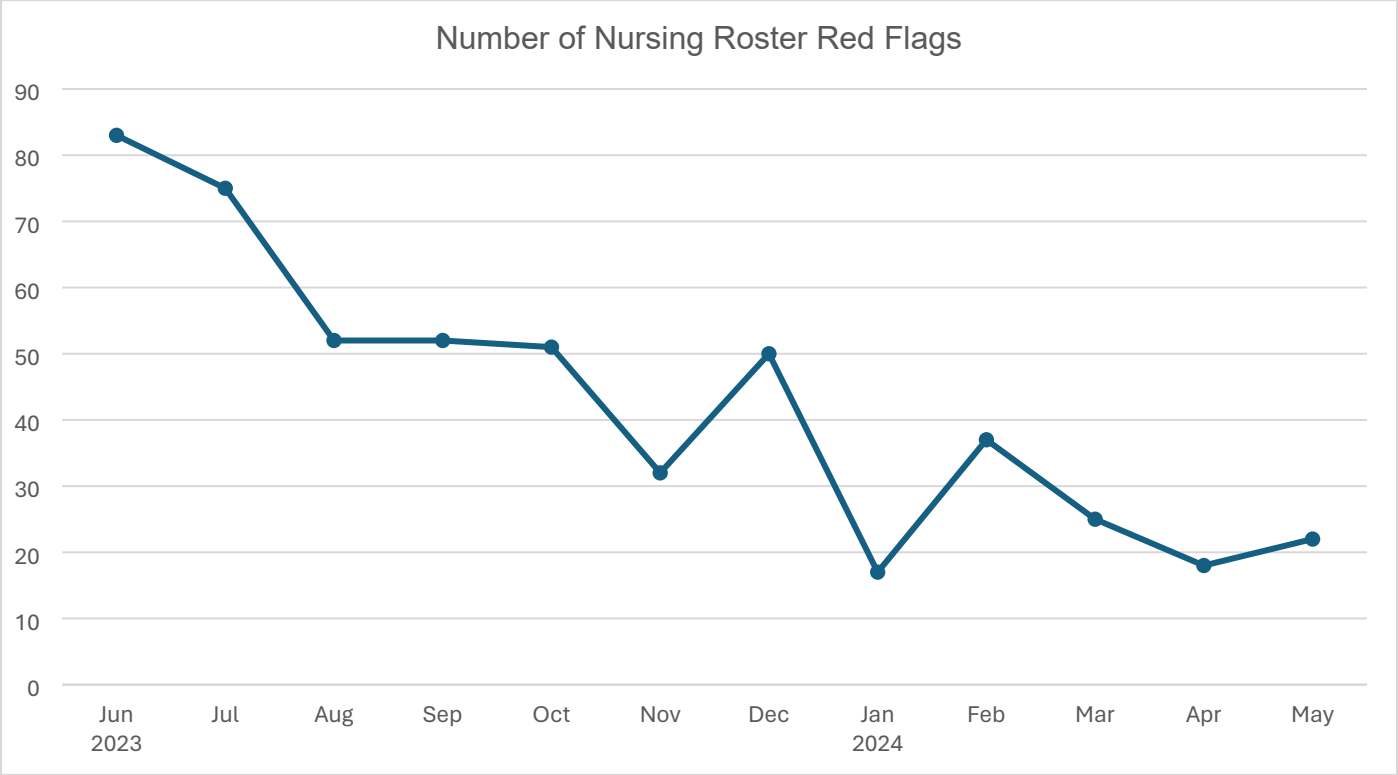


Figure 15: RUHs number of nursing roster red flags, June 2023 – June 2024

Nursing Fill-rates

Table 3 reveals a progressive increase in Nursing staffing fill rates from June 2023 to June 2024, from wards. The fill rates of RNs increased steadily day hours, beginning at 77% and peaking at 89%, with minor fluctuations. HCSWs day hours start at a stable 73% and gradually rise to 86%. Night shifts also show higher consistency, with RNs maintaining over 90% throughout, and HCSWs experiencing some variation but ending at a strong 90%.

Total average	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
Total monthly actual staff Day hours- RN	81%	77%	78%	80%	82%	86%	82%	82%	78%	83%	85%	88%	89%
Total monthly actual staff day hours- HCSW	74%	73%	72%	72%	82%	81%	78%	80%	82%	83%	81%	84%	86%
Total monthly actual staff night hours- RN	92%	94%	92%	94%	96%	97%	96%	94%	94%	93%	95%	95%	98%
Total monthly actual staff night hours - HCSW	89%	88%	89%	90%	87%	88%	85%	86%	89%	87%	91%	86%	90%

Table 3: RUHs Nursing and HCSW fill rates for day and night shifts, June 2023 – June 2024.

Ward Establishment Assessments

Benchmarking using the Model Hospital - Health System

The RUH care hours per patient per day (CHPPD), recommended in the Carter Review (2015),

are provided in the Model Hospital dashboard as a standardised model for Trusts to benchmark. Each month, the hours worked during day and night shifts by registered nurses, midwives, and HCSWs are totalled. The number of patients occupying beds at midnight is recorded daily, summed for the month, and divided by the number of days in the month to calculate a daily average. The total hours worked are then divided by the daily average number of patients to produce the CHPPD rate.

The Nursing and Midwifery workforce care hours per patient per day are in line with the provider and Trust of similar size peer median.

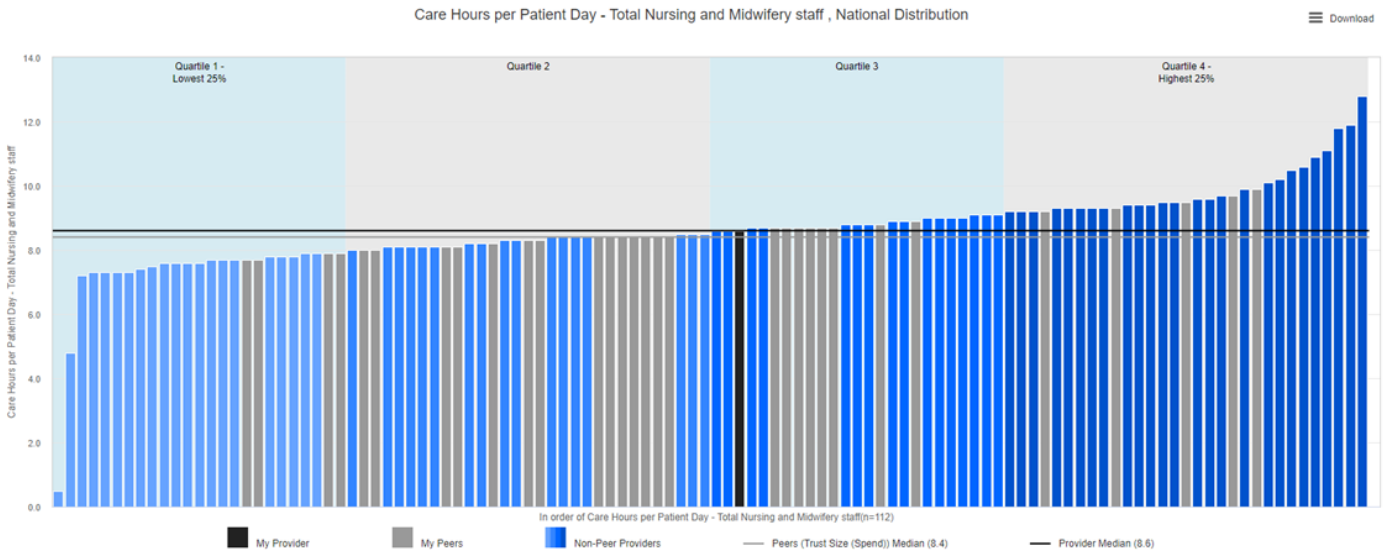


Figure 16: RUHs benchmarking of CHPPD for nursing and midwifery

Twice-Yearly Ward Establishment Review

The reviews acknowledged the increasingly complex cohort of patients across our inpatient wards, many of whom require enhanced care or specialist Mental Health intervention. The review concluded that an Enhanced Care team would address both staff training and patient care needs. The Older Persons Assessment Unit (OPAU) was also recommended to use the new Assessment Unit Safer Care Nursing Tool for future reviews. Details of ward staffing levels, ratios, and CHHPD are in Appendix 2, with principles outlined in the next section.

Safer Nursing Care Tool

In April 2024, the SNCT assessment of all inpatient wards (Adult and Paediatric) introduced new categories for patients needing 1:1 (Level 1C) and 2:1 (Level 1D) enhanced care. The results reinforced the need for more HCSWs to meet the high demand for 1:1 care. As with the establishment review, the recruitment of the Enhanced Care team is expected to mitigate this risk, so no changes were recommended.

Conclusion of establishment assessments

A robust ward staffing establishments reviews and SNCT was conducted using mixed methodologies and aligned with recommendations from the National Quality Board, NICE guidance, and RCN Nursing Workforce Standards. Overall, staffing establishments remain appropriate and

within guidelines. However, some areas with high acuity and dependency still outstrip available HCSW ratios for 1:1 care. Recommendations for uplifts were not made due to the imminent recruitment of the Enhanced Care team, with daily monitoring of this patient cohort overseen by the Associate Director of Vulnerable People

Safe staffing principles

The principles underpinning Safe Staffing as described by NHSI (2018) is that reviews must be evidence based using tools and data, triangulated with outcomes and professional judgement.

Registered Nurse to patient ratios

Registered Nurses to patient ratio was first described by the National Institute for Clinical Excellence (2014) and recommended a minimum of 1:7 RN to patient ratio for inpatient wards. A ratio of 1:7 is now the absolute minimum due to the acuity and dependency of patients has increased in the 7 years since its publication. The RUHs rising acuity of patients, more therapeutic activity taking place overnight and the impact of more geographically spread clinical areas has increased the pressure on the staffing resource both day and night. Therefore, a ratio of 1:7 is now deemed appropriate to ensure staffing levels are within safe limits. The review has calculated the establishments to meet a 1:7 ratio throughout the 24-hour period (Appendix 2).

Registered Nurse to unregistered Nursing staff ratios

The Royal College of Nursing (2006) recommended establishment composition is 65% registered nurse and 35% unregistered care staff for general inpatient wards. For this review 65/35% has been applied where appropriate and is described in Appendix 2. Work undertaken as part of this review includes closer alignment to achieve the 65/35% split or that described as best practice guidance as per specialty.

Six wards are above a 70:30 ratio reflecting the increased complexity of specialties where the intensity of the patient needs requires a higher ratio of registered staff (Paediatrics, Oncology, Coronary care, ICU, Medical Assessment Unit and Surgical Assessment Unit).

Four wards are within an agreed 60:40 ratio (Cheselden, Ward 4, Pierce, and Philip Yeoman) This skill mix reflects the ward layout and the increased dependency of their patients requiring additional Health Care Support Worker workforce. This skill mix does not impact on the Registered nurse to patient ratios of no more than 1:7 remains for these areas. Focus will continue in reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes and are accompanied by appropriate quality impact assessment and evaluation

Registered Nurse to Nurse Associate ratio

The support of Nurse Associate (NA) roles continues to be part of a model of care forming part of the registered nurse ratio. As per Health Education England in response to the Shape of Caring Review (2015) the role helps build the capacity of the nursing workforce and the delivery of high-quality care. The role differs from Registered Nurses in several ways, namely registered with the NMC underpinned by the standards of proficiency for Nursing Associates the role can provide, monitor, and reassess care but cannot perform primary assessments and prescribe care. Nursing Associates can undertake relevant procedures having been assessed as competent, for example

the administration of medication. The Nursing Associate must be the fourth (or above) registrant on duty (consensus across BSW).

Ward Leadership roles

All wards have a supervisory senior sister/charge nurse role assigned, which is one of the key recommendations from the Francis report (2013) and is considered vital to maintain high quality care, address care concerns in a timely manner and support/supervise staff.

The ward coordinator role is excluded from providing direct patient care and is in place across all ward areas for a long day shift seven days a week.

The clinical leadership Band 6 sister/charge nurse role have fully established and funded 24/7 clinical leaders in; Paediatrics, William-Budd, OPAU, ASU, Cardiac, MAU, Respiratory, SAU, Pierce, CCU and Pulteney. In April 2024, the Improvement Program (IPSG) agreed to repurpose the Nursing workforce budget released from PY and DSU bed base transformation. The funding was therefore allocated to the remaining wards that do not have 24/7 clinical leaders (band 6) funded. The next steps are to ensure the recruitment is matched with a programme of leadership development and a knowledge skills framework.

Professional Judgement

Professional judgement is applied to the twice-yearly establishment reviews which includes; the ward purpose, ward geography and layout, patient acuity and dependency, any specialist care requirements which impact on the time taken to provide care i.e., Infection, Prevention and Control (IPC), any staffing standards required for specialist wards i.e., Acute Coronary Unit, Acute Stroke Unit, or any significant workforce learning acuity or significant events that warrant added seniority and specific skills.

Headroom

Headroom is the percentage financial uplift applied when calculating inpatient establishments from Band 3 HCSW shifts to the band 6 co-ordinator (as it excludes the supervisory sister/charge nurse post) this is to ensure there are sufficient staff. The Shelford Group recommends 22%, however the headroom at the RUH is 20%, this is on the low side, and 20% has been applied to all Nursing establishment reviews other than the Emergency Department (ED) and the Paediatric inpatient ward. The ED review includes a headroom of 27% (although a review of budgets in December 2024 indicates only 25% was added to the budgets, this is being verified) as recommended by the Royal College of Emergency Medicine and similarly the paediatric ward including the paediatric assessment unit includes a headroom of 25% as per the Royal College of Nursing. This enables staff to undertake the considerable levels of training and clinical supervision to ensure they possess the right knowledge and skills to deliver safe care.

Divisional specific emerging issues and considerations

The emerging issues and considerations impacting the safe staffing of Nursing and the quality of AHP services within the following Divisions:

Family and Specialist Services division:

- Increased Paediatric Mental Health admissions, acuity, and delayed discharge due to minimal community placements capacity to meet the demand.
- National shortage of Cancer trained Nurses to meet the national increased diagnosis, specifically chemotherapy trained and experienced Nurses for promotion to Clinical Nurse Specialists roles.
- National shortage of Paediatric trained Nurses impacting the considerable vacancies in the in-patient areas. A recruitment and retention plan are in place with a focus on apprenticeships and rotations to Paediatric Theatres and ED.
- Recruitment of Speech & Language Therapists – the Division are working on proposals as this is a difficult to recruit to area.

Medicine Division:

- High turnover of enhanced and advanced care practitioners in the Urgent Treatment Centre, resulting in an enhanced bank rate to maintain service delivery and patient safety. A recruitment and retention plan is in place specifically focusing on organisational development and culture as well as improved roster utilisation across both ED and UTC. The multi-professional workforce requires review which is anticipated to take place in February 2025.
- The Division will review the Therapy provision through Business Planning . Therapist team is
- The Emergency Department did not receive the year 2 investment initially agreed by the Board of Directors in 2022. The department is under sustained pressure; therefore the division has requested a review of multi-professional staffing which is due to be undertaken in February 2025.
- Haygarth ward is a gastro-intestinal ward and cares for people detoxicating from substances. The patients can present with challenging behaviours and high acuity, this establishment is being reviewed and will be addressed in future reports.

Surgery Division:

- High turnover of Operating Department practitioners (ODPs) in Theatres resulting in long-line agency to maintain service delivery and patient safety. A recruitment and retention plan are in place specifically focusing on organisational development, training as well as an establishment review including recovery.
- Within the Intensive Care Unit there is work to be done to ensure the AHP workforce is established and senior enough to meet the GPICS guidance, specifically for Occupational Therapists, Speech & Language Therapists and Dieticians.
- Pulteney ward receives high acuity surgical patients, many are stepped down from ICU. The Divisional Director of Nursing is reviewing establishment relating to the model of care.

Workforce Risks on the Risk register

The RUH currently has five approved risks on the risk register for Nursing and AHPs across three divisions. The highest risk (16, red) of UTC practitioner vacancies which has an action plan with a focus on a recruitment trajectory to be realised by September 2024. The other four risks are medium rated.

ID	Date Added	Directorate and Speciality	Description of the Risk	Current Risk Rating
2631	10/2023	FaSS Paediatrics	Inability to recruit adequate staff to safely run the Paediatric Assessment Unit 24/7 alongside high acuity patients at full capacity in High Dependency Unit.	9
2748	06/2024	Medical division Stroke	Lack of Occupational Therapists provision for Acute Stroke Unit to meet best practice (NICE NG236) due to sickness and vacancy.	12
2075	11/2020	Medical Division Emergency Department	Due to Urgent Treatment Practitioner vacancy patient outcomes and experience may be sub-optimal.	16
2290	02/2022	Medical division Emergency Department	There is a risk that due to staff not receiving appropriate training in the Emergency Department as per national recommendations (RCN/RCEM) patients may experience delays in treatment.	9
2725	04/2024	Medical Division Physiotherapy	Insufficient numbers of qualified physiotherapists with respiratory skills to provide on-call out of hours emergency cover.	12
2473	02/2023	Surgical Division Theatres	There is a risk that due to theatre staff vacancy that operations may be cancelled, and patients may experience delays in treatment.	12

Table 4: RUH Nursing and AHP workforce risks

Trust-wide Nursing and AHP considerations

Increase in Demand, Complexity, and Acuity of Patients with Mental Health and Enhanced Care Needs

Trust-wide, there has been an increase in patient complexity, particularly concerning mental health and learning needs, with more acute crises and high-risk behaviours. Prolonged hospital stays while awaiting community placements are common. Child health has seen a rise in teenagers and young adults needing mental health support, with episodes of violence and aggression requiring additional staffing and training.

A mental health matrix for escalating care needs is used daily, and a local staff pool, showing improvements in managing these patients and reducing reliance on agency support. However, patient numbers remain unpredictable and are managed in real-time during staffing meetings. Recruitment for the enhanced care team is ongoing.

Equality, Diversity, and Inclusion

Research highlights the persistence of discrimination and racism affecting patient outcomes (Marmot, 2005). Racism towards NHS staff harms individuals and compromises patient care quality. Addressing racism and fostering an inclusive work environment is essential for staff well-being and optimal patient outcomes. The Workforce Race Equality Standard (WRES) consistently reports disparities in the experiences of BAME staff compared to white staff, particularly in career progression and discrimination.

In the 2023 RUH WRES data, 19% of Black, Asian and Minority Ethnic (BME) colleagues reported experiencing discrimination at work, compared to 6% of white staff. This rise correlates with a 7% increase in the representation of Black and Minority Ethnic staff within the Trust. To create an

inclusive environment, RUH has implemented actions such as an active Diversity and Inclusion Steering Committee (DISCo), the Developing Aspirant Leaders Programme (Nursing DALS), Route to Success, and the FUSION staff network. Additionally, Cultural Ambassadors and focused support from Professional Nurse Advocates (PNA) and Clinical Practice Facilitators (CPF) enhance the hospital's commitment to equality and diversity.

Global Majority Representation as a % of total Global Majority AfC staff as of June 2024.		
Band	Organisation Overall	Nursing and Midwifery Registered
Band 2	21.9%	Na
Band 3	20.5%	Na
Band 4	9.0%	Na
Band 5	55.7%	67.7%
Band 6	17.9%	23.0%
Band 7	11.0%	7.2%
Band 8a	6.1%	4.6%
Band 8b	8.2%	0
Band 8c	3.7%	0
Band 8d	5.0%	0
Band 9	10.5%	0

Table 6: RUHs global majority representation as a percentage of AfC staff

This data shows that Band 5 has the highest representation of Global Majority staff, with 55.7% overall and 67.7% in Nursing and Midwifery Registered roles. In contrast, higher bands such as Band 8 and 9 have significantly lower representation, indicating a need for improved career progression opportunities for Global Majority staff.

Increased junior workforce and learning acuity

Establishments must account for the time clinical staff need for mandatory training, professional development, revalidation, teaching, mentorship, and supervisory roles, including supporting students and apprenticeships, with a national workforce target of 30% (NHSE). Inpatient areas have a 20% headroom allowance, with study leave funded at 1.5% unavailability. However, the increased number of learners and focus on staff well-being limit supervisory support, especially in non-ward-based areas where headroom is 0% for both nurses and AHPs. The existing headroom is insufficient, and Student Nurse Associates receive only 20% protected for their learning time in placement.

High learning acuity impacts service delivery and staff morale. Weekly one-hour meetings are necessary for practice educators and students. When defining the nursing and AHP workforce, time for practice development, including clinical supervision, assessment, teaching, CPD, mandatory training, revalidation, and lifelong learning, must be considered.

Ward Leaders highlighted supervision challenges with the increasing range of learners, particularly with a junior workforce. New NMC national guidance (2022), implemented in 2023, added preceptorship requirements for all newly registered staff. Robust retention and recruitment strategies

aim to ‘grow our own’ nurses, supporting a diverse range of learners, including T-level and undergraduate students, student nursing associates, nurse degree apprentices, Return to Practice students, newly qualified staff, and overseas nurses awaiting registration.

Education teams have been key in training overseas nurses to full registration. Clinical Practice Facilitators now focus on the wider Nursing workforce, supporting clinical skills, supervising learners, and participating in incident learning. The priority is ensuring 24/7 Band 6 senior leadership in inpatient areas, with funding from the original Nursing budgets supporting this development programme

Priorities for 2024/2025

Zero Vacancies Ambition: Continue working towards zero vacancies across the nursing workforce with a healthy talent pool waiting to join the Trust. Expand the 'grow our own' pipeline of Nursing and AHP staff by increasing T-level placements, pre-registration placements, cadets, and apprenticeships, whilst balancing the learning acuity in the clinical areas. Strengthen relationships with local and regional Higher Education Institutes to develop the future workforce.

Equity and Discrimination: Increase equity and reduce discrimination for staff from a global majority. This includes continuing the development of staff through leadership training and tackling racism directly.

Board Reporting: Strengthen Board reporting by publishing monthly Nursing and Midwifery staffing levels to adhere to Developing Workforce Safeguards (2018).

Training and Skill-mixing: Train the workforce and grow specialist teams to meet the enhanced care and mental health care needs of patients. Review the skill-mixing of areas with higher incidence of mental health care needs; specifically, the paediatric inpatient ward.

NHS Workforce Plan Focus: Expand the focus by emphasising training, retaining, and reforming. Raise the platform and career development opportunities in genomics, research, and digital.

Establishment Review Process: Continue to develop the establishment review process and expand into the Theatres department. Apply the new SNCT for emergency medicine in the RUH ED department and the new SNCT for assessment areas for MAU, SAU, and OPAU. Use these reviews to inform safer staffing and provide Board assurance.

Cross-System Working: Work with system colleagues to identify and undertake workforce focussed cross-system working opportunities.

Good Rostering Practice: Embed good rostering practice across both Nursing and AHP, demonstrated through Roster Key Performance Indicators and a reduction in the reliance on temporary workforce and bank spend.

Eliminate High-Cost Agency Use: Continue working with BSW and Bristol, North Somerset, and South Gloucestershire (BNSSG) colleagues to eliminate the use of high-cost agencies.

Enhanced and Advanced Clinical Practice: Strengthen and standardise enhanced and advanced clinical practice within the RUH for both Nursing and AHPs.

AHP Leadership: Continue to raise the platform of all AHP roles within the RUH and further create and develop expert and leadership roles. Support AHP workforce establishments with the underpinning recommendations, such as SNAP for stroke, SPRINT for physiotherapists, and GPICS for Intensive care.

Recommendations to the Board

- Discuss the report at Trust Board as an ongoing requirement of the National Quality Board and developing workforce safeguards guidance around safe staffing assurance.

- Note the findings of this annual ward establishments review and the Trust's position in relation to adherence to the monitored metrics on nurse staffing levels.

- Recognise the ongoing improvements in RUH compliance with the guidance from the National Quality Board on safe, sustainable, and productive staffing.

- Continue the ongoing advancements in RUH compliance with the NICE guidelines on safe staffing for nursing in inpatient wards.

- Acknowledge the ongoing multiple risks and challenges, including the enhanced care needs of patients, high learning acuity of staff, high sickness rates, and vacancies in specialist areas impacting service provision.

- Support the continued Trust-wide commitment and momentum on actions to fill vacancies and further reduce reliance on high-cost agency and bank staff, against the backdrop of rising acuity and emergencies, and elective recovery.

- To conduct systematic ward staffing reviews to be reported to the Board annually, with six-monthly 'light touch' reviews reported through Divisional Boards.

Conclusion

The establishment review has identified the need for no further investment at this time in Nursing establishments for inpatient wards, paediatrics, and the Emergency Department. The nursing and AHP workforce require continued significant focus to improve staff experience, reduction in temporary staffing, and training a workforce that meets the patient's personalised, complex, and high acuity care needs.

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Appendix 1: National Quality Board Expectations for safe staffing - Safe, Sustainable, and productive staffing (July 2016)

Expectation 1: Right staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e., the use of evidence-based tools, professional judgement, and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.
Expectation 2: Right skills	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multi professional team approach.

	Decisions about staffing should be based on delivering safe, sustainable, and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.
Expectation 3: Right place and time	Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

											Planned CHPPD is calculated based on the type and number of shifts set up in the Template and number of the beds in the ward				Actual Demand CHPPD is calculated based on the Type and numbers of the patients in the ward	Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of the patients the ward had ad midnight
					Budgeted Establishment			Staffing Numbers			Planned on Template (long day factor applied)				Actual Demand average in June 2024 (in Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at Midnight)
Division	**Unit Name**	**Shift**	**Bedbase**	**Total with escalation beds/trolley /chairs**	**Budgeted Total Nursing Workforce (WTE)**	**Budgeted Registered Staff (WTE)**	**Budgeted Unregistered Staff (WTE)**	**Skill Mix (RN:URN)**	**Patient to RN Ratio (RN: Patient)**	**PNA**	**Planned Registred (CHPPD)**	**Planned Unregistred (CHPPD)**	**Total Planned CHPPD**	**Safe Care**	**Total Actual Demand CHPPD**	**Total Actual CHPPD**
FaSS	Paediatric Inpatient Nursing Team 24340	Day	33	33	76.9	65	11.9	84:16	N/A	1	8.2	1.5	9.7	8.2	8.2	14.9
		Night								0						
	William Budd Ward 10420	Day	22	22	48.48	37.73	10.75	77:23	1:4	1	6.9	2.1	8.9	11.5	11.5	6.6
		Night								0						
Medicine	Emergency Medicine 11850	Long Day	71	71	191.28	153.49	37.79	N/A	N/A	0					N/A	
		Night								0						
	Acute Stroke Unit 24141	Day	30	30	61.26	42.78	18.48	69:31	1:4	0	5.7	2.5	8.2	7.7	7.66	8.5
		Night								0						
	Cardiology Ward 24041	Day	36	36	54.17	35.35	18.82	64:36	1:6	1	4.0	2.2	6.2	5.4	5.38	5.8
		Night								0						
	Cheselden Ward 10485	Day	16	22	34.71	20.6	14.11	58:42	1:7	0	3.8	2.7	6.5	8.3	8.29	5.8
		Night								0						
	Combe Ward 10210	Day	26	26	40.21	26.1	14.11	64:36	1:7	1	4.1	2.3	6.4	5.9	5.93	6.1
		Night								0						
	Coronary Care Unit 24042	Day	8	8	23.85	17.8	6.05	74:26	1:3	0	8.9	3.3	12.2	12.3	12.3	13.6
		Night								1						
	Haygarth Ward 10670	Day	24	25	39.42	25.98	13.44	65:35	1:6	0	4.4	2.4	6.8	5.6	5.58	7
		Night								0						
	Helena Ward 10270	Day	18	19	31.35	19.93	11.42	62:38	1:6	0	4.4	2.7	7.1	6.9	6.85	7.1
		Night								0						
	Medical Assessment Unit (MAU) 10650 (24 beds/ 14 Trollies)	Day	38	38	65.38	46.66	18.72	71:29	1:5	0	5.0	2.5	7.5	6.8	6.78	12.2
		Night								0						
	Medical Short Stay 10365	Day	18	22	25.97	17.91	8.06	68:32	1:6	0	3.9	1.9	5.8	5.1	5.13	6.2
		Night								0						
	Older Persons Assessment Unit (OPAU) 10370	Early	27	27	50.84	33.03	17.81	64:36	1:5	0	5.4	2.9	8.3	8.1	8.14	11.5
		Late								0						
		Night								0						
	Older Persons Unit Short Stay (OPUSS) 10230	Day	27	27	42.13	26	16.13	65:35	1:7	1	4.2	2.6	6.8	6.0	5.99	5.8
		Night								0						
	Parry Ward 10430	Day	28	28	39.42	25.98	13.44	65:35	1:7	0	3.8	2.0	5.8	5.3	5.34	6.2
		Night								0						
	Respiratory Ward 10390	Day	31	31	66.97	44.79	22.18	66:34	1:4	1	5.6	2.8	8.4	7.7	7.74	7.9
		Night								0						
	Ward 4 - RUH at St Martins 19843	Day	20	23	35.87	18.06	17.81	57:43	1:7	0	4.1	3.9	8.0	7.5	7.46	7.6
		Night								0						
	Waterhouse Ward 10220	Day	24	24	40.11	26	14.11	64:36	1:6	1	4.4	2.5	6.9	6.4	6.4	6
		Night								0						
Surgery	Charlotte Ward 11550	Day	22	22	30.68	19.93	10.75	64:36	1:7	0	3.6	2.1	5.7	5.5	5.48	5.8
		Night								0						
	Day Surgery Unit 24081 - Trollies	Day	38	38	30.26	20.35	13.62	67:33	1:5	0	2.4	1.6	3.5	5.7	5.67	
	Forrester Brown Ward 10950	Day	24	24	44.79	28.66	16.13	63:37	1:5	1	4.1	3.4	7.5	5.5	5.45	7.4
		Night								0						
	Intensive Care Unit 12400	Day	13	13	103.87	86.96	16.91	93:7	N/A	3					N/A	
		Night								0						
	Philip Yeoman Ward 10940	Day	12	12	18.23	10.5	7.73	58:42	1:6	0	3.8	2.8	6.7	4.0	3.99	11.2
		Night								0						
	Pierce Ward 11020	Day	28	28	47.48	27.99	19.49	58:42	1:6	0	4.1	3.4	7.4	7.2	7.21	7.4
		Night								0						
	Pulteney Ward 10661	Day	30	30	50.17	31.35	18.82	62:38	1:6	1	4.3	2.6	6.9	6.6	6.58	7.3
		Night								0						
	Robin Smith Ward 10666	Day	28	28	40.28	25.5	14.78	62:£8	1:7	1	3.7	2.4	6.1	5.7	5.73	6.6
		Night								0						
	Surgical Assessment Unit (SAU) 10665 (16 beds 11 trollies)	Early	27	28	37.73	26.98	10.75	71:29	1:5	0	4.4	1.7	6.1	5.9	5.88	7.7
		Late								0						

Appendix 3: National Quality Board recommendations, self-assessment

Royal United Hospitals Bath NHS Foundation Trust

Supporting NHS Providers to deliver the right staff with the right skills, in the right place at the right time - safe sustainable and productive staffing – Nursing and Midwifery

37 recommendations: 19 are compliant and complete, 18 require further action which will be monitored monthly through the Nursing, Allied Health Professional and Midwifery Workforce Committee.

Expectation	Descriptor	No.	Recommendation	Current measures in place	RUH Assessment	Identified actions required	Timescale	Lead
		1.1 Evidence-based workforce planning						
1: Right staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement, and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This	1.1.1	The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource	Triangulated approach to staffing establishments well embedded. Shelford SNCT used. Embedded 'safecare' as part of eRostering. Emergency Department workforce RCEM/RCN standards implemented. Royal college/ national guidance utilised to support workforce planning.	**Action Required**	Introduce assessment area SNCT; MAU, SAU, OPAU	10/24	SA
		1.1.2	The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.	All tools used as recommended.	**Complete**	Monitor the impact on the inclusion of 'enhanced care' scoring.	NA	
		1.1.3	Workforce plans contain sufficient provision for planned and unplanned leave, e.g. sickness, parental leave, annual leave, training, and supervision requirements.	20% included in all direct care in-patient areas. Compliance monitored as part of Healthroster reporting suite.	**Action Required**	Move monitoring from ESR to healthroster reporting to aid prompt oversight and action. Create monthly divisional healthroster KPI meeting. Review headroom for inpatient and non-ward-based areas.	05/25	SA

	should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard	**1.2 Professional judgement**						
		1.2.1	Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.	6 monthly staffing reviews include face to face meetings with Corporate Nursing Team/Divisional Directors of Nursing/Matron/Senior Sister/Charge Nurses as well as workforce systems and finance. Professional judgement key part of the reviews	**Complete**		NA	
		1.2.2	Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency, and activity	As above. Professional judgement also used as part of the twice daily staffing review meetings.	**Action Required**	Revision of safe staffing SOP to include clear guidance and process of documented professional judgement.	11/24	SA
		1.3 Compare staffing with peers						
		1.3.1	The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.	Previous benchmarking included through establishment reviews and targeted at specific services under development. Need to strengthen and formalise	**Action Required**	Build on the current benchmarking capabilities included in the Model Hospital. Work with eRoster team to introduce reporting that includes benchmarking data across BSW.	03/25	SA
		1.3.2	The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (e.g. length of stay, occupancy rates, caseload), patient movement (admissions, discharges, and transfers),	All considered as part of the systematic staffing reviews	**Action Required**	Strengthen the use of this data as part of the staffing review process	01/25	SA

	Expectation 1: Right staff Contract		ward design, and patient acuity and dependency.					
		1.3.3	The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: e.g. for acute inpatients, the model hospital dashboard will include CHPPD.	Integrated performance report includes all staffing and quality metrics.	**Complete**		NA	
		2.1 Mandatory training, development, and education						
2: Right Skills	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver	2.1.1	Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.	Senior Sister/Charge Nurse leadership education programme including workforce training.	**Action Required**	Roll-out Band 6 sister/charge Nurse training to maintain competence, skills and knowledge through education sessions and staffing/ establishment review meetings. Introduction of Band 6 Leadership and development programme to include workforce education.	09/25	SA
		2.1.2	Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship, and supervision roles, including the support of preregistration and undergraduate students.	20% headroom allowance and provision of supervisory Senior Sister/Charge Nurse. Funded allocation for study leave is 1.5%l Introduction of revised Clinical Practice Facilitator (CPF) model for all areas to support in areas training and supervision. Nursing and AHP learner dashboard to monitor learner numbers.	**Action Required**	Further scope the learners in all areas and across all programmes, and the time required to supervise. Review the number of assessors within departments to match demand. Review headroom for inpatient and non-ward-based areas Monitor impact of new CPF structure.	05/25	SA

	high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable, and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.							
		2.1.3	Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.	All expectations clearly included in JD and annual objectives for line managers	**Complete**	Monitored as part of ongoing HR key performance metrics	NA	
		2.1.4	The organisation analyses training needs and uses this analysis to help identify, build, and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.	Mandatory and essential training analysis in place per role.	**Action Required**	Review of current department training needs analysis baseline Implementation of training needs analysis for departments and align to CPD arrangements.	07/25	
		2.1.5	The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including selfcare, wellbeing and an ethos of patients as partners in their care.	Comprehensive training programmes in place to equip staff with required Skills.	**Action required**	Monitored through ongoing Evaluation and co-production groups.	02/25	SA
		2.1.6	The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary	Comprehensive training programmes in place to equip staff with required Skills.	**Action required**	Review of mandatory and essential trainings subjects with subject matter experts.	01/25	SA

			education and training to support changes in models of care.					
		2.1.7	The organisation recognises that delivery of high-quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads, and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.	100% Supervisory ward leader time established in all inpatient direct care areas.	**Action Required**	Continue to review % of time achieved as supervisory. Review of previous clinical leadership programme and ongoing training. Consider KPI review of supervisory %.	11/24	SA
		2.2 Working as a multiprofessional team						
		2.2.1	The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.	Range of new roles developed to meet service needs have been implemented within divisional workforce and patient pathways. Successful nurse associate and registered nurse apprenticeship pathways and roles. Introduction of enhanced care team.	**Action Required**	Implement an enhanced practice oversight group Establishment reviews to evaluate nurse associate workforce and align this to skill mix and patient pathways consistently.	02/25	SA

		2.2.2	The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports Improvements in quality and productivity, as shown in the literature	Multiprofessional approach to all aspects of workforce development and training delivered within an integrated Training, Development and Workforce department	**Action Required**	Continue with current approach and strengthen integration. Appoint AHP workforce lead. Develop a Retention Nurse Lead Role.	11/24	SA
		2.2.3	The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.	Strong record of working with other providers both in provider and HEI/FE sector. Continue with current approach and strengthen partnership working with local colleges to maximise T-levels and apprenticeships.	**Complete**		NA	
		2.3 Recruitment and retention						
		2.3.1	Leadership that closely resembles the communities it	RUH plan to address equality and diversity within trust linked to	**Action Required**	Detailed in separate ED&I action	09/25	SA

			serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.	WRES data Supporting equity – DALS and Routes to success programme.		plan. Ensuring any N&M specific actions are also incorporated into the retention toolkit and action plan Band 6 leadership programme.		
		2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Retention and recruitment of Paediatrics and Theatres established maintains the Focus. Continue to monitor monthly.	**Complete**		NA	
		2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention, and career development	Generational work starting to be incorporated into projects for retention and recruitment and specifically, around preceptorship.	**Action Required**	Adverts to focus on generational cohort. Young cancer Nurses. Truly understand needs and how to adapt.	11/24	SA
		3.1 Productive working and eliminating waste						
3: Right Place		3.1.1	The organisation uses 'lean' working principles, such as the as a way of eliminating waste.	Transformation work is underpinned by the 'improving together methodology.' The techniques applied as	**Complete**		NA	

and Time				appropriate including reviews of care hours, SNCT, Quality metrics, and model hospital productivity data.				
	Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board if concerns arise. Directors of nursing, Directors of operations, Directors of finance and Directors of workforce should take a collective	3.1.2	The organisation designs pathways to optimise patient flow and improve outcomes and efficiency e.g. by reducing queuing.	Incorporated in service Redesign. SDECS, fit-to-sit area, DAA, the discharge lounge, and H@H.	**Complete**		NA	
		3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.	Staff are employed to be fully flexible (skills and competence allowing). Continued review as part of daily staffing meetings to maximise flexibility of staff	**Complete**		NA	
		3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.	Staff are employed to be fully flexible (skills and competence allowing). The workforce and quality meetings review productivity. The enhanced care team addressed the areas for further skills.	**Complete**		NA	
		3.1.5	The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.	Included as part of methodology of reviews of staffing. Direct care time monitored. Other roles utilised to maximise direct	**Complete**		NA	

	leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.			Care. Assurance through SafeCare.				
		3.1.6	Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.	Clear escalation processes in place and risk register, daily staffing meeting. PSIRF roll-out will inform the new way to review and learn from any staffing issues. Monthly divisional dashboard support governance to the board.	**Complete**		NA	
		3.2 Efficient deployment and flexibility						
		3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	Involvement of clinical leaders at all levels in setting establishment levels and rostering workforce. This is systematically reviewed through 6 monthly staffing reviews reported to board	**Complete**		NA	
		3.2.2	Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.	Clinical speciality, acuity, dependency and pathways included as part of the systematic review of staffing Levels. Where the skill falls out of an area- the Enhanced care team has been created.	**Complete**		NA	
		3.2.3	Throughout the day, clinical and managerial leaders compare the	Twice daily reviews of staffing	**Complete**		NA	

			actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.	levels planned and actual undertaken at care group, Division and trust wide level through daily staffing meetings linked to site.				
		3.2.4	Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective, and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.	Escalation policies in place into site for unresolved staffing issues. Temporary staffing escalation in place and resource shared Trust-wide when required	**Action Required**	Finalise the Safe staffing SOP with the newly recruited Enhanced care team.	01/25	SA
		3.2.5	Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers and the Carter Review Rostering Good Practice Guidance (2016).	Use of eRoster systematically reviewed and managed through the management team structure. Divisional monthly roster reviews. KPIs reviewed at the monthly workforce committee. Roster policy is being published by HR.	**Complete**		NA	
		3.3 Efficient employment, minimising agency use						
		3.3.1	The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and	Currently undertake 6 monthly staffing reviews that take account of all the recommendations. Staffing reviews closely aligned to the	**Complete**		NA	

			temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.	Retention & Recruitment and temporary staffing strategies and clear actions in place to maximise bank use and reduce agency A programme of work NAMIP provide assurance of 10 active drivers to create efficiencies for bank and agency usage.				
		3.3.2	The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.	Plan in place to reduce agency usage in line with NHSI guidance	**Action Required**	NAMIP plan: Paediatrics and Theatres. Only in exceptional circumstances do we escalate for agency RMN. There is a reduction plan for all three.	04/25	SA
		3.3.3	The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population.	The Nursing workforce teams is very much engaged in the business cycle and local process provided. The sustainability focus is on addressing appropriate headroom and standardised Job plans.	**Complete**		NA	
		3.3.4	The organisation works closely with commissioners and with Health Education England, and submits the workforce plans, using the defined process, to inform supply and demand modelling.	RUH is fully engaged in development of Workforce planning aspects and matching the establishments to commissioned work.	**Complete**		NA	

		3.3.5	The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable, and productive services.	Strong systems in place to identifying placement capacity and monitor student allocation and quality across all staff groups. The NETS survey is monitored with an action plan is in place.	**Complete**		NA	

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**14**
Date of Meeting:	**15 January 2025**		
Title of Report:	**Alert, Advise and Assure Report – People Committee**		
Status:	**For discussion**		
Author:	**Paul Fairhurst, Chair of the People Committee**		

Key Discussion Points and Matters to be escalated from the meeting held on 21 November 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: the People Committee continues to scrutinise plans, programmes and risks related to the target to deliver £19.4m pay cost savings and a reduction of 388 whole time equivalents (WTE).

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

- **New People Plan (ongoing monitoring):** the revised plan will be presented to the January People Committee before submission to March Board.
- **People Directorate Fit for Purpose (ongoing monitoring):** The Committee received further reassurance: new monthly Q&A sessions are in place to help embed a "listen, learn, act" model and are well attended; a short survey is being conducted each month. Upward reports from the new People Performance Review Meeting (PRM) and the people directorate scorecard will be presented to the People Committee from January 2025.
- **People Plan/ Basics Matter (ongoing monitoring):** The Committee received exception reports in relation to some of the eleven elements of the People Plan including (amongst others)
    - Sickness absence: levels are notably high in Cleaning. The Committee was reassured that management of sickness is improving since the appointment of the Cleaning Manager and Matron
    - Pay Gap: the Committee noted that gaps appear to be increasing for female and global majority staff. Future People Plan Dashboards will incorporate pay gap data, including intersectionality data.
    - Appraisal compliance: prior progress seems to have stalled. The Committee was reassured that this is a matter of ongoing focus at PRMs
- **Staff Networks: perspectives of a Network Chair (Staff Story) (ongoing monitoring):** The Enable Network Chair presented on the Network's achievements and challenges. Achievements include (amongst other things) an increase in/ relocation of disabled car parking bays and improved communications regarding bay closures; support for delivery of Oliver McGowan training; and growing Network credibility including through Executive Engagement Sessions. Challenges include lack of budget for network events; time pressures for Network Chairs to do the work; maintaining member engagement in the face of operational pressures; and the need for better training regarding reasonable adjustments and Equality Impact Assessments. Plans for 2025 include seeking funding for activities; increasing Network awareness with support from Comms; work on reasonable adjustments; and supporting the accessibility audit. The Committee noted that some disabled staff felt that "every day is a battle" and recognised that the Trust should aim to be more proactive in addressing the challenges.

- **Breakthrough objective – reducing discrimination (ongoing monitoring)**: The Committee welcomed commitments made at the meeting, including to seek to free up Network Chair time; to find dedicated funding within the People budget; to ensure that action is taken in response to the accessibility audit; to ensure that reasonable adjustments are approved; and to adapt the new policy on Working with Cancer and extend it to colleagues with other long term conditions. The Committee agreed that an update should be provided at every future meeting.
- **Staff Survey**: a final response rate of around 55% is anticipated. Anecdotal feedback is of staff negativity due to operational pressures and the change to paid breaks. This year the survey was 100% digital which may have had an impact.

ASSURE: Inform the board where positive assurance has been achieved

- **Occupational Health (OH) support (Staff Story):** The Associate Chief Nurse for Workforce and Education shared his experience of the OH department following surgery. He referred proactively though his line manager, as he was aware of OH wait times. He reported positively on a personalised and patient centred process, and highlighted pre- appointment communication, simple check-in processes, discussions regarding workplace adjustments and planning for a phased, safe return. He pointed out that it would help to have dedicated parking outside OH and the importance of line managers recognising service wait times. The Committee discussed the need to upskill managers to make referrals earlier; the challenges of unattended appointments; and days lost due to delayed appointments. The Committee will schedule a deep dive review of sickness absence.
- **Halo:** the new digital system (AI enabled) has three elements (1) case management, which is now live but being refined; (2) self-service, which will enable users to open their own tickets; and (3) workforce approvals/ Vacancy Review Panel (VCARP), which will replace the manual/ spreadsheet based approach and reduce administration.
- **Restorative Just and Learning Culture (RJC) programme**: the Committee was advised that resource has been allocated to move this forward.
- **Multiprofessional Education Quarterly Review**: the Committee reviewed the annual quality NHS England review for placement providers, focussing on challenges, achievements and educational funding. The Committee noted areas for celebration including the award-winning preceptorship programme and improvements to simulation training and clinical skills; challenges including quality of accommodation and time and space to train; and issues arising including rates of mental health concerns in learners and an increase in neurodiverse learners. The time to accommodate reasonable adjustments around digital is a challenge and will be a key area of the new People Plan. The report referenced **sexual safety in the workplace** and it was agreed that a report will be presented to the January Committee.

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

No new risks identified

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

- Decrease in leavers inside the first year. This positive progress is reflective of the new joiner experience.

• An unofficial visit by NHS England recognised the Trust as positive outliers in improvements on workplace violence and people reporting less discrimination.
APPROVALS: Decisions and Approvals made by the Committee
None

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**15 January 2025**		

Title of Report:	**You Matter Strategy Quarterly Update Q3 2024/25**
Status:	**For information**
Board Sponsor:	**Joss Foster, Chief Strategic Officer**
Author:	**Fi Abbey, Head of Strategic Projects**
Appendices	**None**

1. Executive Summary of the Report

This paper sets out progress made in quarter 3 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, reasonable progress continues to be made towards delivery of the strategy in quarter 3 against a context of significant external change including National ambitions for the NHS and our move to a more aligned Group model locally:

- Work is underway to understand and address the top contributors to longer lengths of stay, and improvements have been made to improve processes relating to flow, discharge and urgent and emergency care
- The 2024 staff survey has now concluded, with outputs due in Q4
- Improvement programme savings continue to grow with continued work to identify further opportunities to deliver efficiencies
- The number of frontline teams running improvement huddles has increased by a 26% since Q2, showing progress in the Trust's Improving Together maturity as per the enabling breakthrough goal, "We Improve Together to make a difference"

Consideration of contextual changes, requirement for alignment and various drivers of capacity constraint particularly going into winter, has brought challenges in the balance of strategic and operation delivery. This has necessitated some rescheduling/delay of strategic work which is reflected within the report.

The Board has time on the agenda to review the emergent risks, context and considerations for each people group in more detail, as well as assessing current performance against our goals to inform the strategic planning process for next year. The previous classification system has been updated from previous reports to demonstrate more clearly where plans have been either delivered (blue), are on track as per original schedule (green), or off track/delayed (red).

2.	Recommendations (Note, Approve, Discuss)
Board 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. A new ten year health plan has been indicated for release by the Government in Spring as a result of Lord Darzi's report into the NHS. 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.	

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

Priorities are indicated as delivered, on track, or off track. Where relevant, key risks to future delivery have also been outlined.

Significant context during Q3 include:

- **Lord Darzi report** – published in September, the report highlights the major challenges the NHS currently faces and identifies themes expected within the new governments ten year health plan including shifting care closer to home, improving productivity, and unleashing potential of AI.
- **Financial balance** – Medium term financial planning to deliver system-wide recovery programme
- **Group model** – Establishment of a collaborative group operating model between Great Western Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust and Royal United Hospitals NHS Foundation Trust including Joint Chief Executive and a shared Chair. Transformation and change management will be required to ensure that benefits from the case for collaboration will be realised.

5.	Resources Implications (Financial / staffing)
Scale of ongoing transformation has significant capacity implications to deliver at pace. Resource implications linked with delivery of the savings plan for 2024/25 have been mapped and are reviewed through weekly performance discussions by the Executive Team.	

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.

Key EDI related progress for Q3:

- A multidisciplinary working group for reasonable adjustments has been set up as a significant milestone against our breakthrough objective to address discrimination of our workforce with disabilities.
- To support our global majority colleagues to plan and make the UK their home we're offering workshops to provide legal advice on the ILR application and access to a hardship fund
- Our smoking cessation team, part of Health Inequalities Programme, now covers 40% of wards

Risks

- Continuity of Health Inequalities funding past March 2025 remains under consideration.
- Workplace Adjustments: Skills, process and cultural gaps around reasonable adjustments have been identified by the working group which now need to be rapidly addressed.

7. References to previous reports/Next steps

Updates 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

Key sustainability related progress for Q3:

- Sustainability Steering Group to be mobilised
- Green Team Competition underway - teams are writing up and submitting reports ahead of February online Showcase and Awards event
- Climate Change Adaptation Plan & Risk Assessment - a joint AHA project started in December; drafts in development
- RUH Sustainability Day- planning underway, event planned for April 2025
- Heat decarbonisation- social value working group in place, scoping opportunities

Risks:

- Heat decarbonisation**:** Funding opportunities for the £3M Trust contribution to the Heat Decarbonisation Project have been pursued, however, it remains

likely that the Trust will need to commit this from the internal Trust CDEL allocation next year
- RUH Green Plan development: national greener NHS guidance delayed. Green Plan approach proposed to Board in interim.

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.

RUH, SFT and GWH digital leads are working together to progress the adoption and roll out of Artificial Intelligence (AI) technologies.

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 10% 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**
- **Improving Access to Workplace Adjustments**
- **Leadership and Management Framework (and development offer)**
- **Building Change Readiness and Change Management Capability**
- **Restorative, Just and Learning Culture**
- **Violence Prevention and Reduction (VPR) Programme**

- **Health Inequalities Programme**
- **Community Services Tender**
- **Heat Decarbonisation**
- **Financial Improvement Programme** – Clinical productivity, Pay Bill, Income and cost controls
- **Single Electronic Patient Record (EPR)**

Strategic Planning for 2025/26

- Joint Board of Directors and Council of Governors Development Session held on 3rd December 2024
- A full report from the day will be shared with Council of Governors and Board of Directors, a brief summary of discussions is below:

Draft strategic A3s shared:

•**The people we care for** – Cancer
•**The people we care for** – Patient Safety
•**The people we work with**
•**The people in our community** – Finance

Key projects discussed:

•Health Inequalities
•Anchor Organisation
•Improving Together
•Reducing Discrimination

Themes from discussions:

Productivity- balancing productivity with quality and safety, enablers for increasing productivity (e.g. financial flows, Artificial Intelligence)
Now vs future- strategic planning in the context of future changes in how care is delivered, how much should we focus on in-year change vs longer term planning
Group model- opportunities to deliver strategic plans at scale, benefits of working as a Group, sharing learning
Culture change- what culture change is required to enable us to deliver improvement e.g. an open culture that encourages discussions about patient harm
Leadership- including frontline and clinical leadership as key enabler
Change management- supporting readiness for change

- Strategic A3s for 2025/26 are drafted and in final stages of review; outputs from development day to be incorporated

The people we care for

2024/25 deliverables – breakthrough objectives

2024/25 progress (Q3)

Strategic Risks (Board Assurance Framework)

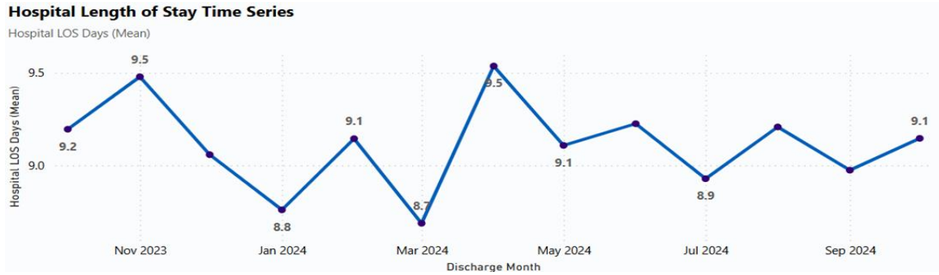
- 1.1 Not meeting internally and externally set standards of quality and safety may result in harm to patients and/or experience below expected – current score 15
- 1.2 Increasing demand for both emergency and planned care is exceeding our capacity to treat patients promptly, leading to longer wait times for procedures. This could negatively impact patient outcomes and satisfaction. Current score 16

Emergent risks/context/considerations

- Lord Darzi rapid review findings and impact of resultant 10-year Government plan for the NHS
- Opportunities and implications of community services procurement to be mobilised in Q3/Q4
- Group model implications on corporate and clinical services
- GP sector disputes creating additional demands on secondary care services and potential for patient impacts
- Impact of Trust financial position and changes to staff payment rates impacting elective recovery
- Flu and winter pressures combining with financial pressure impacting on service access and quality

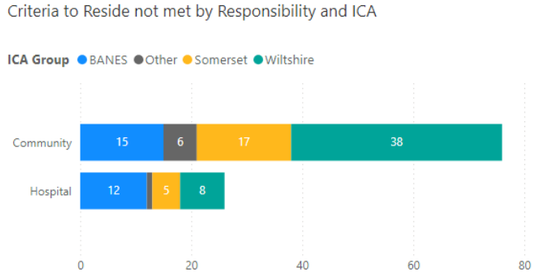
Why not home? Why not now?
Reducing inpatient length of stay top 10% of acute trusts

The RUH has the 13th best mean length of stay for non-elective, however some specialist wards have longer lengths of stay than their peers. Our ambition is to improve from being in the top quartile to the top decile for length of stay.



Work has been done to identify contributory factors to longer length of stay such as bed occupancy and management, local challenges on specialist wards and discharges. Improvements being made include:

- Development of standard work to support flow and discharges
- Putting processes in place to review and implement learning from previous day's discharges
- Improving patient transfers between wards, ensuring clear discharge plans are in place
- Plans for cardiology specifically to make LOS gains
- Learning from recent Critical Incident Response working collaboratively with community teams to support community discharges and reduce admissions



2024/25 deliverables – strategic objectives (please also see sunray on next slide)

Delivered

Quality

- **Quality governance**- Terms of Reference for oversight committees have been updated

LOS

- **Non Criteria to Reside (NCTR)** process mapping event in November to identify root causes for all pathway 0 delays
- **UEC Improvement** team are deploying all new UEC standard work and guidance to ward teams; 4 matron and ward manager events complete
- **Discharges-** 'discharge sprint' completed in October and November
- A3 specifically for cardiology complete to understand reasons driving longer LOS

Digital

- **Paperless inpatients-** in benefits realisation phase

Strategy

Updated clinical strategy delivered Q2; next steps to continued detailed planning for implementation

On track

Quality

- **Quality Governance** project- process mapping workshops held for all workstreams.
- **Website** project underway- new website being built and thorough review of content underway; due to be launched in Q1 2025/26

Clinical improvement and transformation

- **Outpatients transformation-** Explore and Action approach delivered across 17 specialties that will drive OP improvements realising patient, staff and financial benefits which will be mapped in January and delivered by the end of March 25
- Embedding Improving Together across surgery including theatres

Estates

- **Atrium improvements-** Phase 1 small works improvements underway, accessibility audit planned including signage improvements and decluttering
- **PAW fire improvement works** have commenced and are anticipated to continue into the next financial year
- **Sulis Elective Orthopaedic Centre** due to open in Q4
- **Acute Medicine SDEC and Gynaecology Emergency Assessment Room works** have commenced

Strategy

- **Clinical strategy** costed delivery plan in development

Off track

- **Single ICU** works progressing well, however completion delayed by snagging issues with the complex ventilation system - completion and opening are now planned for Q4.
- **Customer Care training-** awaiting further national guidance
- **Innovation Strategy and Communication Strategy** in progress, but will require alignment with Group planning
- **Infection control programme including estates plan –**requires funding to deliver
- **Improve signage to help people find their way around-** delayed due to capacity to take forward
- **UEC and elective performance to trajectory:** further A3 and transformation in development

2024-25

2025-26

The people we care for

Together, we will support you as and when you need us most

Connecting with you, helping you feel safe, cared about and always welcome

- Paperless Inpatients
- Atrium improvement
- Quality Governance
- Infection control programme including estates plan
- Publish patient experience strategy & vulnerable person strategy
- Improve signage to help people find their way around

- 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

- Dyson Cancer Centre & DAU completion
- Sulis Elective Orthopaedic Centre
- Critical infrastructure risk reduction (fire safety)
- One ICU

- Outpatient & theatre transformation
- Service integration with key community services
- Further development of CDC
- Elective productivity
- Urgent emergency care improvement

- Research strategy
- Innovation strategy

- Further development of DrDoctor
- New website
- Patient representatives on all relevant forums
- Customer care training & communication standards
- 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 (Q3)

Strategic Risks (Board Assurance Framework)

2.1 Without fostering a culture of inclusion and actively addressing possible managerial discrimination, we may hinder staff recruitment and retention, expose the Trust to financial and reputational damage, and undermine our ability to deliver the best possible patient care. Current score 16.

2.2 Without strong management and leadership development, including succession planning, we risk limiting our ability to transform and innovate, cultivate a positive culture and sustain improvements. This could negatively impact patient care, staff satisfaction, and workforce stability. Current score 20

Emergent risks/context/considerations

- NHS financial recovery 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.
- Increased controls and centralisation of approval of recruitment activity and changes to existing contracts increasing. Impacting on ability to adopt user-friendly processes and increased admin pressures across the Trust to deliver this.
- Increasing focus of work on change preparedness to ensure we can effectively adapt to the emerging context that we operate in.
- Resuscitation and clinical skills remains an organisational risk (2791 on risk register). Active work ongoing to skill mix and recruit into posts to address this.

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%. An improvement plan for supporting staff with disabilities has been signed off by People Committee.

Report and Support platform went live in August 2024 to offer another channel for staff to report discrimination, including the option report anonymously.

Making best use of available resources
Delivery of financial plan

Workforce efficiencies paybill reduction of £14,488k YTD

Agency spend reduction: In December 2024, we spent <0.9% as a % of our pay bill on agency. This is within the national threshold of 3.2% which has consistently been achieved by the Trust over the preceding quarter. In total we have saved £3.1m in agency spend YTD

Enabling Breakthrough Goal: We "Improve Together" to make a difference

In the November 2024 maturity assessment, 91 out of 128 frontline teams regularly run improvement huddles, a 25% improvement this quarter. 50 teams have priorities listed on their performance board or are working on an A3 linked to a Specialty priority. On track to fully embed by the end of the year. The maturity of the Operational Management System is developing against an ambition of maturity.

2024/25 deliverables – strategic objectives (please also see sunray on next slide)

Delivered

- The internal launch of the case management system for employee relations cases went live in October 2024.
- Launch of the Employer Values Proposition (EVP) September 2024. Enabling us to support retention as well as recruitment through the use of an EVP.

On track

- Build of the digital people solution 'Halo' continues with the launch of VCARP process and forms in January 2025. Further staged implementation will continue with increasing functionality throughout 2025/2026.
- Working with cancer project work has commenced with policy work running concurrently with launch plans in development.
- To support our global majority colleagues to plan and make the UK their home we're offering workshops to provide legal advice on the ILR application and access to a hardship fund
- Pilot for Joy in Work has been completed. Next step to review team development options to align with organisational change context.
- Care covenant work has progressed and the Trust has welcomed their first care leaver into employment through this programme.
- Funding approved from Charities Committee to support redevelopment of the on-site gym

Off track

- Uptake of People & Culture interventions delayed due to capacity pressures
- Calderdale workforce planning is constrained by capacity pressures
- Restorative Just and Learning Culture (RJC) has been delayed on the People Programme however Business Partner resource has now been allocated and rescoping of the work will begin in Q4.
- Workplace Adjustments: Organisation gap in skills and ownership of reasonable adjustments still present which impacts on pace of progress and wider scale change.
- You Matter Programmme and Residential Improvement pace of delivery constrained by capital and people resourcing

The people we work with

Together, we will create the conditions to perform at our best

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

- Refresh RUH People Plan staff engagement programmes
- Sexual safety policy and programme
- Review Recognition Protocols
- Restorative, Just and Learning Culture

- 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).

- Self-service team engagement and development platform
- Renewed Management and Leadership Programme
- Embedding Improving Together into People Functions

- Consolidate, review and enhance interventions under Programme 4 (EDI)
- Focus on high-impact accessibility projects (disability and LTC, workplace adjustments)

- 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

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 (Q3)

Strategic Risks (Board Assurance Framework)

3.1 Failure to deliver a viable financial plan – current score 16
3.2 If Sulis Hospital does deliver its financial target it may have a direct financial impact to RUH financial position. – 16
3.3 By not strategically allocating resources to address the health and care needs of our most vulnerable communities, we may not improve health outcomes, reduce existing inequalities, or ensure equitable access to quality care.- 16
3.4 Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, and a degraded experience for both patients and staff.- 16
3.5 Climate change and its accelerating consequences threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.– 15
3.6 Insufficient investment in digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery - 16
3.7 Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients. - 16

Emergent risks/context/considerations

RUH financial recovery plan requiring £36.3m efficiency target

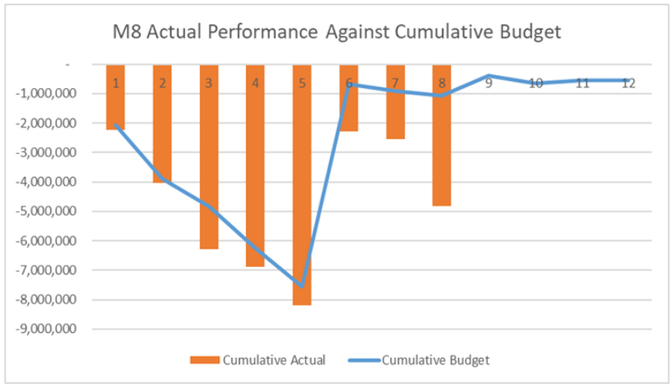
The key risks and enablers to achieving this are:
- Any QIPP delivered non-recurrently
- Run rates above budget
- Group model implications on clinical and corporate services
- Capacity to progress partnership and strategic work at pace is limited

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 8 the Trust is at a deficit position of £4.2 million which is £4.2 million adverse to plan.

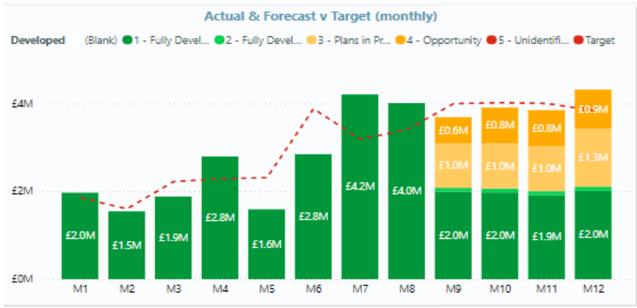


We continue to work towards increasing recurrent savings, but the high level of non-recurrent QIPP remains a risk.

Since 19/20 NHS productivity has shown a decline nationally - 13.3% across the South West Region (RUH 11.8%) measured to month 6. This includes a recovery trajectory of 4.5% for the first 6 months of 24/25 for the RUH (in line with SW Region recovery)

We are working to improve our financial position through enhanced controls, transformation projects and cost saving via the improvement programme.

Whilst we are delivering well on our Improvement Programme, unplanned budgetary pressures mean we require further focus to identify opportunities for savings.



2024/25 deliverables – strategic objectives (please also see sunray on next slide)

Delivered

Community and Anchor
- **Anchor Plan-** programme aims in place with 5 main workstreams, involvement with Future Ambitions Board sub-groups
- **Frome-** Commercial opportunities being delivered and clinical services expanded at Frome site
- Community Day 2024 delivered with planning for 2025 underway

Sustainability
- **Heat decarbonisation-** social value working group in place, scoping opportunities

Health Inequalities
- Smoking cessation team now covering 40% of wards

On track

Finance
- £21.3m delivered (M9) out of £36.3m efficiency target

Community and Anchor
- **Anchor plan-** signing up to WECA Good Employer Charter alongside civic partners, scoping anchor projects
- **Community Open Day 2025-** planning commenced
- **University partnerships-** projects being established e.g. short course commercialisation and routes to corporate placements

Sustainability
- **Sustainability Steering Group** to be mobilised
- **Green Team Competition** underway - teams are writing up and submitting reports ahead of February online Showcase and Awards event
- **Climate Change Adaptation Plan & Risk Assessment** - a joint AHA project started in December; drafts in development
- **RUH Sustainability Day-** planning underway, event planned for April 2025
- **Group**
- **Group Model Strategic Planning Framework** (SPF) in place, development of Group model underway
- **Digital**
- **Artificial Intelligence Programme-** AI programme established with BSW ICS colleagues to plan for AI adoption and roll out

Off track

Finance
- Workforce cost control forms 53% of overall improvement programme target. Good progress is being made however risks remaining around seasonal pressures and organisational redesign capacity
- ICU off track due to ventilation snagging issues resulting in delays seeing financial benefit
- Wide scale efficient corporate services redesign scheduled to 24/25 to align with group planning

Sustainability
- **Heat decarbonisation:** Funding opportunities for the £3M Trust contribution to the Heat Decarbonisation Project have been pursued, however, it remains likely that the Trust will need to commit this from the internal Trust CDEL allocation next year
- **RUH Green Plan development-** national greener NHS guidance delayed. Green Plan approach proposed to Board in interim.

Anchor
- **Manor House project-** initial project scoping meeting planned for January 2025; delayed due to capacity
- **Green spaces project-** scoping opportunity to expand green space offering; delayed due to capacity

Health inequalities
- Funding continuity uncertain for health inequalities programme

Standard Work
- Further progress required to develop standard processes, being taken forward through Improving Together and UEC and elective review work

The people in our community

Together, we will create one of the healthiest places to live and work

Working with partners to make the most of shared resources to plan wisely for future needs

2024/25

- Maximise utilisation of Frome asset
- Productivity improvements
- Increased recurrent QIPP delivery
- Shared EPR
- Group transformation and joint planning
- Standard work
- Efficient Corporate services
- ICU plan delivered

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, smoking and digital programmes
- 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

- Decarbonisation of buildings project
- Carbon awareness & competency training programme & stakeholder engagement plan
- Sustainability risk assessment created
- Sustainability network established
- Community services mobilisation
- Continue to develop services off site/ Frome

- 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

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:	17
Date of Meeting:	15 January 2025		

Title of Report:	RUH Charitable Fund – Review of Terms of Reference
Status:	For approval
Board Sponsor:	Sumita Hutchison, Non-Executive Director
Author:	Roxy Milbourne, Interim Head of Corporate Governance
Appendices	Appendix 1: RUH Charitable Fund – Terms of Reference December 2024

1. Executive Summary of the Report

The Trust's Charitable Fund's Terms of Reference defines the structure and purpose of the Charities Committee. The Committee reviewed its ToR at its meeting in December and are presented for approval and endorsement by the Board of Directors.

As part of the auditing process by Deloitte, an action regarding fraud was highlighted as part their report. In order to address their recommendation, the following bullet has been added to the Committee's objectives:

- Ensure there are relevant controls in place to prevent fraud, ensuring oversight of RUHX's assessment of fraud risks and any controls established to address these risks.

The Committee discussed the quoracy arrangements and agreed that it was subject to a small number of board members (4) who were named in the ToR as members. In order alleviate some of this pressure, the following line has been added:

- Any Trustee may attend the meeting should they wish to do so and will count towards the quoracy of the meeting.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to approve the updated Terms of Reference.

3. Legal / Regulatory Implications

Updating the Committee's Terms of Reference are part of governance best practice, and in line with processes undertaken by other Board Committees.

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

There is a risk that the Charity would not remain compliant with Charity Commission governance requirements should the terms of reference not be updated and approved.

5. Resources Implications (Financial / staffing)

Not applicable.

6.	Equality and Diversity
Not applicable.	

7.	References to previous reports
This review is conducted annually.	

8.	Freedom of Information
Public	

9.	Sustainability
Not applicable	

10.	Digital
Not applicable	

Appendix 1: Charities Committee – Terms of Reference

1. Constitution

The Board of Directors, acting as Corporate Trustee for the Royal United Hospitals Charitable Fund (RUHX), hereby resolves to establish a Committee to the Board of Directors to be known as the Charities Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Purpose and Objectives

- Ensure that individual fund objectives and spending plans are in keeping with the objectives, spending criteria and priorities set by the donors.
- Obtain plans for all individual funds and approve if/when appropriate.
- Ensure that donations and investment income or losses are attributed to individual funds appropriately.
- Ensure the sources of income and the terms on which donations are received are acceptable to the Trustees.
- Ensure that all funds are correctly allocated as restricted, unrestricted, or designated, and accounted for accordingly. This analysis will differentiate between restricted, specific and the General charitable fund.
- Recommend an investment advisor to the Trustees following appropriate tendering procedures and regularly monitor and review their performance.
- Ensure that the investment policy for RUHX set by the Trustees is implemented and that sufficient funds are kept readily available to meet planned requirements.
- Ensure (through the NHS Foundation Trust's Finance Department and accounting systems) that there is an appropriate system of control over income and expenditure, and that there are robust governance arrangements in place.
- Ensure that the NHS Foundation Trust's Standing Financial Instructions and the Scheme of Reservation and Delegation are appropriately interpreted for charitable funds.
- Receive and discuss all audit reports on charitable funds and recommend action to the Trustees.
- Ensure that RUHX drafts a strategy and that this is implemented and delivered.
- Review RUHX's annual accounts and comment/ recommend approval to the Trustees as appropriate.
- Ensure there are relevant controls in place to prevent fraud, ensuring oversight of RUHX's assessment of fraud risks and any controls established to address these risks.

- Respond to requests from the Board of Trustees for review or investigation on relating to charitable funds.

3. Membership
The Committee shall be appointed by the Board to ensure representation by Non-Executive and Executive Directors. Members will include:

- Trust Chair
- Non-Executive Director (Chair)
- Chief Finance Officer (or deputy)
- Chief Nursing Officer

A Non-Executive Director will be appointed as Chair of the Committee. In the absence of the Chair of the Committee, another Non-Executive Director will perform this role.

Any Trustee may attend the meeting should they wish to do so and will count towards the quoracy of the meeting.

Meetings of the Committee shall also be attended by:

- Chief Strategic Officer
- Head of Financial Services or Financial Accountant
- Charities and Technical Accountant
- Head of Fund Raising
- Head of Corporate Governance
- EA to Chief Finance Officer (minute taker)

It is agreed that, if necessary, people with appropriate expertise in charitable, clinical, or other matters, but with no direct connection to the NHS Foundation Trust or RUHX, may from time to time be invited to attend the Committee.

a. Quorum
Quorum – Three voting members of the Board of Directors (at least one Executive Director and one Non-Executive Director). The Deputy Chief Financial Officer must be in attendance if the Chief Financial Officer is absent – the Deputy Director would be a voting member of the Committee in that situation.

Note: All Trustees will be sent copies of the agenda for each meeting and may attend the meeting should they wish to do so.

b. Attendance by Members
The Chair and Lead Executive (or nominated Deputy) of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 75% of all meetings.

c. Attendance by Other Trustees
Any member of the Board of Directors can attend.

4. Accountability and Reporting Arrangements

The Committee will be accountable to the Board of Directors. A report of the meeting will be submitted and presented to the Board by the Chair who shall draw to the attention of the Board issues that require disclosure to the full Board or require executive action.

5. Frequency

The Committee will meet no less than four times a year.

6. Authority

The Committee is authorised to:

- perform any of the activities within its terms of reference;
- obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and
- make recommendations to the Board for actions it deems necessary.

The NHS Foundation Trust is trustee of RUHX registered under charity registration 1058323 and the Charity Committee is appointed as the Trust's agent in accordance with s16 of the NHS Trusts (Membership and Procedures) Regulations 1990.

The Committee is authorised by the Corporate Trustees to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

7. Monitoring Effectiveness

The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties. This review will inform the Committee's annual report to the Board.

8. Secretariat and administration

The Committee shall be supported administratively by the members of the Corporate Governance and Finance teams whose duties in this respect will include:

- Agreement of the agenda with the Chair / Chief Financial Officer
- Collation of the papers which will be disseminated five working days in advance of the meeting.
- Arranging for minutes and actions which will be disseminated five working days after the meeting.
- Accessing advice to the Committee as required.
- Chief Financial Officer and Head of Financial Services / Financial Accountant to advise the Committee on pertinent areas.

9. Review

These terms of reference will be reviewed at least annually as part of the process for managing the Committee's effectiveness.

Approved by Charities Committee: December 2024

Ratified by the Board of Directors: January 2025

Royal United Hospitals Bath
NHS Foundation Trust

RZ2.Report to:	**Public Board of Directors**	**Agenda item:**	**18**
Date of Meeting:	**15 January 2025**		
Title of Report:	**Alert, Advise and Assure Report – Audit & Risk Committee**		
Status:	**For information**		
Author:	**Paul Fox, Non-Executive Director and Chair of Audit & Risk Committee**		

Key Discussion Points and Matters to be escalated from the meeting held on 12th December 2024

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

- The Committee was concerned that the number of overdue Internal Audit Actions is now 13, up from 3 at 1 September 2024.

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

- The Committee considered an Internal Audit report on Risk Management: Health and Safety which was rated Amber/Red on account of delays in reporting RIDDOR events to the Health and Safety Executive, such that legal reporting requirements were not being met.
- The Committee considered an Internal Audit report on Sustainability reporting which was rated Amber/Red highlighting uncertainty about the definition of Sustainability and also of roles and responsibilities.
- The Committee considered an Internal Audit report on Pay controls which was rated Amber/Red highlighting the need to reconcile the post structure in the HR (Electronic Staff Record) and Finance (Unit 4) systems. The audit included a follow-up on the 23/24 e-rostering findings highlighting that only 3/8 had been implemented. The delay is mainly the result of the new e-Rostering Policy not yet being approved.
- The Committee considered an Internal Audit report on Procurement which was rated Amber/Red highlighting the need to improve procedures in respect of conflict of interest.

ASSURE: Inform the board where positive assurance has been achieved

- The External Auditor's Annual Report 23/24 concluded that there was no significant weakness in the Trust's arrangements in respect of Financial Sustainability.

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

- The Committee received a report on the Trust's Grip and Control arrangements. While satisfied that these were comprehensive, the Committee identified the risk that over reliance on this 'emergency break' rather than more substantive savings measures (e.g. service / process change) might have cumulative adverse impacts e.g. stifling innovation.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• The Committee was pleased that the Counter Fraud advice to staff included advice in relation to their own circumstances as well as that of the Trust.
APPROVALS: Decisions and Approvals made by the Committee
• The Committee approved the Standing Financial Instructions and Scheme of Delegation which have been revised to take account of the new role of Trust Managing Director, following the formation of the BSW Group. • The Committee approved the Sulis Accounts subject to the offline resolution of the amount of the audit fee. *(to be updated once this is resolved)* • The Committee approved its 2025 workplan including a standing agenda item to monitor the Trust's progress in completing audit actions and an annual review of risk management processes. • The Committee reviewed the revised BAF (as presented to the December Board) and requested that there be a rolling 12 month assessment (RAG) of whether if implemented the actions would bring the risk rating within target (rather than have a cliff-edge at March 25).

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

Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**15 January 2025**		
Title of Report:	**Board Assurance Framework**		
Status:	**Information**		
Board Sponsor:	**Christopher Brooks-Daw, Chief of Staff**		
Author:	**Christopher Brooks-Daw, Chief of Staff and respective Executive Director leads for related risks**		
Appendices	**None**		

1. Executive Summary of the Report

1.1 Board Assurance Framework (BAF):

The BAF is presented to Trust Board today for information.

The risks have been discussed and approved by the Executive Team, with the full BAF being discussed and approved at the Trust Board in December 2024.

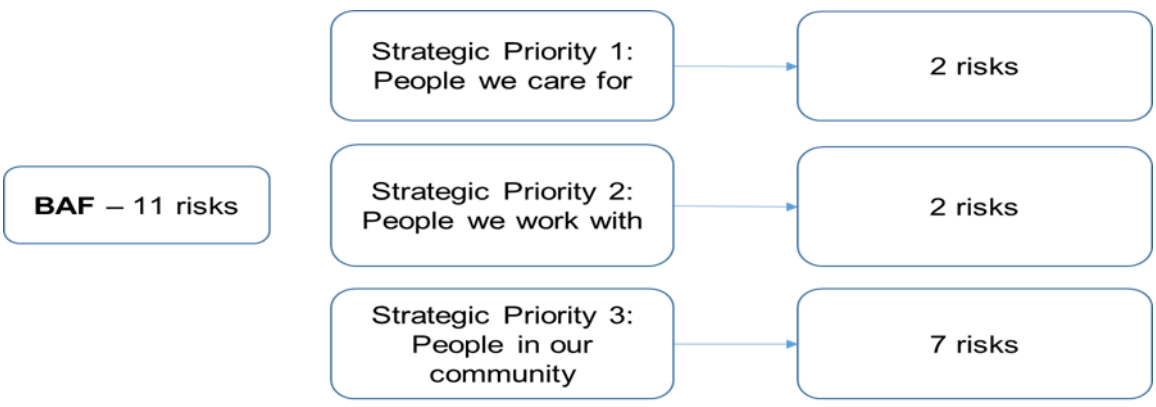
Since the Board last received the BAF, the risks have been reviewed to ensure that they accurately reflect our understanding of each risk, as well as the controls, sources of assurance, gaps and related actions.

The Board Assurance Framework (BAF) is a live document, subject to update and change. It plays a key role in assuring the Board that risks to the achievement of our strategy are identified, with controls and mitigations noted. As such, a BAF will usually include ≤12 risks.

NHS Providers Guide to Good Governance states “The BAF sets out the provider's strategic objectives, the risks to achieving them and the controls and assurance mechanisms that have been put in place to manage risk and deliver the objectives”.

Due to the nature of risks on a BAF, they will change slowly. This is because they usually need significant actions to develop additional controls and/or mitigations for complex issues. They may also be highly dependent on factors that are outside of the direct control and/or influence of the Trust/Executive Lead.

1.2 Board Assurance Framework – RUH content:



1.3 BAF – RUH routine governance:

The routine governance for the BAF is:

Quarterly Reporting (no less than) to:

- Trust Management Executive
- Trust Board sub-committees (each committee will receive a report/update for their respective risks)
- Audit and Risk Committee (to provide assurance to Board about the effectiveness of the BAF process)
- Trust Board

To strengthen rigour and assurance, BAF risks and their controls, mitigation and assurance mechanisms will link into the internal audit programme where possible. This provides the opportunity to understand the implementation and effectiveness of management of risks on BAF.

To support contemporaneous records and reporting, there will be monthly review by Executives/Executive Team.

2.	Recommendations (Note, Approve, Discuss)
The Board is asked to discuss and approve the Board Assurance Framework.	

3.	Legal / Regulatory Implications
It is best practise the have a Board Assurance Framework in place that provides assurance against the principal risks to the achievement of our Trust Strategy.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The Board Assurance Framework sets out the principal risks to the achievement of the Trust Strategy. As such, it forms a key part of the wider risk management framework for the Trust.	

5.	Resources Implications (Financial / staffing)
The Board Assurance Framework sets risks related to resources. It also requires significant time and input to ensure that it reflects the position across multiple areas and functions.	

6.	Equality and Diversity
The content of the BAF sets key risks that may impact equality and diversity. Some of these have a clear link, for example Risk 3.3 “Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care”.	

7.	References to previous reports/Next steps
Board sub-committees routinely receive updates on risks that fall within their areas of responsibility. The Trust Board received the BAF in May 2024. Routine reporting from this	

point will be quarterly.

8.	Freedom of Information
Whereas this BAF update is provided to the Private Board, future updates will be provided to the Public Board as routine.	

9.	Sustainability
The content of the BAF sets out key risks that may be associated with or impact sustainability. The BAF includes a specific related risk: Risk 3.5 “Climate change and its accelerating consequences may threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations”.	

10.	Digital
The content of the BAF sets out key risks that may be associated with or impact digital. The BAF includes two specific related risks: • Risk 3.6 Insufficient investment in digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery. • Risk 3.7 Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients.	

Royal United Hospitals Bath
NHS Foundation Trust
Board Assurance Framework 2024 / 2025
Trust Board January 2025

Board Assurance Framework summary:

BAF SUMMARY					
Ref.	**Lead Executive**	**DESCRIPTION OF RISK**	**Current Rating**	**Movement**	**Updated**
	Monitoring Committee				
Strategic Priority 1: People we Care For - Together we will support you, as and when you need us most Objective: Consistently delivering the highest quality healthcare and outcomes					
1.1	Chief Nurse Quality Assurance Committee	**Description of Risk** There is a risk that not meeting internally and externally set standards of quality and safety may result in harm to patients and/or experience below expected.	15	⟷	12/2024
1.2	Chief Operating Officer Finance and Performance Committee	**Description of Risk** Increasing demand for both emergency and planned care is exceeding our capacity to treat patients promptly, leading to longer wait times for procedures. This could negatively impact patient outcomes and satisfaction.	16	⟷	12/2024
Strategic Priority 2: People we Work With - Together we will create the conditions to perform at our best Objective: Demonstrating our shared values with kindness, civility and respect, all day, every day					
2.1	Chief People Officer People Committee	**Description of Risk** Without fostering a culture of inclusion and actively addressing possible managerial discrimination, we may hinder staff recruitment and retention, expose the Trust to financial and reputational damage, and undermine our ability to deliver the best possible patient care.	16	⟷	12/2024
2.2	Chief People Officer People Committee	**Description of Risk** Without strong management and leadership development, including succession planning, we risk limiting our ability to transform and innovate, cultivate a positive culture and sustain improvements. This could negatively impact patient care, staff satisfaction, and workforce stability.	20	⟷	12/2024

Strategic Priority 3: People in our Community – Together we will create one of the healthiest places to live and work Objective: Working with partners to make the most of our shared resources and plan wisely for future needs					
3.1	Chief Finance Officer Finance and Performance Committee	**Description of Risk** Without delivering the financial plan and ensuring financial accountability across the organisation the Trust may not achieve financial recovery and sustainability, affecting our control to provide safe, appropriate and effective care to our patients.	16	⇔	12/2024
3.2	Chief Finance Officer Subsidiary Oversight Committee	**Description of Risk** If Sulis Hospital does not deliver its financial target it may have a direct financial impact to RUH financial position.	16	⇔	12/2024
3.3	Chief Medical Officer Quality Assurance Committee	**Description of Risk** Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care.	16	⇔	12/2024
3.4	Chief Nursing Officer Non-Clinical Governance Committee	**Description of Risk** Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, failure to meet regulatory requirements in addition to degrading the experience for patients and staff.	16	⇔	12/2024
3.5	Chief Nursing Officer Non-Clinical Governance Committee	**Description of Risk** Climate change and its accelerating consequences may threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.	15	⇔	12/2024
3.6	Chief Finance Officer Non-Clinical Governance Committee	**Description of Risk** Insufficient digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery	16	⇔	12/2024
3.7	Chief Finance Officer	**Description of Risk** Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients.	16	⇔	12/2024