Bundle Public Board of Directors 6 September 2023

0 Agenda
- 0.0 - DRAFT Public BoD Agenda Sept 23 v2.0 - 31.08.23

1 Chair's Welcome and Apologies: Brian Johnson, Andrew Hollowood, Paul Fox

2 Declarations and Conflicts of Interest

3 Written Questions from the Public

4 Minutes of the Board of Directors Meeting Held in Public on 5 July 2023
- 4.0 - DRAFT Public Board of Directors Minutes - July v1.1

5 Action Log
- 5.0 - DRAFT Public BoD Action List July 23 v1.0

6 Governor Log of Assurance Questions and Responses (For Information)
- 6.0 - Governor Log of Assurance Questions v1.2 - 31.08.23
- 6.1 - Appendix 1 - 29.08.23

7 Items Discussed at Private Board

8 Patient Story

9 CEO and Chair's Report
Acute Hospital Alliance Briefing
ICS Update
- 9.0 - CEO Public BoD Report 06.09.23

10 Integrated Performance Report
- 10.0 - Public BoD - Integrated Performance Report - July 2023 Data.doc

11 Quality Governance Committee Update Report and Updated Terms of Reference
- 11.0 - Quality Governance Committee Upward Report to Board Sept 23 v3

12 CQC Update: Letter and Trust Action Plan
- 12.0 - CQC Update Letter and Trust Action Plan Final
- 12.1 - Appendix A CQC Letter August 2023
- 12.2 - Appendix B CQC Improvement Plan Final

13 Winter Planning
- 13.0 - Winter Plan Update - Aug 23
- 13.1 - PRN00645_Delivering operational resilience across the NHS this
- 13.2 - PRN00724_UEC Winter Incentive Guidance_240823
- 13.3 RUH Bed Plan 2023_24 Refresh v3

14 Maternity Update
Quarterly Update Q1
Midwifery and Neonatal Bi-Annual Staffing Report
- 14.1 - MIS Combined Maternity and Neonatal Safety Q1 Report 23-24 (003)
- 14.2 - Bi-annual staffing paper August 2023 (004).doc FINAL

15 Safeguarding Annual Reports
Children's
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16 People Committee Update Report
- 16.0 - People Committee Upward Report to Board

17 People and Culture Strategy Update
- 17.0 - 2023-08-30 RUH People Plan up-date - Board cover paper (FINAL)
- 17.1 - 2023-08-30 RUH People Plan update - FINAL

18 Workforce Race Equality Standard and Workforce Race Disability Standard

18.0 - WRES and WDES People Commitee cover sheet 2.8.2023
18.1 - Appendix 1 Draft_WRES Report 2023 v03
18.2 - Appendix 2 Draft_WDES Report 2023 v03

19 Freedom to Speak Up Update & response to the NHSE letter regarding Lucy Letby
19.0 - 2023-08-30 FTSU Board Update Aug 2023 - FINAL
19.1 - PRN00719_Letter re Verdict in the trial of Lucy Letby_180823

20 Gender Pay Gap Report
20.0 - Gender Pay Gap Report - Cover Paper
20.1 - Appendix 1 Our Gender Pay Gap Report 2022

21 Finance and Performance Committee Update Report
Including RUH Improvement Programme and Return to Financial Sustainability
21.0 - Finance and Performance Committee Update Report

22 Non-Clinical Governance Committee Update Report
22.0 - Non-Clinical Governance Committee Upward Report to Board Sept 23

23 Emergency Preparedness, Resilience and Response Annual Report
23.0 Emergency Preparedness, Resilience and Response Update Report 2023 v1.1 - FINAL

24 Annual Review of Directors' Interests, Fit and Proper Persons Test and Board of Directors Code of Conduct
24.0 - DoI FPP Regulation Paper 2022-23 - 30.08.23

25 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, 6 SEPTEMBER 2023, 13:00 – 16:00
VENUE: Widcombe Social Club, Lower Widcombe Hill, Bath BA2 6AA

Item	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chair's Welcome and Apologies: Brian Johnson, Andrew Hollowood, Paul Fox	Alison Ryan, Chair	Verbal
2.	Declarations and Conflicts of Interests		Pres.
3.	Written questions from the public		Enc.
4.	Minutes of the Board of Directors meeting held in public on 5th July 2023		Enc.
5.	Action Log		Enc.
6.	Governor Log of Assurance Questions and Responses (For Information)		Enc.
7.	Items discussed at Private Board		Verbal
8.	Patient Story	Sharon Manhi, Lead for Patient and Carer Experience	Pres.
9.	CEO and Chair's Report • Acute Hospital Alliance Briefing • ICS Update	Cara Charles-Barks, Chief Executive	Enc.
10.	Integrated Performance Report	Joss Foster, Director of Strategy	Enc.
The People We Care For			
11.	Quality Governance Committee Update Report and updated Terms of Reference	Ian Orpen, Non-Executive Director	Enc.
12.	CQC Update: Letter and Trust Action Plan	Toni Lynch, Chief Nurse	Enc.
13.	Winter Planning	Niall Prosser, Interim Chief Operating Officer	Enc.
14.	Maternity Update: • Quarterly Update Q1 • Midwifery and Neonatal Bi-Annual Staffing Report	Sarah Woodward, Deputy Director of Midwifery / Dr Claire Park, Clinical Lead, Obstetrics	Enc.
15.	Safeguarding Annual Reports • Children's • Adults	Toni Lynch, Chief Nurse	Enc.
The People We Work With			
16.	People Committee Update Report	Paul Fairhurst, Non-Executive Director	Enc.
17.	People and Culture Strategy Update	Alfredo Thompson, Director for People and Culture	Enc.
18.	Workforce Race Equality Standard and Workforce Disability Equality Standard	Alfredo Thompson, Director for People and Culture	Enc.

19.	Freedom to Speak Up Update & response to the NHSE letter regarding Lucy Letby	Alfredo Thompson, Director for People and Culture	Enc.
20.	Gender Pay Gap Report	Alfredo Thompson, Director for People and Culture	Enc.
The People in Our Community			
21.	Finance and Performance Committee Update Report including RUH Improvement Programme and Return to Financial Sustainability	Nigel Stevens, Non-Executive Director Libby Walters, Director of Finance Niall Prosser, Interim Chief Operating Officer Alfredo Thompson, Director for People and Culture	Enc.
22.	Non-Clinical Governance Committee Update Report	Sumita Hutchison, Non-Executive Director	Enc.
23.	Item Deferred		
Governance			
24.	Annual Review of Directors' Interests and Fit and Proper Persons Test; and Board of Directors Code of Conduct	Roxy Milbourne, Deputy Head of Corporate Governance	Enc.
CLOSING BUSINESS			
25.	Any Other Business	Alison Ryan, Chair	Verbal
Date of Next Meeting: 1 November 2023 Venue - Widcombe Social Club, Lower Widcombe Hill, Bath BA2 6AA			

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

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE
PUBLIC BOARD OF DIRECTORS
WEDNESDAY, 5 JULY 2023 13:00 - 16:00
VENUE: WIDCOMBE SOCIAL CLUB, LOWER, WIDCOMBE HILL, BATH BA2 6AA

Present:

Members

Alison Ryan, Chair
Alfredo Thompson, Director for People and Culture
Andrew Hollowood, Chief Medical Officer
Antonia Lynch, Chief Nurse
Antony Durbacz, Non-Executive Director
Ian Orpen, Non-Executive Director
Jocelyn Foster, Director of Strategy
Libby Walters, Director of Finance and Deputy Chief executive
Niall Prosser, Interim Chief Operating Officer
Paul Fairhurst, Non-Executive Director
Paul Fox, Non-Executive Director
Sumita Hutchison, Non-Executive Director

In attendance

Adewale Kadiri, Head of Corporate Governance
Aime Dew, CQC Inspector (joined the meeting at 14:40)
Jamie Caulfield, Deputy Director Estates & Facilities
Lucy Kearney, Head of Communications
Matt Hanna, Homeless Hospital Discharge Team – Item 8
Matthew Butler, Trainee Anaesthetist
Richard Graham, Director of Research & Innovation – Item 13
Sharon Manhi, Lead for Patient & Carer Experience – Item 8
Stephanie Spottiswood, Executive Assistant *(Minute Taker)*

Apologies

Brian Johnson, Director of Estates & Facilities
Hannah Morley, Non-Executive Director
Nigel Stevens, Non-Executive Director

BD/23/07/01 Chair's Welcome and Apologies

The Chair welcomed everyone to the meeting, and confirmed that apologies had been received from Brian Johnson, Director of Estates & Facilities, Nigel Stevens, Non-Executive Director, and Hannah Morley, Non-Executive Director.

BD/23/07/02 Declarations of Interest

The Chief Executive declared that her son had joined the hospital bank staff working in an administrative role during University term break.

BD/23/07/03 Written questions from the public

No questions had been received from members of the public.

BD/23/07/04 Minutes of the Board of Directors meeting held in Public on 3 May 2023

The minutes of the meeting held on 3 May were approved as a true and correct record of the meeting.

BD/23/07/05 Action List and Matters Arising

The actions presented to close where approved and closed.

The Chair noted that there was a very good presentation of the Home is Best Programme at the last Council of Governor's meeting. The Chair suggested that the presentation was added to the Trust website.

Action: Deputy Head of Corporate Governance

BD/23/07/06 Governor Log of Assurance Questions and Responses (For information)

The Chair noted that the log of assurance questions was on the agenda for the Board to note, and would be discussed at the next Council of Governors meeting.

BD/23/07/07 Item Discussed at Private Board of Directors meeting.

The Chair highlighted the key items discussed at the Private Board of Directors meeting:

- 7-Day Hospital: A programme that allowed the Trust to provide as good and safe a service to patients on Saturdays and Sundays.
- Electronic Patient Record (EPR): A joint project with Swindon and Wiltshire Trusts (BaNES, Swindon and Wiltshire – BSW). The financial, operational, and implementation risks of the project were noted, but it was decided that the higher risk was in not going ahead with the project. It was therefore agreed that the EPR would proceed to the next stage of approval.
- People Plan and People Strategy and the Freedom to Speak Up Guardian update would be tabled at the September Public Board meeting.
- The Estates Strategy: This would be presented at Public Trust Board once all the Committees had had sight of the document.

The Trust Board noted the update.

BD/23/07/08 Patient / Carer / Staff Story

The Chair welcomed Sharon Mahni, Lead for Patient & Carer Experience to the meeting.

Sharon Mahni welcomed the guest speaker, Matt Hanna from the Homeless Hospital Discharge Team (HHDT), who shared the story of Sarah (not her real name).

Matt Hannah emphasised that this was a very positive story, which highlighted the good work of the NHS.

Sarah identified as an English traveller who had been on the road all her life. She had become very unwell, with a severe chest infection, which was subsequently diagnosed as pneumonia. In general the traveller community did not engage well with the NHS, but in this instance she was persuaded to visit the Emergency Department at the RUH. Sarah was an in-patient for 2 months. The Cardiac Ward had worked closely with HHDT, which was key to understanding Sarah's fear of hospitals and other such organisations. It also

educated the staff involved to have a better understanding of the traveller and homeless communities.

With the right help and understanding, Sarah stopped smoking, taking drugs and drinking alcohol. Upon discharge Sarah moved into a 'step-down bed', and was working towards moving into her own accommodation with her son. Sarah registered with a GP, and registered with housing support.

Ian Orpen wanted to understand at what point was HHDT aware that Sarah had been admitted to the hospital. Matt Hannah indicated that a lot of work had been done in terms of referral systems, and working closely with Ward Clerks, but some individuals still fall through the cracks. The Chief Nurse noted that the patient outcome in this instance was phenomenal, and asked whether there was more that the Trust could do to ensure individuals sought help when they need it. Matt Hannah highlighted two organisations – the Gypsy Traveller Team who work with Julian House, and the Family & Friends of Travellers, a large organisation based in Brighton. It was important for Trusts nationwide, to educate Trust staff on the marginalised communities within society.

Antony Durbacz asked about staff for these types of situations, and in response, the Chief Nurse remarked that there are staff with an understanding and expertise, but conversely there would be some staff who were ill-equipped in similar situations, and suggested the best way to learn was to meet individuals such as Matt Hannah, and to see their work first hand.

The Chair thanked Matt Hannah for highlighting Sarah's story, and the wider work being done by HHDT with the Trust and in the community.

The Trust Board noted the patient story.

BD/23/07/09 CEO and Chairs Report

The Chief Executive highlighted the following key points.

- The significant impact that the upcoming industrial action by junior doctors and consultants would have on the Trust. This would not only impact the actual days of industrial action, but also post-strike days.
- The CQC would be conducting regular visits to the hospital, giving the Trust's teams an opportunity to present aspects of their work, and for the CQC to visit areas of the hospital. The most recent core service review took place within the Medicine Division, and the Trust received positive feedback from that visit.
- The digital appointment reminder service has been launched, and the department that piloted the service had seen a significant reduction in non-attendance rates.
- A key cardiac service, used by 200 patients a year, had moved back to the Trust from Great Western Hospital.
- On Thursday 22nd June the RUH celebrated the anniversary of the arrival of the Empire Windrush, and acknowledged the contribution of those individuals to creating the new NHS.

Paul Fairhurst asked whether there had been any enquiries from the CQC or NHSE about the Trust's response to the industrial action. In response, the Chief Executive confirmed

there was an established process for shared learnings from industrial action. The Chief Medical Officer explained that during industrial action days there was a 'battle rhythm' to ensure that the Trust had oversight of staffing levels. There had been no contact from the CQC, but the NHSE held weekly meetings with the Chief Medical Officers which showed that performance levels had fallen noticeably in relation to Elective Recovery. It had been noted that the RUH responded comparatively better compared to other Trusts regionally, and that the Trust was able to maintain safety levels during all the strike days.

Ian Orpen asked about the number of Junior Doctors in-training prepared to strike. The Chief Medical Officer noted a varied response, and the Interim Chief Operating Officer observed that the Junior Doctors in-training were keen to ensure that safe working levels were maintained before withdrawing their labour. It was acknowledged however that weekends raised a new level of complexity.

The Trust Board noted the update.

BD/23/07/10 Integrated Performance Report (IPR)

The Director for People & Culture presented the key highlights of the IPR.

- Performance:
  - Electives and Cancer:
    - During May the Trust reported zero patients waiting over 104 weeks; 15 patients waiting over 78 weeks; and 359 patients waiting 65 weeks.
    - During May the Trust delivered 102% activity against the 109% Elective Recovery Fund (ERF) target.
    - During April the Trust's 62 day cancer treatment performance slightly reduced to 68.5%, but generally this was an improving position.
  - Urgent Care:
    - Significant improvements in terms of ambulance handover delays, where the Trust lost 1,327 hours, an improvement of 610 hours from the previous month.
    - The RUH 4-hour performance was 63.7%, which was in line with the previous quarter, with June's indicative data looking more positive.
    - Non-Criteria to Reside (NC2R) had reduced to 108.7, which showed continued improvement.
- Finance:
  - The deficit in May was £5.4m, which was £2.4m worse than plan, primarily driven by industrial action, under-performance of the Elective Recovery Plan (ERP), under-performance on the savings programme (QIPP), and the cost of additional capacity.
- People:
  - Vacancy rates had increased by the end of May to 6.38%, which equated to 359.5 WTE. There was an active pipeline which indicated a healthy position would be achieved by September 2023.
  - Staff turnover and sickness rates remained consistent. There was a concerted focus within the Trust on stress and musculoskeletal (MSK).
  - Agency spend at Trust level increased from 3.34% to 3.69% of the paybill.

  - Statutory/mandatory training compliance levels were slightly above the target level of 85%, sitting at 85.8%. There were a few areas being managed to improve compliance.
  - There was an appraisal improvement programme in place between now and September 2023, with a new appraisal solution being implemented. The Trusts overall appraisal completion level was 73.1% against a target of 90%.
- Quality:
  - Highlighted 3 areas: Clostridioides Difficile, E-Coli, and CQC actions following Medicine Division inspection.

Ian Orpen asked about the levels of patient discharges by midday. The Interim Chief Operating Officer noted that there were a number of mitigations in place to improve discharge performance. This information was tracked internally and would be added to the Operational slides of the IPR.

Action: Interim Chief Operating Officer to add a slide to the Operational Performance slide deck.

Ian Orpen noted that the Trust's cancer performance levels were quite static, and asked about recovery trajectory levels. The Interim Chief Operating Officer confirmed that the 62-day performance was static, partly due to a focus on the backlog of patients waiting over 62 days and 104 days. There was significant improvements in both, which was currently the primary focus. The RUH had performed comparatively well across the region in terms of the current proportion of backlog vs pre-pandemic.

Paul Fairhurst asked about the Elective Recovery Plan (ERP), and the Trusts expectations to recover performance. He also asked for an update on the Trust's Basics Matter programme. The Interim Chief Operating Officer confirmed that the Trust was behind in terms of ERP. The clinical divisions were working on reset plans for the rest of the year, which incorporated the assumption that industrial action would take place every month up to the end of the year. Mitigations included improved productivity and additional activity. The Divisions were working alongside the finance team reviewing plans and reforecasting.

The Director for People and Culture confirmed that there was a joint programme of works that spanned the Trust portfolios on the topic of Basics Matter. He gave an example of a food fair, which would happen twice a month. Work was being done within the catering team on the provision of hot food at the Trust; on-going work in terms of uniforms, which would ensure that staff uniform requirements were met. From a People function perspective, there was a new Trust on-boarding process, which encompassed a first stop for all new employees.

Sumita Hutchison noted that 1% of the Trusts workforce was absent due to anxiety, stress and depression. The Director for People and Culture highlighted the multifaceted nature of sickness absenteeism, and it was important not to ignore wider issues affecting staff, including managing higher bills. From a work perspective, staff had a perceived lack of control in terms of work demands, which was being addressed at the Transformation Board. Another important aspect was to increase the knowledge of line managers.

The Director of Finance noted that the Trust was £2.4m adrift of the financial plan, due to under-delivery of the Trust QIPP, and Elective Recovery Plan (ERP). The whole of the

BSW was off plan. The Trust was not officially in the position whereby there was national intervention required, but the Trust had made the decision to put itself within the national protocol with the aim that this would help the Trust to recover its financial position more quickly. The overarching controls within the national protocol dictate that any spend over £100k that was not within the current financial plan would require system approval. However, the Trust would get additional resources from the regional team to help with the recovery plans. There was substantive work to be done on temporary workforce as the Trust is an outlier in terms of temporary staffing costs.

It was important to note that the Trust would still show an underlying deficit of £32m for 2024/25 even if the Trust delivered the £23m of recurrent savings for 2023/24, which was due to the scale of risk being managed, and the amount of non-recurrent support required to reach breakeven.

Alongside 2023/24 recovery as a Trust, it was important to remain focussed on the long term recovery and breakeven position as a system. The finance strategy was in place to achieve breakeven over the next 4 years, which included 2023/24. A roadmap had been set out as part of the system protocol, which would receive additional scrutiny, but also extra support. Sumita Hutchison asked how the Trust aimed to change the culture in terms of financial ownership. The Director of Finance clarified that the primary aspect of ownership was working with each division to set their budgets, which in turn would lead to divisional budget ownership.

Antony Durbacz noted that the ERP was behind target and asked about the mitigations and path to recovery. The Interim Chief Operating Officer confirmed that the divisions were in the process of working up plans to mitigate the loss of activity. The Director of Finance stressed the importance of the ERP delivering the activity, to ensure that the Trust received the elective funding. The Chief Executive noted the significant amount of work being done over the next month in terms of ERF and agency spend. The challenges had been identified and definitive action was underway.

Paul Fairhurst asked what was being done to drive the recruitment pipeline, referencing the 350 WTE to recruit by September. The Director of Finance noted that nursing levels were not the only drivers in terms of workforce increases. Recruitment to vacancies was part of the Trusts plan, and it was important to manage and balance the message that staff are valued, but it was equally important to challenge the utilisation of workforce and resources.

The Trust Board noted the update.

BD/23/07/11 Item withdrawn

BD/23/07/12 Maternity Update Q4 and Birth Rate Plus

The Chief Nurse presented some key highlights:

- Two perinatal deaths had been reported. All learnings and actions would be reported in the 2023/24 Q1 report.
- The Trust had previously reported a cluster of seven cases to the Healthcare Safety Investigations Branch (HSIB), from March to May 2022. As a result HSIB instigated a monitoring and oversight for a 3 month period, which ended in August 2022. HSIB

confirmed in January 2023 that their investigation found no evidence of systematic safety concerns or any underlying issues that required further escalation. However, the letter identified a number of areas for improvement, detailed within the report update.

- A sub category of the investigation - communication – was noted as varied. As a result, the Maternity services department would implement the Royal College of Obstetrics and Gynaecology Escalation Tool Kit, which would guide and assist with communication going forward.
- In Q4 a Quality Improvement piece was launched to look at triage within Maternity services, with a goal to implement the Birmingham Specific Obstetric Triage (BSOTS) model. However, this would require changes in the current Trust estate to be able to fully implement.
- Whilst work continued on the Trust's estate, the current focus would be to improve the telephone triage service which aimed at creating a centralised triage telephone line with allocated staffing. Scoping audits were planned for Q1 to get a clear understanding of current service size and demand. The ambition was to have a Local Maternity and Neonatal System (LMNS) system-wide approach with GWH and Salisbury, to develop a centralised telephone triage across all three providers. This was in the early stages of discussion and planning.
- 2 serious incidents were reported, of which both identified immediate learnings, which were detailed in the report.
- Continuity of Carer continued to be paused, however, the provision remained in place, where possible, for vulnerable/at risk groups, and those from a Black Asian and Minority Ethnic group.
- Homebirth and community births in Chippenham had resumed in Q4, which resulted in the full restoration of birth options for families.
- The Trust reported full compliance with the initial Ockenden Immediate and Essential Actions. Currently the Trust was not required to submit evidence of compliance for the Ockenden final report, however, work progressed towards compliance.
- Training compliance was achieved in January and February 2023, but was impacted in March by the doctors-in-training strike. Future strikes could also impact compliance.
- The Trust reported full compliance with Saving Babies Lives Care Bundle V2 as well as Year 4 of the Maternity Incentive Scheme Safety Actions.
- Midwifery staffing showed continued improvement with recruitment and retention, with all the newly qualified Midwives who commenced with the Trust in August 2022 still in post. They were supported by the Trusts Midwifery Retention team with regular catch ups, and bespoke training to meet their needs.
- The Trust's first internationally educated midwife has taken up post.
- Maternity continued to work in close partnership with the Maternity and Neonatal Voices Partnership Plus (MNVPP) to hear the voice of service users to improve services. The Trust was also working towards including mandatory inclusivity training for all maternity staff.
- Funding had been agreed for the provision of a Day Assessment Unit, which would provide 5 additional spaces to support the standardisation of triage processes, with aim for the work to be undertaken within 2023/24 financial year.

- Work continued to focus on health inequalities. The LMNS funded a Performance Coordinator, whose primary focus was on data; and also the LMNS funded a 12-month extension to the Inclusion Midwifes role for a further 12-months. The Trust had also been given 7 spaces on the national Black Maternity Matters training course, which was a 6-month programme providing education on health inequalities to drive improvements in patient outcomes. This commenced in June 2023.
- Work continued across the Acute Hospital Alliance to review the requirement to provide a digital electronic platform for maternity services.
- BirthRate+ (BR+) was the only recognised national tool for calculating midwifery staffing levels. The Trust commissioned a review in 2022 to meet Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). The report identified an increase in complexity and acuity of people using the services, therefore recommended an uplift in the establishment for clinical and management roles within maternity services.
- Due to the increase in acuity the recommended midwife to birth ratio changed from 1:28 to 1:24. This would be reported each month as part of the IPR. The Trust was continued to move closer to compliance due to improved recruitment and retention. However, from next month the new ratio would flag a non-compliance.
- The Local and Maternity Neonatal System recommended an increase in headroom to 28%, the current headroom at the RUH was 20%, therefore the required workforce increase was calculated at 20, 24 and 28%. If the 28% was achieved the Trust would be required to recruit an additional 30 midwives. The paper at this point did not identify funding, and work was being done by the Acute Hospital Alliance (AHA) to assess the requirement for maternity services to determine what was required across the system with a view to determining next steps. The Trust continued to work with the LMNS to access any national funds should they become available.

The Chair commented on the growing acuity and complexity of patients, and the requirement for an increasing number of midwives per patient, and asked whether there was additional financial support to meet requirements. The Chief Nurse noted that there was some indication there could be additional national money, but no confirmation as yet. The Chair asked whether there would be a sufficient number of midwives, and the Chief Nurse acknowledged the dearth of midwives, although the Trust had a buoyant recruitment trajectory, with more midwives applying for jobs at the Trust than vacancies available.

Antony Durbacz commented on the figure of 16% understaffing, and asked whether this was a similar number across the BSW. The Chief Nurse noted work being done in conjunction with the Acute Hospital Alliance (AHA). The Director of Finance observed that Birth Rate Plus was a tool similar to Safer Staffing, and asked whether there was consistency across the BSW on how to interpret the tool. The Chief Nurse stated that the wording in the Maternity Incentive Scheme (MIS) was clear that a recognised tool should be used, and confirmed that Birth Rate Plus was used across the BSW, with a funding plan to meet the recommendation of that validated tool. It was important to note that there was further discussion required across the AHA in terms of leadership posts and whether there was any leeway.

The Trust Board noted the update.

BD/23/07/13 Research, Development and Innovation Update

The Director of Research and Development presented some key highlights of the report.

This had been a good year so far with a £1m grant income in Q1 from external bodies. The pandemic had paused research activity, with competing capacity used to deliver direct clinical care, and to deliver research. There was recognition of challenges across the NHS with research backlogs, but the number of studies on-track for delivery was increasing. There were 500 more studies recruiting in the National Institute for Health Research (NIHR) framework across England, than in 2019. Things were improving but not quite at the rate hoped.

Locally commercial studies were becoming an important area of research as it helped develop drugs, and saved the Trust money. NHS Providers estimated that from every patient involved in a commercial research study, the Trust received a net contribution of £9200 from Life Sciences companies, which saved the NHS £5800 per patient where a trial drug replaced the standard treatment. As a result, the Trust was working hard to increase its commercial trial income. An important area in this regard would be cancer research. With the new Dyson Cancer Centre due to open, the Trust's research team was working with the cancer team to look at ways to increase the Trust research offering within the cancer domain.

The Trust had particular success in the Bath Birthing Centre investigating Group B Streptococcus infections, which caused still birth. The Trust was the highest recruiting site nationally. The success of the study was attributed to the commitment and enthusiasm of the midwifery team at the Bath Birthing Centre, working in collaboration with the Midwifery Research Team. Gynaecology and Oncology were noted as specific areas of development within the research arena at the Trust.

The Chief Executive commented on exciting opportunities in terms of broadening research into the provision of care, beyond clinical trials, and a collaborative partnership with Bath University. The Director of Research and Development confirmed that the Trust had a Memorandum of Understanding with Bath University, to look at mutual areas of interest. The delivery of health services and the wider detriments of health were a priority for Bath University. The University was successful in obtaining a £1.25m accelerator grant.

Ian Orpen commented that research was typically driven by individual clinician passions and interests, not necessarily the greater needs of a Trust. The Director of Research and Development agreed, but stressed the importance of a research focus on health inequalities, which was relevant to the wider NHS. The Trust was a member of ARC West – Allied Research Collaboration West – part of the National Institute of Health Research (NIHR), of which the Director of Research and Development was on the Board. NIHR looked at overarching themes pertinent to the NHS. It was important that the Trust mapped its research priorities, alongside the Trust Strategy and therein its priorities, and in turn to reach out to organisations such as NIHR for funding.

Antony Durbacz asked who the Trust would contact if there was research required within Equality, Diversity and Inclusion (EDI), and patient outcomes. The Director of Research and Development confirmed that that would be ARC West.

Paul Fairhurst asked what research opportunities there were the EPR could provide. The Director of Research and Development noted that there were particular opportunities at the BSW system level in terms of its healthcare data and patient pathways.

The Trust Board noted the update.

BD/23/07/14 Quality Governance Committee (QGC) Update Report

Ian Orpen highlighted some key points:

- QGC meetings had moved to monthly meetings, and therefore the report covered May and June.
- Hospital Standardised Mortality Ratio (HSMR) was a perennial issue with challenges. There were positive signs statistically, but there was more to do.
- Patient Safety Incident Response Framework (PSIRF) was due to be implemented. This framework was a different way of reporting safety incident reporting, which would also give the Trust an opportunity to develop a healthier approach to learning from incidents.
- The Chief Medical Officer noted that a new Health Inequalities dashboard had been launched and the committee looked forward to reviewing at a future meeting.
- 7 Day Hospital Annual Update - Ongoing work in relation to system working, and the Chief Medical Officer was assured that this would be an improving picture.
- The nature of the Committee's work was to be reactive to 'live' current issues as and when they arose. This linked to a broader piece or work around governance reviews and leadership processes, ensuring the correct oversight and leadership was in place.

The Chief Nurse raised the following additional points:

- The Trust is focussed on applying continuous learnings in order to improve the outcomes for vulnerable people.
- In Q4 the Trust appointed an Associate Director for Vulnerable People, a newly created post. The individual is a social worker by background and has expertise in the vulnerable person agenda. This role will enhance the Trust's understanding and response to those it cares for.
- The Trust also recruited a new Named Professional for Adult Safeguarding, who organised a seminar for the Board of Directors to enhance the knowledge and skillset of the Board. Part 2 was due to be scheduled.
- The Trust is in the process of creating a Foundations Matter Programme, which will look at the skills and focus required across the organisation to ensure the safety of the most vulnerable. The programme is focussed on clinical skills, vulnerability leadership, Freedom to Speak Up, and Equality Diversity and Inclusion, although not limited to that remit.
- Alongside the Foundations Matter Programme, the Trust is looking at an audit system and options appraisal, which would give more tangible oversight of care outcomes across the Trust.
- RUH Accreditation Programmes enables and delivers high performance wards. The Trust is reviewing how to enhance the delivery of the programme. Currently there is one senior nurse who leads the programme, and its pace was commensurate with the resource. The Trust aimed to achieve Silver Accreditation across the majority of

the Trust wards. There was one ward assisting in the co-production of the standard for Gold Accreditation.

- 7-Day Services predominantly related to medical staffing, but there were plans to include night leadership, which would put in place Band 8a nurses on night shift. This was being built into the rota system.
- The Executive Directors and Non-Executive Directors, had started Quality night visits. The key purpose of the exercise was to ensure the Executive team was connected to all the workforce. There are a number of staff, for various reasons, whose preference is to work night shifts, and it is important that those staff members get to know the executive team, which will enable adequate representation of their needs.
- The Trust's senior sisters are currently on a Development Programme, which covers a number of topics such as leadership, management, Equality, Diversity and Inclusion (EDI).
- The unannounced CQC inspection in August 2022, as previously reported to Trust Board, made note of the Trust's requirement to ensure that staff carried out mandatory assessments for patients, such as capacity assessments, declaration of liberty safeguarding, Respect (end of life).
- The ICB Executive Nurse initiated a Rapid Quality Review Meeting last month, which gave the Trust an opportunity to share learnings, with a focus on continuous improvements in standards of care, particularly where standards may fall below those expected.
- Another key element is Freedom to Speak Up, to ensure that staff know they can speak with someone in confidence. The Director for People and Culture had commissioned and external company to review the service.
- 2 new Deputy Chief Nurses have been appointed. During the on-boarding transition period, a colleague had joined the Chief Nurse to lead on the Quality Governance agenda, and would lead on the Foundation Matters Programme.

The Chair observed that at present, when a root cause analysis was conducted, there seemed to be a lack of curiosity, which ultimately meant the root cause of the incident was not clearly established. The Chief Medical Officer agreed, hence the implementation of a new framework. The Chief Executive asked for confirmation that the new framework would continue to be overseen via QGC, and reported up to Trust Board. Ian Orpen confirmed that would be the line of reporting.

The Trust Board noted the update.

BD/23/07/15 NHSE Equality Diversity & Inclusion (EDI) – 6 Priorities

The Director for People & Culture presented the report and highlighted some key points.

- The EDI paper was published in June 2023 by NHSE, which set out high level actions to improve equality, diversity and inclusion, and to enhance the sense of belonging for all NHS staff to improve their experience.
- The aim of the report was to provide some detail to give a level of assurance to the Board that the Trust had an active plan to address the 6 priorities.

The Chair commended the workshop, which had involved Board members and culminated in the acknowledgement that there was a problem with racism within the Trust. One of the

questions now being asked of potential appointees at interview is: 'We have a problem with inclusivity, what have you done that improved inclusivity of people with protected characteristics?'

The Chief Executive noted that over the past few weeks powerful messages about the standards the Trust expects, and the standards that were not acceptable, have been shared. The communications have led to positive discussions, empowering staff to question anything that did not reach the standards the Trust expected from its staff. In response to a question as to how many times the video had been viewed, the Chief Executive confirmed that there had been approximately 1300 views. It was also being used at team meetings.

Sumita Hutchison asked about the Trust's priorities, where EDI was placed on that list, and where the resources to address the issues that had been identified would come from. The Director for People and Culture confirmed that EDI was a breakthrough objective for the next 18 months, using the Improving Together methodology, and all the divisions had developed action plans. All leadership development programmes would focus on creating a safe and inclusive work environment.

The Trust Board noted the update.

BD/23/07/16 Item Withdrawn

BD/23/07/17 Trust Strategy Approval

The Director of Strategy presented the Trust Strategy, and requested Board approval.

- The vision had been launched in September 2022 with a series of staff engagements and marketing activities, which included the roll-out of the Trust's new branding. However, the public launch of the strategy had been delayed by purdah. The strategy was discussed in draft form with the Governors and the Board of Directors, of which all comments were incorporated into the document before being published on the Trust website.
- Some mapping was done in line with the full BSW strategy, which was signed off by the Integrated Care Board (ICB), with a focus on prevention and intervention, and fairer health and wellbeing outcomes. Another key component of the Trust Strategy was excellent health and care services.
- It was important to note that the Trust Strategy was a 'living and evolving' document, which would continue to be developed, and would also incorporate standard operating processes on how to regularly review and monitor progress, and to continue to shape the document.
- A Board Assurance Framework had been created, which detailed key risks against delivery of the strategy.
- It was hoped that the Trust could host a community event in the autumn, which may become an annual event.
- The key components for the first year would be Basics Matter for staff, and the Foundations Matter for patients. The first year would focus on 3 work streams – Governance, Quality of Care and Culture.

- The paper acknowledged the risks involved with delivering the strategy: Keeping it 'live', and ensuring everything linked back to the strategy, communication, keeping it engaging, and challenging sceptics.

Sumita Hutchison asked whether the Trust values should evolve to reflect the strategy, and whether it linked to the behaviour framework. The Chief Executive noted that during the development of the strategy, detailed conversations were held about the Trust's values.

Paul Fairhurst referenced staff retention and asked whether there was anything in the plan's early stages that would either create opportunities to accelerate or potentially change direction. The Director for People and Culture noted that the People Plan set out a foundation for national workforce plans. The RUH People Plan incorporates 3 pillars - Culture, Capability and Capacity, which encompassed all round staff retention, creating a safer inclusive environment, and collaborative working across BSW and BNSSG. A significant part of the Trust's organisational structure was geared towards collaboration across the AHA and BNSSG.

The Board approved the Trust Strategy and there linked Communications Strategy.

BD/23/07/18 Finance and Performance Committee (FPC) Update Report

In Nigel Stevens' absence, the Chair noted that the key topic of discussion at FPC was the Electronic Patient Record (EPR).

The Chief Executive confirmed that the Chief Medical Officer would join FPC as a permanent member, as it was important to have a clinical voice within that forum. The Chief Medical Officer also led the Transformation Programme, which underpinned the transformation programme for the Trust, ultimately supporting the Trust's return to financial breakeven.

The Trust Board noted the update.

BD/23/07/19 Audit & Risk Committee Update Report

Antony Durbacz, the Chair of the Audit & Risk Committee presented the key highlights of the report.

- The main business of the Committee was to recommend that the Trust Board approved the annual report and accounts. The evidence to confirm the recommendation included:
  - The head of internal audit's opinion
  - The external auditors report
  - The BAF
  - Going concern representation
  - The HFMA audit guide to audit committees on year end statements
- KPMG was nominated as the new provider to the Trust for counter fraud service. It was important to note that KPMG was also the Trust's internal auditor, and there was a working presumption that there would be some synergy.
- KPMG presented their plan for the year.

- One area of focus was ensuring audit actions were actioned and completed in a timely manner. The Executive Team had committed to continue improving the follow up processes.

The Chair thanked Antony Durbacz, the Director of Finance, the finance teams and the Audit Committee for getting the accounts prepared and ready for sign-off.

Paul Fox confirmed that he would be taking over as the Chair of the Audit Committee, and wanted clarification on the review ToR sign off process, and whether the 5-year forward plan had been reviewed by the Executives. The Director of Finance confirmed that for each internal audit the lead Executive would agree the terms of reference, a report was produced, including management actions, which then required the Executive lead to confirm agreement prior to the document being finalised. The internal audit provider sets out the 5-year plan based on the risks, which would have been taken into consideration when the executive team agreed the proposed internal audit annual plan.

The Board approved the annual report and accounts.

BD/23/07/20 Charities Committee Update Report

Sumita Hutchison, newly appointed Chair, presented the key highlights from the report.

- There was a shortfall in two of the accounts, details of which would be reviewed and a decision would be made on potential spending freezes.
- There were planned events whereby Board members would have the opportunity to meet some of the charity sponsors.
- There was a presentation on the differing roles the volunteers played within the Trust. Some feedback from the volunteers was that there could be more positive support from ward matrons.
- The Charities Committee had approved funding for Artificial Intelligence Auto Contouring, which was part of the Radiotherapy department, and the Bath Oncology services.

The Chief Executive asked about engaging clinical champions to support the charity and suggested an offline conversation into how to potentially progress opportunities.

The Trust Board noted the update.

BD/23/07/21 Annual Review of Board of Directors Terms of Reference (ToR)

The Chair commented that the new guidance issued by NHSE, was presented in the Private Board meeting. The new guidance noted that all members of the board not only have a duty to make sure their organisation functions as well as it can, but also as a system. The guidance implicitly noted that system trumps organisation.

The Head of Corporate Governance reflected on the Board's role in promoting the interests of the system, and noted that the ToR may need to be more explicit in terms of the possibility that the Board may need to give certain approvals that might not necessarily be in the direct interest of the organisation. The Chief Executive clarified that it was important to stress that it was the system as a collective service. From an acute hospital perspective it was a move away from not only looking at things from an angle of providing acute care,

to a wider scope of responsibility around prevention, addressing inequalities, and a wider population health aspect.

The Chair noted that the Trust must be mindful that we do not just refer to BSW, as the Trust also serves the people of Mendip.

The Trust Board approved the update subject to the recommended changes.

BD/23/07/22 Any Other Business

None discussed.

The Meeting closed at 15:58

Royal United Hospitals Bath
NHS Foundation Trust

Agenda Item: 5

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY 5 JULY 2023

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB593	**Action List and Matters Arising** Deputy Head of Corporate Governance to arrange for the Home is Best Programme to be added to the Trust website.	BD/23/07/05	July 2023	Sept 2023	Added to Trust website with the June Council of Governors papers. **To close**	Deputy Head of Corporate Governance
PB594	**Integrated Performance Report** Interim Chief Operating Officer to add information on mitigations to improve discharge performance to the operational slides.	BD/23/07/10	July 2023	Sept 2023	Complete. **To close**	Interim Chief Operating Officer

Royal United Hospitals Bath
NHS Foundation Trust

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

Title of Report:	**Governor Log of Assurance Questions and Responses**
Status:	**For Information**
Board Sponsor:	**Alison Ryan, Chair**
Author:	**Roxy Milbourne, Deputy Head of Corporate Governance**
Appendices	**Appendix 1: Governor Log of Assurance Questions July 2023**

1. Executive Summary of the Report

The purpose of this report is to provide the Board of Directors with an update on all questions on the "Governors' log of assurance questions" and subsequent responses.

The Governors' log of assurance questions is a means of tracking the communication between the Governors and the Non-Executive Directors.

Two new questions relating to estates, sustainability and investment in the EPRR Programme were raised on 27 July 2023 and a response will be available by the next Council of Governors meeting on 14 September 2023.

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.

The Governors are required to hold the Non-Executive Directors to account for the performance of the Board of Directors and this is one way of demonstrating this.

5. Resources Implications (Financial / staffing)

There are no or financial implications.

6. Equality and Diversity

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

7. References to previous reports

July 2023

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:	**27th July 2023**
Source Channel	**Email sent into to the Membership inbox**
Date Sent & Responder	Sent to NEDs on the 27th July 2023.
Question and ID	**July23-** • Are the NEDs assured that the implementation of the Estates and Sustainability plans are getting the attention they need? The BAF entries on these topics suggest that they are not. • Are the NEDs assured that the proposed investment in the EPR programme over the next three years will not prevent the hospital from addressing its other IT and data management needs?
Process / Action	Sent to NEDs, Sumita Hutchison and Nigel Stevens in the process of formulating a response which will be available by the next Council of Governors meeting on 14th September 2023.
Answer	
Closed?	Open

Report to:	Board of Directors	Agenda item:	9
Date of Meeting:	6th September 2023		

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

1. Executive Summary of the Report

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

Updates included in this report are:

- Overview of current performance, encompassing finance, people and performance
- Industrial Action
- Lucy Letby
- Care Quality Commission
- Updates regarding areas of recognition, ongoing developments and new initiatives;
  - RUH Photographs Chosen for Prestigious 75th Birthday Exhibition
  - Additional Support for Visually Impaired Hospital Patients
  - Ensuring Vulnerable Patients Get the Care and Support They Need
  - RUH Consultants Warn of Dangers of Swimming While Wearing Contact Lenses
  - Three Specialities at RUH Bath now Offering Robotic Surgery
  - Certificates of Bravery for Young RUH Patients
- RUH Membership and 2023 Governor Elections
- 2023 Annual General Meeting
- Senior Management Appointments
- Consultant Appointments
- Use of Trust Seal
- Chairs Update

2. Recommendations (Note, Approve, Discuss)

The Board is asked to note the report.

3. Legal / Regulatory Implications

Not applicable

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

Strategic and environmental risks are considered by the Board on a regular basis and key items are reported through this report.

5.	Resources Implications (Financial / staffing)
Not applicable	

6.	Equality and Diversity
Nothing to note	

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

8.	Freedom of Information
Private	

9.	Sustainability
Not applicable	

10.	Digital
Not applicable	

CHIEF EXECUTIVE AND CHAIR'S REPORT

1. Performance

The hospital has been continuing to respond to the on-going NHS wide industrial action, which during July there were 8 days affected. There is significant amount of energy being put into ensuring the hospital is able to effectively maintain safety and ensure high quality care for our patients. The industrial action is also causing some challenges in delivering our elective recovery that we are working towards. The Trust has also responded to industrial action during August which will be reported next month and additional strike action has been announced during September and October.

On elective activity

- The Trust delivered a year to date Elective Recovery Fund of 100% against the 23/24 annual plan. There has been a rebasing of the ERF plan in light of national guidance and therefore to deliver the financial plan, the Trust now needs to deliver 105%. The clinical divisions have developed recovery plans for the year ahead which are anticipated to deliver 98%, with ongoing work to close the gap.
- We reported zero patients waiting over 104 weeks, 15 patients waiting over 78 weeks and 474 patients waiting over 65 weeks. The challenged areas remain Cardiology and Gastroenterology. The reasons for delays are driven by patient choice, impact of industrial action and complexity of pathways and work is on going to reduce the delays.
- The Trust delivered a British Association Day Case Surgery day case rate of 87% against a target of 85%
- Cancer performance is reported a month in arrears, and June 62 days performance was 69.5% which is consistent with the last couple of months. The performance cancer backlog is currently under pressure due to challenges within Colorectal and Skin. We have built a recovery plan for each speciality to deliver by Q4.

On urgent care

- We have seen significant improvement in our ambulance handover with us reporting our best month in July for the last 14 months with a loss of 1,058 hours ambulance handover delays.
- 4 hr performance has also improved to 66.5%, the last couple of months have seen improvement and we are forecasting further improvements in August.
- Non Criteria to Reside has also reduced to 92 patients waiting for on going support, in July 22 this was 137. We are working with the BSW system to reduce to no more than 80 patients waiting.
- Our urgent care improvement strategy and recent improvements has also been assessed by Stevan Bruijns who is the South West NHS England Clinical Advisor who has strongly complimented our plan.

2. Finance

At the end of July, the Trust is in a deficit position of £7.0 million which is £1.6 million worse than plan. A large proportion of the adverse position is due to costs relating to industrial action of £0.9million. There are a number of financial risks being managed, the most significant being the delivery of the £23.5 million savings target; continued industrial action; an increase in non-pay costs; temporary staffing costs to meet demands in services

and under delivery of the elective recovery programme. The Trust's Improvement Programme is focussing on managing these risks.

3. People

Basics matter - We have defined the basics for staff to include hydration, food, access to rest spaces, access to exercise facilities and we are making progress on all of these in collaboration between the People Team, Strategy Team & Estates and Facilities Team.

Restorative, Just and Learning - Further work is underway to assess the learning from cases and to improve our policy framework for employee experience. A deep dive into issues of violence towards staff, ahead of the Dignity at Work Policy implementation is proving to be effective. The launch event of the new Culture Change Team is planned for the end of August. The RUH Kindness and Civility Week takes place between 12-14th September including drop-in interactive sessions led by RUH colleagues and workshops

Equality, diversity and inclusion - 'Positive action' recruitment processes are being developed to support career progression for those with protected characteristics. The leadership programme for first line managers has been developed with a list of new managers ready to begin the programme soon.

Wellbeing - We are recruiting to the 'four tier' service to prevent and support staff experiencing 'burnout'.

Learning and Development - The LearnTogether platform continues to be developed and we are receiving positive feedback from colleagues. The new support for appraisal and supervision is coming soon.

Workforce Planning - Preparation for the 2024/25 workforce planning round is taking place. The people team has appointed a new Workforce Planning Lead.

4. Industrial Action

The British Medical Association balloted their junior doctor membership who voted to take industrial action from 7.00am on Friday, 11th August until 7.00 am on Tuesday, 15th August 2023. The British Medical Association also balloted their Consultant members who voted in favour of industrial action which occurred from 7.00 am on Thursday, 24th August for 48 hours. Consultant members are scheduled to undertake further strike dates on the 19th and 20th September and 2nd to 4th October 2023.

The Trust, led by the Chief Medical Officer, interim Chief Operating Officer, Chief Nurse and Director for People and Culture put plans in place to respond to the recent industrial action and will be holding debrief meetings to identify any learning. However, it is acknowledged that services are likely to be impacted by this scale of the industrial action.

5. Lucy Letby

On 18 August 2023, Nurse Lucy Letby was convicted of murdering 7 babies and attempting to kill six other infants on the Neonatal Unit at the Countess of Chester Hospital between 2015 and 2016. On 22 August 2023, Lucy Letby was given a whole life term sentence, with no chance of parole. This is a tragic case and our thoughts are with the families and all those affected.

A number of changes have been implemented since that time. The introduction of medical examiners in 2021 has provided independent scrutiny of all deaths not investigated by a

coroner, improving data quality, making it easier to identify potential problems. This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS which represents a significant shift in the way Trusts respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

Last year NHS England rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest. The Trust is compliant with this policy.

All NHS Trusts have been requested by NHSE to urgently review the Freedom to Speak Up service to seek assurance that staff can speak up with confidence and whistle-blowers are treated well as detailed in the letter in item 22 on the Board agenda. The Trust is compliant, however prior to the Lucy Letby conviction, the Director for People and Culture commissioned an external review of the Freedom to Speak Up service, which is due to conclude by end of September. The recommendations and subsequent actions will monitored via the Board of Directors and presented to public Board.

It is also important to recognise the additional safeguards that are now in place which provide increased oversight and scrutiny of neonatal outcomes which were not in place at the time of Lucy Letby crimes. The implementation of the Perinatal Mortality Review Tool (PMRT) in 2018 provides a process for a systematic, multidisciplinary, high quality review of care leading up to and surrounding all stillbirths and neonatal deaths. The Board Level Maternity, the Neonatal Safety Champions and Maternity and Obstetric Safety Champions have also created further opportunities for staff to speak up through listening events and walk-about which is shared via the Perinatal Quality Surveillance tool (PQST). The Trust works in collaboration with the Maternity Voices Partnership Plus (MVPP) which contribute to the development of maternity care and improve the quality of maternity care and as part of this they focus on listening to and seeking out the voices of women (birthing people), families and carers using services. The results of the PMRT and PQST are shared with the Board of Directors on a monthly basis to strengthen Board oversight of maternity and neonatal safety, quality indicators and outcomes.

The Trust will continue to evaluate the emerging information and learning following this case and be curious to ensure learning from this case is applied to the Trust.

6. Care Quality Commission

On 27 July, the Care Quality Commission (CQC) undertook a unannounced inspection of Medical Care. The Trust received a letter following the inspection, from the CQC on 9 August 2023 (item 12 on the agenda) to summarise their assessment, acknowledging that the letter does not replace the draft report which is scheduled to be available at the beginning of October 2023.

The CQC provided an overview of their feedback which pertains to:

- They saw a number of committed and dedicated nursing staff, staff spoke passionately of being proud to work with their colleagues and leaders were proud of their teams
- Doctors described a positive culture
- Staffing levels were short with 50 vacant Health Care Support Worker vacancies
- Skill mix was not always sufficient and training provision was not sufficient to meet the numbers of staff requiring training

- Documentation was not always completed which mainly focussed on recorded pain scores and incomplete fluid charts
- Combe ward environment was noted to have a bright and airy day room and there was evidence of arts and crafts being undertaken with patients, however other wards had limited space, a lack of storage and an ageing estate which impacted the patient experience with a lack of day rooms and space to undertake rehabilitation
- Controlled drugs were not always totalled as per Trust policy
- Patient records were not always stored securely.

The CQC thanked the Trust for the help in facilitating the inspection and for the cooperation that they experienced from our staff.

The Trust has commenced an action plan in response to the letter which will be enhanced on receipt of the final report.

7. RUH Photographs Chosen for Prestigious 75th Birthday Exhibition

Two moving photographs from RUH staff were featured in a prestigious national exhibition, celebrating the 75th birthday of the NHS. Ahead of the NHS reaching the historic milestone on Wednesday, 5th July, staff across the country were invited to submit photographs that capture what makes our health service so special.

RUH Family Liaison Facilitator Mims Yacomeni and Biomedical Scientist Jenny Potasznik were chosen to have photos included in the gallery, on display at Fujifilm's House of Photography during July and August.

Mims entered a moving photograph of the entwined hands of a husband and wife, who were reunited when they were being cared for at the RUH on different wards. Jenny's picture represents the sharing and learning that takes place between colleagues in the labs, where work may go unseen but is essential to care.

8. Additional Support for Visually Impaired Hospital Patients

Visually impaired inpatients at the RUH will now benefit from additional support and equipment during their stay. The new initiative is being led by the family of Bob Brown, who was blind and who spent the last few weeks of his life in hospital in the south of England.

Bob spoke of how isolated and alone he felt during his stay in hospital, so his family decided they wanted to do something to help other people in a similar position – and the Bob's Boxes project was born.

Thanks to the fundraising efforts of Bob's family, the RUH, daughter Becky's local hospital, has received three new boxes stocked full of useful equipment to make hospital stays more comfortable for people with visual impairment.

The boxes contain things like a talking clock, which tells the time and date at the push of a button, a digital radio, a non-slip cupholder and a device for recording voice messages.

9. Ensuring Vulnerable Patients Get the Care and Support They Need

A new strategy is being developed by the Trust to ensure that patients who need additional care always get the care and support they need at the hospital.

The aim of the new Vulnerable People Strategy is to make sure that vulnerable patients receive care and support specific to their individual needs from the moment they arrive at the RUH until they leave, as well as any aftercare they may need once they have left hospital.

For the first time this new strategy will clearly set out what our patients with additional needs can expect from the RUH and our commitment to them as individuals. It will build on the positive work already being done and recognise and act on what more can be done to continue to improve our services.

A key part of developing the strategy is a survey, which patients, local people, RUH partner organisations and local community and volunteer groups have been asked to complete.

10. RUH Consultants Warn of Dangers of Swimming While Wearing Contact Lenses

Eye specialists from the RUH have warned of the dangers of swimming or showering while wearing contact lenses, which can lead to sight threatening infections.

Following a reduction in the number of cases of cornea infections seen during the COVID-19 pandemic, consultants are now seeing a rise in cases, back to pre-pandemic levels. Cornea infections, or microbial keratitis, can occur when the cornea, which is the clear window at the front of the eye, becomes infected, and can be caused by bacteria, fungi or parasites. These cornea infections are much more common in people who wear contact lenses, particularly those who use extended-wear lenses.

People who swim or shower while wearing contact lenses run the biggest risk of contracting an infection, which in extreme cases can lead to a loss of sight.

Symptoms of infections can include blurry vision, eye pain, red eyes, watering from the eye, increased light sensitivity and the feeling that there is something in the eye.

11. Three Specialities at RUH Bath now Offering Robotic Surgery

Operations in three different specialities have now taken place at the Trust using its new surgical robot.

The RUH carried out its first gynaecology oncology and radical prostatectomy surgeries earlier in July. This follows its first ever colorectal operation using the technology in June. This means that the RUH now has three specialities that can operate on the people it cares for with greater precision, and perform complex procedures with minimal access, while ensuring the highest levels of patient safety.

This is part of the commitment that has been made across the local area to invest in the latest technology. Great Western Hospital in Swindon has also recently completed its first robotic surgery, with Salisbury NHS Foundation Trust set to follow later this year.

12. Certificates of Bravery for Young RUH Patients

Young patients undergoing surgery at the RUH are being presented with certificates in recognition of their bravery.

The initiative is the idea of Claire Bracey, Operating Department Practitioner, who wanted to help reduce anxiety in the ENT & Maxillofacial surgery's paediatric patients and make coming to the hospital a more positive experience for them.

Often the certificates are for being brave but can also be for something more personal, such as being a good big brother or sister, achieving a high score on a computer game or being on their school team.

13. RUH Membership

We are always actively seeking new members to help us shape the future of the hospital and directly influence the development of our services for the better. Membership is completely free and is a great way to show your support for the RUH. There are three different levels of involvement for you to choose from. Simply sign up here: https://secure.membra.co.uk/RoyalBathApplicationForm/

14. 2023 Governor Elections

Throughout July our members had the chance to put themselves forward for election to the RUH Council of Governors. Voting is open from 21st August until 5pm on 14th September and as of 25th August only 4.54% of members have voted. It is incredibly important that you make your vote count and we strongly encourage every eligible member to take this opportunity to have your say.

If you have any questions or are unsure whether you are eligible to vote please contact the Membership Office on 01225 821262 or via email at RUHmembership@nhs.net.

15. 2023 Annual General Meeting

This September Trust will be holding its first face to face Annual General Meeting combined with Annual Members Meeting since the beginning of the Covid-19 pandemic:

Date	Time	Location
Wednesday 20th September	Refreshments from 4:30pm	Apex City of Bath Hotel, James Street West, Bath, BA1 2DA

This year's AGM will mark the relaunch of our popular Caring for You events with presentations on our brilliant Hospital at Home Service and Da Vinci surgical robot which uses cutting edge technology to perform complex procedures with greater precision. The robot was generously funded by RUHX and will be great for the future of our community – we're really proud of our teams who have worked tirelessly to make this happen and look forward to telling you all about it. Make sure you secure your seat:

- Website: **https://RUHAGM23.eventbrite.co.uk**
- Phone: 01225 821262

16. Senior Management Appointments

The Trust has appointed two Deputy Chief Nurses following a selection process on 25th and 26th April 2023. Olivia Ratcliffe who is currently Divisional Director of Nursing for Family and Specialist Services at the RUH was appointed along with Jason Lugg who joined the Trust on 14th August 2023 from Royal Devon University Healthcare NHS Foundation Trust where he was the Director of Nursing (Northern Services).

Following a rigorous recruitment process on the 8th & 9th June 2023, the Trust has appointment Paran Govender as its new Chief Operating Officer.

Paran, who will start at the RUH on Monday, 2nd October, joins the Trust from Guy's and St Thomas' NHS Foundation Trust, where she has been based for the last four years. Paran has worked at a number of NHS organisations, most especially King's College NHS Foundation Trust where she held a number of roles over her 18 years with the Trust.

Paran brings with her extensive clinical and leadership experience as an Occupational Therapist, Chief Therapist and Director of Operations and Partnerships in South East London. Paran is a respected leader focussing on clinical pathway redesign, operations, system wide transformation and strategic development. Driven by her commitment to make a positive difference, Paran has successfully built collaborations to design and deliver a range of services to the diverse community served and is looking forward to joining our team to deliver outstanding care for the people in our community.

The Trust has appointed two Deputy Chief Medical Officers following an interview process on Monday, 21st August 2023. Ms Sarah Richards, Clinical Lead for General and Emergency Surgery, Consultant in Laparoscopic Surgeon and Interim Deputy Chief Medical Officer at the Trust was appointed along with Dr Reston Smith who is currently Divisional Clinical Director; Anaesthesia, Surgery, Critical Care and Renal (ASCR) and a Consultant in Intensive Care Medicine at North Bristol NHS Trust. Start dates for both roles are yet to be confirmed.

17. Consultant Appointments

The following Consultant appointment has been made since the last report to Board of Directors:

Dr Jessica Spaull, Specialty Registrar 8 at Gloucestershire Hospitals NHS Foundation Trust was appointed to the post of Consultant Paediatrician on 3rd July 2023.

18. Use of Trust Seal

The Trust seal was used on the 10th July 2023 for the Deed of Variation in relation to an agreement for laboratory services (Lot 8 services – POCT blood gas analysis) and service transfers for interim solution.

19. Chairs Update

During the last two months I have spent a considerable amount of time, as Chair of the Members Board of Wiltshire Health and Care, and also the Acute Hospital Alliance, working with colleagues in the system to create a sustainable and developmental pattern for our future health services. We are faced with short term difficulties but also need to look to the longer term to reform the financial and structural arrangements which currently lead to patients being treated too late and at the most expensive arm of the NHS rather than being supported better, earlier and cheaper.

In addition, I was honoured to attend the celebrations around the creation of the Bath National Pain Centre. This unique quaternary service which helps patients from all over the UK with intractable pain was originally part of the RNHRD and transferred to the Combe Park campus in 2020. Patients stay on site for a couple of weeks at a time in their own bed sitting rooms with a beautiful adapted garden and are taught the coping regimes – both physical and psychological – that allow them to live full lives despite the pain which they endure. Increasing numbers of these patients are younger people whose pain results

from otherwise successful cancer treatment and they spoke very warmly of the transformation in their lives provided by the course.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**6 September 2023**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor(s):	**Alfredo Thompson, Director for People & Culture Niall Prosser, Interim Chief Operating Officer Toni Lynch, Chief Nurse Libby Walters, Director of Finance and Deputy Chief Executive**		
Author(s):	**Jane Dudley, Deputy Director for People & Culture Niall Prosser, Interim Chief Operating Officer Rob Eliot, Head of Quality Assurance / Katia Montella, Quality Assurance Manager Tom Williams, Head of Financial Management**		
Appendices	**Appendix 1: Integrated Performance Report**		

1. Executive Summary of the Report

The report provides an overview of the Trust Performance as at the end of July 2023, aligned to our True North Pillars and breakthrough objectives agreed for the year.

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

Workforce

- The RUH establishment in July 2023 was 5645 whole-time equivalents (WTE).
- Vacancies at the end of July had slightly reduced to 330.9 WTE from 339.6 WTE; decreasing the vacancy rate from 6.02% to 5.86%. This small reduction still places us outside of our target position of 4.0%
- Staff turnover is at 9.48%, which is a continued positive variance against a target of 11.00%; there is focused work taking place around retention tool-kits and preceptorship programmes.
- Sickness absence in July was 4.3% placing us just within the parameters of our target position. Anxiety, stress and depression were the main causes of sickness absence during the month at 1.19%.
- Global majority likelihood of appointment remains decreased slightly, with global majority applicants having a less then equal chance of appointment.
- The Nurse Agency spend as a proportion of the Registered Nursing pay bill has decreased from 4.9% in June to 4.5% in July. The overall agency spend has also slightly decreased in month from 3.85% to 3.39%.
- The percentage figure for Appraisal completion is 90%; all parts of the RUH remain significantly below this target at 75.88%. Corporate (61.3%) and Emergency Medicine (67.66%) have the lowest compliance levels.
- Mandatory and Statutory Training (MaST) training compliance levels are at 88.2%, against a revised target of 85.00%. Information governance compliance has increased from 77.5% in June to 78.5% in July.

Actions are being taken to improve our workforce performance:

Recommend Trust as Place to Work
Improving the feedback from staff regarding 'recommending the RUH as a place to work' requires a multi-faceted approach, as set out in the RUH People Plan. Current priorities are focusing on getting the basics right with a project team (Basics Matter Group) looking to improve the experience through recruitment, changing facilities, car parking, wellbeing support and access to hot food.

Sickness absence attributed to anxiety, stress, and depression.
Support to colleagues is provided through preventative measures such as 'Supporting Sickness Absence' and 'Effective Conversations' training along with utilising Stress Risk Assessments, Occupational Health support, modification of duties and phased return to work. We also encourage wellbeing conversations. Our work on culture and addressing incivility is anticipated to have a positive impact on absence levels and will be evaluated.

Equality, Diversity and Inclusion
There are several work-streams in 2023/23 that are taking place with the aim of reducing unfair discrimination within the workplace, these include (but are not limited to): launch of the Dignity at Work policy, 'Commonalities' campaign, 'Inclusive Recruitment' training and a Positive Action leadership programme.

Recruitment
Improvement work continues in the Recruitment Team to reduce time to hire and improve user experience. The new induction and joining experience launched in July with initial feedback from the face to face induction sessions indicating a positive improvement. The international recruitment pipeline is aiming to welcome 120 Nurses to the Trust by the end of the year to support a reduction in our vacancy rate. To date we've offered 116 positons, of which 48 have already joined us.

Agency
Work is also underway to reduce our agency spend across the Trust via our Agency Reduction plan. Key principles include removing off-framework suppliers, centralising all bookings through Staffing solutions and growing our bank pool of resource. We're looking to support Managers to develop exit plans for high cost agency workers by recruiting to vacancies, moving agency workers onto our Bank or where necessary switching to framework suppliers.

Collaborative work within the BSW has procured a direct engagement model enabling the RUH to release financial savings on agency bookings (excluding nursing). We'll be the first of the three Trusts to go live with implementation underway to support a September launch.

<u>Operational Performance</u>
The Trust continued to manage the impact of strike action in July (8 days).

Urgent Care

- The Trust lost a total of 1,058 hours in ambulance handovers, which is the best performance for the last 14 months. This was driven by improvements in ED processes (introduced fit2sit), and reduced bed occupancy, which supported better flow.
- RUH 4-hour performance during July was 66.5% for the Trust and 57.3% for the RUH footprint, which continues the recent performance delivered over recent months. Further changes are being developed, which should support improved performance over the coming months.
- The Trust had an average of 92 patients waiting who had no criteria to reside, which is 45 fewer than this time last year. Additionally the BSW system is working towards reducing the number to 80, although there remains significant risk.
- The Trust has also recently had its strategy for Urgent Care improvement reviewed by the regional clinical advisor, Stevan Bruijns, on Urgent Care bundle implementation for NHSE southwest. He highlighted the RUH's plan noting "*very impressive and ambitious plan… Just reviewed Bath's UEC dataset. What a brilliant job you guys are doing"*

Elective and Cancer

- In June 62 Day performance improved to 69.5%, which has been consistent for several months now. However, the cancer 62 day backlog has unfortunately increased, due to pressures within Colorectal and Skin. Additional actions are in place and we are forecasting improvement by October/ November, and still forecast achieving the fair share backlog allocation by March 2024.
- ERF year to date is at 100% against the 2023/24 plan, although there has been a review of the plan following national guidance, which means, to deliver the financial delivery the Trust has to deliver 105% ERF. This means the Trust right now has a 5% gap in delivery. The clinical divisions have developed recovery plans, which anticipate delivering 98% of the 2023/24 plan, although further work is ongoing.
- Analysis from theatres demonstrates that without the strike action, the Trust would be delivering the required level of activity.
- During July the Trust reported zero patients waiting over 104 weeks, 15 patients waiting over 78 weeks, and 474 patients waiting over 65 weeks. The challenged specialities remain the same - Gastroenterology and Cardiology.
- The Trust continues to maintain improvement in the British Association of Day Surgery (BADS) day case rate with 87% of eligible patients being discharged on the same day of their treatment.

Quality

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

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

- Serious Incidents with Overdue Actions: There were 3 against a target of <5
- Patient safety incidents per 1000 bed days which in July was 50 against a target of >43
- Number of Hospital Acquired Pressure Ulcers Category 2

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

- Hospital acquired infections
- Never Events (n=2)
- Number of Hospital Acquired Pressure Ulcers Category 3 & 4
- Number of falls resulting in significant harm (n=3)

MRSAB
There was one 1 contaminated sample reported in June, we are no longer required to report this to UKHSA, and the case has been removed from the system.

Clostridioides Difficile
There were 4 cases of Clostridioides Difficile infection (CDI) reported during July with 2 being healthcare onset and 2 hospital associated. There have been 29 cases against a trajectory of 41 for 2023/24. This remains above trajectory.

E coli
There were 14 cases of E coli infections reported during July 2023. 8 cases were hospital onset and 6 were hospital associated. 35 cases have been reported against a trajectory of 72 for 2023/24. This is above trajectory. The cases were associated to: Gastrointestinal (n=4), Lower urinary tract infection no catheter (UTI) (n=3), Unknown (n=4) Hepatobiliary (n=2), skin and soft tissue (n=1).

Klebsiella
There were 4 Klebsiella infections reported during July 2023. 3 cases were hospital associated and 1 community associated. The cases were associated to: Lower urinary tract infection (n=1), Lower urinary tract infection with a catheter (n=1), Gastro (n=2), Hepatobiliary (n=1). 11 cases have been reported against a trajectory of 25 for 2023/24. This is above trajectory.

Pseudomonas Aeruginosa
There were 3 cases of Pseudomonas Aeruginosa infections reported during July. 8 cases have been reported against a trajectory of 12 for 2023/24. This is just over trajectory.

Never Events
There are 4 open Never Events with 2 reported in July 2023, 1 in August 2023 and 1 in March 2023:

- Datix 118940: Wrong Site Surgery (Dermatology) – reported August 2023
- Datix 115436: Wrong Site Surgery (Oral & Maxillofacial Surgery) – reported

July 2023
- Datix 117755: Wrong Site Surgery (Gynaecology) – reported July 2023
- Datix 114057: Wrong Site Surgery (Dermatology) – reported March 2023

Each of the incidents is being reviewed, with common trends and themes being explored. An action plan will be developed to address areas for improvement.

Pressure Ulcers
The ambition for 2023-24 is to have no more than 10 category 2 pressure ulcers, no more than 4 device related pressure ulcers and no category 3 or 4 pressure ulcers.

There was one category 2 pressure ulcer and one category 3 pressure ulcer in July

To strengthen knowledge and skills and improve safety, the Tissue Viability Nurses have been delivering extended face-to-face training sessions around pressure ulcer prevention and management, skin care and equipment usage. The RUH remains a leader in the prevention of pressure ulcers in the region and benchmarking has been added to the report going forward.

Number of falls resulting in significant harm
There were 3 falls resulting in moderate harm or above against a threshold of 3 per month in July. All incidents are being investigated as part of the Falls Serious Harm process and the QI Falls lead is working with teams in the higher contributor areas.

A revised Falls Fishbone has been created and the falls work plan updated to focus on key preventative measures including deconditioning, appropriate footwear, enhanced observations and staff knowledge and training.

Falls training has also been completed with the Clinical Practice Facilitators for top contributing areas for falls to enable them to provide additional local training for falls prevention for staff in these areas.

Actions following unannounced CQC inspection of Medical care
Targets are not currently being met for Adult Safeguarding Training for Level 2 with compliance at 84.02%. Direct contact is being made with staff who are coming out of compliance or non-compliant for Safeguarding training with a particular focus on Level 2 training.

Compliance for Level 3 training has increased with 93.04% compliance. A new daily audit form for assessing adherence to Mental Capacity Assessments (MCA) and Deprivation of Liberty Safeguards (DoLS) requirements has been developed on MS Form and is being piloted on Combe Ward before being rolled out to the rest of the Trust.

Patient Support and Complaints Team (PSCT)
Response Timeframe for Complaints

63% of complaints closed during July met the required timescale of 35 working days (12/19), representing a worsened performance to the previous month. The worsened response rate deteriorated across the 3 clinical Divisions. Weekly meetings are held to monitor progress. The number of re-opened complaints remains very low.

The number of complaints received has decreased again in July and remains well under the average (30) for the year. The single point of access for concerns and complaints is working well and it is likely that this has contributed to the reduction in the number of formal complaints.

There were 389 PSCT contacts in July, which is a reduction from the number in June (440). The number of contacts responded to within 2 days has decreased from 57% in June to 54% in July. The complexity of some of the cases and a vacancy in the PSCT team meant that it was difficult to resolve concerns within 2 days.

59% of contacts were resolved in 5 days. The additional member of staff in the PSCT started in post in August and it is expected that this will support an improvement in response times.

Friends and Family Test (FFT)
The proportion of patients across the Trust that responded positively (very good or good) about their overall experience this month was 97.7%. All 3 clinical divisions scored above 97% (target = 95%).

The Trust has signed an annual contract with Healthcare Communications to send out text messages to patients who attend the hospital – this includes the Emergency department, inpatient wards, outpatients, maternity, etc. It is expected that this will increase the amount of feedback that we receive. Feedback will be seen in 'real-time' and will be available to the wards via a ward dashboard.

Finance

- At the end of July, the Trust is in a deficit position of £7.0 million which is £1.6 million worse than plan. A large proportion of the adverse position is due to costs relating to industrial action of £0.9million.
- There are a number of financial risks being managed, the most significant being the delivery of the £23.5 million savings target; continued industrial action; an increase in non-pay costs; temporary staffing costs to meet demands in services and under delivery of the elective recovery programme. The Trust's Improvement Programme is focussing on managing these risks.

2.	Recommendations (Note, Approve, Discuss)

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

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

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The Integrated Performance Report is linked to the Board Assurance Framework and Risk Register. A failure to demonstrate systematic quality improvement in the delivery of patient care could risk the Trust's registration with the Care Quality Commission.	

5.	Resources Implications (Financial / staffing)
Risks as set out in the paper. Funding awaited for hand-held devices in ED for deteriorating patient safety priority.	

6.	Equality and Diversity
None identified.	

7.	References to previous reports
Monthly updates to Finance and Performance Committee, and Trust Quality & Safety Group.	

8.	Freedom of Information
Private	

9.	Sustainability
None identified.	

10.	Digital
Deteriorating patient priority identifies actions requiring IT input that links to the Trust's Digital Strategy. New E obs Deteriorating patient form to go live.	

NHS
Royal United Hospitals Bath
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Integrated Performance Report

August 2023 (July 2023 Data)

The RUH, where you matter

22/23 Priorities

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

Business Rules

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

The people we work with

The RUH, where you matter

Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

August 2023 (July 2023 Data)

The RUH, where you matter

Executive Summary I

	Performance Indicator	Performing	Outside Tolerance	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4
Trust Goal	Staff Recommend Trust as Place To Work	>=75.0%	<70.0%	56.14%	58.59%	65.34%	57.87%	52.50%	53.90%		
Breakthrough Goal	Experienced Discrimination from Manager/Colleague	<=5.0%	>5.75%			7.63%		12.59%	17.10%		

* Discrimination Question not asked in Pulse Survey prior to Q1 2023/24. Q3 22/23 reflects National Survey results

	Performance Indicator	Performing	Outside Tolerance	Last 12 Months Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Key Standard	Trust Vacancy WTE (Unit 4)	<=296.0	>322.6	267.2	307.3	240.0	194.9	150.9	133.3	114.3	102.8	319.7	359.5	339.6	330.9
Contextual Information	Trust Establishment WTE (Unit 4)			5368.7	5368.7	5368.7	5368.7	5368.7	5368.7	5368.7	5368.7	5586.4	5633.6	5642.7	5645.5
Contextual Information	Substantive WTE (Unit 4)			5101.4	5061.4	5128.7	5173.8	5217.7	5235.4	5254.4	5265.9	5266.6	5274.1	5303.2	5314.6
Key Standard	Vacancy Rate	<=4.7%	>5.2%	4.98%	5.72%	4.47%	3.63%	2.81%	2.48%	2.13%	1.91%	5.72%	6.38%	6.02%	5.86%
Key Standard	In Month Turnover	<=0.92%	>1.00%	1.14%	1.09%	0.83%	0.55%	0.78%	0.56%	0.70%	0.78%	1.00%	0.56%	0.74%	0.39%
Key Standard	Rolling 12 Month Turnover	<=11.0%	>12.0%	12.05%	11.75%	11.72%	11.78%	11.74%	11.44%	11.16%	10.63%	10.78%	10.43%	10.08%	9.48%
Contextual Information	Leavers Inside 1st Year WTE (Permanent Contract Held, All Reasons)			15.0	13.2	13.2	4.9	7.6	8.9	6.2	11.2	10.5	7.0	7.2	2.2
Contextual Information	Bank Use (Staffing Solutions Data)			261.5	284.3	343.6	300.4	261.9	288.6	267.3	290.2	312.6	336.7	311.8	222.2
Contextual Information	Agency Use (Staffing Solutions Data)			130.9	126.0	109.1	85.3	80.8	100.7	84.1	89.3	75.1	87.0	87.0	82.7
Key Standard	Agency Spend as Proportion of Total Pay Bill	<=2.5%	>3.5%	5.40%	3.87%	3.37%	2.98%	3.50%	3.44%	3.20%	4.19%	3.34%	3.69%	3.85%	3.39%
Contextual Information	Agency Spend			£1,269K	£1,051K	£817K	£710K	£876K	£805K	£830K	£1,127K	£855K	£1,000K	£976K	£863K
Key Standard	Nurse Agency Spend as Proportion of Registered Nursing Pay Bill	<=3.0%	>4.0%	12.08%	8.46%	11.46%	5.50%	3.07%	7.65%	5.53%	4.59%	4.36%	4.58%	4.90%	4.50%
Key Standard	In Month Sickness Rate (Actual) - Reported 1 month behind	<=3.9%	>4.4%	4.57%	4.44%	5.02%	4.61%	5.75%	4.98%	4.60%	4.70%	4.20%	4.23%	4.30%	
Contextual Information	In Month Sickness - Estimated Cost (£m)			£0.68m	£0.66m	£0.78m	£0.71m	£0.94m	£0.84m	£0.66m	£0.74m	£0.63m	£0.72m	£0.71m	
Key Standard	Rolling 12 Month Sickness Rate - Reported 1 month behind	<=4.3%	>4.8%	5.59%	5.55%	5.49%	5.43%	5.43%	5.32%	5.25%	5.08%	4.93%	4.89%	4.81%	
Tracker	Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.17%	1.11%	1.05%	0.99%	0.98%	0.99%	0.99%	1.01%	1.00%	1.01%	1.05%	
Contextual Information	In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.02%	0.94%	1.04%	0.90%	1.00%	1.05%	1.00%	1.05%	1.04%	1.03%	1.19%	

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

** Vacancy figures does not include reserves or QIPP

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Recommend Trust as Place to Work	• 53.9% of staff recommended the Trust as a place to work in the latest survey, whilst only 17.7% stated that they would not. The positive response rate is an improvement on the previous survey, but is one of the lowest rates across surveys to date.	The 'Basics Matter' programme looks to improve staff experience by getting the basics rights to include car parking, uniforms, pay, and food offerings.
Experienced Discrimination	• 17.10% reported experiencing discrimination from a manager or colleague in the latest pulse survey. This is an increase of 4.5 percentage points on the previous survey.	
Vacancy	• Vacancy Rate has marginally improved to 5.85% based on the current data held. Work is ongoing to improve the quality and accuracy of the vacancy data.	Work is beginning to develop a plan for every post to establish our true vacancy position. The approach will support improving quality and accuracy of our vacancy data, which in turn enables us to build a recruitment pipeline with a trajectory on when we'll have a positive impact on the vacancy rate.
Sickness Absence	• The rolling 12 month sickness rate continues to improve, but at	HR Business Partners continue to work with local areas to support colleagues.

Executive Summary II

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
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	0.63	Not Available	Not Available	Not Available	0.87	0.82	0.72	0.67	0.68	0.69	0.73	0.67
Contextual Information	% of Band 6/7 who are from Global Majority Background (WTE)			11.74%	11.98%	12.48%	12.47%	12.53%	12.83%	12.72%	12.81%	13.05%	13.00%	12.99%	12.93%
Contextual Information	% of Band8A+ who are from Global Majority Background (WTE)			4.42%	4.67%	4.76%	5.09%	5.08%	5.25%	5.21%	5.03%	5.13%	5.43%	5.99%	5.56%

				Last 12 Months											
	Performance Indicator	Latest Month Target	Outside Tolerance	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Key Standard	Appraisal Compliance Rate	>=90.0%	<85.0%	71.85%	72.88%	72.96%	74.75%	75.51%	72.73%	77.89%	76.00%	74.89%	73.12%	72.76%	75.88%
Contextual Information	Global Majority Appraisal Compliance Rate	>=90.0%	<85.0%	74.00%	72.95%	73.93%	75.07%	76.37%	75.00%	76.40%	73.89%	72.48%	71.46%	71.13%	74.33%
Key Standard	Mandatory Training Compliance (exc Bank)	>=85.0%	<80.0%	85.10%	85.40%	85.80%	86.40%	86.50%	86.00%	86.00%	85.80%	85.80%	85.80%	87.30%	88.20%
Key Standard	IG Training Compliance	>=95.0%	<90.0%	75.30%	75.50%	77.40%	77.80%	76.70%	75.70%	76.90%	76.30%	75.80%	77.00%	77.50%	78.50%
Key Standard	Safeguarding Adults Level 1 Compliance	>=90.0%	<85.0%	82.90%	82.80%	83.10%	83.30%	83.40%	82.70%	83.30%	83.30%	83.10%	83.30%	85.60%	87.30%
Key Standard	Safeguarding Adults Level 2 Compliance	>=90.0%	<85.0%	81.60%	81.60%	81.50%	81.70%	81.90%	81.70%	82.90%	82.60%	82.80%	83.00%	85.50%	86.30%
Key Standard	Safeguarding Adults Level 3 Compliance	>=90.0%	<85.0%	63.80%	61.60%	59.70%	67.70%	66.10%	65.20%	73.70%	66.70%	71.10%	81.80%	81.60%	88.40%
Key Standard	Safeguarding Children Level 1 Compliance	>=90.0%	<85.0%	82.80%	82.90%	83.30%	83.60%	84.00%	83.40%	83.80%	84.10%	84.30%	84.40%	85.50%	87.00%
Key Standard	Safeguarding Children Level 2 Compliance	>=90.0%	<85.0%	82.60%	83.00%	83.30%	84.00%	84.30%	84.00%	84.50%	84.80%	85.40%	85.60%	86.30%	87.10%
Key Standard	Safeguarding Children Level 3 Compliance	>=90.0%	<85.0%	78.70%	81.10%	80.40%	79.40%	81.60%	83.40%	84.80%	82.30%	85.40%	86.30%	86.90%	89.40%

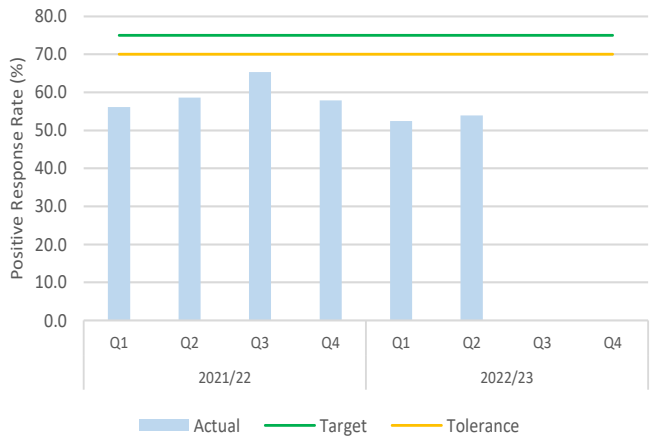
** Training data based on Learning Together from Jun-23

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Appraisal	• Compliance has improved to 75.88%, reversing the recent downward trend. However this remains some way off the 90% target.	Development of electronic appraisal system is underway on the new LMS. The aim is to improve data quality, user experience and compliance.
Agency Spend	• Agency spend was 3.39% of the total pay bill, exceeding target by 0.8 percentage points.	An Agency Reduction plan is being rolled-out to reduce our reliance on agency workers. Key principles include: • Removing off-framework suppliers • Centralising all bookings through Staffing solutions • Growing our bank pool of resource • Supporting Managers to develop exit plans for high cost workers by recruiting to vacancies, moving agency workers onto the Bank, and where necessary switching to framework suppliers.
IG Training	• IG compliance continues to fall short of its 95% target at 78.5%	IG training compliance is being reviewed at monthly IG group

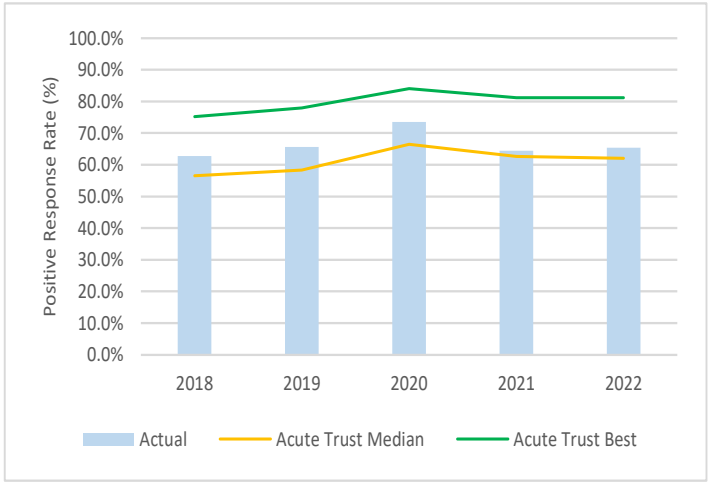
Trust Goal | Staff Recommend the Trust as a Place to Work

Making a Difference Survey Result



Latest Survey	53.9%

National Survey Results



Latest Survey	65.3%

Is standard being delivered?

• 53.9% of staff recommended the Trust as a place to work in the latest Pulse Survey. Whilst this is a marginal improvement from the previous survey, this still constitutes one of the lowest favourable scores received in the local surveys to date.
• It should be noted that whilst 44.1% did not give a positive response, only 17.7% gave a negative response.

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

•Medicine (47.5%) and Corporate (47.6%) had the lowest positive response rates at Divisional level.

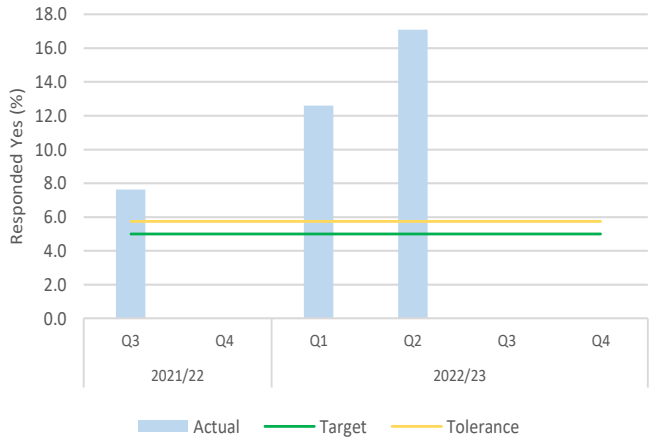
Countermeasure Summary

Countermeasure/Action	Owners
Improving the feedback from staff regarding 'recommending the RUH as a place to work' requires a multi-faceted approach, as set out in the RUH People Plan; delivery of all elements of the plan is required. Current priorities include: 1.Getting the basics right (through recruitment, changing facilities, wellbeing support, access to hot food etc) 2.Supported first year of employment 3.Equality, diversity and inclusion for all staff. 4.Leadership Development. 5.Refreshing our values and behaviours	All in People Directorate Partnership with Strategy Team and Estates and Facilities

Breakthrough Goal |

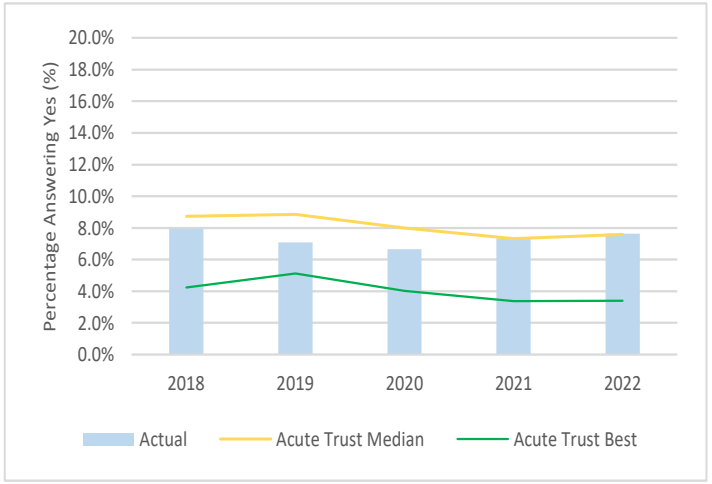
Reduce Proportion of Staff Reporting Experiencing Discrimination from Line Managers/ Colleagues

Making a Difference Survey Result



Latest Survey	17.10%

National Survey Results



Latest Survey	7.63%

Is standard being delivered?

• 17.10% reported experiencing discrimination from a manager or colleague in the latest pulse survey - an increase of 4.5 percentage points on the previous survey.

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

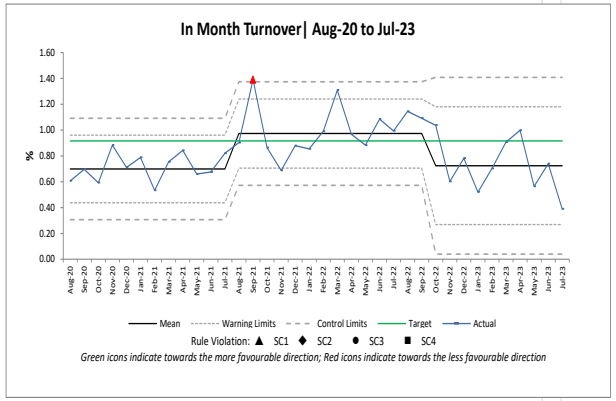
• In percentage terms, Facilities (26.5%) and Surgery (22.7%) had the highest proportion of staff reporting that they had experienced discrimination. However, this was only 13 and 17 people respectively. FASS (29), Corportate (29) and Medicine (30) all had a higher number of individuals reporting a negative experience.

Countermeasure Summary

Countermeasure/Action	Owner
There are a number of work-streams in 2023/23 that are taking place with the aim of improving our colleagues experience of discrimination within the workplace, Current priorities include: 1.Dignity and work policy 2.Commonalities campaign 3.Inclusive recruitment training 4.Positive Action programme at RUH 5.ED&I embedded into induction and leadership programme.	All in People Directorate ED&I team, leadership team, security team

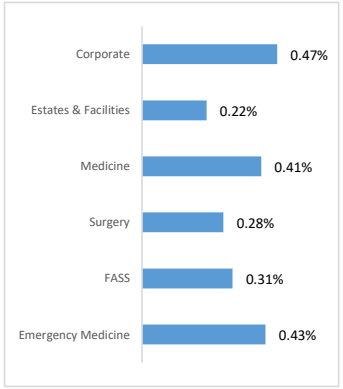
Key Standard| Turnover Rate

In Month Turnover - Trust

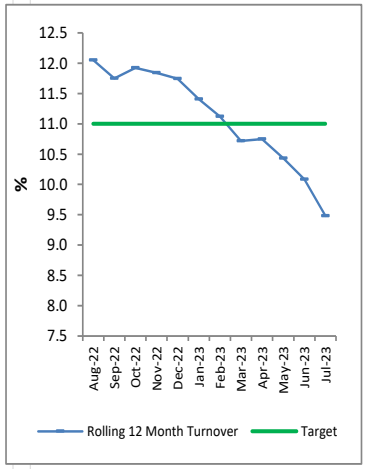


Turnover Rate	0.39%

In Month Divisional Turnover



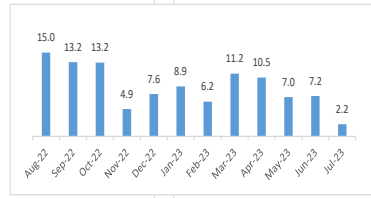
Rolling 12 Months Turnover - Trust



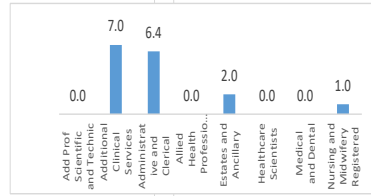
Turnover Rate	9.48%

Leavers Inside 1st Year (Permanent Contract)

Trust Trend



Staff Group - Last 3 Months



Is standard being delivered?

• In month turnover for July was particularly low at 0.39%. As with every month, late notification of leavers could see a rise in this rate. However, it is still expected to be a favourable month.
• Given the low in month turnover, 12 month turnover has naturally also reduced and is now at 9.48%. With August and September 2022 having had in month turnover rates towards the higher end of the spectrum, it is plausible that the 12 month turnover rate could fall further in the immediate future.

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

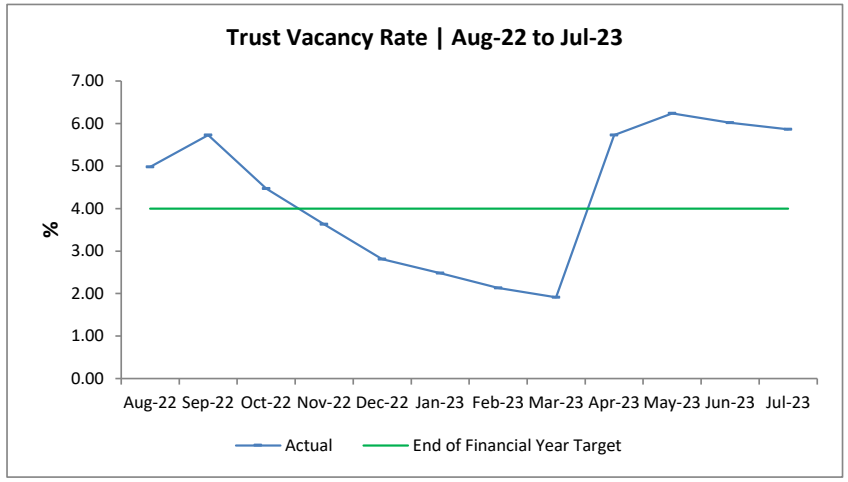
• Of the main Divisions, Estates and Facilities and Corporate are the only areas with rolling 12 month turnover rates exceeding 10% at 12.1% and 11.1% respectively.
• Although AHPs continue to have the highest 12 month turnover of all Staff Groups, recent in-month turnover has been lower.

Countermeasure Summary

Countermeasure/Action	Owner
• Work underway to develop a Retention toolkit	Helen Back
• Preceptorship programme to become mandatory for new starters	Nursing workforce
Basics Matter project launched to address getting some of the basics right for staff. A group of people from across the Trust have come together with the vision to improve staff experience by taking a look at everything from parking, uniforms, food, pay, joining experience and more.	Strategy Team
The on-boarding experience for new starters to extend to their first 12months within the new People Directorate structure to support a reduction in new hire attrition	Recruitment Team

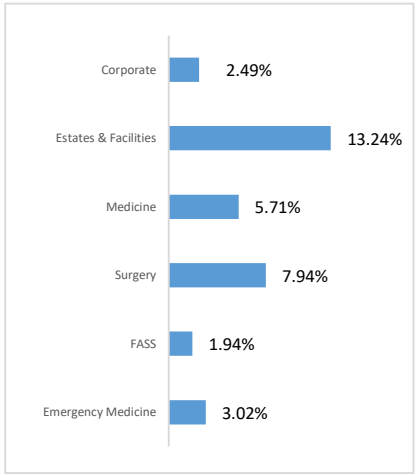
Key Standard| Vacancy Rate

Vacancy Rate - Trust

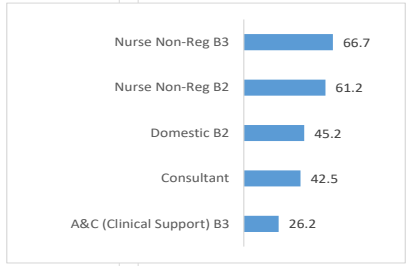


Vacancy Rate	5.86%

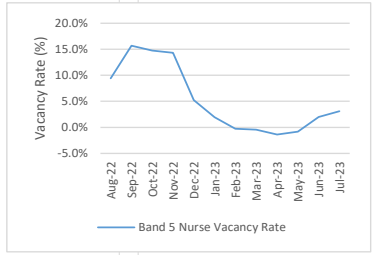
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

• The vacancy rate based on Unit 4 data has marginally reduced to 5.85%, with the vacancy WTE cut by c.9 WTE on the previous month. This exceeds the target set to see the Trust bring its vacancy down to 4% by the end of the Financial Year.
• A significant caveat to the reported figures is the accuracy of the budgets set. Work remains ongoing to improve the quality of this data.

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

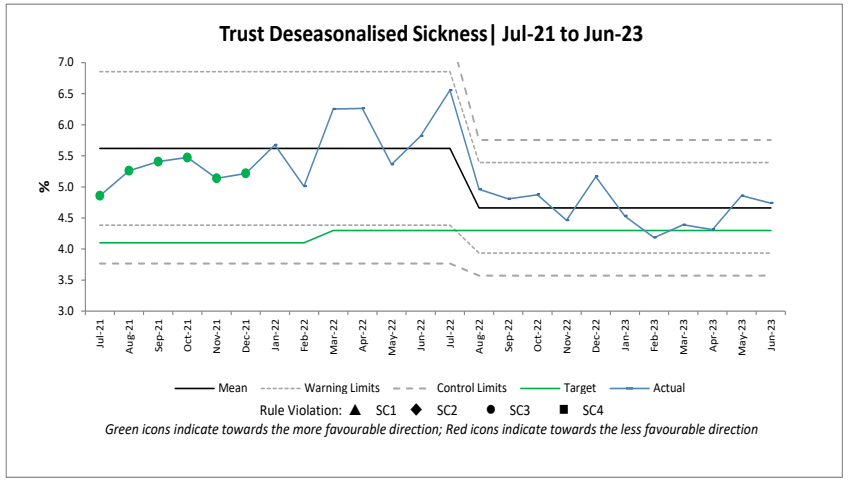
• G07B and G07C - which both relate to unregistered nursing continue to be the two codes with the highest vacancy WTE. However, this is likely to not be fully accurate. For example, 12 WTE were moved from G07C in Forrester Brown this month to C11C to reflect the correct coding following the HCA moves. As further cleansing work is undertaken, a truer picture will emerge. These account codes have greatest impact on Medicine and Surgery, which partially accounts for these areas having the highest vacancy WTE.
• Domestic staff have the third highest vacancy WTE by account code and are the main contributor to Estates and Facilities high vacancy rate.

Countermeasure Summary

Countermeasure/Action	Owner
• The overall position on vacancies is above target as establishment increased in new financial year. The Operating Plan for 2023/24 will require workforce plans to address key shortages.	Deputy Director for People and Culture
• Work is beginning on creating plans for every post to support a recruitment pipeline/trajectory on the vacancy rate	Recruitment Team
• Improvement work continues in the Recruitment Team to reduce time to hire, digitise processes and improve user experience.	Recruitment Team
•International Nursing recruitment pipeline for 2023 set to welcome 120 new joiners by end of year, with a view to having a positive impact on the Band 5 Nursing recruitment pipeline.	Recruitment Team
•The new induction and joining experience launched in July. Initial feedback from the face to face induction is positive.	Digital Talent Programme
•Staff engagement to test the look and feel of the Employee Value Proposition is underway.	Digital Talent Programme

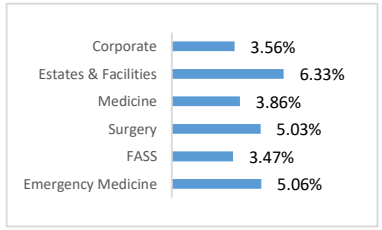
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

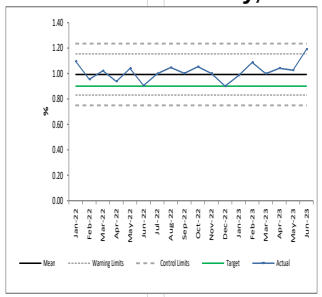


In Month Actual	In Month Deseasonalised	Rolling 12 Months
4.30%	4.74%	4.81%

In Month Divisional Sickness Rates



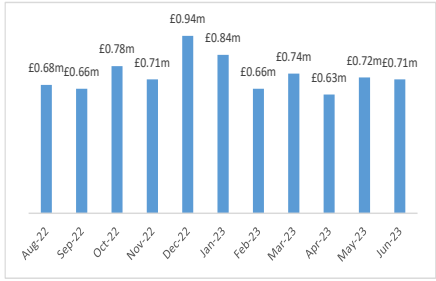
Anxiety, Stress & Depression - Trust



Absence Rate

1.05%

Estimated Absence Cost



RIDDOR Reporting - Employees

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

Is standard being delivered?

• The In Month Sickness rate for June saw a month on month rise to 4.30%. This rate is above target for this point in their year, if the 12 month target of 4.30% is to be realised by the end of 2023/24.
• Rolling 12 month sickness continues for now on a downward trajectory as more historic Covid sickness rolls off the calculation. At 4.81%, it remains half a percentage point above target.

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

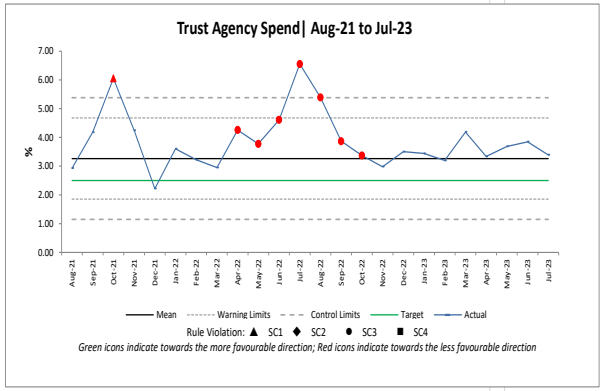
• After a period of relative stability, Anxiety, Stress and Depression rose from 1.03% to 1.19% in June. At this stage, it is plausible that this is simply natural variation, but this will be monitored.
• Estates and Facilities, Emergency Medicine and Surgery all had in month sickness absence rates above 5%.

Countermeasure Summary

Countermeasure/Action	Owner
• Preventative work is focused on anxiety and stress, with staff being encouraged to access support.	People Directorate
Burnout work planned as a tiered approach with an early focus on outreach, stress & burnout prevention with specialist interventions offered in a more targeted way following triage.	Wellbeing Team
• Our work on culture and addressing incivility is anticipated to have a positive impact on absence levels and will be evaluated.	People Directorate with all leaders and managers

Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

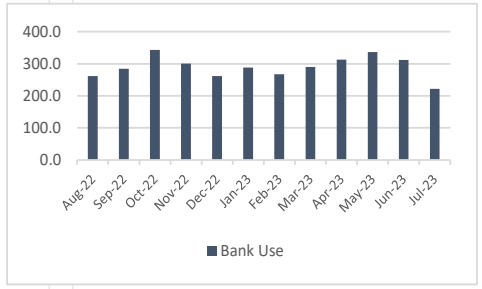


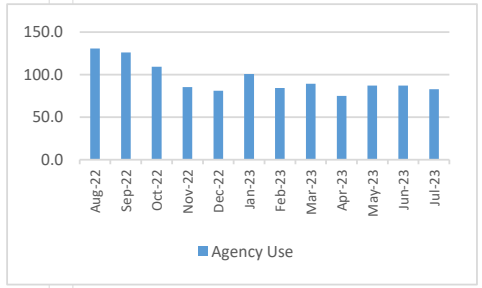
Proportion	3.39%

Agency Spend Breakdown

	In Month	FYTD
Consultants	£248,082	£1,058,158
Junior Medical Staff	£13,466	£62,814
Non Medical - Non-Clinical Staff	£172,621	£769,785
Registered Nurses & Midwives	£353,190	£1,479,775
ST&T - Allied Health Professionals	£75,636	£317,371
ST&T - Health Care Scientists	£0	£1,438
ST&T - Other	£0	£4,556

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

- Agency spend as a proportion of the total pay bill fell marginally from 3.85% to 3.39% in July and remains in control on the SPC chart. However, this continues to exceed the 2.50% target with the SPC chart indicating that it is unlikely that this target will be realised on a consistent basis.
- Nurse Agency spend slightly reduced in July to 4.50% from 4.9%. The Nurse agency spend is broadly stable although we remain above the 4% target.

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

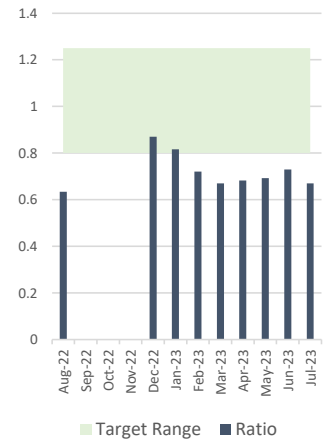
- Registered Nursing accounted for just over 40% of the in month agency spend and remain the highest area of spend for the financial year to date.
. Consultants (28.8%) and Non-Clinical staff (20.0%) were the next highest contributors.
- Nursing & Patient Care, Theatre Staff, Emergency Medicine Medical Staff and Pulteney Ward were the top contributing departments for Nurse Agency spend during July.

Countermeasure Summary

Countermeasure/Action	Owner
Agency usage is reduced primarily by filling vacancies and encouraging the use of the Staffing Solutions (Bank) workforce rather than filling gaps through agency.	Deputy Director for People and Culture
Procurement awarded ID Medical the BSW Direct Engagement model enabling the Trust to release financial savings. Implementation underway with 'Go live' in September	Eugenie Mellon
Joined the Locums Nest Digital Collaborative Bank with effect from Monday 10th July to increase our available pool of Doctors via this new supply route.	Eugenie Mellon
Agency Reduction plan in place to reduce our reliance on agency workers. Key principles include removing off-framework suppliers, centralising all bookings through Staffing solutions and supporting Managers with exit plans to move agency workers onto the Bank, moving to framework or recruiting to vacancies.	Eugenie Mellon & Fern Egan

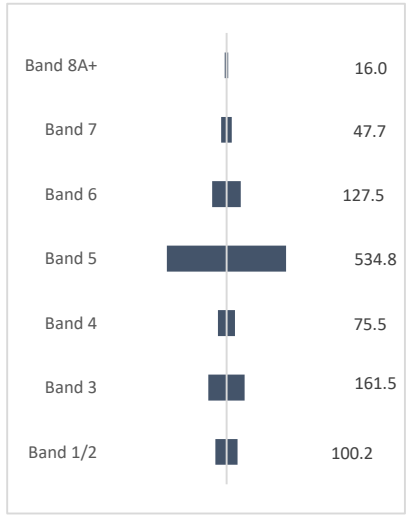
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

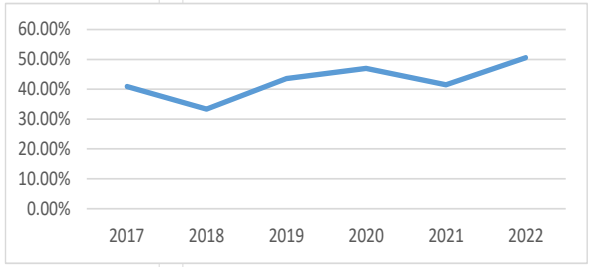


Proportion	0.67

Agency Spend Breakdown



Bank & Agency Use – Staffing Solutions Data



Is standard being delivered?

• The ratio of Global Majority to White appointments remains outside of the two-fifths rule window (0.8 to 1.25) at 0.67.

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

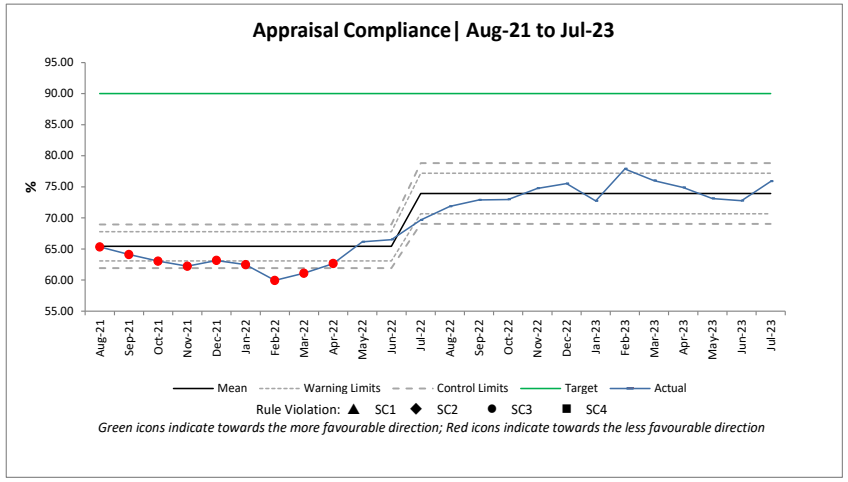
• The calculation does not factor in the recruitment of Overseas Nurses (due to who shortlists) which would inevitably increase that ratio.
• Candidate distribution across vacancies is masked by the aggregation and this has a significant impact in determining the overall figure.

Countermeasure Summary

Countermeasure/Action	Owner
• Positive action leadership programme procured to support colleagues from black and minority ethnic backgrounds access leadership positions. RUH received 5 applicants for the BSW aspiring leaders programme also (highest in BSW).	ED&I lead
• Inclusive recruitment eLearning course launching in September for all recruiting managers to start to challenge bias.	ED&I lead
NHS de-biasing recruitment is also being reviewed to find actions to adapt our current processes.	ED&I lead and Recruitment

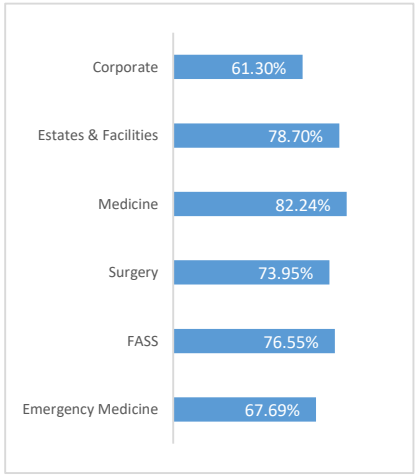
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	75.9%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff 75.7%

M&D Staff 78.2%

Consultants 79.4%

White 76.2%

BME 74.3%

Is standard being delivered?

• Following the recent downward trend, appraisal compliance has recovered to 75.88%, back close to the level witnessed in March. Despite the uplift in compliance this is still below the 90% target.

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

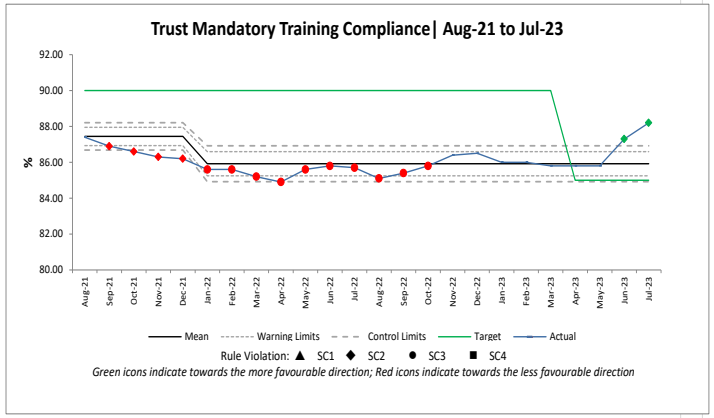
• Corporate has the lowest compliance rate of the main Divisions at 61.30%, with several Directorates currently showing a compliance rate below 40%.
• Emergency Medicine has the next lowest compliance of the Divisions at 67.69%

Countermeasure Summary

Countermeasure/Action	Owner
Development of electronic appraisal system is underway. We're currently building the new solution in the LMS. The aim is to improve data quality, user experience and compliance.	Marjolein Gubb

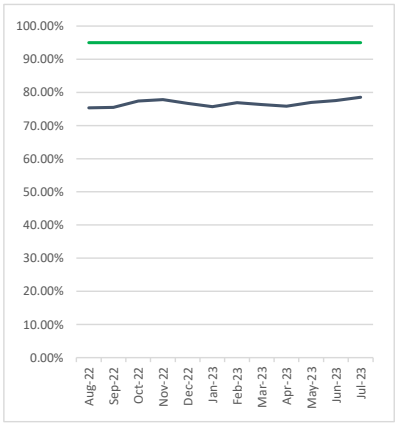
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



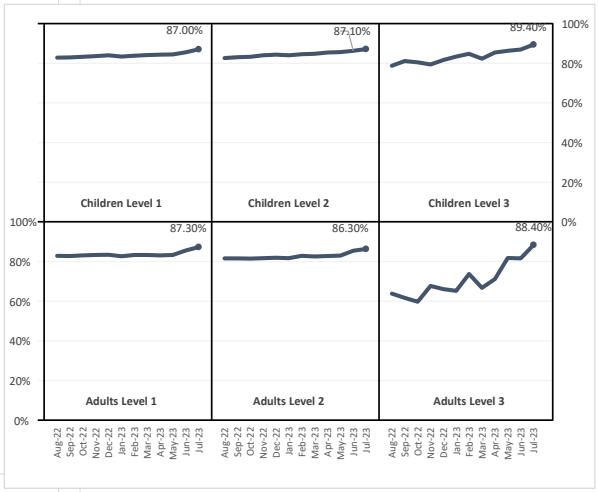
Compliance Rate	88.2%

Information Governance Training Compliance Rate - Trust



Compliance Rate	78.5%

Safeguarding Training Compliance Rates - Trust



Is standard being delivered?

- Mandatory Training compliance continues to improve. This potentially reflecting the recent attention of the introduction of Learning Together. At 88.2%, it is comfortably above the target of 85%.
- IG training compliance continues to improve, but the likelihood of achieving the 95% target in the short term appears low given this would require an 11.5 percentage point increase on the current compliance .

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

- Estates and Facilities has the lowest compliance rate of the main Divisions for both Mandatory Training and IG compliance.

Countermeasure Summary

Countermeasure/Action	Owner
• Work is underway to streamline the MaST Programme, such that compliance is facilitated, both by placing a reduced training requirement upon staff and making learning materials more accessible, through the new Learning Management System (LMS).	MT lead
• IG training compliance being reviewed at monthly IG group.	IG group
Face to face core skills training – bringing back face to face learning for some core skills areas, to support different ways of learning	Head of L&D

The people we care for

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Operational Performance Report

August 2023 (July 2023 Data)

The RUH, where you matter

Executive Summary: Performance

Royal United Hospitals Bath NHS
NHS Foundation Trust

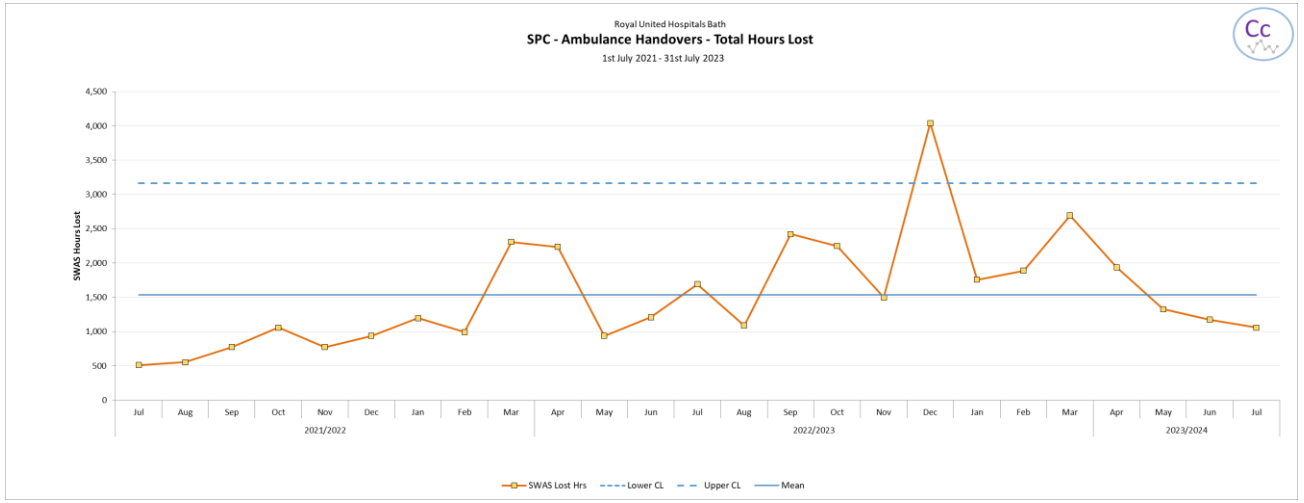
Strategic Goal		Performance Indicator	Target		2022/23						Trend	Movement From Previous Month
			Performing	Under Performing	Feb	Mar	Apr	May	Jun	Jul		
Trust Goals	People in our Community	Ambulance Handover Delays	>=39	<39	689	949	704	460	453	415		
Breakthrough Objectives	People We Care For	4 Hour Performance (Total RUH Footprint, including MIU & Booked)	>=95%	<95%	58.5%	61.5%	64.4%	63.7%	67.0%	66.5%		
	People in our Community	Non Criteria to Reside	<=62	>62	118	123	116	109	108.2	92.3		
Key Standards	People We Care For	RTT - Incomplete Pathways in 18 weeks	>=92%	<92%	61.2%	61.2%	60.9%	61.9%	61.8%	60.2%		
		62 day urgent referral to treatment of all cancers	>=85%	<85%	64.5%	72.5%	68.5%	61.7%	69.0%	(LAG 1)		
		Diagnostic tests maximum wait of 6 weeks	<=1%	>1%	43.5%	39.5%	40.1%	40.2%	41.0%	42.4%		

Measures requiring focus and a countermeasure summary this month are;

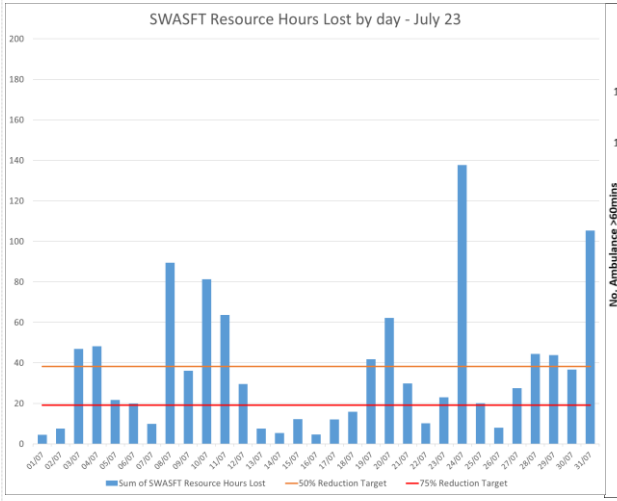
Measure	Change	Executive Summary
Ambulance Handover	↓	In July the Trust lost a total of 1,058 hours in ambulance handovers, a decrease on the previous month. This is the best performance for the last 14 months. The Trust has been making a number of changes within ED to support improved flow (such as introducing Fit2Sit) but also a reduction in the bed occupancy supported further improvements.
4 Hour Performance	↓	RUH 4 hour performance in July was 66.5% and 57.3% on the RUH footprint. The performance over the last two months has been a positive step change. Continued focus on implementing the refreshed urgent care and patient flow strategy is driving improvements in the bed occupancy and supporting more timely flow out of ED. Further work is coming online over the coming weeks that should support further improvements.
Non Criteria to Reside (NC2R)	↓	During July the Trust had an average of 92.3 patients waiting who had no criteria to reside, this is the lowest since February 2021. Compared to July 22 this is 45 fewer patients waiting. The average length of stay is reducing for this cohort of patients. BSW system has committed to reducing the number of patients waiting down to 80 but will struggle to go further.
Referral to Treatment	↓	During July the Trust had 15 patients waiting over 78 weeks at the end of May and over 65 weeks to 474. This is partly caused by delays in patient's pathways due to ongoing Doctors in Training, Consultants and Radiographers strikes. Specific challenges remain within Cardiology and Gastroentrology. Clinical divisions have developed recovery trajectories and interventions for each speciality.
Cancer 62 Days	↑	In June performance of 62 Day performance improved to 69.5%. Skin recorded the largest number of breaches with waiting times for treatment under Oral Surgery a significant factor, as well as waits minor ops procedures in Dermatology. Colorectal performance continues to be challenged by the long waiting times for endoscopy and CT. Urology performance improved in month but still recorded a number of breaches most frequently due to waiting time for prostate MRIs.
Diagnostics	↑	July's > 6 week performance was 42.35%, which represents an increase from previous month (+1.33%). The Trust has rebased its plans for the year to ensure it delivers the national target of 15% patients waiting over 6 weeks. Challenge remains in UltraSound, CT and endoscopy. Driven by demand challenges in cancer pathways.
Elective Recovery	↑	The Trust is delivering 100% of the 23/24 plan year to date although due to a revision of the plan there is a requirement to deliver 105%. Clinical divisions are revising the delivery plans for the year end. Analysis of theatres demonstrates sufficient activity is taking place on non-strike days that would indicate, without strike action, the Trust would be delivering sufficient activity to meet the ERF plan.

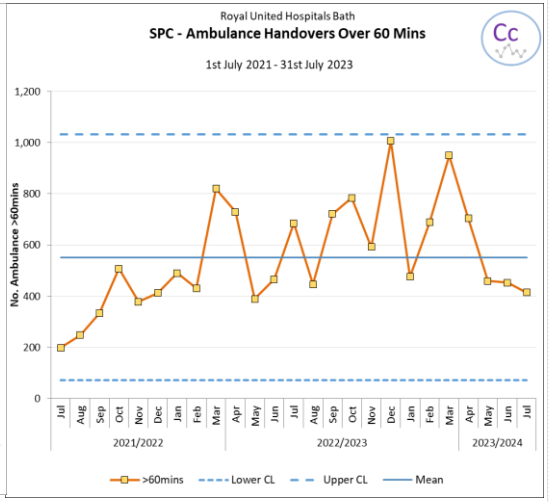
Trust Goal | Ambulance handover delays

Historic Data: hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

In July the Trust lost a total of 1,058 hours in ambulance handovers. This is an improvement compared to June and is the best performance for the last 14 months.

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

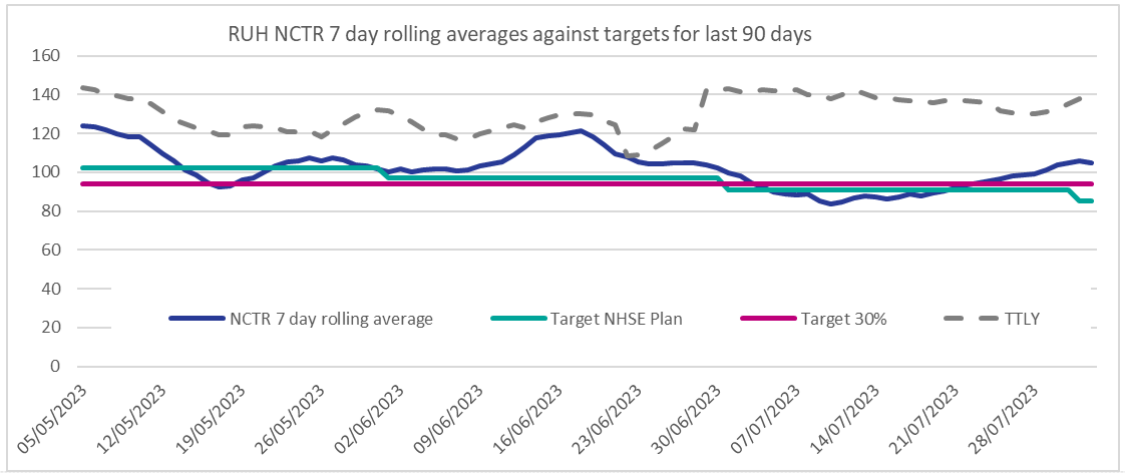
The Trust has continued to drive improvement within the ambulance handover, this is driven by

- Improved Bed Occupancy. During July the bed occupancy was 93.49%
- ED introduced Fit2Sit, which had a phased opened on the 19th of June but was open to 18 patients by the 17th of July. Use within Fit2sit has continued to improve.
- The third graph highlights the greater consistency of improvement over recent months but the middle graph demonstrates that we are still experiencing days of continued pressure.
- 65.1% of ambulances were handed over within 30 minutes.
- Pre-midday discharges within the hospital for July was at 21% against a national target of 33%.

Countermeasures / Actions	Owner	Due Date
Continue to maximise the usage of fit2sit to ensure continuous offloading	ED leadership team	September 23
Continued work to improve the flow functions (site team/ discharge lounge/ ward based work) to bring forward discharges	Niall Prosser	October 23
further reductions in NC2R are being targeted as ways of reducing bed occupancy	Prosser	October 23
ED launching work streams focusing on internal professional standards, streaming and observation ward and focusing on offloading processes	Forsyth	September 23

Breakthrough Goal | Non criteria to reside

Historic Data: as of 05/08/23



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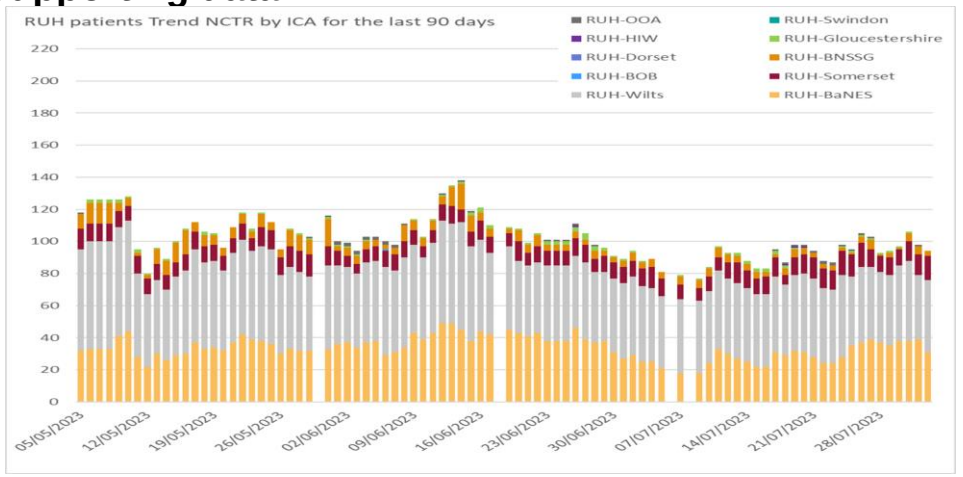


Is the standard being delivered?

During July the Trust had an average of 92.3 patients waiting who had no criteria to reside, which is the lowest average number of waiters since February 2021 and 45 better than this time last year.

This remains above the system target of 80.

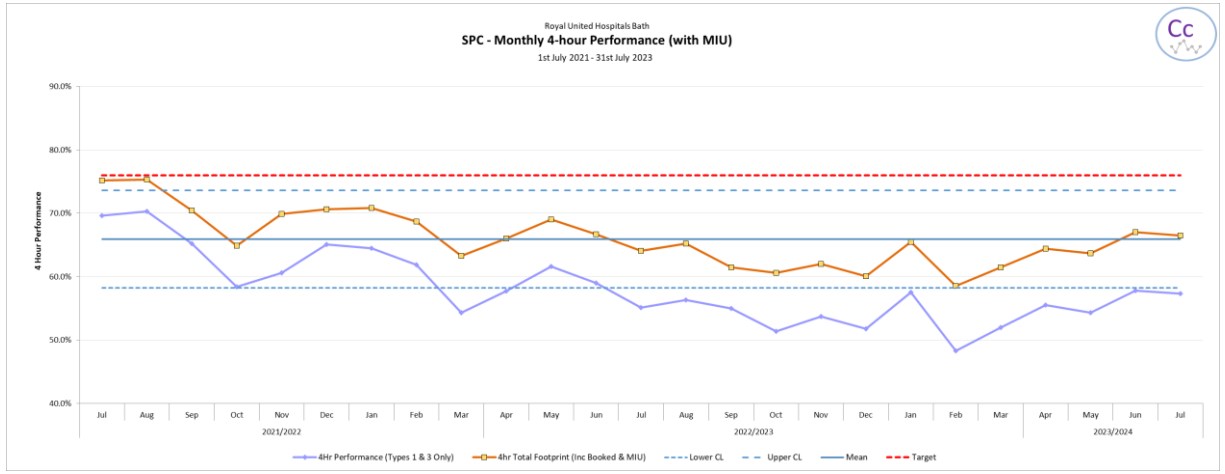
What's the top contributor for under/over achievement?

- Graph top right demonstrates the breakdown of NC2R by locality. The Trust has supported the BaNES system to drive significant improvements over recent months. With work on going to maintain no more than 20 waiters.
- The Wiltshire system has unfortunately seen a worsening of position with limited improvements. There are currently circa 50 patients waiting wiltshire
- The Trust P0 performance has improved over recent months. It is anticipated that we will consistently report between 10-15 pts waiting. All will have a reported delay of less than 2 days.

Countermeasures / Actions	Owner	Due Date
Identifying with each ICA the actions required to deliver performance in line with 50% target within 2023/24. - further work to support wiltshire	Goddard	October 23
Growing the RUH community services through Hospital at Home to 35 pts, ART+ to 40 pts and UCBaNES to deliver 1,000 care hours	Hopkins / Griffiths	October 23
Exploring alternative options for supporting the likely remaining 55-80 NC2R patients within the RUH – linked to winter plan	Prosser	September 23
Urgent actions with Wiltshire system to recover the position – spending £500k to improve the position	BSW ICS	August 23

Key Standards | 4 hour Emergency Standard

Historic Data



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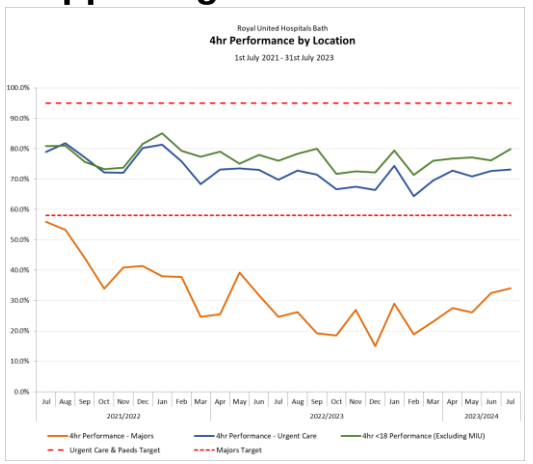
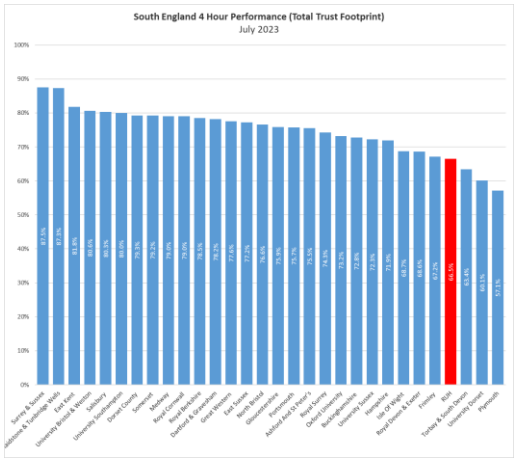




Is the standard being delivered?

RUH 4 hour performance during July was 66.5% at Trust wide level and 57.3% within the RUH footprint. The Trust is targeting getting to 76% by October, with a national plan requirement to deliver by end of 23/24. The stretch target is 80% within Q4.

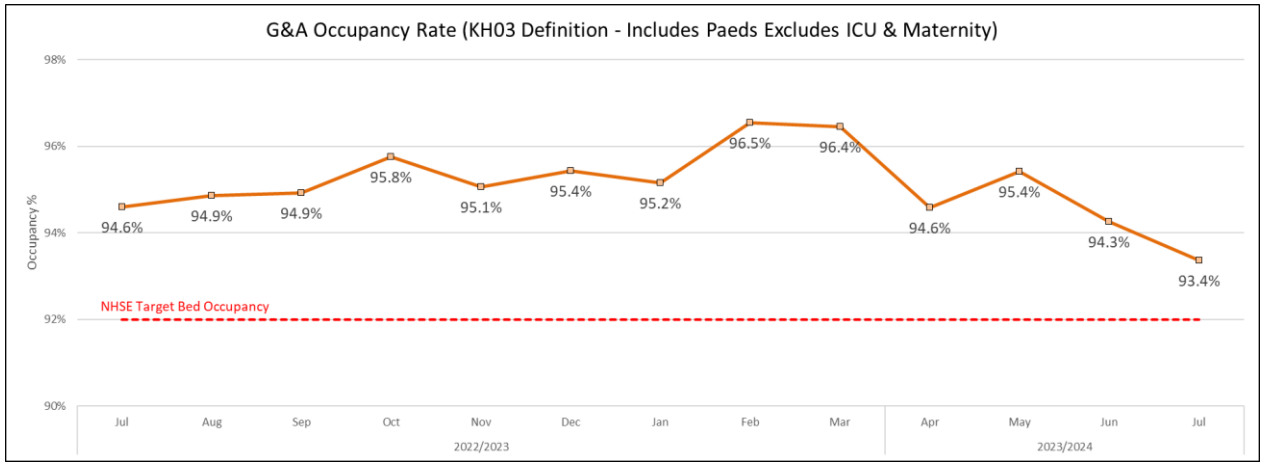
What's the top contributor for under/over achievement?

- As part of the Transformation plan the Trust is utilising the subject matter expert to test the assessment of the challenges that present. The focus is also on reviewing the actions and plans identified within the Improving Patient Flow Strategy and ensuring that the delivery mechanisms are in place.
- Bed occupancy remained above target in month at 93.49%, which causes periods of delay.
- Urgent Care Performance (as a subsect of the total 4 hour performance) during April was 73.22%.

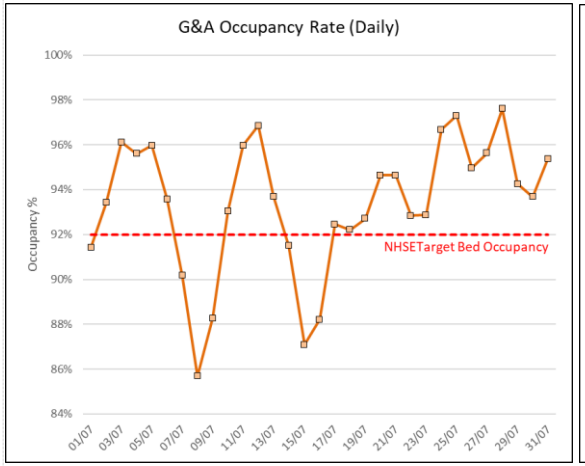
Countermeasures / Actions	Owner	Due Date
Development of Medical staffing business case to support delivery of activity in 23/24	Forsyth, Prosser	In progress
System agreement for the Urgent Treatment Centre to change its service provision between 2200-0800 each day.	Prosser	September 23
Launching new Urgent Care rota which is expected to improve demand and capacity.	Thorn	October 23
Ensuring implementation of the revised Emergency and Urgent Care Strategy is complete for winter.	Prosser	November 23
On going cultural work within ED to highlight importance of 4 hr performance.	Forsyth, Thorn	September 23

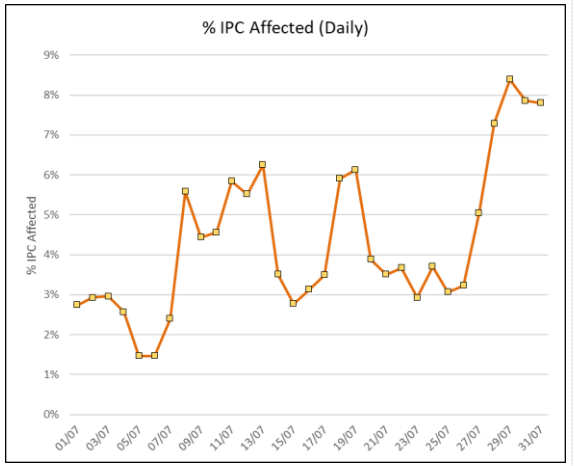
Key Standards | Bed Occupancy

Historic Data



Supporting data





Is the standard being delivered?

NHS England target as described in the Urgent and Emergency Care Recovery Plan indicates that bed occupancy should be 92%. For July the Trust's bed occupancy reduced to 93.4%

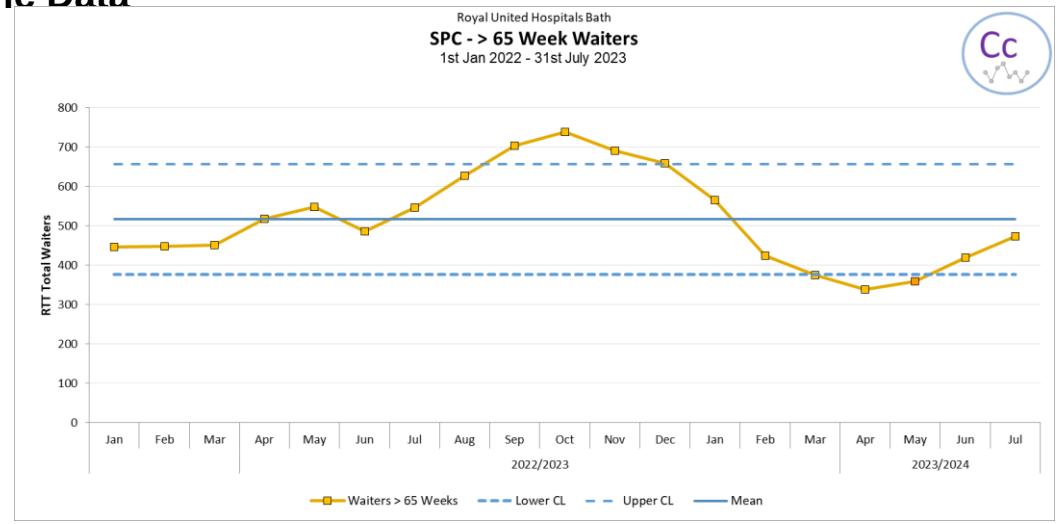
What's the top contributor for under/over achievement?

- Bed occupancy is driven by;
  - Number of beds available – during May the Trust saw a reduction in the beds impacted by outbreaks as we dropped from circa 10% in April to an average of 5% in July.
  - SDEC rate – the Trust has performed well on SDEC. In July the Trust discharged 33.6% pts on the same day. The Trust is targeting 40%
  - Length of stay – Non Elective Length of stay for the Trust in July was is 3.8 days – improvement of circa 10%. Likely linked to additional consultant presence on wards during strikes.
  - NC2R – As highlighted in the above slides, this has improved but further work to reduce to target level. BSW system has committed to get to at least 80 pts. Wiltshire remains significantly challenged.

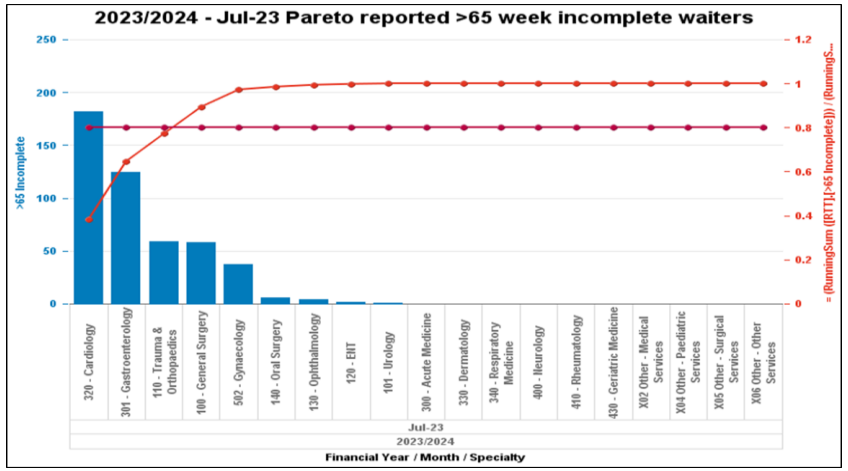
Countermeasures / Actions	Owner	Due Date
Recruiting to agreed business case expanding SDEC to support reaching 40% same day discharge	Medicine	Q3 23/24
Implementation of urgent care and patient flow strategy to support further bed reductions	Surgery	Q3 23/24
Midford ward reopened during May – third of ward remains closed. Using B36 to offset	Medicine	October 23
Implementation of winter plan actions to further reduce bed occupancy over winter	Prosser	November 23

Key Standards | Referral to Treatment

Historic Data



Supporting data - *Pareto 65+ by Specialty*



Is the standard being delivered?

- In July the Trust had 474 patients waiting over 65 weeks, 55 more than June.
- 15 patients waiting over 78 weeks,
- RTT performance was 60.2% in July, -1.6% change from June
- The National average RTT performance is 58.8% (latest published data May-23) GWH achieved 56.1%, and Salisbury 61.7% in May-23

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

- The top contributors of waiters over 65 weeks are; Cardiology (38%), Gastroenterology (26%)
- Cardiology 65+ wait count has increased by 9 to 182, Gastroenterology has increased by 36 to 125. General Surgery and T&O are close behind, around 59 each
- Progress continues with patients currently breaching 78+ (target 0 by Mar'23). at the end of July there were 15 patients waiting 78+ weeks (Cardiology 8, Gastro 4, T&O 2, Ophthalmology 1)
- The Trust is seeing delays in pathways as a result of the 8 days of strike action undertaken by doctors in training and consultants during July.

Countermeasures / Actions	Owner	Due Date
Individual trajectories and interventions required have been developed for each speciality. The required actions are being monitored through the Trusts RTT delivery group.	Prosser	Q4 23/24
Additional activity has been identified within Cardiology and Gastroentrology to ensure delivery of improvement trajectory	Hudson	October 23
Identifying better use for available Sulis capacity within diagnostic specialities – reducing waits in pathways	Doyle	September 23
Transformation schemes for Theatres and Outpatients have been launched. These are supporting increasing Activity through enhanced productivity. Will support further improvements in RTT.	Prosser	Q3 23/24

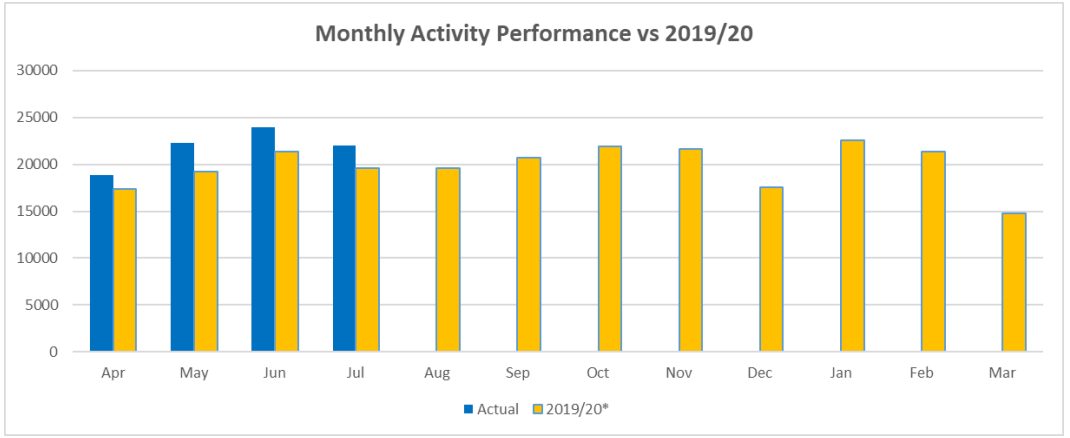
Key Standards | Elective Recovery

ERF Performance

	vs 19/20					vs 23/24 plan				
	M1	M2	M3	M4	YTD	M1	M2	M3	M4	YTD
FASS	101%	121%	130%	121%	118%	88%	94%	105%	99%	96%
Medicine	111%	124%	130%	113%	120%	101%	111%	116%	106%	109%
Surgery	79%	95%	106%	83%	91%	79%	98%	111%	89%	97%
RUH	91%	108%	117%	98%	103%	92%	101%	111%	96%	100%

Supporting data

ERF Activity Delivery



Is the standard being delivered?

- The Trust is delivering 100% of the 23/24 plan year to date although due to a revision of the plan there is a requirement to deliver 105%.

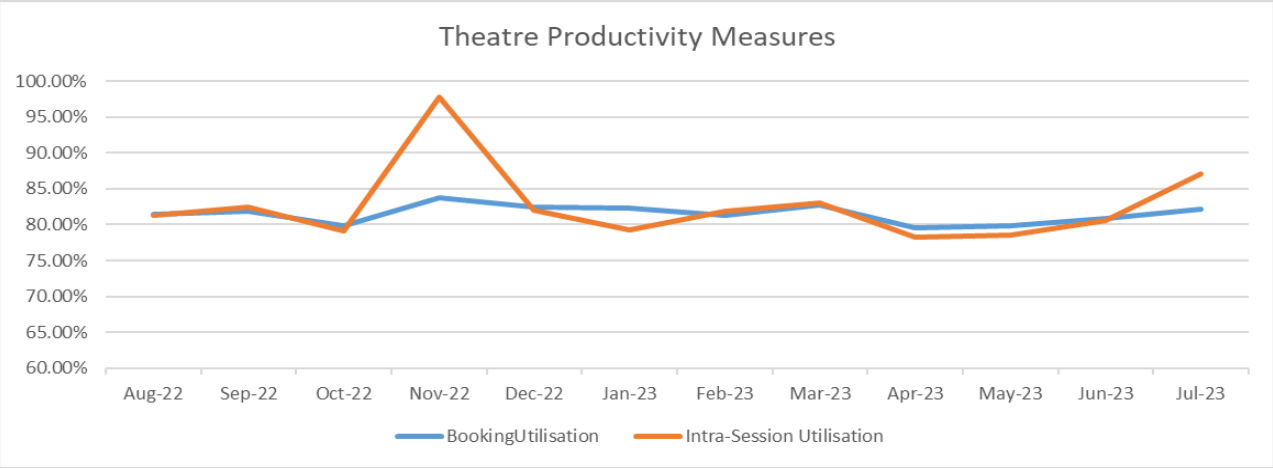
What's the top contributor for under/over achievement?

- July ERF activity down on June, although exceeded 2019/20 and plan volumes
- Junior doctor, Consultant and Radiographer strikes all occurring in July, reducing elective activity delivery
- Elective inpatient particularly challenged in Surgical specialties
- Daycases almost at 2019/20 levels, although remain below plan
- FaSS Daycases are lower, driven by Oncology.
- OP news continue to be high in Cardiology, Gastro, Orthopaedics, Paeds and Oncology
- OP procedures particularly high in Ophthalmology, Cardiology and Dermatology
- Orthopaedic volumes at Sulis lower in July, 40 vs 53 in June and 65 in May.

Countermeasures / Actions	Owner	Due Date
Clinical divisions have developed ERF recovery plans, currently having transformation overlayed – implementation being monitored	Prosser / Walters	September 23
Continuation of endoscopy insourcing – business case being assessed	Hudson	Roberts
Additional work on going with finance income team and Business Intelligence to identify where activity isn't being appropriately recorded	ERF working group	August 23
Further work to ensure Sulis modular theatre is being utilised as per business case – new clinical lead appointed and uplift in case volume	Surgery Division	August 23

Key Standards | Productivity

Historic Data:



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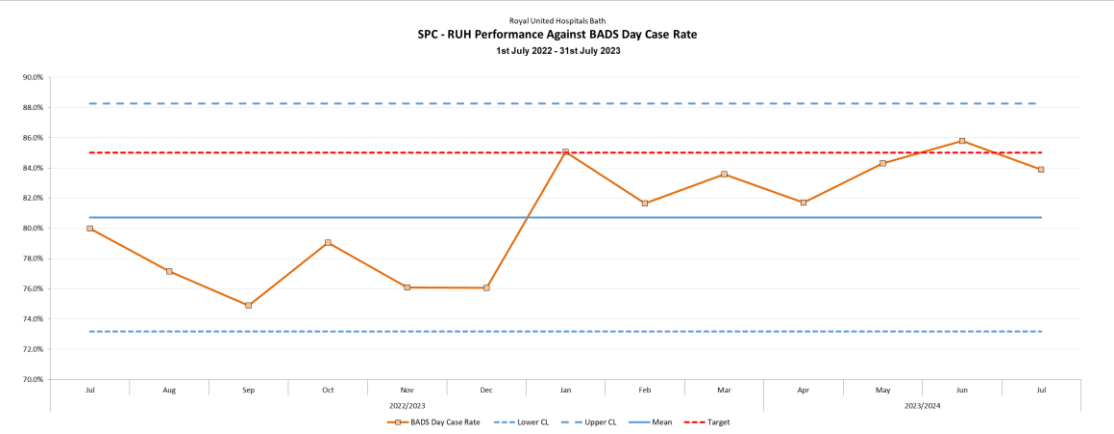


Is the standard being delivered?

- The Trust has established a target that 85% of theatre intrasession (total time a patient is in the theatre). This builds on the national considered best practice. During July the Trust performed at 87%.
- The RUH also aims to book to 85% list available minutes (to allow for turnaround time), in July this was booked to 82%
- The Trust has also identified a target of 85% of procedures which are deemed suitable for Day Case to be undertaken as a day case. In May the Trust performed 86.7%

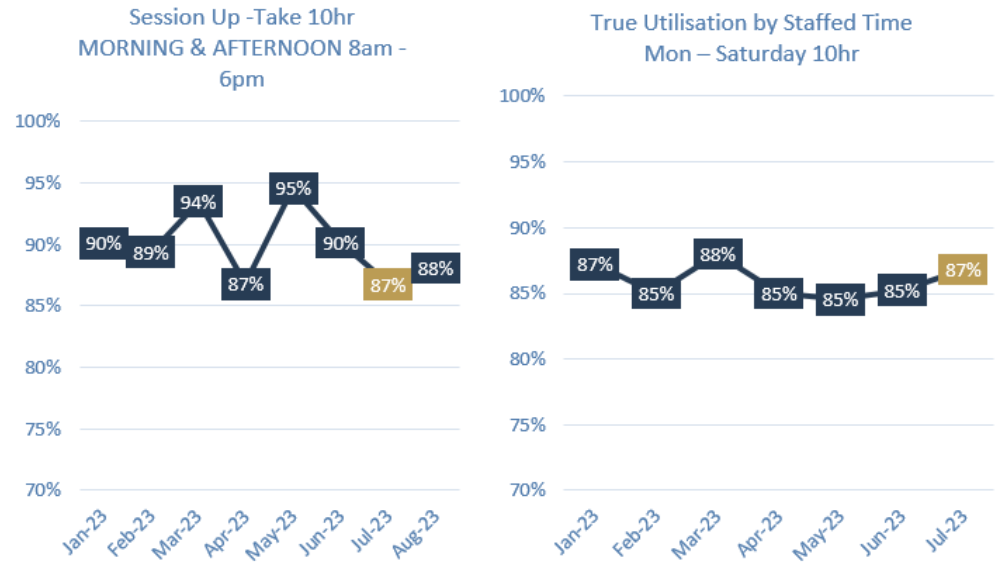
What's the top contributor for under/over achievement?

- Trust is utilising in sourcing company to support theatre staffing position to ensure list up take can continue to improve.
- The on going strike action is causing significant challenges for theatre productivity. Analysis demonstrates that on non strike days theatres are doing enough activity to meet the plan.
- Transformation workstream has identified opportunities for additional activity.

Countermeasures / Actions	Owner	Due Date
Theatre productivity workstream has been launched – aiming to standardise the theatre performance to be in line with national model	Prosser	October 23
Outpatient working group also launched. Similarly about to undertake similar work within Endoscopy and Cath labs	Prosser/ Hudson	September 23
New clinical leads for theatres and anaesthetics, Sulis and general surgery have been appointed	Robinson	August 23.

Key Standards | Sulis

Historic Data: Theatre vacant sessions



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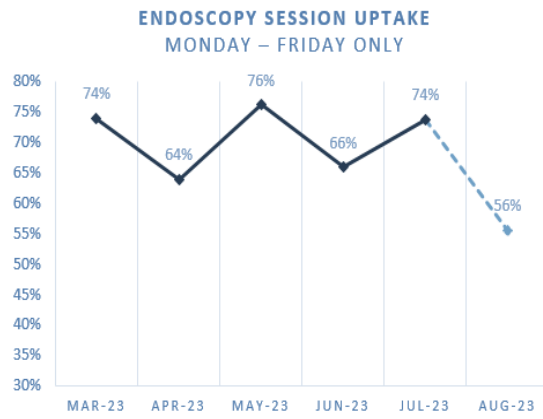
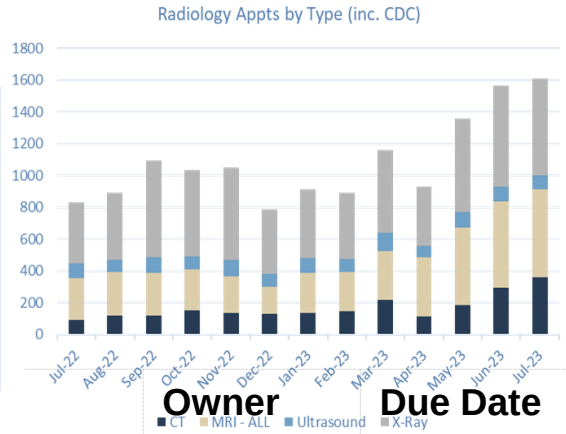




Is t

- T tent at 85%
- Endoscopy session uptake increased to 74% in July although significant risk in August (linked to strikes)
- Radiology volumes increased compared to last month but below March's performance. Metric excludes CDC activity, which continues to grow.
- RTT performance improved and is at 80% - improvement on March.

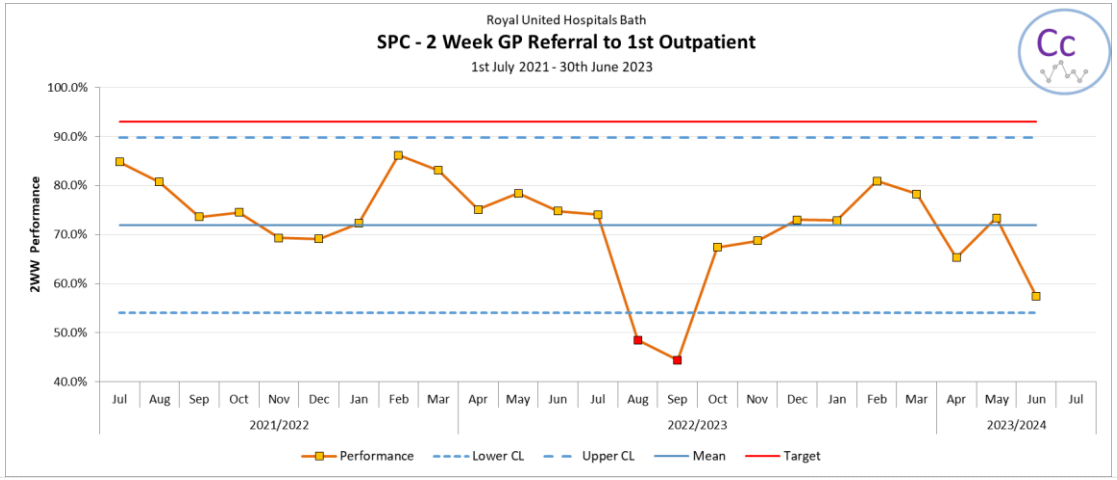
What's the top contributor for under/over achievement?

- Reduction in covered theatre and endoscopy lists at Sulis linked to annual leave and reduced elective sessions as consultants cover strikes at RUH.
- Consultant illness impacted theatre utilisation during the month
- First patients received from Cornwall Trust to introduce new IPT pathway. In additional Somerset Trust have started to send more patients. IPT volumes grown exponentially MoM

	Owner	Due Date
Diagnostic investment into resource and digital infostructure to support additional CDC targets and patient bookings.	Harrison	Q 2
Improve fallow theatre session tracking and improve up-take through a forward-looking mechanism.	Milner	July 23
Additional Endoscopist and improve pathways with RUH are being established to ensure routine flow of 2 week and 6 week wait volumes. - reviewing additional options for scopists as well.	Milner	August 23

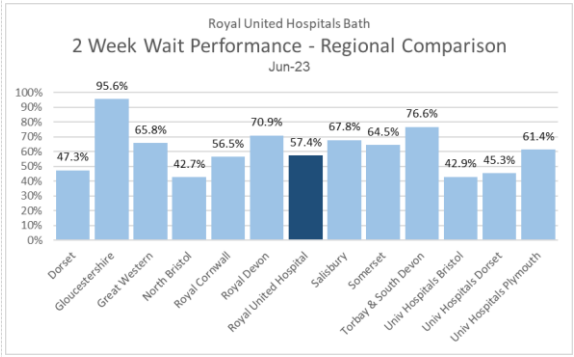
Key Standards | Cancer 2 week wait

Historic Data

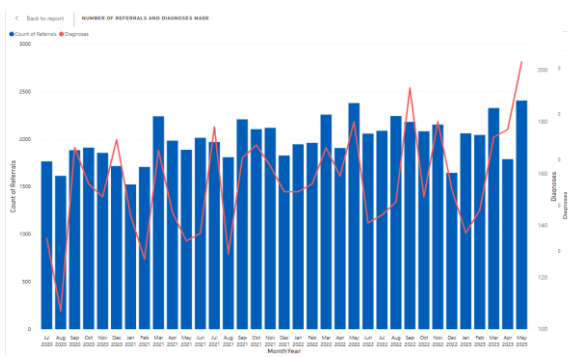


Supporting data

2 week wait Regional Comparison



2 week wait demand and diagnoses



Is the standard being delivered?

In June performance deteriorated to 57.4%.

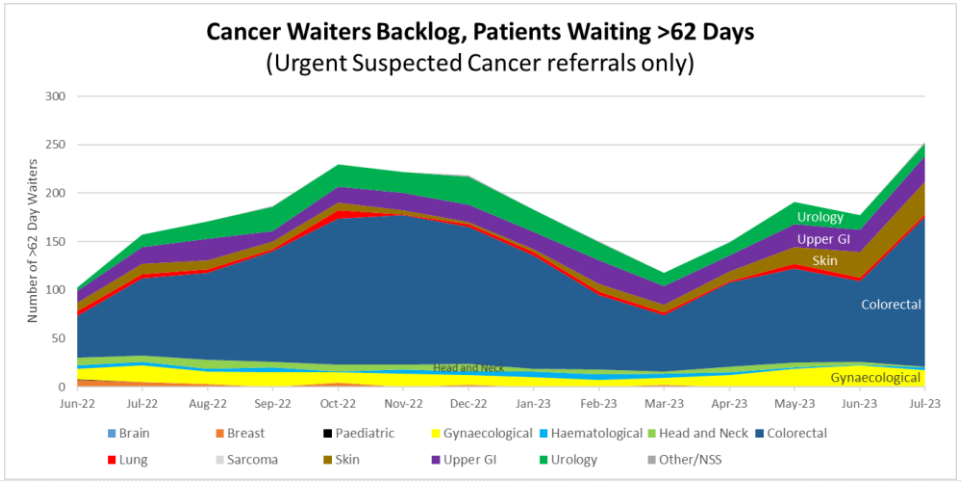
What's the top contributor for under/over achievement?

- A significant proportion of Skin patients were booked outside of their 2ww target. I May Dermatology had received an unprecedented number of referrals which led to an overall increase in waiting times which ran into June. Two consultant vacancies and the impact from strikes resulted in a lengthening of waiting times.
- Colorectal continued to record large volume of breaches, due to the waiting time for endoscopy as well as that for outpatient appointments in Gastro (telephone) or General Surgery (F2F).
- Skin and Colorectal combined accounted for 68.5% of total Trust breaches.
- Upper GI recorded breaches, due also to endoscopy and Gastro OPA waiting times.
- The Gynaecology position improved but breaches were still sustained in the first half of the month due to the sickness of a key clinician in the PMB service.
- In Urology Industrial action has led to larger numbers of breaches and challenges in providing additional U/S capacity for haematuria clinic is impacting recovery.
- NHSE have announced the 2ww target will cease from 1 October 2023.

Countermeasures / Actions	Owner	Due Date
Colorectal – Weekly recovery meeting established.	Griffiths / Roberts / Hudson	July 2023
Colorectal/Upper GI – Endoscopy capacity increased from September following staff recruitment.	R Weston	September 2023
Colorectal – 2ww Nurse Practitioner interviews scheduled in September.	L Brown	September 2023
Skin – WLIs in place across summer, review of Cinapsis process to support demand management.	G Lewis	September 2023
Urology – Additional U/S capacity options being agreed with Radiology (RUH and Bath Clinic)	J Prosser N Aguiar	September 2023

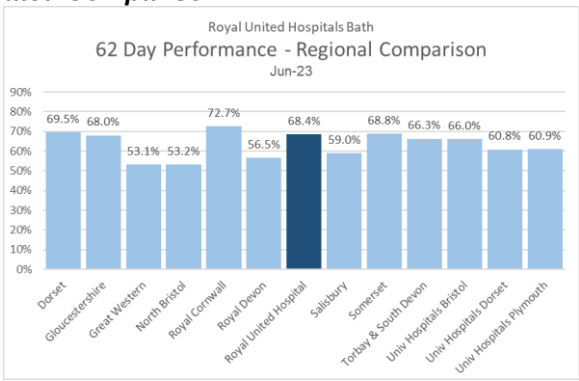
Key Standards | Cancer 62 days

Historic Data



Supporting data

Regional 62 Day Treated Comparison



Is the standard being delivered?

In June performance improved to 69.5%. (July's position is still being validated)

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

62 Day Treated:

- Skin performance deteriorated in month with 11.5 breaches recorded. Waiting times for treatment under Oral Surgery a significant factor, and waits minor ops in Dermatology.
- Colorectal performance continued to be challenged with only 17.4% of patients achieving the 62 day target. Waiting times for endoscopy and CT were apparent in several breaches.
- Urology performance improved in month to 73.8% but a number of breaches were still sustained, most frequently due to waiting time for prostate MRIs.

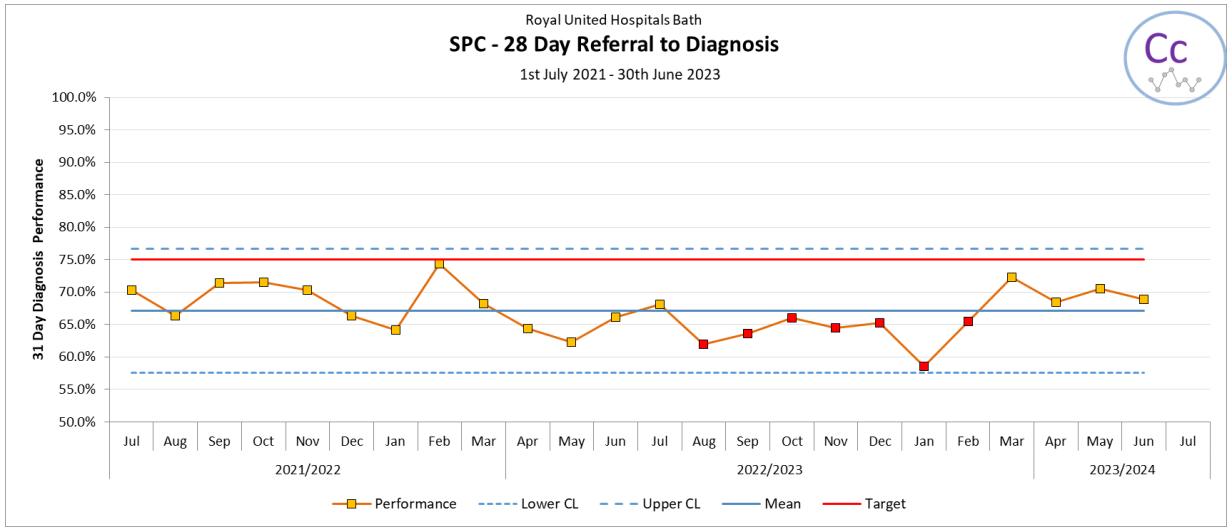
62 Day Waiters (backlog)

- Trust backlog increasing predominantly due to a rise in waiters in Colorectal and Skin.
- Colorectal accounts for 65% of Trust backlog - most patients in diagnostic pathway.
- Upper GI increasing, impacted by the waiting time for EUS and specialist MDT at UHBW.
- Gynaecology slowly reducing, main challenge being wait for hysteroscopy.
- Waiters increasing in August - deterioration in Trust position on national comparison.
- Colorectal and Trust position improving October following endoscopy/radiology actions.

Countermeasures / Actions	Owner	Due Date
Colorectal – Endoscopy capacity increased from 40-47 lists per week in September following staff recruitment.	R Weston	Sept 2023
Radiology – Capacity from Bath Clinic (CT/MRI) and insourcing (U/S) - funding approved	N Aguiar	Aug 2023
Radiology – New GI consultant commencing Oct 23, additional CTC radiographer trained Sept 23 – extra CTC list p/w from Sept 23	N Aguiar	Sept/Oct 2023
Endoscopy – Implement new booking software	R Weston	Nov 2023
Gynaecology – Increase number of hysteroscopies per list.	A Joyce	Aug 2023
Skin – Utilise community BCC service, implement 2ww RAS, new consultant - July 23.	H Cox	Aug 2023

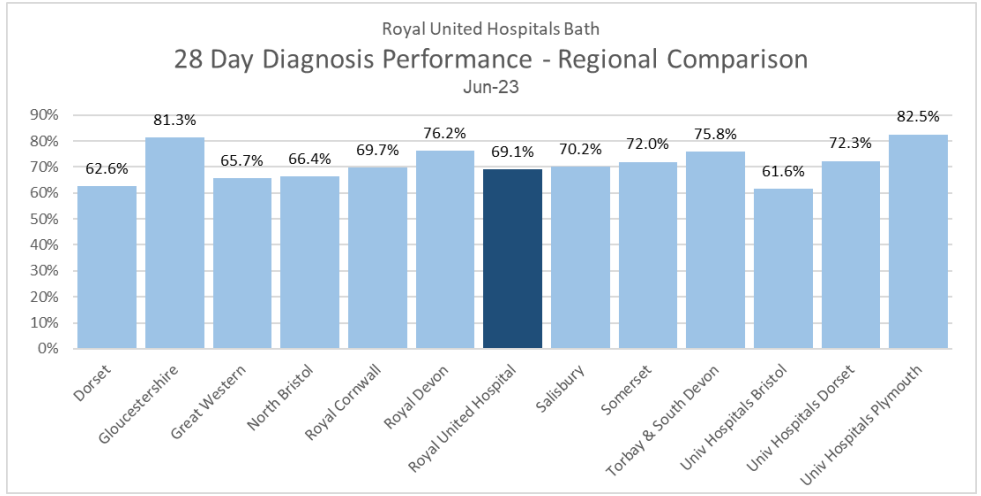
Key Standards | Cancer 28 days

Historic Data



Supporting data

28 Day Regional Comparison



Is the standard being delivered?

In June performance maintained at just below 70%.

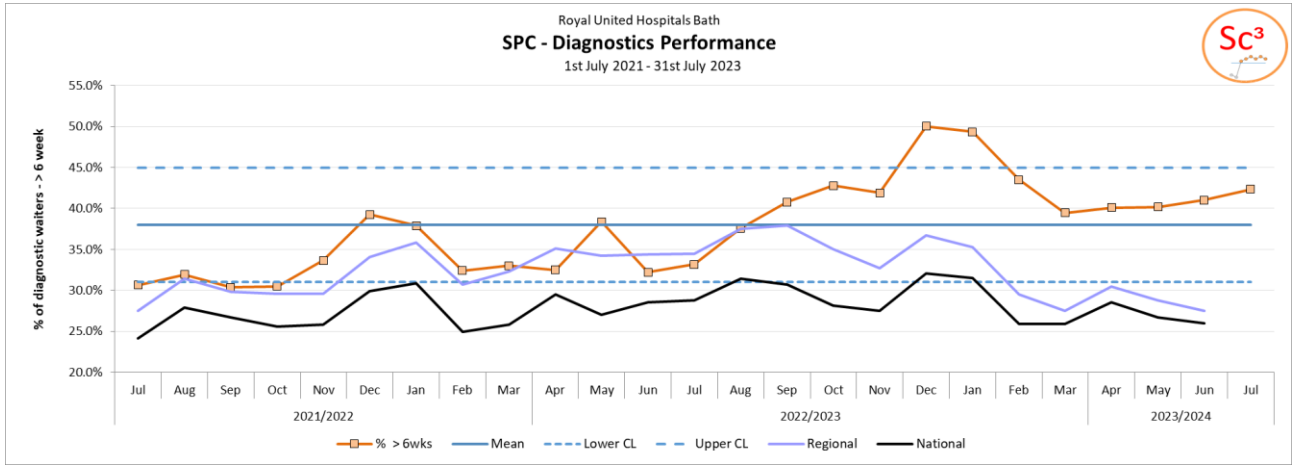
What's the top contributor for under/over achievement?

- Colorectal were responsible for 36% of Trust breaches. The challenges remain with waiting times for endoscopy and CTC.
- Breast recorded the second largest number of breaches, yet achieved over the 75% target.
- Skin breaches increased due to waiting times for minor ops in Dermatology.
- Upper GI performance remained challenged impacted by waiting times for outpatient and endoscopy, and whilst patients under the care of UHBW for specialist diagnostics and MDT.
- In Urology the prostate pathway also recorded breaches as all the necessary steps within the pathway are not currently happening quickly enough to deliver the 28 day pathway, the main area of pressure being for the MRI scan and report.
- Industrial action in August and September is anticipated to impact cancer diagnostic waiting times further.

Countermeasures / Actions	Owner	Due Date
Colorectal – Endoscopy capacity increased from 40-47 lists per week in September following staff recruitment.	R Weston	Sept 2023
Endoscopy – Implement new booking software	R Weston	Nov 2023
Urology – Reorganise consultant outpatient capacity to increase joint clinics	J Prosser	September 2023
Radiology – Reduce prostate MRI scan waiting time to two days – Bath Clinic capacity	N Aguiar	Sept/Oct 2023
Radiology – New GI consultant commencing Oct 23, additional CTC radiographer trained Sept 23 – extra CTC list p/w from Sept 23	N Aguiar	Sept/Oct 2023

Key Standards | Diagnostics 6 weeks

Historic Data



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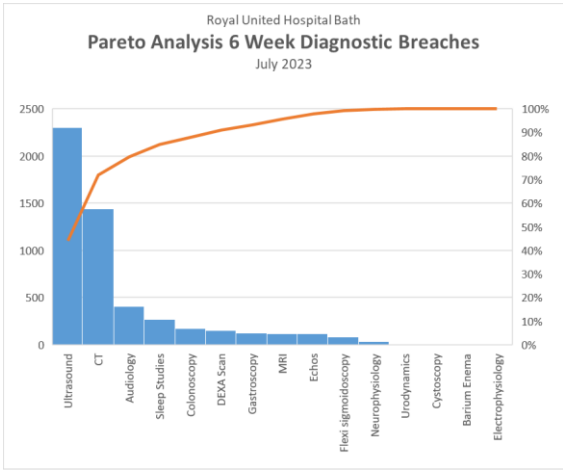
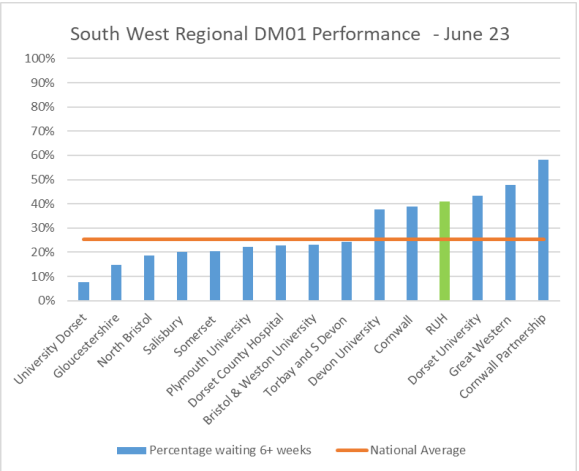




Is the standard being delivered?

July> 6 week performance was 42.35%, which represents an increase from previous month (+1.33%). Impact of the 3 strikes in this month has impacted on overall performance, reducing capacity whilst demand remains above forecast. The target is to get to 15% by March 2024.

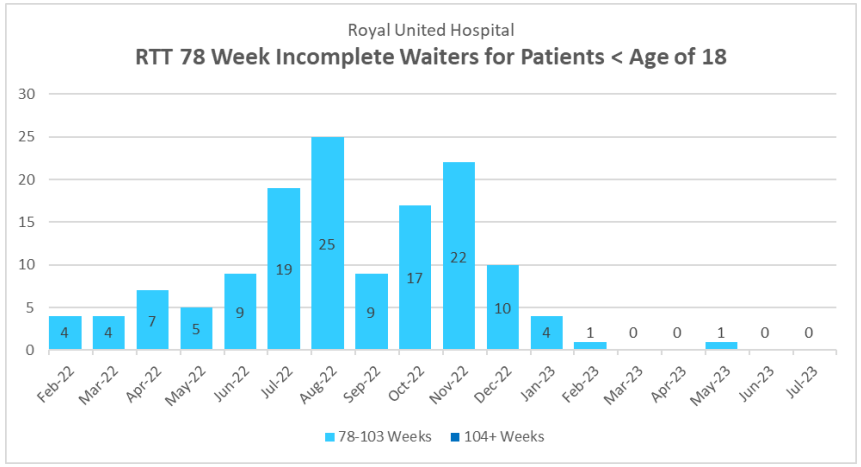
What's the top contributor for under/over achievement?

- Top contributors: Ultrasound, CT, Audiology and Sleep Studies.
- Improvement in performance in Echo, MRI and Colonoscopy.
- Decline in performance in-month for Audiology, CT, USS Sleep Studies.
- Key impact on performance in Jully - loss of capacity due to strikes (Junior Doctor, Consultants and Radiographers) and demand levels remains consistently above forecast.
- High demand for both clinically urgent (2WW) and long RTT waiter requests continue to impact of overall capacity for routine investigations.

Countermeasures / Actions	Owner	Due Date
Audiology reviewing admin and booking process, to ensure all data is being captured and monthly position is accurate – BIU supporting.	K. Rye	August-23
Endoscopy trajectory review	J Pegram / R Weston	July-23
Service review commenced within Respiratory labs. 3rd Respiratory – works in progress	M Warner-Holt	In progress
Review forecasted impact of strikes in August (x2) and what mitigations may be possible.	All modalities	August-23
Increased CT capacity available at Sulis following extension of scanning hours	N Aguiar	August-23
Review and early action: • > 52 weeks referrals booking • > 26 weeks breaches review and booking	J Saddington / N Aguiar	Ongoing

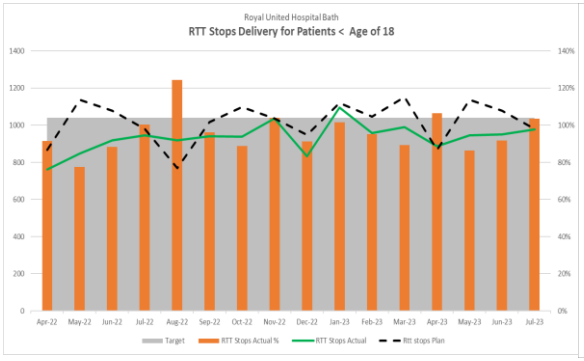
Key Standards | Paediatrics

Historic Data

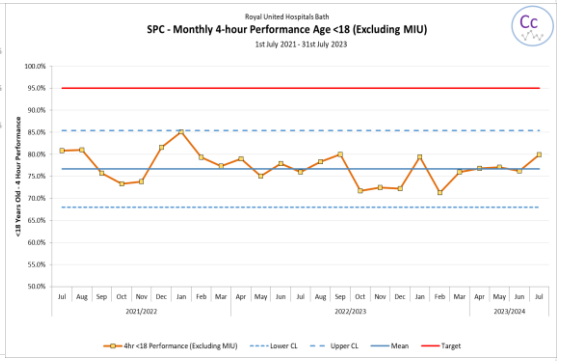


Supporting data

Stops v Plan



4 hr performance



Is the standard being delivered?

- RTT non-compliant – In July we reported 0 patients <age of 18 waiting >78 weeks
- Cancer 2ww non-compliant – There were was 1 2ww breach out of 4 pts for a patient who was seen by Dermatology. The patient was discharged following the appointment as non-cancer.
- Cancer 28 Day Diagnosis compliant – There was one breach in June for a patient awaiting breast imaging following an outpatient clinic. The patient was non-cancer.

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

Countermeasures / Actions	Owner	Due Date
New Day Surgery working group set up to optimise performance – increased dental booking to 8 cases per list	Goodwin	In progress
Paediatric lists to run through Day Surgery Unit x 2 days per week – being rolled out further	Roberts	August 23
ED paediatric team and PAU working closer together to improve pathways and processes	Gilby / Potter	In progress

Royal United Hospitals Bath
NHS Foundation Trust

Quality Report

August 2023 (July 2023 Data)

The RUH, where you matter

Executive Summary | Quality

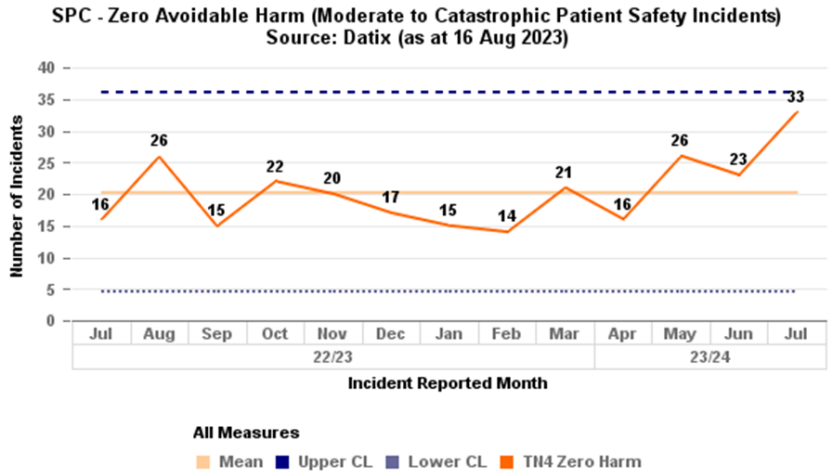
Strategic Goal		Performance Indicator	Description	Target		2022/2023												Trend
				Performing	Under Performing	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Trust Goals	People we care for	Connecting with you - helping you feel safe, understood and always welcome	Reported Patient Safety incidents resulting in significant harm (moderate to catastrophic), excl. rejected			16	26	15	22	20	17	15	14	21	16	26	22	32	
Tracker Measures	People we care for	Patient safety incidents - rate per 1000 bed days	Total no of reported patient safety incidents for the Trust, per 1000 patient bed days.	>43	<=43	45	47	54	59	55	56	56	51	51	47	53	56	50	
		Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	1	2	1	2	3	4	2	5	4	3	4	4	3	
		Number of falls resulting in significant harm (Moderate to Catastrophic)		<=1	>=3	1	2	1	1	8	1	1	1	4	1	7	0	3	
		ED time to triage	Percentage of ED attendances triaged within 15 minutes			48.2%	54.7%	53.5%	56.1%	58.0%	52.9%	61.5%	57.1%	55.5%	54.6%	54.2%	52.1%	55.6%	
		Falls per 1000 bed days	Includes all falls			6.5	6.1	6.0	6.2	5.3	7.0	6.4	6.6	7.3	6.2	6.5	6.6	6.5	
		Medication Incidents per 1000 bed days	All Incidents			5.8	6.6	7.5	6.9	7.0	6.5	6.8	6.8	8.5	6.9	7.3	6.2	7.7	
		Number of Patients given medication by scanning device				14.2%	14.5%	15.9%	16.5%	21.3%	18.4%	19.5%	20.5%	21.7%	22.8%	23.4%	23.4%	24.9%	
		Early Identification of Deteriorating Patient				19.4%	20.8%	21.0%	19.7%	22.0%	18.5%	22.8%	23.6%	21.2%	20.7%	20.5%	19.6%	18.1%	
		Hospital acquired infections				15	21	23	21	37	17	25	15	20	24	22	17	24	
		Number of COVID nosocomial infections				110	16	33	61	9	79	43	43	26	38	26	8	14	
		Mixed Sex Accomodation Breaches				16	16	17	14	11	18	9	15	16	113	172	118	57	

Measures requiring focus and a countermeasure summary this month are;

Measure	Executive Summary
Healthcare Associated Infections	There were 24 Healthcare Associated Infections in July 2023. ○ There were 4 cases of Clostridioides Difficile infection (CDI) reported during June. 2 were healthcare onset Healthcare associated, 2 were Community onset healthcare associated. ○ There were 14 cases of E coli infections reported during July 2023. 8 cases were hospital onset and 6 were hospital associated. 35 cases have been reported against a trajectory of 72 for 2023/24. ○ There were 4 Klebsiella infections reported during July 2023. 3 cases were hospital associated and one community associated. 11 cases have been reported against a trajectory of 25 for 2023/24. ○ There was 3 cases of Pseudomonas Aeruginosa infections reported during July. 6 cases have been reported against a trajectory of 12 for 2023/24.
Number of falls resulting in significant harm (Moderate to Catastrophic)	There were 3 falls resulting in significant harm in July. These falls occurred in Acute Stroke Unit, Haygarth and Parry wards.
Number of Hospital Acquired Pressure Ulcers Category 3	There was 1 category 3 pressure ulcers in July. This was on Pierce ward.
Mixed Sex Accommodation Breaches	There were 57 mixed sex accommodation breaches for July 2023 as the Trust is now also reporting breaches on assessment wards whilst working toward a resolution.

Trust Goal | Zero avoidable harm

Historic Data

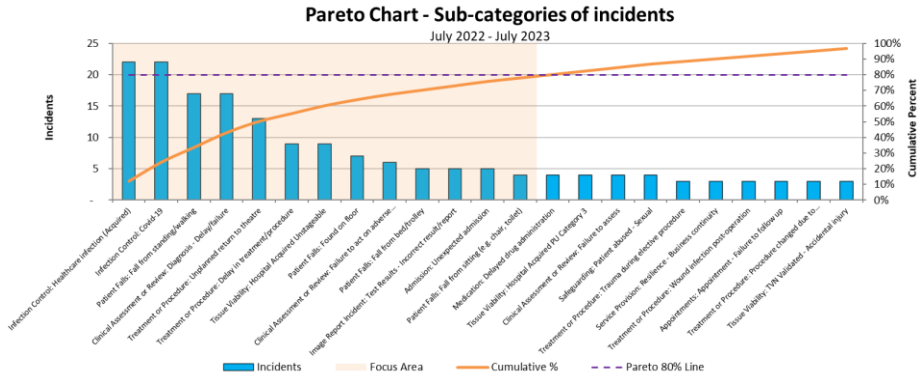


Is the standard being delivered?
In July 2023 there were 33 reported moderate to catastrophic incidents compared to a target of no more than 30 incidents.

What's the top contributor for under/over achievement?
The top contributors for incidents reported for July 2023 were Treatment or Procedure (n=9), Clinical Assessment or Review (n=5), Patient Falls (n=4) and Infection Control (n=4). The top reported sub-categories of incidents for Treatment or Procedure were Unplanned return to theatre (n=4) and for Clinical Assessment or Review the top sub-category was Diagnosis – Delay / Failure (n=3). The top reported Infection Control sub-category was acquired healthcare infection, (n=2).

The most frequent types of reported incidents between July 2022 to July 2023 are healthcare infection (Acquired) (n=22), COVID-19 (n=22), Patient falls: fall from standing / walking (n=17) and Diagnosis delay / failure (n=17).

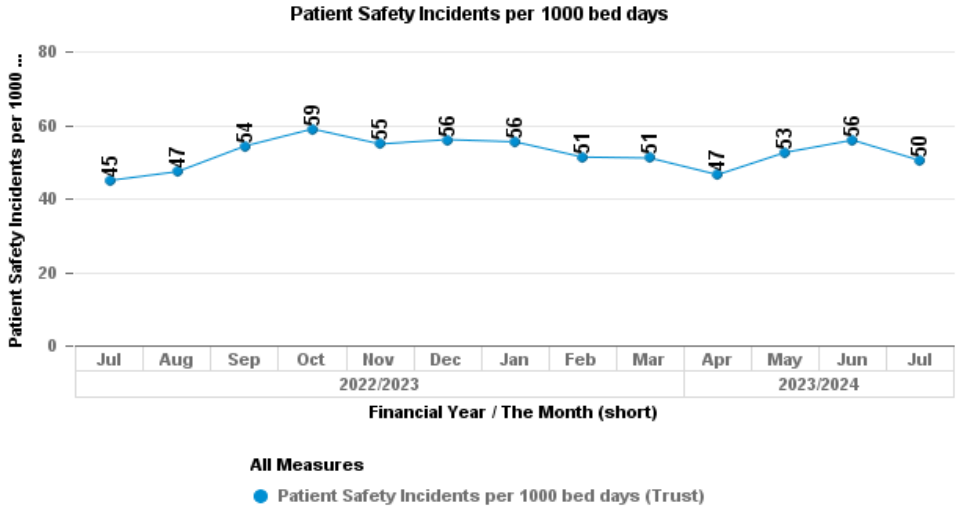
Supporting data



Countermeasures / Actions	Owner	Due Date
Gap analysis completed for requirements to transition to PSIRF and actions allocated.	PSIRF Project Group	Aug-23
Analysis of incident themes per division to identify specific divisional improvement work streams aligned to Trust priorities. Completed for maternity in Aug 23.	Risk team / divisional safety nurses	Sep-23
Development of PSIRF plan and policy for Trust Board sign off.	Interim Quality Lead/ Associate Chief Medical Officer (ACMO), Patient Safety and Quality Improvement/ PSIRF Project Group	Oct-23
Align Patient Safety Priorities to Divisional performance metrics .	Improving Together Lead	Sep-23
Implementation of formal action planning meeting with work streams / stakeholders to confirm action and align to work steams.	Divisional Patient Safety (PS) Nurses/ Risk team/ Priority Leads/ Trust Assurance Lead	In progress. Commenced for some SIs

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

Historic Data

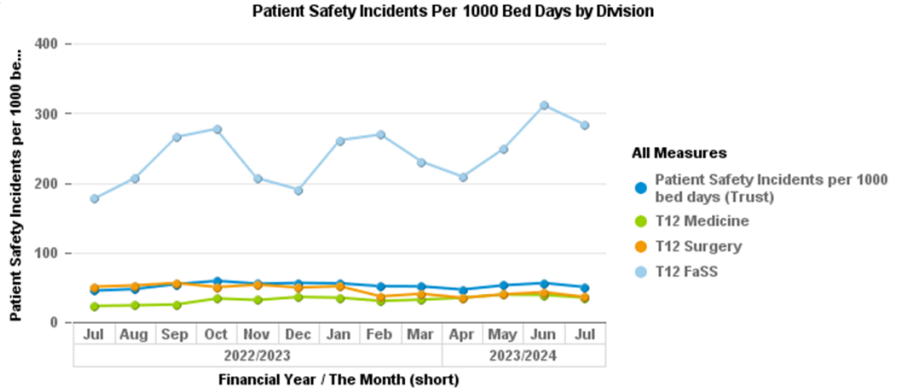


Is the standard being delivered?
There were 50 incidents reported per 1,000 bed days in July.

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

The top reported patient safety incidents are Patient Falls (n=115) followed by Medication (n=93) and Obstetrics (n=85).

Supporting data



Countermeasures / Actions	Owner	Due Date
National Patient Safety (PS) e-learning on staff records – 75% staff completed L1 and 66% staff L2 up to July 23 (aim 80%).	ACMO, Communications team	Dec-23
PSIRF Systems Training commenced by Divisional PS nurses.	Divisional PS nurses	Oct-23
PSIRF plans focus of development of 'Insight' to ensure high quality information available to enable review all incidents.	Interim Quality Lead/ ACMO /Trust Assurance Lead/Risk teams	Sep-23
Review subgroup categories datix – aim to simplify to aid staff engagement and analysis.	Risk team	Sep-23
Plans established for implementation of mandatory amendment to Datix.	Risk team	Nov-23
PSIRF communication plan to be rolled out.	Trust Coms Lead	Sep-23
4 Patient Safety Partner roles appointed to start in September.	Patient Experience Lead	Sep-23
Specific accredited training required for PSIRF now available and places being allocated.	Risk Lead/ Interim Quality Lead/ ACMO	Nov-23
World Patient Safety Day workshops and promotion PSIRF/ Patient Safety Priorities (PSP) planned.	Risk Lead/ ACMO	Sep-23

Tracker Measures | Serious incidents with overdue actions

Historic Data

Supporting data

Datix ID	Category of SI	Division	Action details	Due date
103325	Obstetrics	Family And Specialist Services	It is recommended that the trust to develop and implement a guideline for the management of CVST, to inform future care provisions and guide clinicians for the treatment and management of CVST.: Education to be improved through training Guideline and pathway to be formulated and disseminated	30/06/2023
107032	Clinical Assessment or Review	Surgical Division	Lack of handover and named consultant responsibility when locum consultants move from Trust: · Clarify process for handover to named consultant when locum consultants move on · Education to staff to highlight risks if no named consultant named; cautionary tales, newsletter, safety huddles	31/07/2023
107032	Clinical Assessment or Review	Surgical Division	Incomplete documentation in medical notes regarding results and care planning: · Ongoing mandatory and induction training to medical and other staff about importance of documenting results in notes and subsequent clinical plan · To Safer Surgery meetings with clinicians from surgical division · Raise in safety briefings, newsletters and huddles& Cautionary Tales	31/07/2023
110773	Treatment or Procedure	Surgical Division	The patient did not have a timely chest drain insertion for with postoperative surgical emphysema: · Discussed with clinicians in ED · Discussed with theatre staff and education re appropriate locations for insertion of chest drains · Education to cascade through meetings/safety briefings	31/07/2023
110773	Treatment or Procedure	Surgical Division	There is no clear guidance to when a chest drain should be inserted : · Review and update SOP if already present and implement more appropriate training for staff. · If no SPOP present develop and cascade to staff through training	31/07/2023
110773	Treatment or Procedure	Surgical Division	The patient was admitted under ENT but required admission under General Surgery or Medicine (Respiratory): · Highlight to Surgical Division re accepting patients that have or might need a chest drain · Include information in Safety Briefings, newsletters and huddles, M&M Meetings	31/07/2023

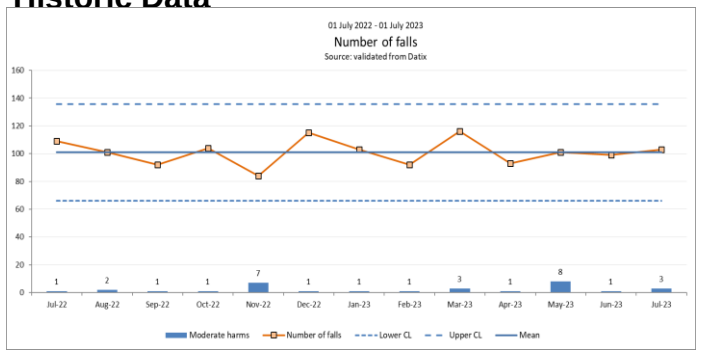
Is the standard being delivered?
There were 3 Serious Incidents with overdue actions for July 2023, compared to a target of less than 5.

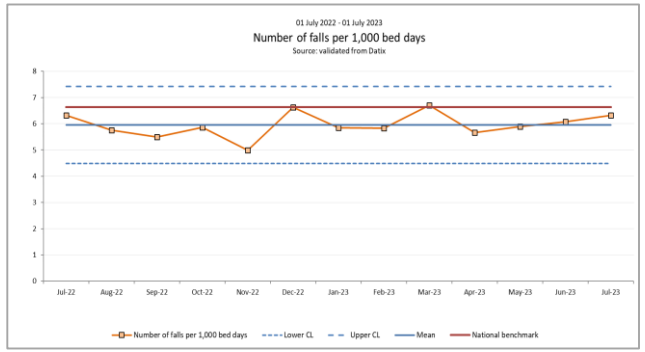
What's the top contributor for under/over achievement?
There are 6 SI actions that remain overdue from 3 SIs with 5 overdue actions for Surgery Division and 1 for Family and Specialist Services.

Countermeasures / Actions	Owner	Due Date
Monthly report produced for each Division summarising any overdue actions and these are followed up with the leads for each action.	Head of Quality Assurance	Monthly update

Tracker Measures | Falls

Historic Data

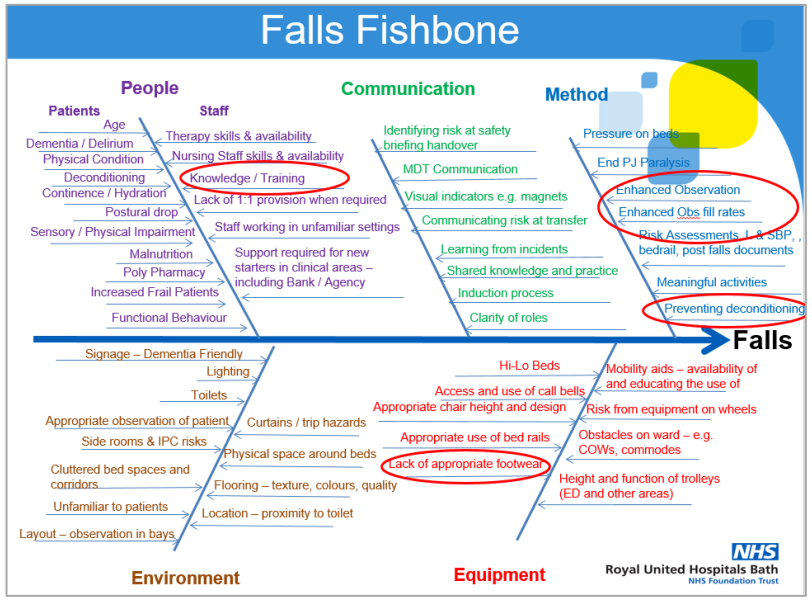




Is the standard being delivered?

In July there were 3 falls resulting in moderate harm or above against a target of 3 per month: occurring in Acute Stroke Unit (ASU), Haygarth and Parry. All incidents are being investigated as part of the Falls Serious Harm process and the Quality Improvement (QI) Falls lead is working with teams in the higher contributor areas.

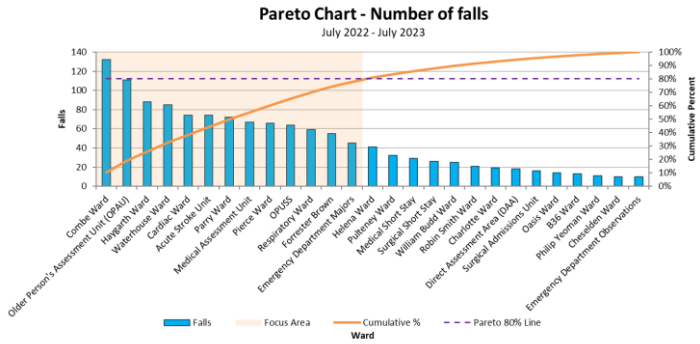
Supporting information : Revised Fishbone



Fishbone revised with Falls Steering group –
Main contributory factors

- Deconditioning
- Lack of appropriate footwear
- Enhanced observation – resource for enhanced care
- Knowledge /training

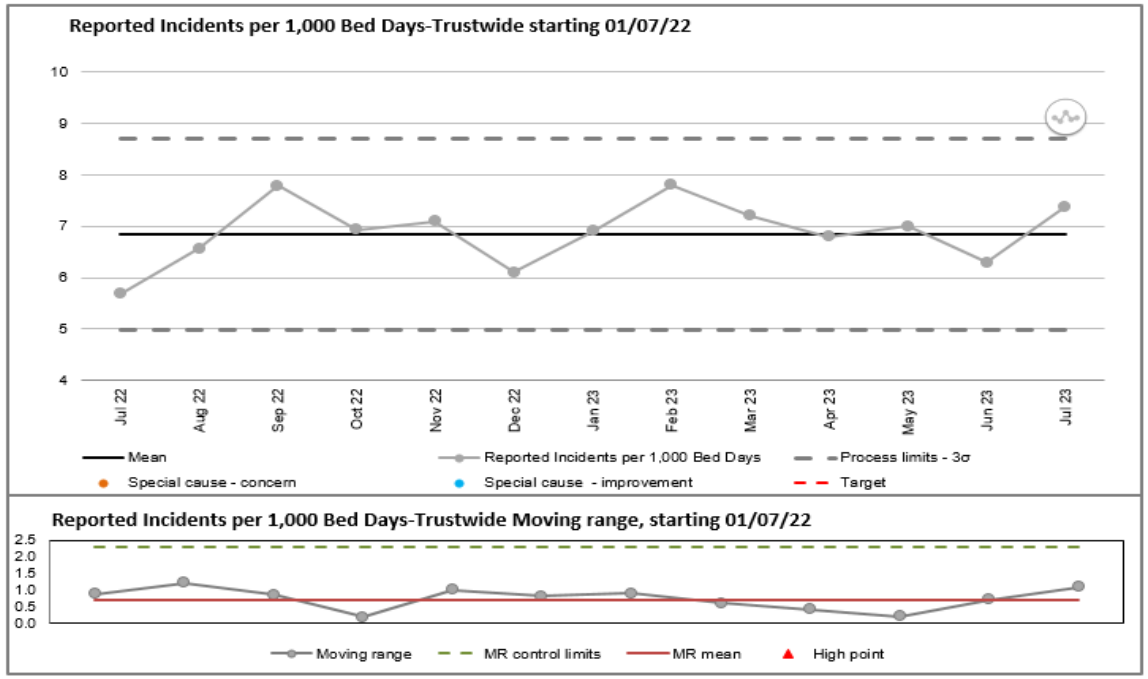
What's the top contributor for under/over achievement?

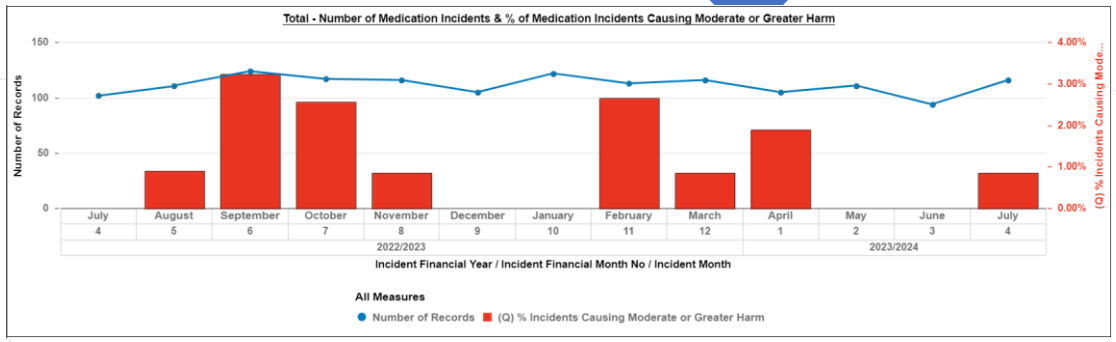


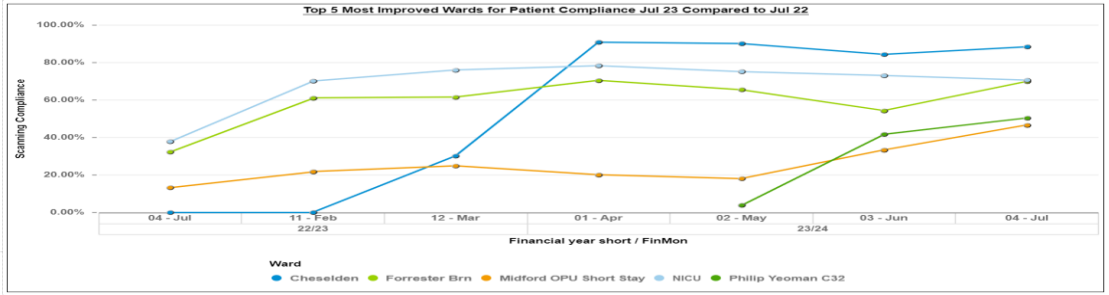
The Pareto chart shows the top contributors to falls. The Quality Improvement Team provide targeted support for the wards with high numbers of falls.

Countermeasures / Actions	Owner	Due Date
Falls training half day all areas 30 March, 25 May,15 June, next date planned in September.	QI Falls lead	Sep-23
QI falls lead leading focused falls training with Clinical Practice Facilitators (CPF) in Combe, Waterhouse, Older Persons Unit Short Stay (OPUSS) and Emergency Department (ED).	QI Falls lead	Sep-23
Falls fortnight focused event in ED – commencing 14 August	QI Falls lead	Ongoing
RUH campaign following National Reconditioning games –linked to Safety priority "Keep moving" Designing campaign for launch Falls awareness week.	Senior Nurse QI & Falls QI Lead	Sep-23
Bath Inpatient Mobility Scale (BIMS) relaunch baseline data collected, training resources developed trolley dash planned for August.	QI Falls QI Lead	Sep-23
Supporting the design of Standard Operating Procedure (SOP) and guidance for bed rails use with the Clinical Holding and Restraint Working Group.	QI Falls Lead	Sep-23

Quality| Medicines Safety







Is the standard being delivered?

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

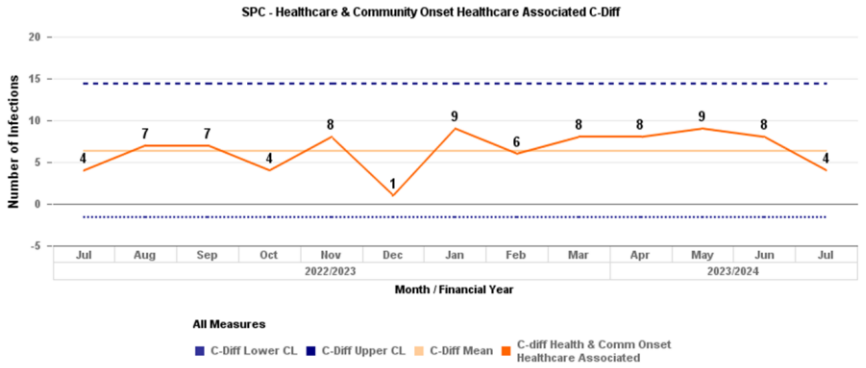
What's the top contributor for under/over achievement?

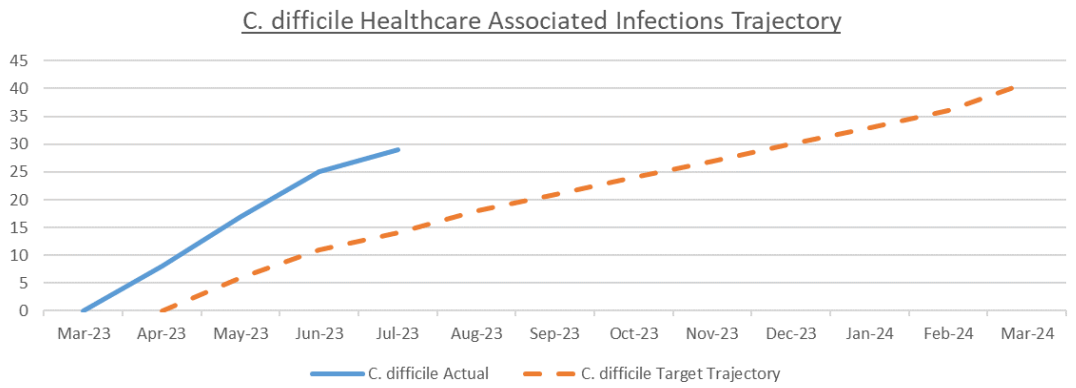
- Medication incidents: for information only – reported incidents/1,000 bed days incidents within normal variation.
- Barcode Scanning: Medicines compliance 18.6%. Cheselden top contributor (66.9%), most improved ward Medical Assessment Unit (MAU), (6.2% to 17.6%).

Countermeasures / Actions	Owner	Due Date
New huddle process for rapid review of hospital acquired thrombosis (HAT) being set up. Electronic Prescribing Medicines Administration (EPMA) changes to Venous Thromboembolism (VTE) risk assessment proforma agreed	Director of Pharmacy	Aug-23
Provide required hardware and training support to wards to enable improved barcode scanning: current phase Midford, Philip Yeoman, Surgical Assessment Unit. Wards given access to new report to show 'Top scanner of the month'.	IT/Specialist Nurse, Meds Management	Sep-23
Lack of secure medicine storage in escalation areas to be addressed – SOP being written	DDoN/Medicines Safety Officer	Sep-23

Breakthrough Objective | *Clostridioides Difficile*

Historic Data





Is the standard being delivered?

There were 4 cases of *Clostridioides Difficile* infection (CDI) reported during July, 2 were healthcare associated, 2 were community onset healthcare associated. There have been 29 cases against a trajectory of 41 for 2023/24.

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

Learning: 1 patient had been a CDI carrier in another organisation on the 31/5/23. The patient was on a protein pump inhibitor (PPI), which was switched upon testing positive at the Trust. The second patient had received several courses of antibiotics for a recurrent urinary tract infection (UTI) by the GP and was admitted for intravenous therapy for the UTI. CDI was detected on day 3, but more likely to be community associated in view of the history.

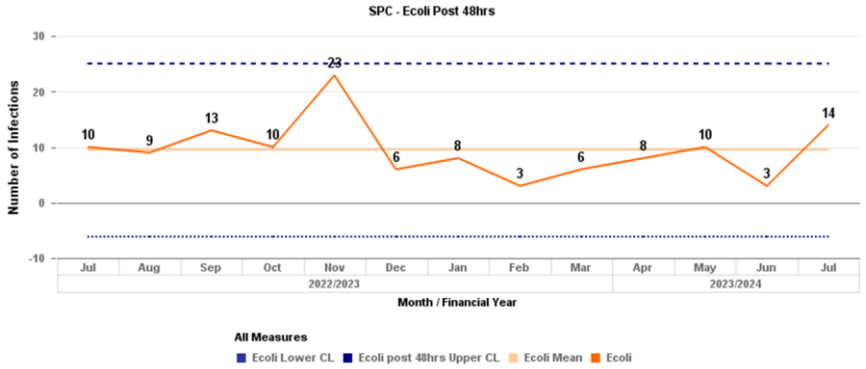
CDI Benchmarking data –

Trust	Rate (May 23)	Rate YTD
SW rate	**34.72**	**31.38**
RUH	**51.43**	**49.34**
GWH	55.88	45.26
SFT	7.1	10.88
Gloucester	26.47	46.46

Countermeasures / Actions	Owner	Due Date
Infection, Prevention and Control (IPC) to focus training on accurate risk assessment completion, ensuring staff know where to locate the flags. IPC to audit practice and share with ward leaders and matrons.	IPC and ward leaders	Sep-23
Focus on ward level knowledge and skills for completing stool charts, sampling and isolation requirements.	IPC and ward managers	Jul-23
Follow up on all previously agreed action plans for IPC related root cause analysis at the Infection Control Committee.	DDONS	Sep-23

Breakthrough Objective | E coli

Historic Data



Is the standard being delivered?

There were 14 cases of E coli infections reported during July 2023. 8 cases were hospital onset and 6 were hospital associated. 35 cases have been reported against a trajectory of 72 for 2023/24.

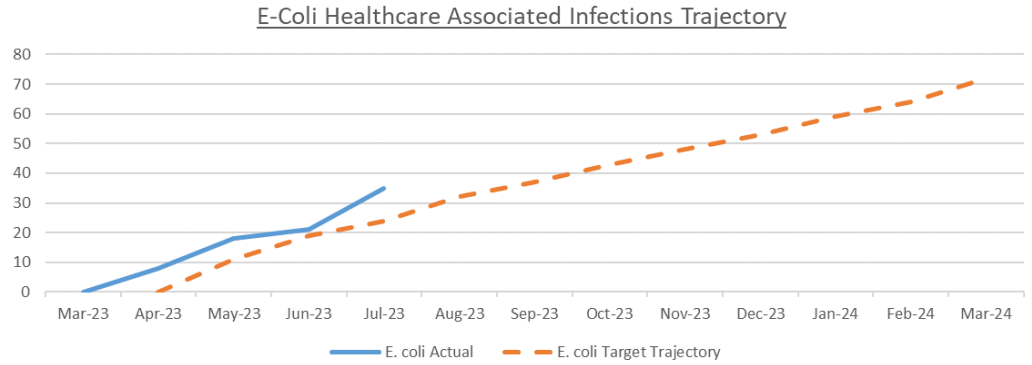
What's the top contributor for under/over achievement?

The cases were associated to: Gastrointestinal (n = 4), Lower urinary tract infection no catheter (UTI) (n=3), Unknown (n=4) Hepatobiliary (n=2), skin and soft tissue 1.

Benchmarking data:

Trust	Rate (May23)	Rate YTD
SW rate	**34.72**	**34.15**
RUH	**57.15**	**52.2**
GWH	72.65	50.76
SFT	21.29	10.64
Gloucester	26.47	17.15

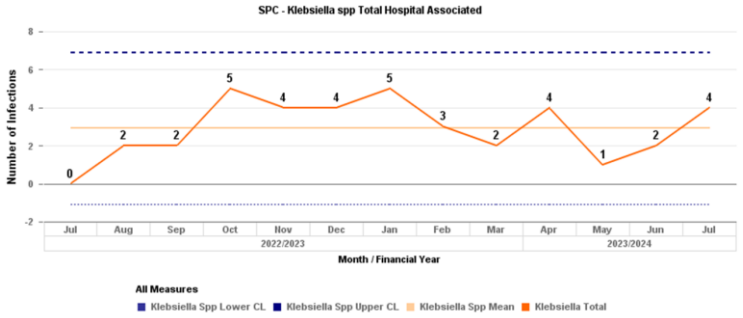
Supporting data

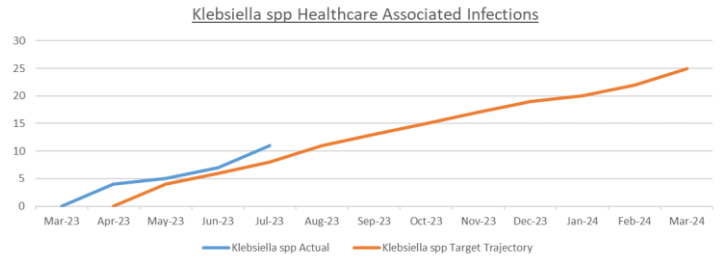


Countermeasures / Actions	Owner	Due Date
ICB Hydration Improvement Group commenced have now published the resource pack, which has been shared with the RUH for use.	Matron / Quality Improvement Centre	Aug-23
Review of urinary catheter insertion training and competency required, although this is not the biggest cause of the E.coli cases reported.	Senior nurses/ matrons	Sep-23
Review the policy for the insertion and management of lines. The policy was submitted at ICC in July.	Training Department / Matrons	Completed Jul-23

Breakthrough Objective | Klebsiella and Pseudomonas

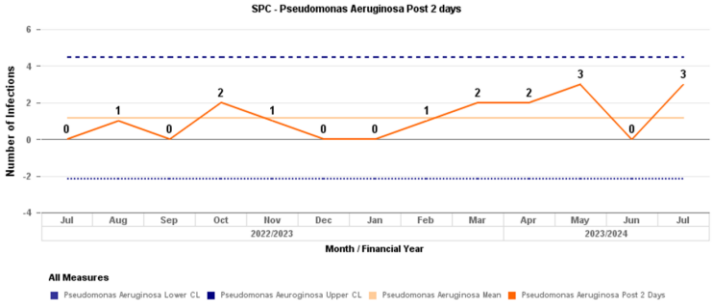
Performance (Klebsiella)

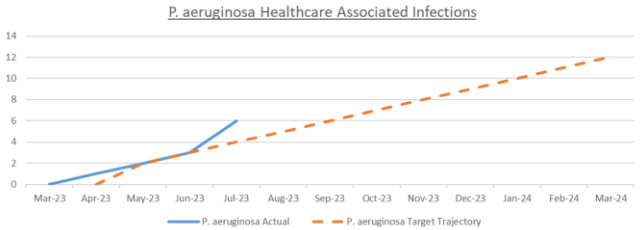




Trust	Rate (May 23)	Rate YTD
SW rate	**9.78**	**8.97**
RUH	**5.71**	**14.67**
GWH	16.76	19.93
SFT	14.19	10.76
Gloucester	3.78	9.71

Performance (Pseudomonas)





Trust	Rate (May 23)	Rate YTD
SW rate	**6.63**	**6.25**
RUH	**17.14**	**14.48**
GWH	11.18	22.91
SFT	0	0
Gloucester	11.35	5.67

Is the standard being delivered?

There were 4 Klebsiella infections reported during July 2023. 3 hospital associated and one community associated. 11 cases have been reported against a trajectory of 25 for 2023/24.

There was 3 cases of Pseudomonas Aeruginosa infections reported during July. 6 cases have been reported against a trajectory of 12 for 2023/24.

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

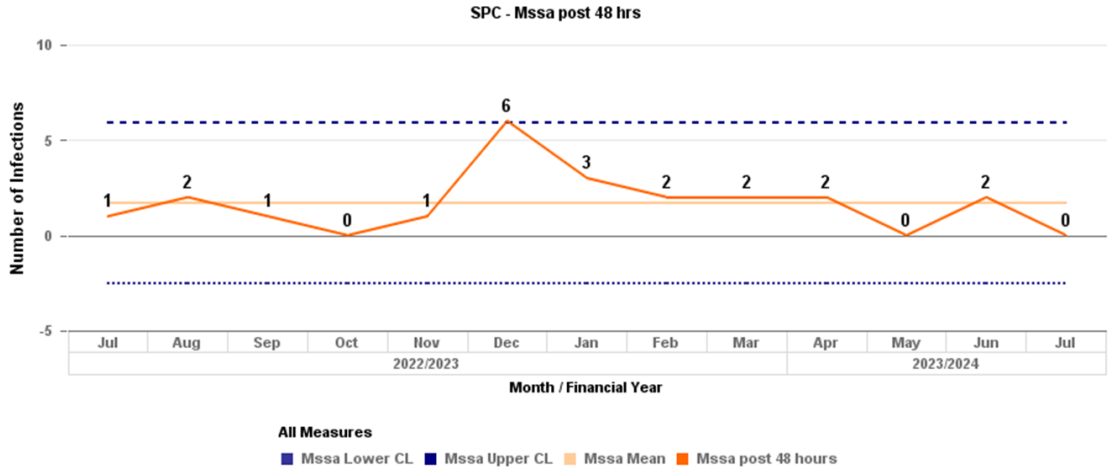
Klebsiella's were associated to: Lower urinary tract infection (n=1), Lower urinary tract infection with a catheter (n=1), Gastro (n=2), Hepatobiliary (n=1).

Pseudomonas was associated to: Lower urinary tract infection (n=1), Lower urinary tract infection with a catheter (n=1) and 1 unknown.

Countermeasures / Actions	Owner	Due Date
Review of urinary catheter insertion training and competency required.	Senior nurses/ matrons	Sep-23
Review of urinary catheter care practice and discharge processes as a preventive measure to infection developing- share learning with ICB. Trust continence lead invited to next collaborative meeting (dates have been rescheduled).	Continence group/ IPC and matrons	Oct-23

Breakthrough Objective | MSSA

Historic Data



Supporting data

Benchmarking data:

Trust	MSSA (May22)	Rate YTD
SW rate	**15.46**	**14.74**
RUH	**17.14**	**17.43**
GWH	11.18	11.36
SFT	14.19	7.1
Gloucester	7.56	15.51

Is the standard being delivered?
There were no hospital onset Methicillin-Susceptible Staphylococcus Aureus (MSSA) blood stream infection during July 2023.

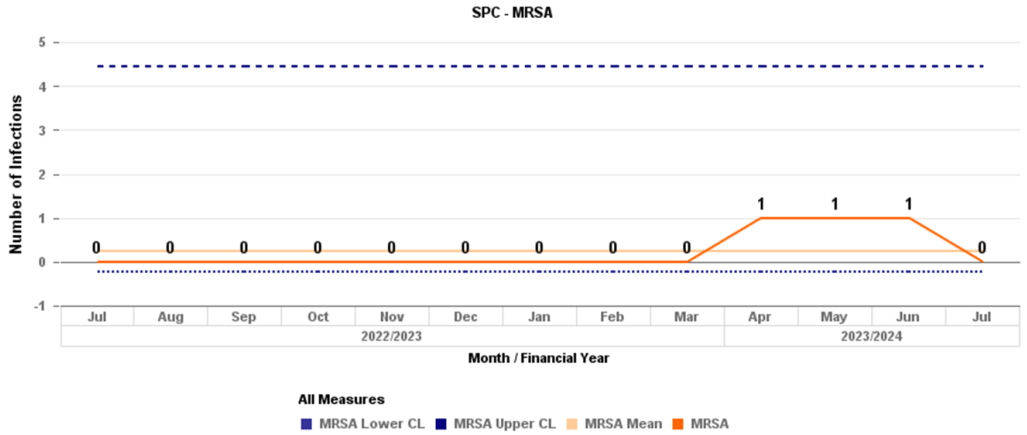
4 Trust cases have been reported to date, there are no thresholds for this infection.

What's the top contributor for under/over achievement? No data to report on.

Countermeasures / Actions	Owner	Due Date
Review of urinary catheter insertion training and competency required.	Senior nurses/ matrons	Sep-23
New (additional) cannulation device being trialled over the summer for inpatient areas (Not theatres). No issues anticipated with the product, training will be provided for the correct insertion technique.	IPC, Procurement and training team	Sep-23

Breakthrough Objective | MRSA

Historic Data



Is the standard being delivered?

There was no Methicillin Resistant Staphylococcus Aureus (MRSA) reported during July 2023.

The Trust has reported 2 hospital associated cases and 1 contaminate during 2023/24.

Countermeasures / Actions	Owner	Due Date
Review of IV cannulation and venepuncture training package and competencies of staff.	Senior nurses/ matrons	Sep-23

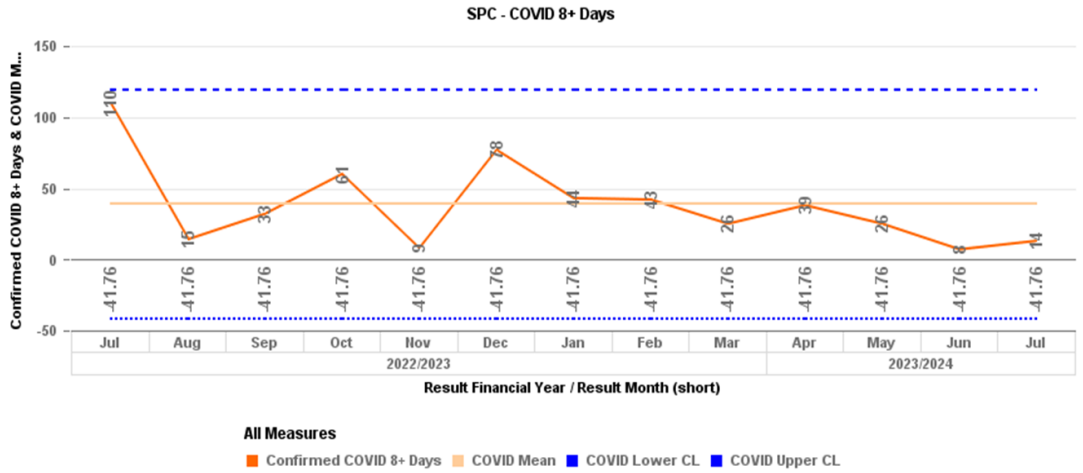
What's the top contributor for under/over achievement?

The Trust are flagging as a local outlier for the number of case reported his year to date. 1 community associated case has been reported to date.

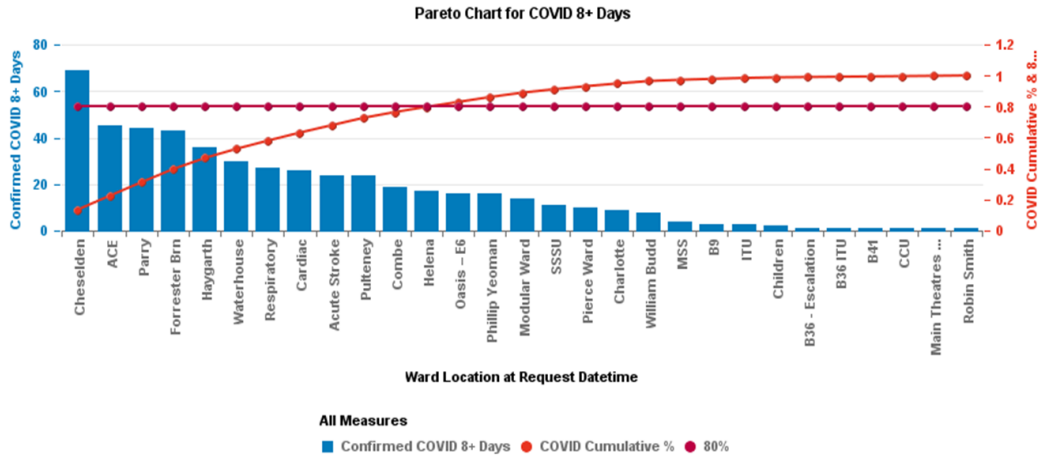
Trust	May 23	YTD
SW	0.95	1.13
RUH	5.71	5.81
GWH	0	0
SFT	0	0
Gloucester	0	0

Breakthrough Objective | Confirmed COVID-19

Historic Data



Supporting data



Is the standard being delivered?

There were 48 COVID positive cases detected during July 23.
14 cases were confirmed as COVID-19 8+ day infections. There was 1 mortality associated to a nosocomial COVID-19 infection during July.

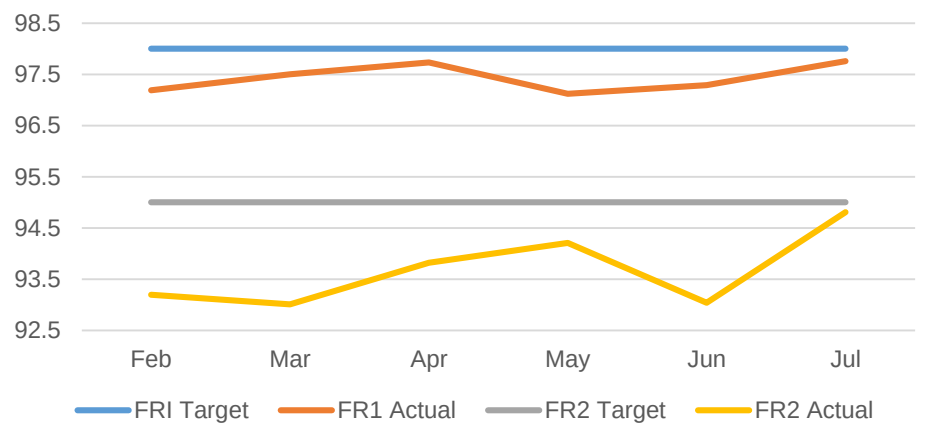
What's the top contributor for under/over achievement?

Cluster outbreaks were seen on OPUSS, both bays were closed to new admissions, and Parry ward had 1 bay effected at the end of July.

Countermeasures / Actions	Owner	Due Date
Winter planning has commenced and this will include clear criteria for front door COVID and Flu screening.	IPC, Ops and Micro.	Sep-23

Breakthrough Objective | Cleaning

Historic Data – Cleaning Audit scores – FR1 and FR2



Is the standard being delivered?

Audit scores below target, team understaffed – however significant, ongoing, sustainable improvements being made.

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

1. Vacancies in both Cleaners and Management (see Supporting Data - Staffing).
2. High sickness rate.
3. High agency use – high turnaround of new staff.
4. Cleaning schedules - require review.
5. Training still required in new Cleaning Schedules - loss of Facilities Training lead, Supervisor vacancies.

Supporting Data – Cleaning Audit scores – all FR levels

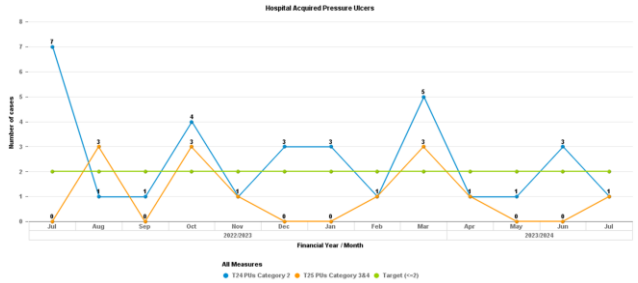
	Target	Frequency	Feb	Mar	Apr	May	Jun	Jul
FR1	98	Weekly	97.19	97.5	97.73	97.12	97.29	97.76
FR2	95	Monthly	93.2	93.01	93.82	94.21	93.04	94.81
FR3	90	Bi-monthly	90.77		83.11		91.57	
FR4	85	Quarterly	90.04	89.72	92.54	85.81	91.34	96.88
FR5	80	6m		87.06		86.82	95.12	
FR6	75	Annual	88.1	74.69	89.11	88.66	88.83	

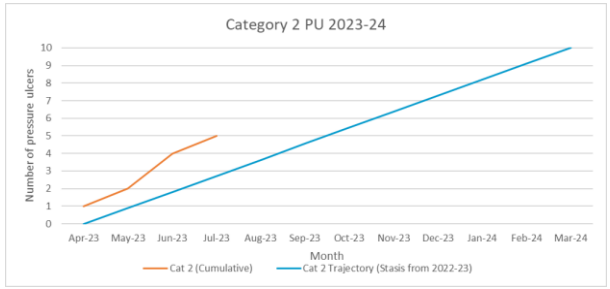
Countermeasures / Actions - Owner: Cleaning Transformation Team
Due Date - end of 2023

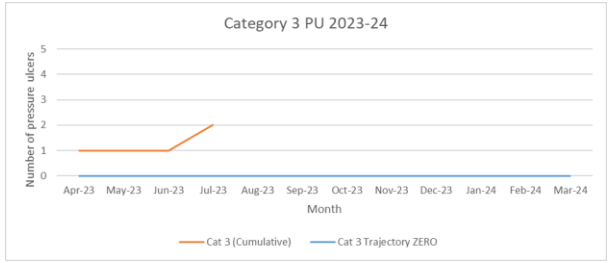
1. Vacancies: Rolling recruitment drives, refer a friend scheme, supervisor to work exclusively on driving forwards recruitment, recruitment events in surrounding region, internal events planned.
2. High sickness rate: Focus on supporting colleagues, increasing wellbeing support and promotion of a positive working environment. Oversight of sickness management.
3. High agency use: Focus on recruitment to fill establishment and reduce reliance on agency. Agency is reducing month on month.
4. Cleaning schedules: Schedules being reviewed, supervisors reallocated to have ownership and accountability for specific areas.
5. Training still required: Training post filled, recruiting new supervisors which will support training.

Tracker Measures | Pressure Ulcers

Historic Data







Is the standard being delivered?

The ambition for 2023-24 is to have <10 category 2 pressure ulcers, <4 device related pressure ulcers and zero 3 or 4 pressure ulcers.

July reported one category 2 pressure ulcers on Pierce ward. One category 2 pressure ulcer has been removed from Waterhouse in June following investigation. This brings the Trust total for category 2 pressure ulcers to 5 year to date.

There has been one category 3 pressure ulcer on Pierce ward.

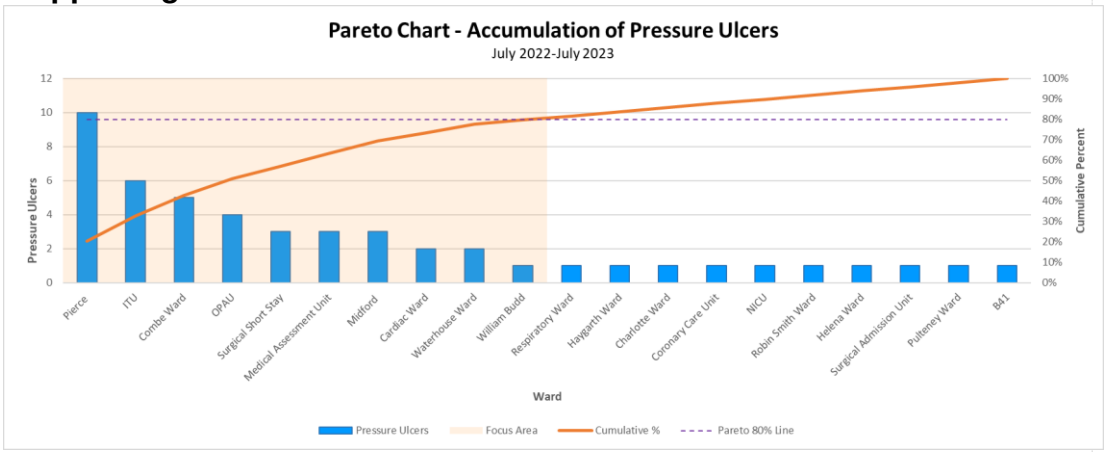
Benchmarking	Overall HA PU May 2023	Overall HA PU June 2023
RUH	1	3
UHBW	0	4
NBT	15	18
GWH	26	31
Salisbury	35	Unavailable

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

The top 3 contributors for total number of pressure ulcers are: Pierce, Critical Care and Combe.

Key themes for July: inconsistent skin assessment and repositioning.

Supporting data



Countermeasures / Actions	Owner	Due Date
Action plan to be delivered for the re-education of all staff on Pierce ward to increase knowledge and confidence regarding pressure ulcer prevention and essential hygiene needs – delivered by the Tissue Viability Nurses (TVN) and the Practice Education facilitators, monitored by the Surgical Division DDON/ Supporting Pulteney ward with implementing their monthly focus of pressure ulcer prevention	Surgical DDON TVNs	Sep-23 Aug-23
Delivering extended tissue viability sessions to the new to care Health Care Support Workers (HCSW) to increase knowledge and confidence	TVNs	Ongoing

Quality | Mortality

Supporting data

Metric	M12 HES Release	M13 HES Release
HSMR	100.9	101.9
Emergency Weekday HSMR	101.2	102.2
Emergency Weekend HSMR	101.7	102.7
SMR	99.1	99.8

No new monthly Hospital Episode Statistics (HES) data has been produced since the last report. The data above highlights any changes to the mortality data for the 22/23 financial year now that we have the final M13 extract of data. This has been compared with the M12 extract which contained the first submission of data for the 22/23 financial year.

Is the standard being delivered?
HSMR has increased by 1.0 but remains within the expected range.
Emergency weekday HSMR has increased by 1.0 but remains within the expected range.
Emergency weekend HSMR has increased by 1.0 but remains within the expected range.
SMR has increased by 0.7 but remains within the expected range.

What's the top contributor for under/over achievement?
NHS England have informed the Trust of a systemwide shortfall of data that affects the M13 publication. Due to an issue with the processing of Token Person Identifiers, some data has not been correctly matched and has been dropped from the M13 HES extract. This issue will affect all HES extracts nationally and not just those sent to Telstra Health UK. NHS England will rectify the issue when they publish the annual refreshes later this year.
We have conducted an impact assessment and concluded that overall, the shortfall in the M13 data is 0.38% compared to the published M12 position. For the Trust, the shortfall is 0.50%.

Countermeasures / Actions	Owner	Due Date
Regular reviews diagnoses that flag as outlier for readmission or long Length of Stay (LOS), as well as mortality. No concerns identified, except for coding challenges for Ambulatory care and Hospital at Home flagging as readmissions, resulting in alerts.	Clinical Outcomes Group	Ongoing
Review of learning points from sepsis deaths in Surgery (including from Structure Judgement Reviews (SJR), tonsillectomy re-admissions and cardiac pacemaker or defibrillator.	Clinical Governance Lead, Surgery	Aug-23 Complete
Template to be developed for standardising dissemination of learning from reviews undertaken through the Clinical Outcomes Group.	Chief Medical Officer	Aug-23

Update on actions following unannounced CQC inspection of Medical care

Safeguarding Adults Level 2

Certification Name	Compliance	Sum of Target Audience	Sum of Staff Trained	Sum of Not Trained
Safeguarding Adults Level 2	**84.02%**	**5088**	**4275**	**813**
427 Bank	66.99%	936	627	309
427 Corporate Division	84.18%	158	133	25
427 Emergency Medicine Division	73.90%	272	201	71
427 Estates and Facilities Division	100.00%	1	1	0
427 Family and Specialist Service Division	91.89%	900	827	73
427 Medical Division	87.80%	1565	1374	191
427 Non-Paid & Recharge (L3)	40.00%	10	4	6
427 Research & Development	87.76%	49	43	6
427 Surgical Division	88.97%	1197	1065	132
Total	**84.02%**	**5088**	**4275**	**813**

Safeguarding Adults Level 3

Certification Name	Compliance	Sum of Target Audience	Sum of Staff Trained	Sum of Not Trained
Safeguarding Adults Level 3	**93.04%**	**115**	**107**	**8**
427 Corporate Division	100.00%	22	22	0
427 Emergency Medicine Division	100.00%	1	1	0
427 Estates and Facilities Division	100.00%	1	1	0
427 Family and Specialist Service Division	100.00%	9	9	0
427 Medical Division	91.94%	62	57	5
427 Surgical Division	85.00%	20	17	3
Total	**93.04%**	**115**	**107**	**8**

Targets are now being met for Adult Safeguarding Training for Level 3. The actual total is **95.5%**. There are 3 staff who are excluded (secondment, left organisation, long term sick) but still remaining on the list of staff requiring training. This is due to be updated on the system.

What's the top contributor for under/over achievement?
The lowest compliance for Safeguarding Level 2 training is for Bank staff and Non-Paid & Recharge.
Focussed review to achieve compliance with all safeguarding training, with a particular focus on Level 2.

Mental Capacity Assessments (MCA) / Deprivation of Liberty Safeguard (DoLS) referrals and completion of the MCA in TEP/ReSPECT forms not consistently completed.
Enhanced focus across Medicine assessing every patient to ensure timely assessments are made. Focus at Safety Briefings, Board Rounds and Bullet Rounds. Senior Sister and Matron review of all patients lacking capacity.

Results from the daily Senior Sister / Matron checks

Standards	May-23	June-23	Jul-23
If the patient lacks capacity and has a TEP/ReSPECT decision, has the Mental Capacity Assessment been completed ?	94.6%	85.58%	90%
Where the patient on the ward lacks capacity to consent to serious medical treatment and / or change of accommodation / discharge plans, has the Mental Capacity Assessment been completed?	100%	96.25%	100%
Where the patient has been unable to consent to remain in hospital, has the DoLS authorisation been completed?	97%	96.80%	100%

Countermeasures / Actions	Owner	Due Date
Daily audit of every patient undertaken by the Senior Sister/Matron reviewing MCA, DoLS and Best Interest decisions. Developed electronic completion of audit through MS Form. This is being piloted on Combe Ward before rolling out to the rest of the Trust.	Divisional Director of Nursing Head of Quality Assurance	Aug-23
Monthly Level 3 Safeguarding Training sessions available . Bespoke training sessions focussing on organisational abuse, values and culture being rolled out across the Trust. These have been well attended and monthly sessions available as a rolling programme. Bespoke MCA / DoLS training continuing with wards requesting sessions. Bespoke training sessions to OPUSS continue.	Lead Professional, Adult Safeguarding	Monthly
Direct contact with staff who are coming out of compliance or non-compliance for safeguarding training, to request attendance. Particular focus will now be on Level 2 training.	Lead Professional, Adult Safeguarding	Last day of each month
Rolling programme of bespoke MCA / DoLS training delivered across the Trust	Lead Professional, Adult Safeguarding	Ongoing
Thematic audit for: focussing on quality of MCA assessments and application for DoLS.	Lead Professional, Adult Safeguarding	Monthly
Creation of Information packs, tips and examples of robust MCAs, DoLS application and myth busters. Packs being finalised and will be sent to staff on wards and appropriate out patient areas.	Lead Professional, Adult Safeguarding	September

Executive Summary

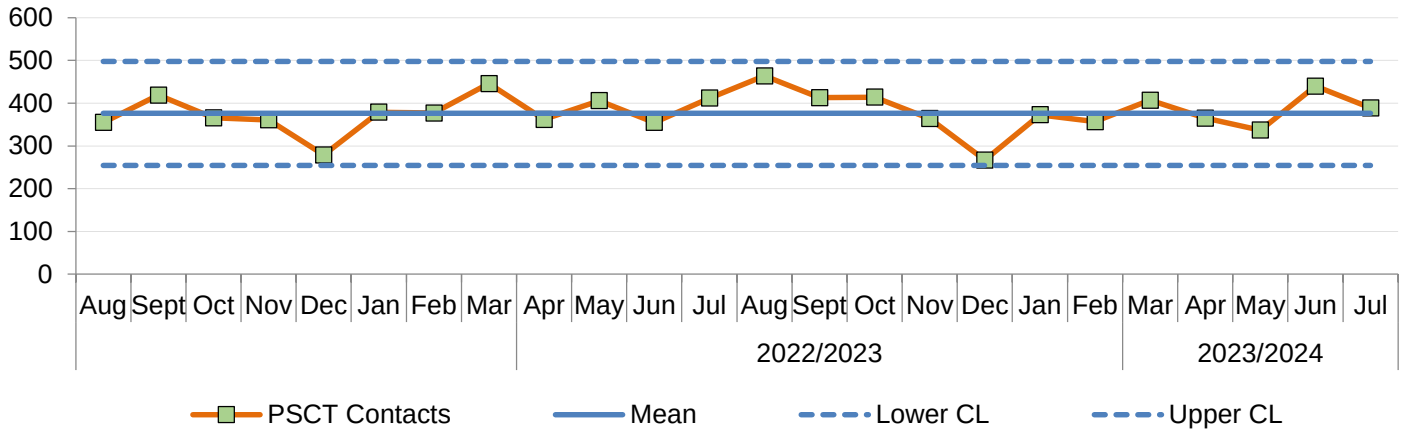
Strategic Goal		Performance Indicator	Description	Target		2022/2023												Trend
				Performing	Under Performing	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Tracker Measures	People we care for	% of Complaints responded to within target		>=90%	<90%	52.4%	60.9%	57.9%	64.5%	76.0%	77.3%	52.6%	55.6%	74.4%	69.2%	76.5%	88.2%	63.2%	
		Number of formal complaints		<30	>=30	33	39	29	18	33	16	29	35	29	14	29	22	19	
		Number of re-opened complaints		<=3	>3	2	2	1	6	2	3	2	4	1	2	4	4	1	
		PALS Response Time	% of Responses acknowledged within 2 days	>90%	<90%	72.0%	65.0%	62.0%	61.0%	62.0%	66.0%	60.0%	64.0%	69.0%	59.0%	61.0%	57.0%	54.0%	

Measures requiring focus and a countermeasure summary this month are;

Measure	Executive Summary
Percentage of complaints responded to within target	Overall**,** 63% of complaints closed during July met the required timescale of 35 working days (12/19). This metric has decreased from last month. The number of re-opened complaints remains low. Weekly Divisional Complaint meetings are held with the Head of Complaints to support ongoing improvements to the response times. The reasons for the timeframe exceptions are varied but predominantly: • 3/7 late cases were closed within 3 days of the due date • Complexity of case and further information required from external partner • Key member of investigating team away from the Trust To support improvements to the timeliness of complaint responses, a review of the severity of complaints using the risk matrix has been undertaken. Complaints categorised as low-medium with low frequency are now approved and signed by the Divisional Triumvirate. The Patient Support and Complaints team are supporting patients and families to achieve the most appropriate resolution with an early conversation about expected outcomes
Patient Support and Complaints Team (PSCT) response time	The national standard for responding to PSCT cases is 5 working days. The RUH standard for responding to PSCT cases is 2 working days. The numbers of PSCT contacts in July was 389, this was a decrease from June (440)**.** The reasons for the timeframe exceptions are mostly due to: • Workload of clinicians causing delays in responding • The volume, complexity and logging of cases for a small team 62% of PSCT enquiries were responded to within 5 working days. 54% of PSCT enquiries were responded to within 2 working days.

Tracker Measure | PSCT

Historic Data



Is the standard being delivered?
Situation report: There were **389 contacts with PSCT in July 2023.**

KPI: Performance against 48hr standard resolution timeframe 54% of cases were resolved in 48 hours or less; a further 8% were resolved in 5 days and 14% between 6-14 days. 24% of the complex cases took more than 14 days.

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

Communication and information (n=73). The highest number of contacts were general enquiries 22% (n=16), communication concerns accounted for 16% (n=12). 14% were telephone issues (phone not answered) (n=10). Inappropriate/inaccurate/incomplete correspondence accounted for a further 14% (n=10).

Appointments (n=61). The highest number of enquiries related to the length of time patients were waiting for new and follow up appointments (n=29) 48%. Hotspot areas are Orthopaedics (n=6) and General Surgery (n=5).

Clinical care and concerns (n=47). The highest number of contacts were around inappropriate care and treatment 28% (n=13). Hotspot area was Orthopaedics (n=4).

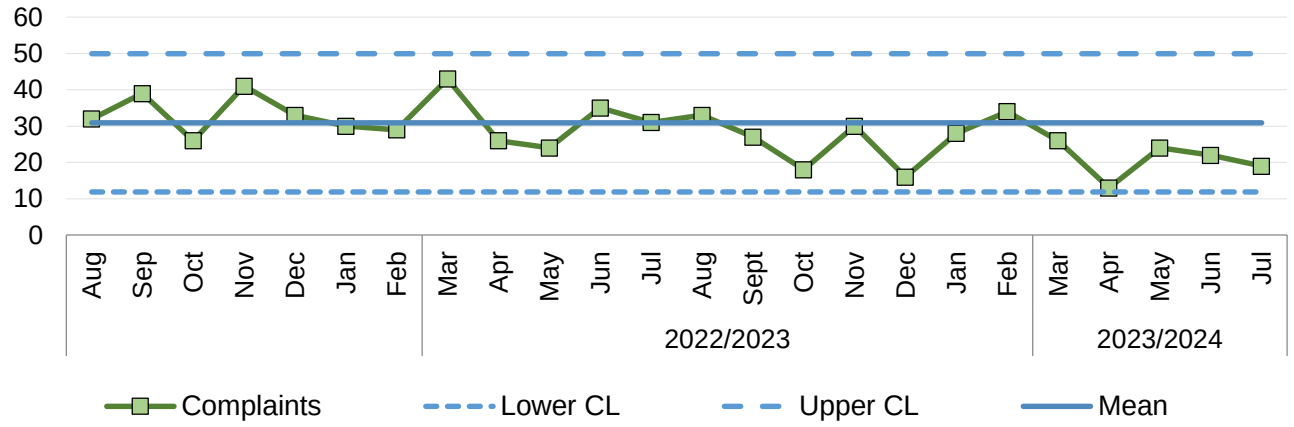
Supporting data

- 227 Required resolution (58%)
- 133 Requested advice or information (34%)
- 23 Compliments (6%)
- 6 Provided feedback (2%)
- 73 Communication and information
- 61 Appointments
- 47 Clinical Care and Concerns

Countermeasures / Actions	Owner	Due Date
Additional Patient Support and Complaints team officer now in post. This will allow for improved responsiveness and increase the outreach activity to wards and departments.	PSCT Manager	Ongoing
Information on the top 3 contributors to PCST cases is will be shared with the Divisional Leads and included in the specialty Executive Performance Review meetings.	Lead for Patient & Carer Experience	September 2023

Trust Goal | Patient complaints

Historic Data



Response Rate	Medicine	Surgery	F&SS
Completed within timescale	64% (9/14)	67% (2/3)	50% (1/2)

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

Is the standard being delivered?

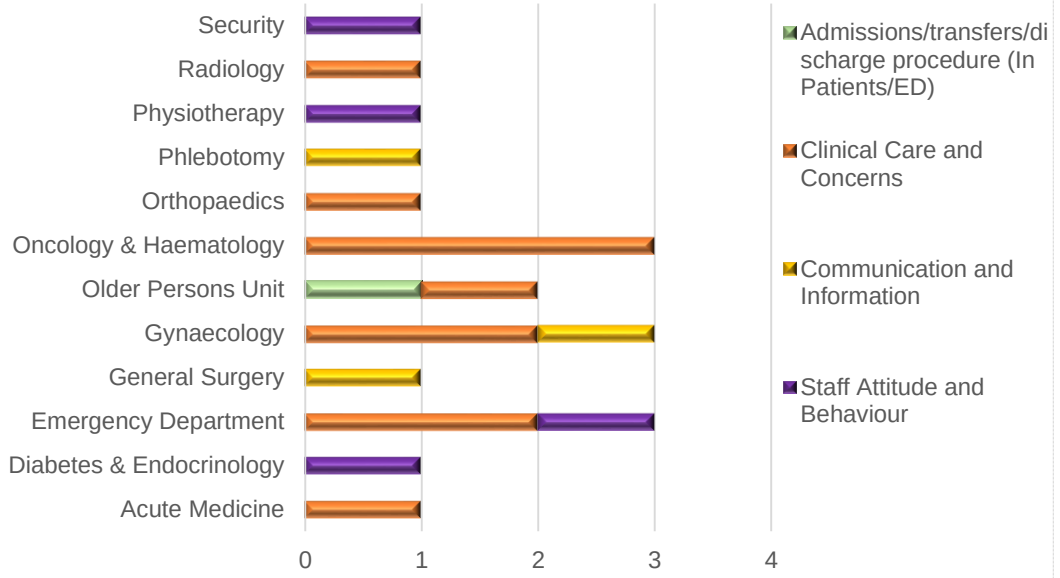
The Trust received 19 formal complaints in July 2023. The numbers of complaints is continuing to fall This is 12 less than the mean average for the rolling 24 months. Underperforming >=34, Performing <30.

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

Clinical Care and Concerns accounted for 56% (n=11) of complaints. Oncology & Haematology (n=3), the Emergency Department (n=2) and Gynaecology (n=2) received the highest number of clinical care complaints. The majority complaints related to inappropriate care/treatment.

63% of complaints closed during July met the required timescale of 35 working days (12/19). This is a decrease on the response rate in June (88%).

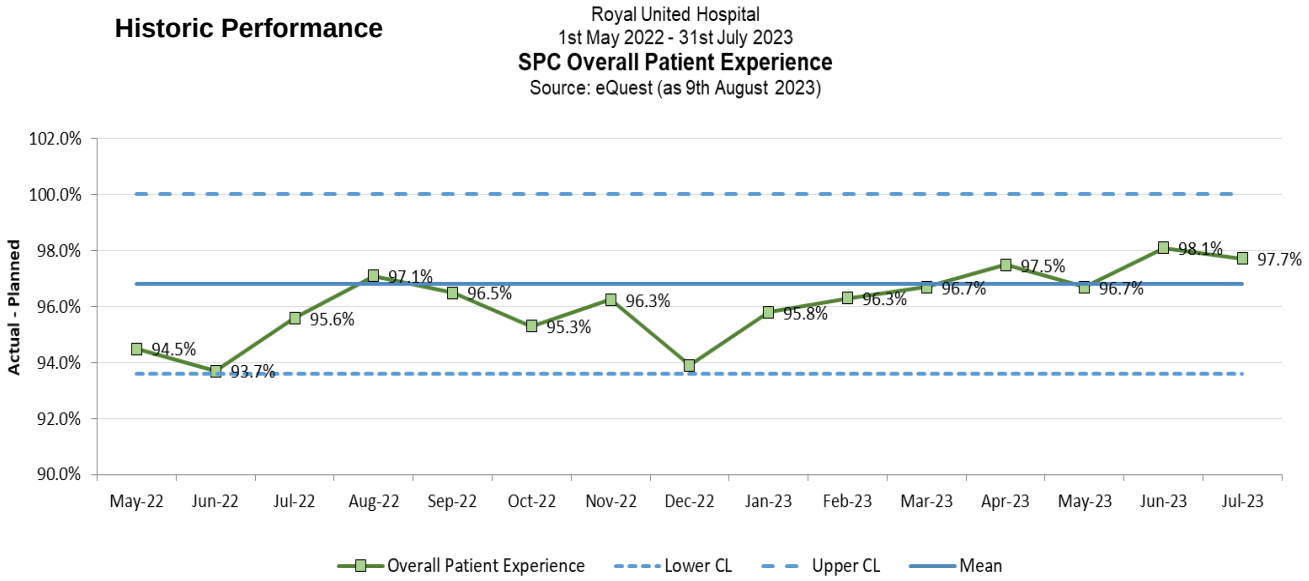
Supporting data

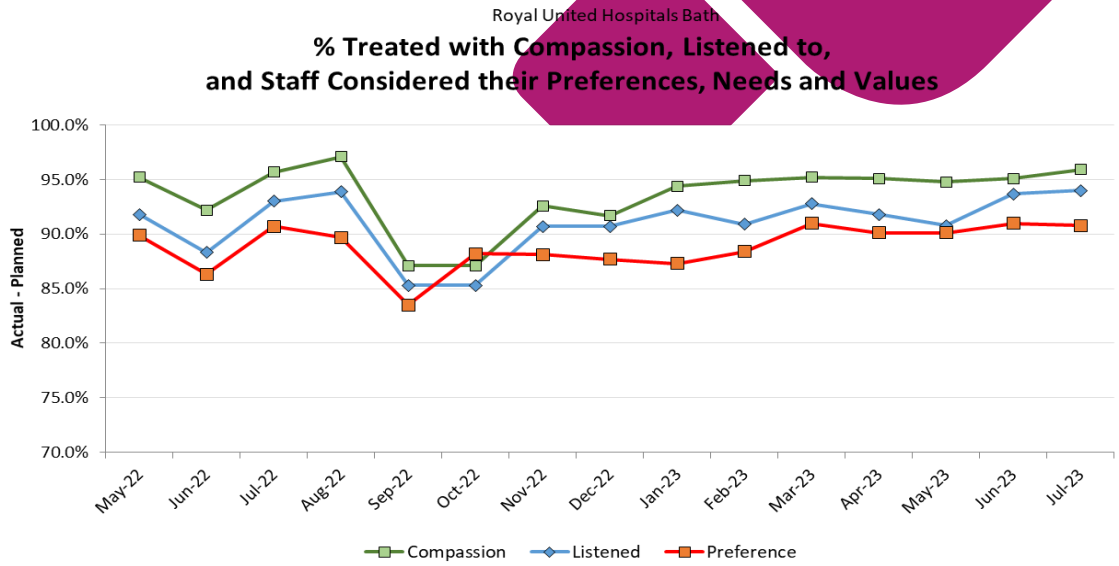


Countermeasures / Actions	Owner	Due Date
Continue with weekly Divisional complaints meetings.	Head of Complaints	Complete
Monitor benefits of single point of access and complexity of complaints.	HH/NE	Nov-23
Audit of complaint responses to be completed by Non- Executive Directors. This will focus on the quality of the response and questions answered.	HH/AG	Sept-23

Patient | Friends and Family Test

Historic Performance





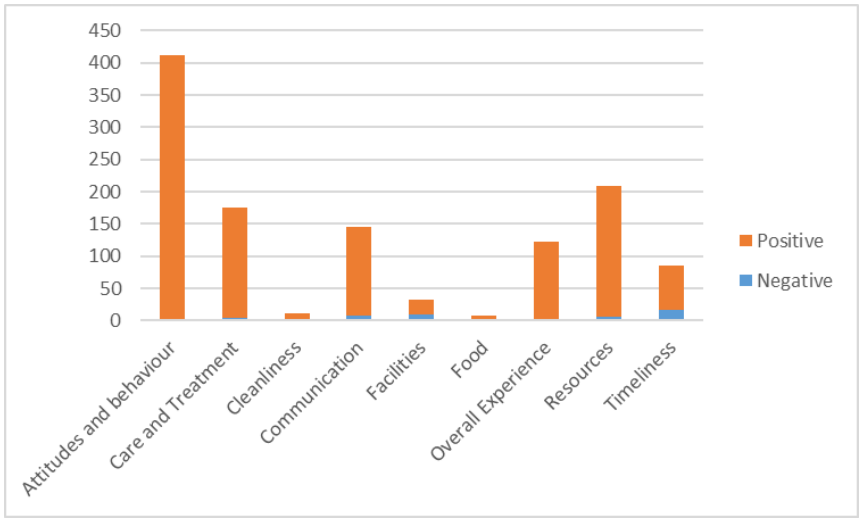
Is standard being delivered?

The proportion of patients across the Trust that responded positively (very good or good) about their overall experience this month was **97.7%. Above the 95% target on the Trust scorecard. All clinical divisions scored above the 95% target for July 2023.**

From 1st April 2023 the ED FFT responses are included in the Medicine Division figures.

FFT responses June 2023	'Overall how was your experience of our service?'		
	Medicine Division	Surgery Division	F&SS
Very good/ good	**97.2% (419)** =	**98.4% (305)** ↑	**97.2% (134)** ↓
Poor/ very poor	1.63% (7)	0.65% (2)	2.2% (3)
Neither good nor poor	0.93% (4)	0.97% (3)	0% (0)

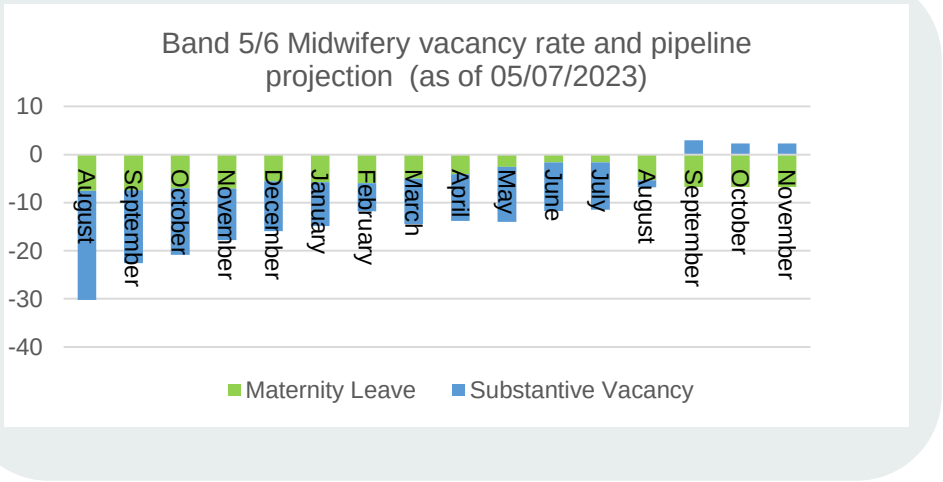
Themes - Patient experience comments collected via FFT in July 2023:



FFT Positive feedback – top three themes are:
Attitudes and behaviour of staff (n=409), Resources (n=203) and Care and Treatment (n=171).

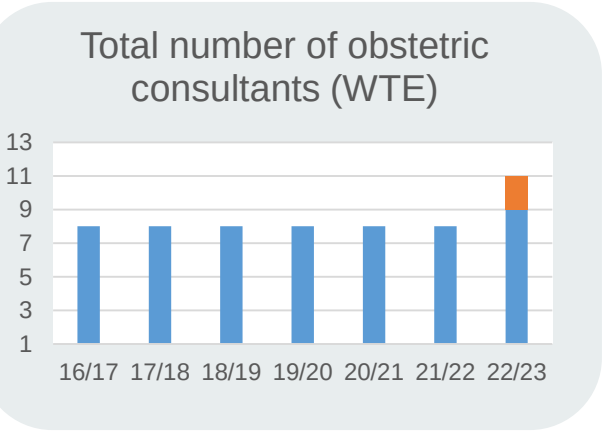
FFT Negative feedback – top three themes are:
Timeliness (n=17), Facilities (n=10) and Communication (n=8).

Safe – Maternity& Neonatal Workforce



Average Shift Fill Rates

		May 23	June 23	July 23
Midwives	Day	93.3%	88.2 %	86.4 %
	Night	93.1%	89.8 %	89.3 %
MCA/MSWs	Day	56%	58%	55%
	Night	91%	79.0 %	83.0 %



The RUH, where you matter

Is the standard of care being delivered?

- 1 to 1 care in labour was achieved at all times.
- There were 2 care episodes where a co-ordinator was unable to maintain a supernumerary status in July.
- Neither of these care episodes related to intrapartum care.
- The Midwife to birth ratio is below the new BR+ recommended 1:24 births
- There is a – 11.4 WTE midwifery workforce gap including maternity leave

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

Vacancy rate
Maternity leave
Accuracy of data capture for fill rates (MSW day rate)
Human error in data capture

Countermeasure /Action (completed last month)	Owner
Repeat BirthRate+ (BR+) report shared with Division and full paper presented to Board supporting the Maternity bi-annual staffing paper. Midwife to birth target ratios amended to reflect BR+ report findings	DOM
Assessment and break down of vacancies across maternity service, working with finance to ensure externally funded posts are removed from establishment to reflect more accurate vacancy factor.	DOM
12.48 WTE band 5 and 6 midwives recruited April 23 anticipated start dates during September.	DOM
Obstetric Consultant representation amended to reflect the current secured funded establishment and the Locum Consultant posts with no current secured funding to add into establishment. Risk assessment undertaken for representation on maternity risk register.	Obstetric Lead Consultant

Countermeasure /Action (planned this month)	Owner
Continuing work with NHSE to establish the longer term workforce plan for acute/community sites & continuity of carer.	DOM
Continued work with Human Resources (HR) and Finance to ensure pipeline position is accurate and externally funded posts are visible and clear narrative to explain Electronic Patient Record (ESR) variation related to administrative lags.	DOM
Fixed term increase in obstetric workforce to go into business planning for permanent funding in progress to ensure safe medical staffing.	Clinical Director Maternity
Continue work with Staffing Solutions to improve data capture for Maternity Support Worker (MSW) day shifts – currently including community data. Acute services Matron meeting with Roster Systems Manager.	Acute Matron
A further 5 international recruits are anticipated to joining over coming months with staggered starts, totalling 8 new team members.	DOM

Safe – Workforce

	Target	Threshold			May 23	June 23	July 23	SPC	Comment
		Green	Amber	Red					
Midwife to birth ratio	1:27	<1:24		>1:28	1:29	1:32	1:32		Changed target ratio ↓from 1:27 to 1:24 in response to the BR+ report of 2023.
Midwife to birth ratio (including bank)	1:27	<1:24		>1:28	1:25	1:28	1:29		
Labour ward coordinator (LWC) not supernumerary episodes	0	0		>1	0	0	2		No provision of intrapartum care.
1:1 care not provided	0	0		>1	0	0	1	H P	Reviewed by LWC lead, data error.
Confidence factor in BirthRate+ recording	60%	>60%		<50%	78%	69.4%	67.7%	H	Percentage of possible episodes for which data was recorded.
Consultant presence on BBC (hours/week)	98	>97			98	98	98	H F	Meeting Royal College of Gynaecologists (RCOG) recommendation from Jan-23.
Daily multidisciplinary team ward round	90%	>90%		<80%	97%	93%	97%		
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0	L P	

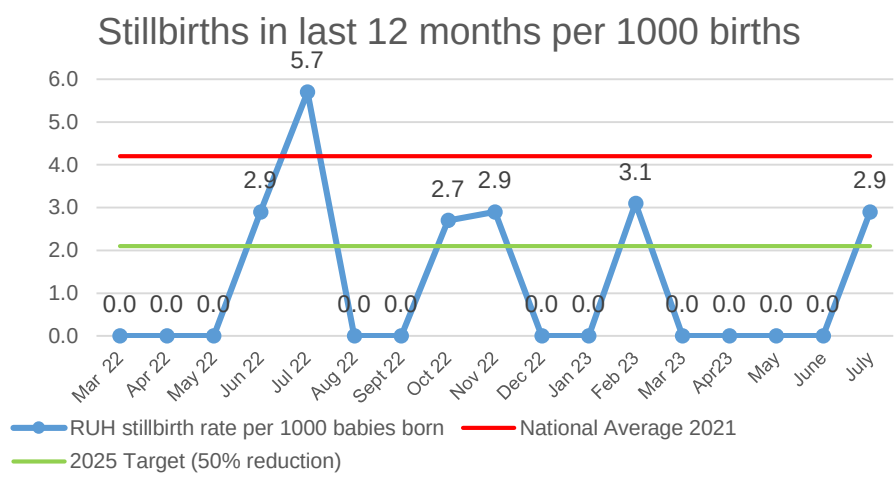
What is SPC?
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation to guide appropriate action. A recommendation of the East Kent Report, is that measures are analysed and presented using SPC to identify the 'signals among noise'.

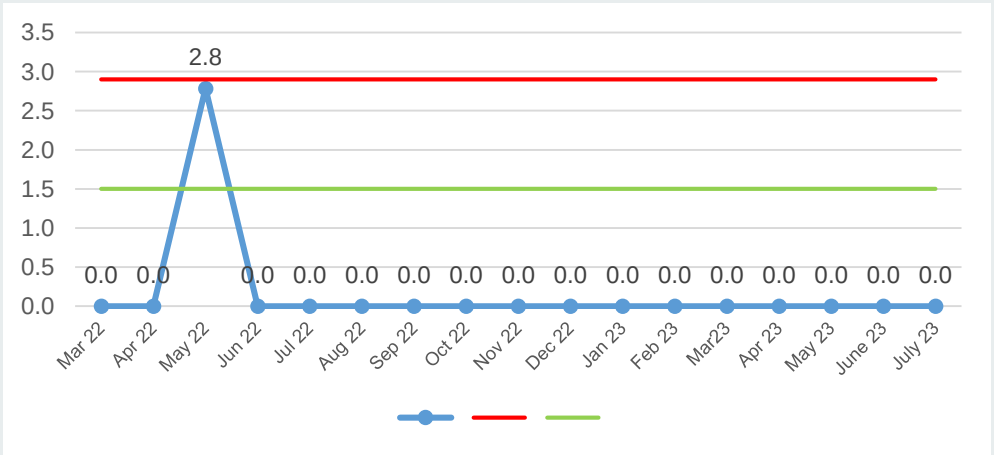
The RUH, where you matter

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

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

Safe- Perinatal Mortality Review Tool (PMRT)





All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT) since 2018. PMRT reporting is Safety Standard 1 of the NHSR Maternity Incentive Scheme year 4. A quarterly update paper is shared with the board.

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

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

1 perinatal death was reported in July of a 35 week stillbirth, care has been reviewed as part of an MDT initial review, no initial concerns have been raised. This will follow a full review via PMRT.

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

Perinatal Case ID	Issue Text	Action plan text	Implementation text	Person responsible	Target date	Completed
No outstanding PMRT actions						

Responsive

Quarterly feedback from families – MVPP (Mar 23-May23)

Positive:

- Positive praise for the maternity team's professionalism and individualised care which instilled feelings of safety.
- Appreciation expressed for volunteer breastfeeding peer supporters who supported colostrum expression while baby was in Neonatal Unit.

Areas for improvement:

- Feeling unheard and lack of time taken to listen. Feeling that care decisions were based upon hospital rather than individual needs.
- Request for more advice relating to caesarean wound aftercare and medication.
- Desire for more recliner chairs on Mary Ward.
- Inconsistent breastfeeding advice.
- Request for more evidence based research to support informed decision making.

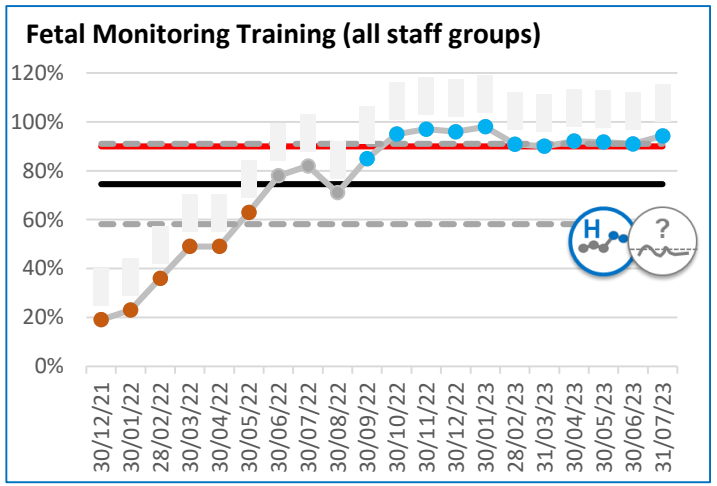
Feedback from Staff – Safety Champions

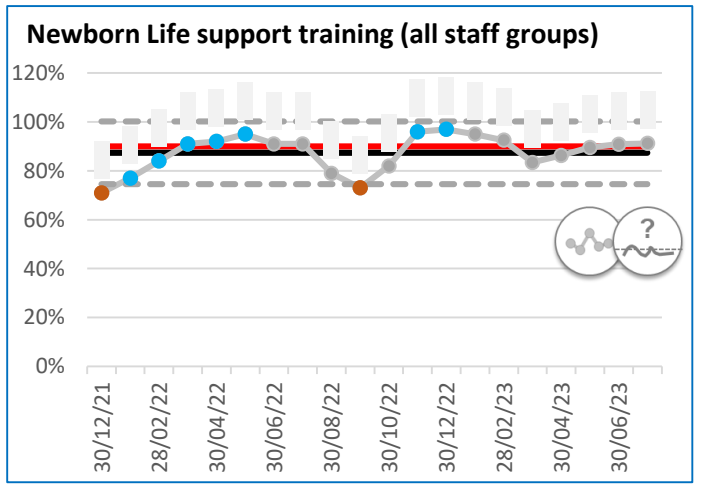
- Recruitment updates, positive on going recruitment – international midwives started in post.
- Self-rostering discussion from exit interviews feedback.
- Discussions regarding homebirth team and models of care.
- On call provisions specifically in community settings.

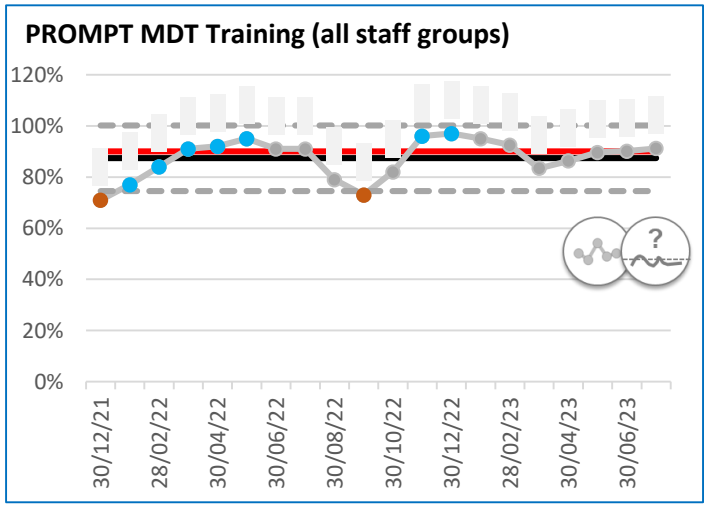
Feedback from families - PALS

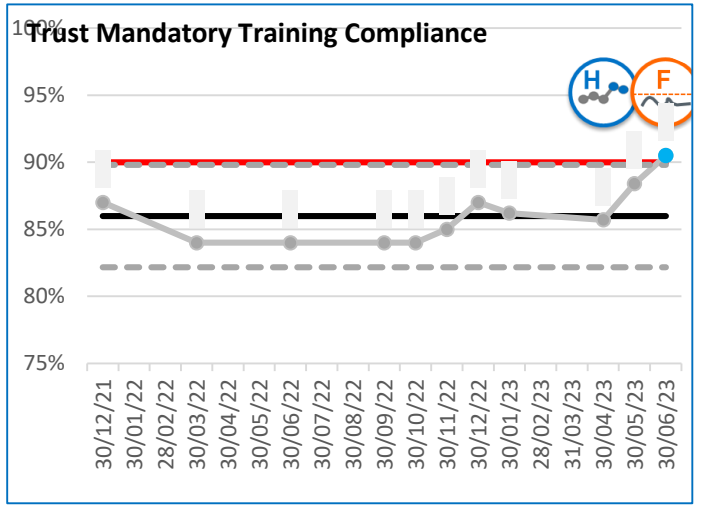
Compliments	1	Complaint and contacts in July 23: No complaints received in July PSCT: Car parking fines. Birthing outside of guidance. Call handling. Compliment: 'staff worked tirelessly to ensure our safety, wellbeing and comfort.'
Online compliments	-	
PALS contacts/concerns	6	
Complaints	0	

Well-led – Training







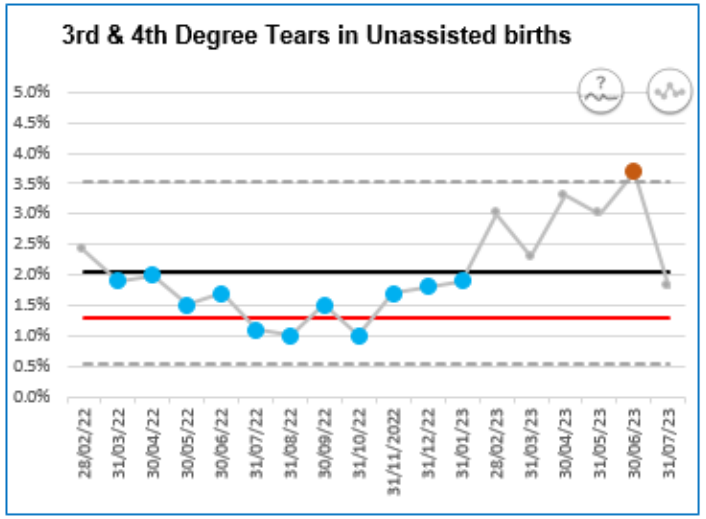


Training
Compliance monitoring and booking system now in place supporting future compliance. Updated Training Needs Analysis awaiting formal departmental ratification. Compliance data being sent to all multi-disciplinary team (MDT) leads monthly to ensure good information sharing between all staff groups.

Countermeasures/actions:
- Additional training dates secured for period of peak staffing changes (doctor change over/midwifery pins/new starters). These will run in Sept, Oct and Nov 2023. Long-term plans to introduce additional dates in Feb and March.
- Prompt train the trainer conducted on 22 March to develop faculty and improve standard of training for MDT teams.
- Bespoke refresher skills sessions available for community staff: Skills drills and new-born 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.
- Continued with Practical Obstetric Multi-Professional Training (PROMPT) training in July despite doctor strikes, working with Consultant Leads to improve compliance amongst doctors relating to booking of training prior to arrival.

Risks:
- The use of our own compliance tracker 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.
- August staffing level projections anticipate a suspension of mandatory training dates for the month of August.
- Influx of new MDT staff in September, October & November please see countermeasure above.
- Obstetric registrar compliance currently 66.7%

Safe – Themes of low and No harm

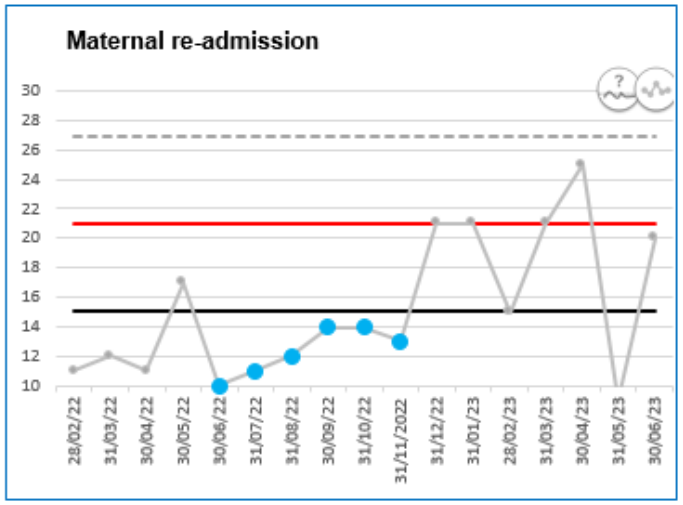


Is standard being delivered?

No – Significant rise noted in February, and sustained rate above previous rate indicating potential rising trend in 3rd and 4th degree tear rate in unassisted births.

Countermeasure/actions:

- Review of cases by Pelvic Health Team. Review of cases by Pelvic Health Team presented to Maternity Specialty Governance in June.
- Continued investigation of raw data for modifiable factors within the supporting data.
- Identified 7/22 births within the reviewed cohort were Obstetric Anal Sphincter Injury (OASI) care bundle compliant.
- Additional OASI study days and ad-hoc training sessions agreed and taking place during July and August by clinical skills facilitators, Pelvic health physiotherapist, and Obstetric consultants.
- Continued observation to ensure trajectory continues to identify improvement in response to measures above.

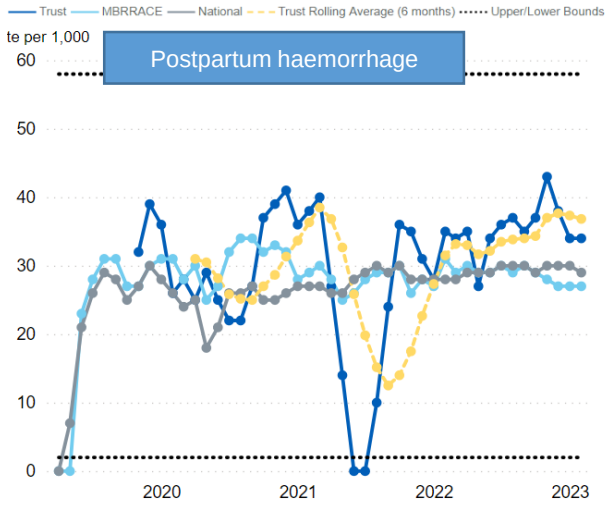


Is standard being delivered?

No – potential upwards trend in maternal re-admissions identified. Currently unstable fluctuation.

Countermeasure/actions:

- To complete a full review of maternal re-admissions into maternity services from December of 2022 until present in progress being undertaken by Obstetric registrar.
- Continued observation to establish whether isolated peaks or increasing trend.



Is standard being delivered?

No –RUH Maternity Services currently sitting above the national average for rate of Postpartum Haemorrhages >1500mls per 1000 births.

Considerations: Review the SOP for blood loss estimation. The RUH currently weighs all blood loss and the national standards are to estimate blood loss. This will form the basis for the terms of reference.

Countermeasure/actions:

- As rate is stable, plans to complete a case cohort review, and thematic analysis of the current RUH maternity process for the identification and management of Post Partum Haemorrhage >1500mls.
- Data collection is complete analysis to commence in august. Results will be shared at September Maternity Service Governance (MSG). Led by Lead Consultant supported by PS team.
- Continued observation to establish whether theme or trend emerging.

Responsive

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

MIS RAG rating	
RED	Significant challenge to compliancy
AMBER	Expecting compliancy – plan in place to achieve
GREEN	Currently compliant

Maternity Incentive Scheme Year 5

Is standard being delivered?

No –current gaps in compliance identified within Safety Action 1,2,3,4,7,8,9,10.

It is anticipated following the work in progress we will be in a position to demonstrate compliance for 9 of the 10 standards.

Key areas of risk to compliance are:

- SA5 - There is no current secured funding for increased midwifery establishment in response to the BR+ report (2023) safe staffing requirements
- SA6 – Saving Babies Lives (SBL) V3 recommends scan pathway for Fetal Growth Reduction surveillance, currently not in place and will require significant amendments to current practice, guidance, additional training and referral processes to embed. This will also generate anticipated increased scan demand. Ultrasound (USS) capacity is featured within the maternity risk register entry 1963 (High Risk 12).
- SA6 - SBL V3 - The provision of a dietetic practitioner as part of the multidisciplinary antenatal clinics for pre-existing diabetic mothers. Current challenges to recruit and lack of recurrent funding.

Responsive – Health Inequalities

Priority Area	Measure	Target	Baseline 22/23	Progress
Roll out Black Maternity matters training.	• Number of Midwives who complete the programme. • Number of completed QI projects in this area.	7 staff across the maternity and neonatal.	N/A	Training commenced 6/06/2023
Roll out cultural competency training.	• % of staff who have completed training. • Assessment of impact.	100% of maternity, neonatal and obstetric staff.	30 Staff	Training to commence September 23
Access-defined as late booking of pregnancy.	• % of women in each ethnic category who have their pregnancy booked by 12/40.	To reduce the number of late bookings in black women to be in line with other ethnic groups.	White - 94.4% Mixed – 90.2% Asian or Asian British – 84.9% Black or Black British – 76.7% Other - 83.6%	July 23 data White - 92.7% ↓ Mixed – 100%↑ Asian or Asian British – 100% ↑ Black or Black British – 80% ↑ Other – 85.7%↑
Breastfeeding-defined as % of women who initiate breastfeeding.	• % of women who initiate breastfeeding (BF) at birth.	To increase breastfeeding initiation in white women living in Indices of Multiple Deprivation (IMD) 1 and 2 to be in line with other IMDs.	IMD 1 (10% of most deprived across the country) – 61.5% IMD 2 – 70.9 % IMD 10 (10% of the least deprived across the country – 92%	The 'Milk Project' was launched in 2022 in an area of deprivation. It is currently too early to collate data on outcomes.
Communication-defined as access to patient information in spoken language.	• Number of patient information sources available in the top 10 spoken languages. • % of women where an interpreter was used when English is not a spoken language.	100%	None	Currently unable to pull data on use of interpreters as the system does not allow for this. Now completing a Datix for all times an interpreter was not available.
Data Quality - defined as breastfeeding at discharge, smoking at the time of delivery and ethnicity recording.	• % of women recorded as 'not known' or 'not stated'.	<5%	Ethnicity recording – 4.1% smoking at time of delivery (SATOD) Missing breastfeeding data at discharge – 85%	Ethnicity recording missing data has reduced to 4.1% from 16% July 0.6% New data quality analyst commenced May 23.

The people in our community

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 4

The people in our community

The RUH, where you matter

Summary

Overall Position

- At the end of July, the Trust is in a deficit position of £7.0 million which is £1.6 million worse than plan. The RUH adverse positon in part relates to direct staff costs of covering industrial action £0.9 million, £1.0 million increased run rate pressure of Medical and Surgical consumables, increased agency / bank costs over the vacancy level mainly partly offset by a rebate for previous years rates and additional income through interest.

Operational Pressures

- The number of non-criteria to reside patients has reduced with an average of 92 which is only 2 above the planned level. This reduction does reduce operational pressures but Non-Elective Activity remaining significantly high and is 104.6% of planned levels. Agency usage has slightly reduced as a proportion of total pay costs and for the month is 3.8%, 0.8% above the 3% target. Beds occupied with Covid patients has also remained low in July at an average of 3 patients in beds per day.
- Elective recovery plan (ERF) income has continued to be matched to plan, with costs matching income year to date. The M4 activity position worsened compared to June, at 96% of the plan and is 100% of planned elective activity levels year to date.

Financial Variances

- £2.1 million of savings have been delivered in month over-achieving against plan by £1.5 million. The Improvement Programme target remains at £28 million of efficiencies to deliver the £23.5 million of planned savings, of which £4.4 million has been delivered to date. The delivery of the schemes is planned to be predominantly in the last three quarters of the year to enable them to be developed and implemented.
- Non-Pay budgets are overspent by £1.1 million in month. The main focus of the overspend continues to be medical and surgical consumables costs. Work is underway to understand the change in non-pay expenditure and implement mitigating actions.
- The RUH has identified risks within the plan of £33.4 million. £0.8 million of the adverse position to plan related to impacts in areas of known risk such as industrial action and over-delivery of QIPP, the remainder is due in the main to an increase in non pay costs.
- Total capital expenditure was £6.2 million year to date at Month 4 which is £1.0 million ahead plan, mainly linked to the net impact of IFRS16.
- The closing cash balance for the Group was £53.4 million which is £16.8 million higher than the plan.

Emerging risks and Forecast Outturn

- Our largest emerging risks continue to be the delivery the £23.5 million QIPP; continued industrial action; increases in non-pay consumable costs and not delivering the elective recovery programme.

BSW

- At the end of month 4 the BSW ICS reported a financial position of an adverse variance of £11.3m.
- As s system BSW have placed ourselves in the finance protocol in order to improve the rate of financial recovery.

Executive Scorecard

	Performance Indicator	Description	Target: Performing	Target: Under Performing	Baseline	Actual 2023/24: Apr-23	May-23	Jun-23	Jul-23
Sustainability Tracker Metrics	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	£0	(£0.989m)	(£2.389m)	(£1.125m)	(£1.559m)
	Forecast delivery of Group financial plan	Forecast variance from year to date plan	<=0	>0	£0	£0	£0	£0	£0
	Group delivery of breakeven	Total year to date financial performance	<=0	>0	£0	(£2.390m)	(£5.389m)	(£5.625m)	(£7.045m)
	Delivery of QIPP	Total QIPP delivery	N/A	N/A	N/A	£0.216m	£0.345m	£0.663m	£2.757m
	Delivery of QIPP against plan	Performance against plan	<=100%	>100%	48.0%	76.0%	61.0%	113.0%	190.4%
	Reduction in agency expenditure	Agency costs as a % of total pay costs	<= 3%	> 3%	3.0%	3.3%	3.6%	4.5%	3.8%
	Sickness against plan	Actual levels of sickness against average pre-pandemic levels	<= 4.1%	> 4.1%	7.7%	3.3%	3.2%	3.2%	3.5%
	Reducing no criteria to reside patients	No criteria to reside to reduce by 40% from December 2021	<= 90	> 90	149	117	108	108	92
	No COVID admissions	Average number of beds occupied by COVID patients	<=30	>30	64	29	12	5	3
	Reducing staff vacancies	Total vacancies reported each month	<=7.4%	>7.4%	7.40%	5.10%	6.20%	6.30%	6.50%
	Net impact of high cost drugs and devices	Total expenditure and income against plan for high cost drugs and devices (YTD)	<=0	>0	£0	£0	£0	£0	£0
	Increase productivity	Implied productivity based on financial and operational performance (Quarterly)	>=3%	3%	-20%	-22%	-22%	-22%	-24%
	Elective recovery	In Month Performance against planned levels of activity (Value based)	>= 100%	< 100%	n/a	92%	101.0%	111.0%	96%
	Non elective activity	Performance against planned levels of activity (Value Based)	<= 102%	> 102%	n/a	101.5%	107.1%	106.4%	104.6%
	Delivery of capital programme	Variance from year to date planned capital expenditure (Internally Funded Schemes)	-5%	<5%	n/a	15.3%	79.4%	35.8%	-15.7%
	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+ or - 5%	><5%	n/a	0	0	0	0
	Delivery of planned cash balance	Variance from year to date planned cash balance	- 10%	<10%	n/a	11.6%	10.20%	64.90%	45.9%

True North | Breakeven position

Statement of Comprehensive Income	Total					
	202304			YTD		
Period to 202304	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Commissioner Income (NHSE/CCG)	38,633	38,923	290	147,090	147,986	896
Other Patient Care Income	1,858	1,953	95	7,284	7,871	587
Other Operating Income	1,469	2,254	785	13,867	16,217	2,350
Unallocated	0	0	0	0	0	0
Income Total	41,960	43,129	1,169	168,241	172,074	3,833
Pay	(28,391)	(28,038)	353	(112,754)	(112,974)	(221)
Non Pay	(11,910)	(13,058)	(1,148)	(50,257)	(52,811)	(2,553)
Depreciation	(1,814)	(2,371)	(556)	(7,249)	(7,796)	(547)
Impairment	0	0	0	0	0	0
Expenditure Total	(42,115)	(43,467)	(1,352)	(170,260)	(173,581)	(3,321)
Operating Surplus/(Deficit)	(155)	(337)	(182)	(2,019)	(1,507)	512
Other Finance Charges	(859)	(819)	40	(3,437)	(2,956)	481
Other Gains/Losses	10	6	(4)	10	16	6
Finance Charges	(848)	(813)	36	(3,427)	(2,940)	486
Surplus/(Deficit)	(1,003)	(1,150)	(147)	(5,446)	(4,447)	998

Adjusted Financial Performance						
Add back all I&E impairments/ (reversals)	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	(1,003)	(1,150)	(147)	(5,446)	(4,447)	998
Remove capital donations/grants I&E impact	17	(269)	(286)	(40)	(2,597)	(2,557)
Adjusted financial performance surplus/(deficit) including PSF as per accounts	(987)	(1,420)	(433)	(5,486)	(7,045)	(1,559)
Adjusted financial performance surplus/(deficit)	**(987)**	**(1,420)**	**(433)**	**(5,486)**	**(7,045)**	**(1,559)**

Tracker Measure | Sustainability – Workforce

Pay Spend by Staff Group	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000
Medical Staff	(86,866)	(28,784)	(29,181)	(397)
Nursing and Midwifery	(97,714)	(32,403)	(32,342)	60
Scientific, Technical and Therapeutic	(37,479)	(12,498)	(11,815)	683
Support to Clinical	(50,612)	(17,251)	(17,644)	(393)
Infrastructure	(29,832)	(12,789)	(12,832)	(43)
Other	(1,095)	(365)	(523)	(158)
Adjusted Pay	(303,597)	(104,091)	(104,337)	(247)
Pay Directly Funded	(6,323)	(2,619)	(2,552)	67
Pay Total	(309,920)	(106,710)	(106,890)	(180)

Pay Spend by Staff Group	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000
Substantive	(94,103)	(31,274)	(28,380)	2,894
Bank	(1,542)	(440)	(2,483)	(2,043)
Agency	(2,069)	(689)	(1,480)	(790)
Enhanced Hours	0	0	0	0
Pay Directly Funded*	(1,466)	(489)	(580)	(91)
Total Pay	**(99,180)**	**(32,891)**	**(32,922)**	**(31)**
Adjusted Pay	**(97,714)**	**(32,403)**	**(32,342)**	**60**

WTE by Staff Group	YTD Plan	YTD Actual	YTD Vacancies	YTD Vacancies %
Medical Staff	724	706	18	2.4%
Nursing and Midwifery	1,726	1,671	55	3.2%
Scientific, Technical and Therapeutic	676	618	58	8.5%
Support to Clinical	1,680	1,502	178	10.6%
Infrastructure	840	779	61	7.2%
WTE Total	5,645	5,276	369	6.5%

Is standard being delivered? ***Use this section to write about the key drivers behind the cost moves.***
No

What is the top contributor for under/over-achievement?
The RUH currently had 369 vacancies at the end of June, 6.5% of the roles. This has increased in part due to the release for budgeted ERF roles than have not yet been filled, as well as vacancies for support to clinical and specific services such as Pathology.

Agency costs (£0.8 million) in Medical staff are more than offset by vacancies. Some of these vacant roles are being recruited into to support Elective activity.

High level of vacancies in infrastructure are related to cleaning roles, which are currently covered through premium agency reducing the underspend. Support to clinical currently holds significant vacancies. This includes unqualified nurses typically covered through bank.

HR and Finance are working together to update Electronic Staff Records (ESR) to ensure that the budget position is reflected in this system, allowing a real time view of staff in post and vacancies.

Countermeasures completed last month

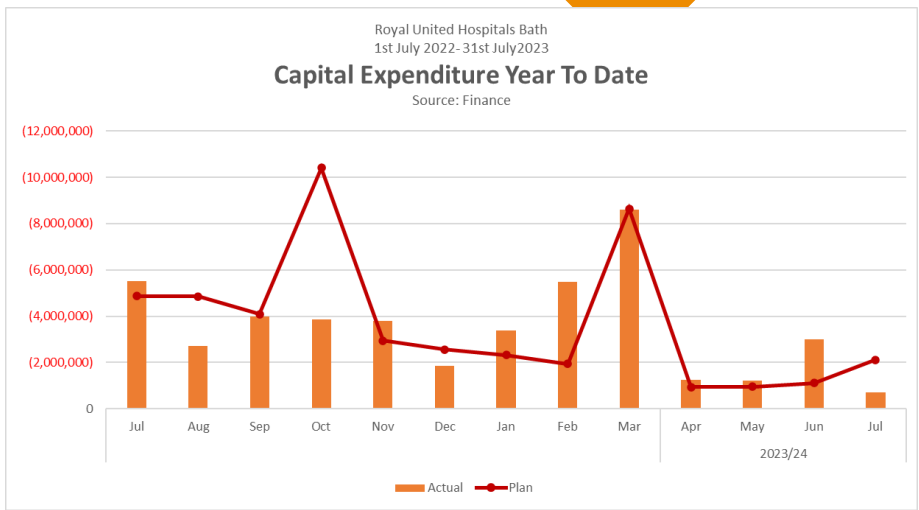
Countermeasures for the month ahead

Countermeasure /Action	Owner
Review and further impact of industrial action on pay spend. Budgeted establishments being aligned in the ledger and ESR to ensure robust vacancy reporting. Identify further actions to reduce RMN's / HCP's	Divisional Finance Managers and Specialty Managers Finance and HR Director of Nursing & DDoNs

Tracker Measure | Sustainability – Capital (RUH and SULIS)

Capital Programme

Capital Position as at 31st July 2023	Annual Plan	Forecast	Year to Date Plan	Year to Date Actuals	Year to Date Variance
	£000s	£000s	£000s	£000s	£000s
Internally Funded schemes	(13,878)	(13,216)	(790)	(666)	124
IFRS 16 Lease Schemes	(7,555)	(7,555)	(1,469)	0	1,469
External Funded (PDC & Donated):					
Cancer Centre PDC	(6,650)	(6,650)	(2,450)	(2,549)	(99)
SEOC PDC	(10,090)	(10,090)	0	(46)	(46)
BSW EPR PDC	(3,360)	(1,713)	0	0	0
Digital Diagnostic PDC	(299)	(299)	(72)	0	72
Community Diagnostic Centre PDC	(2,923)	(2,923)	0	0	0
Donated	(5,697)	(5,398)	(340)	(2,896)	(2,556)
Total	**(50,452)**	**(47,844)**	**(5,121)**	**(6,158)**	**(1,036)**



Is standard being delivered? No

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

Trust funded programme is £1,593k under plan year to date, this relates mainly to IFRS16 schemes for which funding cover arrangements are still awaiting HM Treasury approval. Excluding IFRS 16 the Trust was £124k under plan (15% behind plan).

External funded schemes are £2.62 million over plan, this relates to the timing of donated schemes, with the Robotic equipment purchase complete. The forecast for donated schemes is less than plan as funding was brought forward to 2022-23 for the Cancer Centre.
The Community Diagnostic Centre funding has been agreed and included in the annual plan.
The forecast outturn for the BSW EPR scheme has been reduced for this year, with the reprofiling of the scheme into 2025/26. The business case is due to be submitted in August.

Countermeasures completed last month

Countermeasure /Action	Owner
N/A	

Countermeasures for the month ahead

Countermeasure /Action	Owner
CPMG to continue to monitor delivery of projects and schemes	Head of Financial Services
Review of Capital 5 Year Plan	Director of Finance/Head of Financial Services

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

	31/07/2023 Plan £'000	31/07/2023 Actual £'000	Variance £'000
Non current assets			
Intangible assets	7,052	7,132	80
Property, Plant & Equipment	288,131	289,568	1,437
Right of use assets - leased assets for lessee	51,036	49,001	(2,035)
Investments in associates and joint ventures	56	56	0
Trade and other receivables	1,997	5,074	3,077
Non current assets total	**348,272**	**350,831**	**2,559**
Current Assets			
Inventories	5,389	8,120	2,731
Trade and other receivables	17,383	21,131	3,748
Cash and cash equivalents	36,648	53,410	16,762
Current Assets total	**59,420**	**82,661**	**23,241**
Current Liabilities			
Trade and other payables	(48,300)	(60,028)	(11,728)
Other liabilities	(5,915)	(22,226)	(16,311)
Provisions	(263)	(228)	35
Borrowings	(2,155)	(2,314)	(159)
Current Liabilities total	**(56,633)**	**(84,797)**	**(28,164)**
Total assets less current liabilities	**351,059**	**348,695**	**(2,364)**
Non current liabilities			
Provisions	(1,525)	(1,525)	0
Borrowings	(55,287)	(53,298)	1,989
TOTAL ASSETS EMPLOYED	**294,246**	**293,872**	**(374)**
Financed by:			
Public Dividend Capital	239,658	238,286	(1,372)
Income and Expenditure Reserve	7,942	8,940	998
Revaluation reserve	46,646	46,646	0
Total Equity	**294,246**	**293,872**	**(374)**

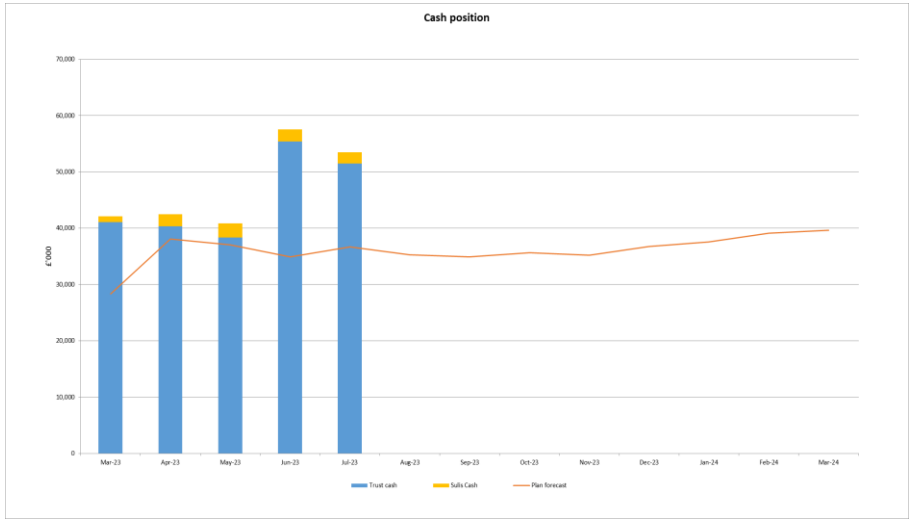
The Group Balance Sheet (RUH and Sulis)

Month 4 against plan:

- Overall non current assets have increased against the plan. The movements relate in the main to capital expenditure incurred in month.
- Inventories have increased against assumptions included in the plan, however remain static against Month 3.
- Trust receivables continue to remain above the plan, the key driver is increases in prepayments for expenses paid in advance of use.
- Trust payables continue to remain above plan. This is net of increases in expenditure and PDC dividend and a decrease in capital creditors.
- Trust other liabilities are above plan and have increased due to the deferral of the pay award funding for 2023/24.
- Cash has increased as referenced on the slide detailing the cash movements

Tracker Measure | Sustainability – Cash (RUH and SULIS)

Group Cashflow Statement Month 4



Cashflow statement	Actual £'000
Operating Surplus/(deficit)	(1,507)
Depreciation & Amortisation	7,796
Income recognised in respect of capital donations (cash and non-cash)	(2,896)
Working Capital movement	11,380
Provisions	(35)
Cashflow from/(used in) operations	**14,738**
Capital Expenditure	(7,340)
Cash receipts from asset sales	16
Donated cash for capital assets	2,896
Interest received	798
Cashflow before financing	**(3,630)**
Public dividend capital received	2,100
Capital element of finance lease rental payments	(889)
Interest on loans	(43)
Interest element of finance lease	(791)
Net cash generated from/(used in) financing activities	**221**
Increase/(decrease) in cash and cash equivalents	**11,330**
Opening Cash balance	**42,079**
Closing cash balance	**53,410**

Is standard being delivered for cash? No

The Group cash balance is £16.8 million higher than than the planned NHSI return submitted for 2023-24.

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

The variance against plan is driven by an increase in income for donated capital assets and working capital which relate to cash paid in full for the pay award for 2023-24, outside system ICBs blocks, maternity incentive payments and donated income.

Countermeasures completed last month

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

Countermeasures for the month ahead

Countermeasure /Action	Owner
Continue to update cash flow based on recent trends and known changes	Financial Accountant

QIPP | Financial Progress (RUH & Sulis) – Programme against NHSI plan

		NHSI			NHSI			
	Period 4 2023_24	PLAN YTD	ACTUALS ATD	VARIANCE	PLAN FY	FCST FY	VARIANCE FY	
	Divisional QIPP	**,000**	**,000**	**,000**				**Delivered**
	Corporate	£ 176	£ 594	£ 418	£ 564	£ 564	£ -	£ 617
	Facilities	£ 111	£ 87	-£ 25	£ 478	£ 478	£ -	£ 234
	FASS	£ 222	£ 100.814	-£ 121	£ 951	£ 951	£ -	£ 209
	Medicine	£ 449	£ 70	-£ 379	£ 1,927	£ 1,927	£ -	£ 177
	ED	£ 86	£ -	-£ 86	£ 367	£ 367	£ -	£ -
	Surgery	£ 404	£ 277	-£ 127	£ 1,735	£ 1,735	£ -	£ 798
	Total Divisional QIPP	**£ 1,448**	**£ 1,129**	**-£ 319**	**£ 6,022**	**£ 6,022**	**£ -**	**£ 2,034**
Transformation QIPP					*Plan to deliver £17.5m QIPP*			
Productivity & Efficiency	Outpatients	£ -	£ 96	£ 96	£ 850	£ 850	£ -	£ 96
	Radiology	£ -	£ -	£ -	£ 300	£ 300	£ -	£ -
	Patient Flow	£ -	£ -	£ -	£ -	£ -	£ -	£ -
	Theatres/Elective Pathway	£ -	£ 46	£ 46	£ 1,250	£ 1,250	£ -	£ 46
	Pathology	£ -	£ -	£ -	£ 750	£ 750	£ -	£ -
	Sulis	£ -	£ 25	£ 25	£ 1,100	£ 1,100	£ -	£ 25
Workforce	Nurse & Therapies Staffing	£ -	£ -	£ -	£ 333	£ 333	£ -	£ -
	Central HR Initiatives	£ -	£ -	£ -	£ 442	£ 442	£ -	£ -
	Nurse & Therapies Staffing	£ -	£ -	£ -	£ 926	£ 926	£ -	£ -
	Medical Staffing	£ -	£ -	£ -	£ 1,350	£ 1,350	£ -	£ -
	A&C Clinical / Non Clinical & Mana	£ -	£ -	£ -	£ 1,000	£ 1,000	£ -	£ -
	Central HR Initiatives	£ -	£ -	£ -	£ 750	£ 750	£ -	£ -
Cost & Control	Pharmacy Services & Medicines M	£ -	£ -	£ -	£ 943	£ 943	£ -	£ -
	Procurement & Inventory Manage	£ -	£ -	£ -	£ 500	£ 500	£ -	£ -
	Contract optimisation	£ -	£ -	£ -	£ 500	£ 500	£ -	£ -
Estate Management	Estate / Facility Utilisation / Site Re	£ -	£ 1,136	£ 1,136	£ 925	£ 925	£ -	£ 1,136
Income (Commercial)	Commercial Opportunities	£ -	£ -	£ -	£ 379	£ 379	£ -	£ -
	Private Patients	£ -	£ -	£ -	£ 300	£ 300	£ -	£ -
	Overseas Patients	£ -	£ 53	£ 53	£ 200	£ 200	£ -	£ 53
	SLAS	£ -	£ -	£ -	£ 300	£ 300	£ -	£ -
Income clinical	Clinical Coding	£ -	£ -	£ -	£ 850	£ 850	£ -	£ -
	Elective Income	£ -	£ -	£ -	£ 2,030	£ 2,030	£ -	£ -
	Contract Income	£ -	£ 272	£ 272	£ 1,500	£ 1,500	£ -	£ 981
	Best Practice Tariffs	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Cost pressure challenge	Cost Avoidance	£ -	£ -	£ -	£ -	£ -	£ -	£ -
	Total Transformation QIPP	£ -	£ 1,629	£ 1,629	£ 17,478	£ 17,478	£ -	**£ 2,338**
	Total QIPP in PLanner	**£ 1,448**	**£ 2,757**	**£ 1,309**	**£ 23,500**	**£ 23,500**	**£ -**	**£ 4,372**

Overview by NHSI reporting - £23.5 million

Overall QIPP for year delivered has improved by approx. £2.26 million for full year (£2.112 million M3 to £4.372 million M4). Increase is predominately due to a rate rebate of £1.136 million and an increase in interest rates. The delivery of the Improvement Programme continues to pick up pace and more workstreams are expected to start delivering in the coming two periods.

M4 delivered £2.752 million of QIPP verses a £1.448 million target so delivered over the target by £1.309 million. The programme forecasts over delivery of QIPP against NHSE phased target for M5, M6 and M7. However the budget phasing accounted for majority of the QIPP being delivered in the last 5 months of the year.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**11**
Date of Meeting:	**6 September 2023**		
Title of Report:	**Alert, Advise and Assure Report from the Quality Governance Committee**		
Status:	**For discussion**		
Author:	**Ian Orpen, Non-Executive Director and Chair of the Quality Governance Committee**		

Key Discussion Points and Matters to be escalated from the meeting

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

- Nothing to report.

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

- The Board Assurance Framework risks presented to the Committee did not provide full assurance as there remained a number of gaps to provide committee member with a complete picture of the risk or provide sufficient solid evidence to challenge the risks. The BAF would continue to be monitored.
- The Committee were informed that there had been an increase in the number of Level 2 pressure ulcers; this would continue to be monitored by the Committee alongside the mitigating actions.
- The Committee received the Midwifery and Neonatal Bi-Annual Staffing Report and were positively assured on the progress over the last 6 months. However as a result of the increased staffing requirements following the latest Birth-rate Plus review, this requires further monitoring as this will require additional resource, as yet not identified.

ASSURE: Inform the board where positive assurance has been achieved

- The Committee gained reasonable assurance around the positive work and progress being undertaken across maternity services to drive improvement; and the steps being taken to address what presented as complex challenges with staffing and training.
- The Committee were presented the MIS Combined Maternity and Neonates Quarterly Report provided positive assurance.
- The Committee received the Children's Safeguarding Report and were positively assured
- The Committee received the End of Life Care Annual Report and were positively assured
- The Committee received the Tissue Viability Annual Report and were positively assured.

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

- The committee discussed the Board Assurance Framework (BAF) risks 1.1 and 3.3.
- There were no risks added to the BAF

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• The Committee were very pleased to hear that for staff across Safeguarding Children and Safeguarding Adults services, there had been a significant increase in compliance with training on Level 3 now up to 90% which was a commendable achievement. • A number of ward areas
APPROVALS: Decisions and Approvals made by the Committee
• The revised Terms of Reference focusing on revised membership, process and a redefined scope were APPROVED by the Committee, noting that there may be further changes to these following the AQUA review. The updated Terms of Reference are attached at appendix one for Board APPROVAL.

The Board is asked to **NOTE** the content of the report and **APPROVE** the Terms of Reference.

Royal United Hospitals Bath
NHS Foundation Trust

Appendix 1

Quality Governance Committee
Terms of Reference

1.1 Purpose

To provide assurance to the Board that the Trust has a robust framework for the management of key critical clinical systems and processes focussing on the quality of these systems and processes.

1.2 Objectives

To provide assurance to the Board on the overall delivery of the trust's strategic objectives in the context of quality of care and services and the effective mitigation of identified risk, relating to the quality of care and services, specifically in relation to:

- continuous improvement in the quality of services, against each of the dimensions set out in *A Shared Commitment to Quality* (NHSE 2021), including driving improvements though the lens of reducing inequalities in the quality of care provided across all services
- embedding an effective quality management system that supports the effective delivery of the trust's strategic objectives and the provision of sustainable, high-quality care;
- to consider the impact of performance on the quality of services, patient care and to improve the experience of our patients and those in the community;
- to ensure an assurance alliance between the People Plan and the transformation plan; to enable a focus on safeguarding vulnerable adults and reduce health inequalities
- delivery of agreed national and local performance plans, ensuring that both quality and performance data and business intelligence is used to support improvements and sustain best practice;
- facilitating and evidencing the identification and sharing of best practice and learning across the trust;
- demonstrating compliance with statutory and regulatory requirements;

2. Membership

The Committee shall be appointed by the Board to ensure representation by Non-Executive and Executive Directors as well as representation of the views of users, carers and Trust services.

The membership of the Committee shall consist of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors
- Chief Nurse (Lead Executive)
- Chief Medical Officer
- Chief Operating Officer

Each member will have one vote with the Chair having the casting vote, if required. Should a vote be required a decision will be determined by a simple majority.

The following members are required to attend meetings of the Quality Governance Committee:

- Head of Corporate Governance
- Deputy Chief Nurse and Deputy Chief Medical Officer (with a responsibility for Quality Governance)
- Divisional Directors

Where the Committee deems it necessary, other colleagues may be invited to attend for specific matters as and when appropriate

3. Quorum

Business will only be conducted if the meeting is quorate. The Committee will be quorate with three members, including at least two Non-Executive Directors (of which one may be the Chair), either the Chief Nurse or the Chief Medical Officer (or their formally nominated deputy).

Members should attend 75% of the scheduled meetings.

4. Accountability and Reporting Arrangements

The Committee will be accountable to the Board. The Chair of the Committee will present a monthly upward report to the Board of Directors on the activity of the Committee at its last meeting.

The Committee shall refer to the other Board Committees (Audit, Non-Clinical Governance, People, Finance and Performance, and Subsidiary Oversight Committee), matters considered by the Committee deemed relevant for their attention. The Committee will consider matters referred to it by those other Committees.

The Committee will develop and maintain a work plan which will outline the key reports it will consider during the year.

5. Sub-Groups

The Committee may establish, where relevant, sub-groups to provide further in-depth analysis about specific aspects of the Committee's work programme.

All sub-groups are to have terms of reference that are developed and approved by the Committee.

All sub-groups will provide a highlight report to the Committee in line with the agreed work plan and an annual report to include a review of the effectiveness of the sub-groups.

The current sub-groups of the Committee are:

- Trust Quality and Safety Group

6. Frequency

The Committee will meet on a monthly basis. The Committee will meet as a minimum nine times a year.

Additional meetings may be arranged when required to support the effective functioning of the Trust.

7. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

8. Monitoring Effectiveness

The Committee will undertake an annual review of its performance against its Terms of Reference and work plan in order to evaluate the achievement of its duties. This review will be presented to the Board in the form of the Committee's annual report.

9. Other Matters

The servicing, administrative and appropriate support to the Chair and Committee will be the responsibility of the Head of Corporate Governance.

10. Review

These terms of reference will be reviewed annually as part of the monitoring effectiveness process.

Terms of Reference reviewed by the Quality Governance Committee on: 17 August 2023.

Ratified by the Board of Directors on:

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**6 September 2023**		

Title of Report:	**CQC Update: Letter and Trust Action Plan**
Status:	**For discussion**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author:	**Rob Eliot, Head of Quality Assurance**
Appendices	**Appendix A: CQC feedback letter** **Appendix B: CQC Improvement Plan**

1. Executive Summary of the Report

The purpose of this report is to update the Board of Directors on the Care Quality Commission (CQC) unannounced inspection of Medicine in July 2023.

Following the visit, the CQC issued the Trust with a feedback letter (Appendix A) to provide the Trust with an overview of the initial inspection findings based on the observations, interviews and data reviewed so far. This has been provided to enable the Trust to share the initial positive findings and to start to address any issues raised by the CQC.

The letter identified a number of areas of good practice including the commitment and dedication of nursing staff who were providing care despite unrelenting operational pressures and a positive culture described by doctors. The letter also identified a number of areas for improvement.

These included:

- Staffing shortages
- The skill mix of staff not always being sufficient to meet the needs of patients (including from newly recruited international and domestic staff)
- Incomplete documentation including for pain and fluid charts
- Limited space and a lack of storage on wards
- Instances where Controlled Drugs were not always totalled every 24 hours
- Some patient records not always stored securely.

An initial improvement plan has been developed (Appendix B) detailing the actions that will be taken to address the known findings from the CQC feedback letter. The improvement plan will be updated with further actions and detail on receipt of the full CQC inspection report and any further recommendations made by the CQC.

It is anticipated that a draft inspection report will be provided by the CQC in the first two weeks of September 2023. The Trust will have an opportunity to comment on the factual accuracies of the report before the final inspection report is published. It is likely that the Trust will not receive the final version until October 2023. At this stage, it remains unknown if the inspection will be rated. If the inspection is rated, the rating will be aggregated with the existing position in areas that were not rated (caring, effective and responsive).

2.	Recommendations (Note, Approve, Discuss)
The Board of Directors is requested to discuss the initial CQC inspection findings highlighted in the letter from the CQC and the initial actions being put in place to address the identified areas for improvement.	

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

5.	Resources Implications (Financial / staffing)
The costs of compliance with the CQC fundamental standards are embedded within operational delivery costs.	

6.	Equality and Diversity
Areas for improvement are identified within the CQC improvement plan.	

7.	References to previous reports/Next steps
None	

8.	Freedom of Information
Public.	

9.	Sustainability
None identified.	

10.	Digital
The transition to Paperless Inpatients will impact on compliance for completion of nursing documentation.	

CQC Update: Letter and Trust Action Plan

1 Introduction

1.1 The Care Quality Commission (CQC) undertook a focused unannounced inspection of the Medicine core service on 27 July 2023.

1.2 The inspection was of the Safe and Well-led Key Lines of Enquiry (KLOE).

1.3 At the request of the CQC, a message was also sent to staff in Medicine informing them of the inspection and inviting them to provide feedback to the CQC about their experience of the leadership, culture and governance in Medicine Division and any patient safety issues.

1.4 Formal interviews were undertaken by the CQC during and after the inspection with the following staff:

- Chief Nurse as Executive Lead for Safeguarding
- Medical Care Division Leadership Team
- Trust Freedom to Speak Up Guardian
- International Nurse Induction Lead / Pastoral Support for International Nurses
- Tissue Viability Lead for Medicine
- Falls lead for Medicine
- Discharge lead for Medicine
- Infection, Prevention and Control lead for Medicine
- Safeguarding lead

1.5 The CQC have also requested a meeting with Medicine to understand how the Risk Register is reviewed and actions from risks updated.

1.6 The CQC issued the Trust with an information request on announcement of the inspection detailing required evidence under the Safe and Well-led KLOE to support the inspection process. This included audits undertaken for falls, Venous Thromboembolism (VTE), National Early Warning Score2 (NEWS2), medical records, Malnutrition Universal Screening Tool (MUST), pharmacy and Infection Prevention and Control, staffing data, training compliance, policies and governance structures and minutes of meetings.

1.7 Following the visit, the CQC issued a letter to the Trust (Appendix A) providing an overview of the initial inspection findings based on the observations, interviews and data reviewed thus far. This has been provided to enable the Trust to share the initial positive findings and to start to address the areas for improvement raised by the CQC.

1.8 The CQC are aiming to send the Trust a draft inspection report within the first two weeks of September. At this point the Trust will have an opportunity to check the report for factual accuracy before the final inspection report is published. This is currently expected in early October 2023.

1.9 It remains unknown if the inspection will be rated. Should the inspection be rated, the rating will be aggregated with the existing position in areas that were not rated (that is caring, effective and responsive). The CQC feedback letter highlighted a

number of areas of good practice. The CQC recognised the commitment and dedication of nursing staff who were providing care despite unrelenting operational pressures. Staff were resilient and talked passionately of being proud to work with their colleagues. Leaders were proud of their teams on wards.

1.10 Doctors who spoke to the CQC described a positive culture and they told the CQC how they felt valued and engaged.

1.11 Some wards were noted to have a welcoming and engaging environment which was patient-focused. Combe Ward was noted to have a bright and airy day room with arts and crafts activities being used by patients during the inspection and displays of patients' artwork on the walls.

1.12 The letter highlighted a number of areas for improvement. These included staffing shortages, the skill mix of staff not always being sufficient to meet the needs of patients (including from newly recruited international and domestic staff), incomplete documentation including for pain and fluid charts, limited space and a lack of storage, instances where Controlled Drugs were not always totalled every 24 hours and some patient records not always stored securely.

2 CQC Improvement Plan

2.1 An initial improvement plan has been developed (Appendix B) detailing the actions that will be taken to address the initial findings from the CQC feedback letter. Six areas for improvement have been identified and these are detailed within the improvement plan under CQC comments. Additional comments from the RUH have also been added under the CQC comments to highlight actions that were already in place at the time of the inspection to address the areas of concern identified by the CQC.

2.2 The improvement plan will be updated with further actions and detail on receipt of the full CQC inspection report and any further recommendations made by the CQC.

2.3 Each action on the improvement plan has been RAGB (red, amber, green, blue) rated to indicate whether the actions are progressing according to the timescales identified in the improvement plan. The comments / action status column has been updated to reflect progress towards implementing the actions.

3 Monitoring the implementation and effectiveness of the improvement plan

3.1 Delivery of the improvement plan will be monitored through the Divisional Governance Meeting, the CQC Assurance and Improvement Group, and Quality Governance Committee on a quarterly basis.

3.2 The CQC findings and improvement plan will inform and be included in the developing Foundations Matter Programme (associated updated provided through separate paper to the September 2023 Trust Board).

4 Recommendations

4.1 The Board of Directors is requested to discuss the initial CQC inspection findings highlighted in the letter from the CQC and the initial actions being put in place to address the identified areas for improvement.

Appendix A

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Our reference: INS2-16496946371
Cara Charles-Barks
Royal United Hospital Bath
Directors Offices, Royal United Hospital
Combe Park
Bath
Avon
BA1 3NG

Date: 9 August 2023

CQC Reference Number: INS2-16496946371

Dear Ms Charles-Barks

Re: CQC inspection of (Royal United Hospital Bath)

Further to the feedback meeting with Andrew Hollowood and Toni Lynch on 27 July 2023, I wanted to provide you with written feedback to enable you and your team to begin thinking about the issues raised and to be able to celebrate the positive findings we shared. The inspection is still underway as we still have people to speak with and data to review.

This letter does not replace the draft report we will send to you. We are aiming to have published this report around the start of October. However, we will keep you updated in relation to timeframes.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report, this correspondence should be used to inform discussions with the board.

The inspection of Medical Care was in response to concerns raised with us. We inspected two domains of our core service framework – safe and well led.

Please pass our thanks to your team who made sure we had everything we needed during the inspection. It is not possible to underestimate the difference it makes to be so well supported during an inspection.

As you would expect, there are a mix of findings.

Appendix A

An overview of our feedback

- We saw a number of committed and dedicated nursing staff who were providing care after what has been – and continues to be – unrelenting operational pressures. Staff were resilient and talked passionately of being proud to work with their colleagues. Leaders were proud of their teams on wards.
- We spoke with doctors who described a positive culture, and they told us they felt valued and engaged.
- As you would expect, staffing shortages were felt across teams. The majority of wards we visited were short of planned numbers. We understand there are currently 50 vacant health care assistant positions and the nurses in charge of wards cited this as one of their main areas of concern.
- There were a lot of newly recruited staff both international and some domestic staff. This meant the skill mix of the wards was not always sufficient to meet the needs of patients. The training provisions did not always match the number of staff that required training which led to delays in some staff receiving the necessary training.
- We saw documentation was not always completed across some wards. This was mainly centred on the lack of recorded pain scores and incomplete fluid charts. One of the incomplete fluid charts reviewed related to a patient with acute kidney disease.
- Some wards had a welcoming and engaging environment which was patient-focused. For example, Combe Ward had a bright and airy day room with arts and craft activities being used by patients during our inspection and there were displays of patients' artwork on the walls. However, there were some wards where limited space, lack of storage and ageing estate made them difficult to work in and was not good for patient experience. For example, Cheselden Ward did not have a day room, limited space for patients to have rehabilitation and one of the shower rooms was being used as storage for equipment.
- We saw that controlled drugs were not always being totalled once in 24 hours as per the trusts policy. We saw instances of this in Coombe Ward and the OPU.
- Patient records on some wards were not always stored securely.

Next Steps

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report.

Could I take this opportunity to thank you once again for the arrangements that you made to help facilitate the inspection, and for the cooperation that we experienced from you and your staff.

Appendix A

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Roger James

Deputy Director Secondary Care

Appendix B: CQC Inspection of Medicine (July 2023): Improvement Plan

Ref No	1
CQC Comments	Staffing shortages were felt across teams. The majority of wards we visited were short of planned numbers. We understand there are currently fifty vacant Health Care Support Worker (HCSW) positions and the nurses in charge of wards cited this as one of their main areas of concern.
RUH Comments	The two areas with the highest number of HCSW vacancies are Ward B41 (opened in April 2023) and the Medical Assessment Unit (MAU). The MAU has recently recruited to all its vacancies, staff will commence in post of the next two to three months. A mitigation plan exists for Ward B41, temporary staffing (bank and three pool nurses) are prioritised to this clinical area. One stop recruitment events had been scheduled, which were planned prior to the Care Quality Commission (CQC) inspection, for Registered Nurses (RN) and Healthcare Support Workers. The next event is being run on 16 September 2023. The Trust has a dedicated team who manages the HCSW recruitment and advertising. The HCSW recruitment programme has been enhanced over the last 12 months to reduce turnover. All HCSWs start on the same day every month, they have an intensive and comprehensive induction package which includes training, education and simulation based learning to prepare them for their clinical role. Active promotion of nursing and HCSW roles on the Trust social media platforms including weekly Facebook and Instagram posts, daily posts on RUH Careers X (Twitter) and Workplace (internal social media platform). The Career Zone is updated with the latest new job opportunities. This is a dedicated area in the main entrance of the RUH, visible to all visitors, staff and patients and has a number of job board for displaying opportunities. New recruitment web pages have been created to direct social media adverts to ensure people can easily find the roles being promoted. Recruitment opportunities are included within the Nursing and Midwifery newsletter for colleagues to see what the latest opportunities are and share recruitment news. The new nursing establishments, agreed by the Board of Directors in 2022 are being realised through recruitment, this moves the skills mix to a 65:35% ratio (65% RN, 35% HCSW), and as such the requirement for HCSW will reduce.

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc.)*	**Expected Outcome from implementing action**
1	Undertake Safer Staffing Bi-annual Staffing Review for all wards across the Trust.	31/10/2023	Associate Chief Nurse Workforce and Education & Divisional Director of Nursing (DDON) for Medicine.	Green	B41 is an additional medical ward which opened in April 2023 with a focussed recruitment plan. The Associate Chief Nurse for Workforce and Education & Divisional Director of Nursing for Medicine is undertaking the Bi-annual Safe Staffing review w/c 11 September 2023.	

Author: Rob Eliot, Head of Quality Assurance
Date: 26/08/2023 (Version 4)

Action no	Actions required *(specify "None", if none required)*	Action by date	Person responsible *(Name and grade)*	Status	Comments/action status *(Provide examples of action in progress, changes in practices etc.)*	Expected Outcome from implementing action
					The Bi-annual Safer Nursing Care Tool (SNCT) Audit is scheduled for September 2023.	
2	Undertake one stop recruitment events.	30/09/2023	Trust Recruitment Leads.	Green	The Trust has a dedicated team who manages the HCSW recruitment and advertising. A recruitment open day will be held at the RUH on 16 September, 1000-1400 hours. As at 23 August, 28 people have registered an interest in HCSW roles.	Recruitment HCSW and reduce the vacancy rate.

On completion of all actions above, what data will be collected to demonstrate that these actions have led to improvements?		
Key Performance Indicators / Outcome Measures	**Target**	**Summary of performance**
New RN and HCSW establishment numbers to be reviewed for month 7 (M7) in October 2023 for all wards (post Bi-annual review) to ensure they fully reflect the changes following the changes agreed by the Board of Directors in 2022.	Full funded establishment across all medicine inpatient ward areas.	Review of staffing data for vacancies and fill rate. Demonstrate increase in HCSW recruitment.

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Ref No	2
CQC Comments	There were a lot of newly recruited staff both international and some domestic staff. This meant the skill mix of the wards was not always sufficient to meet the needs of patients. The training provisions did not always match the number of staff that required training which led to delays in some staff receiving the necessary training.
RUH Comments	There is a comprehensive induction, training and education programme for internationally educated colleagues who join the Trust. The programme enables them to be supernummary for 6 months with a blended learning programme divided between classroom, high and low fidelity simulation and ward/department based learning, supported by Practice Educators. This enables colleagues to pass the Objective, Structured, Clinical Examination (OSCE) required to become registered with the Nursing and Midwifery Council (NMC). The Trust has an Induction Process Flowchart for Internationally Educated colleagues which details the training received and support provided. The Trust runs a multi-disciplinary preceptorship programme which has been developed internally, this is noted to be exemplar and being rolled out across the Acute Hospital Alliance. This aims to provide staff with wider skills and confidence to work in the Trust. The Trust has recently reviewed the induction programme for all staff, this has been innovated, moved to face to face delivery and is being well evaluated. The Trust does not have a centralised Clinical Skills Team, an issue which was identified prior to the CQC inspection. The Associate Director for Workforce and Education is working with the Associate Director for Learning and Culture to undertake a case for change. Since August, the Trust has piloted weekly drop in sessions for staff to discuss clinical skills and be supported to develop these. The Trust identified, prior to the CQC inspection, a need to undertake a training needs analysis for all ward based areas to ensure all nursing staff have the right knowledge, skills and confidence to meet the changing needs to the patient population. This programme is being developed with clinical and education staff. The wards and departments have a number of learners: Student Nurses, Trainee Nursing Associates, and colleagues on the Registered Nurse Degree Apprenticeship, new to care HCSW, newly registered and new staff joining the Trust. As such, the Trust commenced a review of the provision of Practice Educators which aims to share resource equitably across wards and departments to meet the needs of the learning community.

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc.)*	**Expected Outcome from implementing action**
The actions detailed below were commenced prior to the CQC inspection. Further actions may be required, dependent on the contents of the finalised CQC report.						
1	Implementation of a Clinical Skills Team.	30/11/2023	Associate Director for Learning and Culture, Associate Chief Nurse Workforce and	Green	There is a requirement to have a Clinical Skills team to provide training for all staff.	High performing clinical team with the right knowledge and skills.

Action no	Actions required *(specify "None", if none required)*	Action by date	Person responsible *(Name and grade)*	Status	Comments/action status *(Provide examples of action in progress, changes in practices etc.)*	Expected Outcome from implementing action
The actions detailed below were commenced prior to the CQC inspection. Further actions may be required, dependent on the contents of the finalised CQC report.						
			Education & Deputy Chief Nurse.			
2	Development of the Foundations Matter programme, a ward by ward training and education programme. This will include standardised and bespoke clinical training relevant to each clinical speciality.	31/10/2023	Interim Quality Programme Director, Deputy Chief Nurse(s) & Deputy Chief Medical Officer(s).	Green	See Foundations Matter paper.	High performing clinical team with the right knowledge and skills.
3	Conclude the review of provision of Practice Educators to ensure equitable access and implement changes.	30/11/2023	Associate Chief Nurse Workforce and Education & Deputy Chief Nurse.	Green		Equitable access to Practice Educators across wards.

On completion of all actions above, what data will be collected to demonstrate that these actions have led to improvements?		
Key Performance Indicators / Outcome Measures	**Target**	**Summary of performance**
Allocation of Practice Educators and staff satisfaction surveys.	TBC	
Pre and post surveys following the implementation of the Foundations Matter programme. Outcome metrics under development.	TBC	
Evaluation of training requirement and provision by the Clinical Skills Team.	TBC	

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Ref No	3
CQC Comments	We saw documentation was not always completed across some wards. This was mainly centred on the lack of recorded pain scores and incomplete fluid charts. One of the incomplete fluid charts reviewed related to a patient with acute kidney disease.
RUH Comments	Nursing documentation is not yet digitalised; therefore oversight relies on a manual inspection of paper records. Documentation is audited as part of the Nursing and Midwifery Audit Programme and the digital programme to support the recording and visibility of results is outdated. The Trust is reviewing audit systems to improve oversight to underpin improvements in practice. The Nursing documentation is being digitalised in 2024, all documentation has been reviewed in preparation for the change. This will ensure oversight of documentation to reduce unwarranted variation.

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc.)*	**Expected Outcome from implementing action**
1	Implement digitalised Nursing documentation.	03/24	Chief Nursing Information Officer & Divisional Directors of Nursing.		This has been a live project for the last 24 months.	Visible oversight of documentation standards to reduce unwarranted variation.
2	Add documentation checks including fluid balance charts to the Daily Safety briefs / Senior Sister and Matron audits.	30/09/2023	Divisional Directors of Nursing / Matrons.	Green		Reduction in unwarranted variation.
3	Complete the review of audit systems to enhance oversight and completion of actions and sustained improvements at ward level.	31/10/2023	Head of Quality Assurance / Divisional Directors of Nursing.	Green	Options appraisal to be finalised. Companies are currently demonstrating systems to the nursing community.	Visible oversight of audit results, actions and sustain improvements.

On completion of all actions above, what data will be collected to demonstrate that these actions have led to improvements?		
Key Performance Indicators / Outcome Measures	**Target**	**Summary of performance**
Results from audits on completion of pain scores.	90%	
Results from audits on completion of fluid balance charts.	90%	

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Ref No	4
CQC Comments	There were some wards where limited space, lack of storage and ageing estate made them difficult to work in and was not good for patient experience. For example, Cheselden Ward did not have a day room, limited space for patients to have rehabilitation and one of the shower rooms was being used as storage for equipment.
RUH Comments	The Trust has an aging estate and had previously been expected to get funding from the New Hospitals Programme, however the Trust was removed from this programme in 2021. The Trust continues to review its priorities given the continuing competing demands for capital funding. The Trust is also reviewing new ways of working and agile working which may provide opportunities to increase clinical space and improve space utilisation. Any ward refurbishment will take into consideration increasing storage as well as improving the environment, although this is limited in the current footprint. A meeting to review the ward refurbishment is planned for September 2023. The Trust prioritises the construction and refurbishment through the Construction and Refurbishment Group.

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc.)*	**Expected Outcome from implementing action**
1	Schedule for ward by ward refurbishment as part of the Capital Plan.	TBC	Director of Estates and Facilities & Clinical Lead for Capital Projects.		The meeting is planned for September 2023 which will inform action dates.	

On completion of all actions above, what data will be collected to demonstrate that these actions have led to improvements?		
Key Performance Indicators / Outcome Measures	**Target**	**Summary of performance**
To be determined.	TBC	

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Ref No	5
CQC Comments	We saw that controlled drugs were not always being totalled once in 24 hours as per Trust policy. We saw instances of this in Combe Ward and the Older Persons Unit (OPU).
RUH Comments	The Controlled Drug audit includes assessment of compliance with daily CD checking. The Nursing Quality Assurance Framework was launched in September 2022 which includes daily oversight of CD checking.

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc.)*	**Expected Outcome from implementing action**
1	Review of Nursing Quality Assurance Framework, results and actions at ward level.	30/09/2023	Divisional Directors of Nursing/Deputy Chief Nurse.	Green	Enhance oversight and action in response to results.	Reduce unwarranted variation.

On completion of all actions above, what data will be collected to demonstrate that these actions have led to improvements?		
Key Performance Indicators / Outcome Measures	**Target**	**Summary of performance**
Results of checks from Matron monthly oversight audits.	100%	

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Ref No	6
CQC Comments	Patient records on some wards were not always stored securely.
RUH Comments	This had been identified prior to the CQC inspection through the Nursing Audit and has an associated action plan. The actions required are temporary, pending the introduction of digitalised records.

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc.)*	**Expected Outcome from implementing action**
1	The Specialty Governance leads and Matrons to ensure record storage is secure.	30/09/2023	Interim Divisional Director of Nursing, Medicine and Divisional Director of the Medicine Division.	Green	Enhanced oversight of the results of the Nursing Quality Assurance Framework.	Compliance with records storage.
2	Add to the Daily Safety briefings to review notes storage.	30/09/2023	Matrons.	Green		Compliance with records storage.
3	Confirm if the current notes trolleys can be made lockable.	31/10/2023	Estates.	Green	Review of notes trolleys completed in June by the Quality Improvement Team. Discussion with Estates on next steps and feasibility of adding locks to the notes trolleys (taking into account the move to Paperless Inpatients by March 2024).	Enable secure storage of patient notes.

On completion of all actions above, what data will be collected to demonstrate that these actions have led to improvements?		
Key Performance Indicators / Outcome Measures	**Target**	**Summary of performance**
Compliance with records storage audit.	100%	

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Report to:	**Public Board of Directors**	**Agenda item:**	**13**
Date of Meeting:	**6 September 2023**		

Title of Report:	**Refresh of the RUH winter plan v1**
Status:	**For approval**
Board Sponsor:	**Niall Prosser, Interim Chief Operating Officer**
Author:	**Niall Prosser, Interim Chief Operating Officer**
Appendices	**Appendix 1: Letter: UEC delivering operational resilience across the NHS this winter** **Appendix 2: UEC Winter Incentive Guidance** **Appendix 3: RUH Bed Plan 2023/24 Refresh v1**

1. Executive Summary of the Report

In April 2023 the Trust Board agreed the Trusts plan for 2023/24, which included 2023 winter period. However, a number of underlying planning assumptions have changed:

- No longer able to utilise William Budd as a winter ward.
- Q1 saw very low COVID activity, however, the risk remains for additional COVID activity during Q3 and Q4, specifically with a new variant of concern.
- National letter (appendix 1) outlines that there would not be any winter funding available this year, however, there would be access to £150m of national capital funding if any Trust met certain thresholds.
- Non Elective Activity during the first 3 months of 2023/24 is at 107% of the planned activity.
- We have seen a reduction in length of stay, and the current Non Criteria to Reside (NC2R) position is delivering in line with the plan.

The update also refresh's the do nothing scenario, which identified the Trusts bed occupancy would be over 100% during winter. In this scenario the Trust would be required to use the previously used escalation areas (e.g. day surgery unit, cath lab recovery, vascular lab and boarded beds), which has been forecasted to cost £1.7m, and likely lead to a conservative loss of elective income of circa £2m. This scenario would also lead to significant safety concerns with long delays and high volume within ED, and within our community through long ambulance handover delays.

In assessing whether there are further internal improvements the Trust could make to deliver above current plan, there are three elements being considered;

- The RUH patient flow improvement plan has been assessed and reviewed by the regional clinical advisor on urgent care, who highlighted that the improvements the RUH is forecasting, with delivery this year, are "*very impressive and ambitious*", and the improvements seen so far are *"brilliant"*.
- The paper highlights that the Trusts headline length of stay is currently better than the regional average, and further opportunities targeted through the on-going improvement plan.
- The plan for NC2R currently is to have no more than 80 patients waiting. There remain risks within the BSW system being able to deliver improvements beyond this point.

The paper highlighted a number of new mitigations that have been identified and could be, following further governance sign off, implemented to support the RUH bed

occupancy get close to the national target of 92%.

The revised plan also reduces the cost of the winter plan from a previously agreed spend of £2.5m to £2m.

2.	Recommendations (Note, Approve, Discuss)

Discussion and approval on the proposed refreshed Winter plan.

3.	Legal / Regulatory Implications

Failure of a robust winter plan and appropriate mitigations would lead to significant risk of CQC inspections and warning notifications as the hospital would not be providing a safe service, and likely lead to a deterioration within the urgent care and elective care tier allocation (currently in tier 3 – the lowest).

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

The implementation of the refreshed winter plan influences the following BAF scores:

- Risk 1 - Failure to deliver safe, high quality care due to poor compliance with internal and external set standards on quality and safety, with potential risk to patients.
- Risk 2 - Failure to provide safe and quality care to patients attending the hospital in emergency as a result of a mismatch between capacity and demand. This could cause serious risk to patient safety.
- Risk 3 - Failure to reduce elective waiting times through improving elective capacity and productivity. This could lead to poor outcomes and experiences for patients.
- Risk 6 - Failure to deliver a viable financial plan would impact on the Trust's ability to achieve financial recovery and sustainability, and could ultimately affect its ability to provide safe, appropriate and effective care to our patients.

5.	Resources Implications (Financial / staffing)

In April 2023 the Trust Board agreed a winter plan with the cost of £2.5m. This was agreed based on the working assumption that there would be additional winter funding available during 2023/24. The national UEC Recovery Plan letter within appendix 1, notes that there will not be any available funding.

The paper highlights that the do nothing scenario is likely to lead to unplanned expenditure and forecasted loss of income of £3.7m.

The updated plan has therefore rebased the forecasted expenditure for 2023/24, and reduced the figure to £2m.

6.	Equality and Diversity

Failure to deliver a successful winter plan will lead to significantly worsening outcomes for elective patients who are likely to have their elective surgery cancelled at short notice. Evidence highlights the disproportionate effects on patients in lower social economic groups.

7.	References to previous reports/Next steps
Previous version of the winter plan was presented at April Finance and Performance Committee (FPC), and April Trust board.	

8.	Freedom of Information
Private	

9.	Sustainability
Neutral – whilst schemes included lead to more travel, it is also anticipated that the plan is limiting the need for additional buildings within the RUH site.	

10.	Digital
Neutral	

To:
- ICB:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- NHS acute, community and mental health trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- Primary care networks

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

27 July 2023

Dear Colleagues,

Delivering operational resilience across the NHS this winter

This letter sets out our national approach to 2023/24 winter planning, and the key steps we must take together across all parts of the system to meet the challenges ahead.

In January, we published our delivery plan for recovering Urgent and Emergency Care (UEC) services: an ambitious two-year plan to deliver improvements for patients across the integrated Urgent and Emergency Care (iUEC) pathway. This plan, along with the Primary Care Recovery Plan, Elective Recovery Plan and the broader strategic and operational plans and priorities for the NHS, provides a strong basis to prepare for this winter.

The publication of the UEC Recovery Plan followed an incredibly challenging winter – with high rates of infectious disease, industrial action, and capacity constraints due to challenges discharging patients, especially to social and community care. We know these challenges have continued but want to thank you for the work you have done in the face of this to ensure that there have nonetheless been significant improvements in performance. Thanks

to these improvements, we are in a significantly better place compared to last summer. Compared to last June, A&E performance has improved and Category 2 performance is 14 minutes faster.

This progress and the plan we are today setting out for winter preparedness are key steps in helping us achieve our two key ambitions for UEC recovery of:

- 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25.

To help achieve these ambitions, we have ensured that systems have had clarity over finances well before winter to allow them to plan effectively and further roll-out the measures that we know will improve services for patients. We have invested extensively in this, including:

- £1 billion of dedicated funding to support capacity in urgent and emergency services, building on the £500 million used last winter.
- £250 million worth of capital investment to deliver additional capacity.
- £200 million for ambulance services to increase the number of ambulance hours on the road.
- Together with DHSC, an additional £1.6 billion of discharge funding over 2023/24 and 2024/25, building on the £500 million Adult Social Care Discharge Fund.

While we are making good progress towards achieving our overall ambitions, we want to encourage providers to achieve even better performance over the second half of the year. We will therefore be launching an **incentive scheme** for those providers with a Type 1 A&E department to overachieve on their planned performance in return for receiving a share of a £150 million capital fund in 2024/25. We are asking providers to meet two thresholds to secure a share of this money:

- Achieving an average of 80% A&E 4-hour performance over Q4 of 2023/24.
- Completing at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

We recognise that these are stretching targets but know that many providers will be able to achieve these to help the NHS as a whole make greater headway towards improving care for patients. Providers should already be putting measures in place which will contribute towards reaching these, including a greater focus on the longest times in department, particularly those spending longer than 12-hours, and wider system flow. We will communicate more details on this shortly, including how we will be working with you to improve data quality.

Turning to our wider planning for winter, we are clear that the challenges are not just in ambulance services or emergency departments, and recovery requires all types of providers to work together to provide joined-up care for patients. ICBs will play a vital role in system leadership but the actions we take need to extend across the wider health and care system including mental health services, services for children and young people, community health services, primary care and the voluntary, community and social enterprise (VCSE) sector.

We are therefore setting out four areas of focus for systems to help prepare for winter:

1. Continue to deliver on the UEC Recovery Plan by **ensuring high-impact interventions are in place**

Together with systems, providers, and clinical and operational experts we have identified 10 evidence-based high-impact interventions. These are focused around reducing waiting times for patients and crowding in A&E departments, improving flow and reducing length of stay in hospital settings. Delivering on these will be key to improving resilience in winter. We have recently written to all systems to ask that they assess their maturity against these areas as part of the universal improvement offer for the UEC Recovery Plan. Systems will then receive dedicated support on the four areas they choose to focus their improvement for winter.

More detail on these areas can be found at Appendix A and on the NHS IMPACT website.

2. **Completing operational and surge planning** to prepare for different winter scenarios

We have already collectively carried out a detailed operational planning round for 2023/24 but we are now asking each system to review their operational plans, including whether the assumptions regarding demand and capacity remain accurate. Although this will cover surge planning for the whole winter, specific plans should be made for the Christmas/New Year/early-January period which we know is often the most challenging time of the entire year.

In addition to this, and recognising the importance of planning for multiple scenarios, we are asking systems to identify how they will mobilise additional capacity across all parts of the NHS should it be required to respond to peaks in demand driven by external factors eg, very high rates of influenza or COVID-19, potential further industrial action.

This planning is essential to ensure winter plans protect and deliver elective and cancer recovery objectives, as well as deliver the primary care access programme, and proactive care for those most at risk of hospital admission (guidance on proactive care will be published shortly).

Next week, we will be issuing each ICB with a template to capture their surge plan and overall winter plan. We will work with those areas that are facing the greatest challenges across the UEC pathway via our tiering programme to support them in completing these returns. If you think you require additional support, please contact england.uec-operations@nhs.net.

All returns should be sent to england.uec-operations@nhs.net by **11 September 2023**.

3. **ICBs should ensure effective system working across all parts of the system**, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.

ICBs will play a vital role in system leadership and co-ordination but it is important that all parts of the system play their role. The NHS England operating framework describes the roles that NHS England, ICBs and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

To help systems plan, we have developed a set of recommended winter roles and responsibilities (**Appendix B**) to ensure clarity on what actions should be undertaken by each part of the system. These will require broad clinical leadership to implement, and systems should be using these to develop their winter planning return, reflecting how these relate to the circumstances within their individual system.

DHSC is also writing to local authorities and the adult social care sector shortly to set out priority actions for improving winter resilience and encouraging cross-system working with the NHS on winter planning.

To assist system working this winter, next week, we will also be publishing an updated specification for System Co-Ordination Centres and an updated Operational Pressures Escalation (OPEL) Framework to ensure we are taking a consistent and co-ordinated approach to managing pressures across all systems.

4. **Supporting our workforce** to deliver over winter

This year colleagues have continued to work incredibly hard in the face of increased demand. We know how much supporting your workforce matters to you, and it is crucial that employers ensure that they take steps to protect and improve the wellbeing of the workforce.

Last winter, we saw flu return at scale. It is vitally important that we protect the public and the health and care workforce against flu and other infectious diseases, and the best way of doing this is to ensure they are vaccinated. Providers should also ensure that they have an

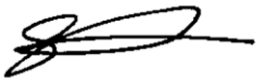
established pathway for identifying patients at-risk of COVID-19 and flu in their care, including those who are immunosuppressed.

Systems and providers should also continue to improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise, as set out in 2023/24 priorities and operational planning guidance and more recently in the NHS Long Term Workforce Plan, and ensure continued supply through maintaining education and training.

We want to thank you and everyone across the NHS for your continued hard work this year, we have again faced some unprecedented challenges but through strong partnership working we have once again risen to these.

The coming months will undoubtably be difficult, but we will continue to support you to ensure that we collectively deliver a high-quality of health service to patients and support our workforce. Thank you again for all your efforts as we work to build a more resilient NHS ahead of winter.

Yours sincerely,



Sarah-Jane Marsh
National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Julian Kelly
Chief Financial Officer
NHS England

Appendix A: 10 High-Impact Interventions

Action	
1.	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2.	**Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3.	**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4.	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5.	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6.	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8.	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.
9.	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment
10.	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

NHS England

UEC Winter Incentive – operational measurement guidance

The NHS winter letter published 27 July introduced the incentive scheme for providers with a Type 1 A&E to achieve even better performance over the second half of the year in return for receiving a share of a £150 million capital fund in 2024/25.

Capital money will be allocated to providers achieving the required performance levels.
To be eligible for a share of this fund providers must:

- have a Type 1 A&E department
- achieve an average of 80% all-type A&E 4-hour performance over Q4 of 2023/24
- complete at least 90% of ambulance handovers within 30 minutes from arrival of the ambulance during Q3 and Q4 of 2023/24 (with 95% or more handovers having a valid handover time)
- improve performance in the above areas compared to winter 2022/23.

We expect that these targets will be delivered by:

- increased focus on faster handover of patients and release of ambulances,
- reducing the time patients spend in A&E – with a specific focus on reducing the % that spend more than 12-hours in A&E,
- improving hospital flow, including reducing discharge delays in collaboration with local social and community care providers.

Providers should already be putting measures in place which will contribute towards reaching these. We recognise that these are stretching targets but know that many providers will be able to achieve these to help the NHS as a whole make greater headway towards improving care for patients.

Publication reference: PRN00724

Financial guidance

If the eligibility criteria above are met, providers will be allocated a share of a £150m capital fund.

This capital allocation will form part of the provider operational capital allowance, and providers will be responsible for deciding how this is spent.

A&E data

We will use all types A&E performance from the published Monthly A&E Attendances and Emergency Admissions data to identify those providers with a Type 1 A&E who achieve 80% all-type A&E 4-hour performance over Q4 2023/24. Performance will be assessed at acute Trust footprint level and will therefore include any Type 3 activity mapped to the trust.

Reductions in the percentage of patients spending 12-hours in A&E will be monitored via the 12-hour element of the Supplementary ECDS Analysis publication.

Ambulance handover data

We will use ambulance handover data from the Daily Ambulance Collection to identify those providers with a Type 1 A&E who complete at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

We want to ensure that there is a standardised approach to collecting data and so ambulance services will be required to adopt the following definitions in AQI submissions, the Daily Ambulance Collection and all other handover reporting to ensure a consistent approach nationally.

Cohorting

Cohorting is defined as the handover of patient care to other ambulance service clinical colleagues prior to the formal handover to the hospital. It takes place when ambulance service clinical colleagues at the hospital take over the care of conveyed patients arriving in a different ambulance, to release the arriving crew to attend other incidents.

This will usually be inside the hospital and could be one ambulance crew looking after several patients simultaneously. This type of cohorting is only applicable where patients are transferred between ambulance crews (or sub-contracted ambulance service provision). It **does not** include cohorting by the hospital.

Patients subject to ambulance service cohorting are not considered to have had their care transferred to a hospital and will continue to be recorded as a handover delay until their care has been handed over to the hospital.

Recording handover clock start and clock stop

The Standard NHS Contract https://www.england.nhs.uk/nhs-standard-contract/ technical guidance https://www.england.nhs.uk/nhs-standard-contract/23-24/ provides high-level definitions for how handovers should be recorded. Further clarifications and additional guidance are provided here.

Handover clock start:

Standard Contract definition

When ambulance wheels stop in the patient offloading bay (handbrake applied and 'Red at Hospital' button is pressed on the Mobile Data Terminal [MDT]).

Additional guidance

If an ambulance stops in the queue for the patient offloading bay this also counts as clock start.

Geofence times can also be used for clock start. Where both the 'Red at Hospital' button press and geofence data points are present and valid, the earlier time should be used.

Ambulance services must ensure their geofence trigger matches the ambulance waiting area at the hospital, to avoid incorrect early time triggers.

Handover clock stop:

Standard Contract definition

The time at which clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned enabling the ambulance crew to leave the department.

Additional guidance

Handover times should be agreed and recorded jointly between the ambulance service and hospital at the time of handover.

Where no handover time is recorded jointly, the handover time recorded by the ambulance crew on vehicle systems should be used. Where no handover time is recorded by either provider, this should be reported as missing data. The data on the number of missing handovers will be reported and should be routinely shared with hospital trusts to improve reporting and data quality.

Note that crew clear time **should not** be used as a proxy for the length of handover when a handover time is missing.

Operational (resource) Measures for inclusion in the AQIs will define the clock stop time as:

- Where the patient is clinically handed over to the care of the hospital from the conveying vehicle, or
- Where the patient is transferred to an ambulance cohorting function from the conveying vehicle, the clock stop is the time the conveying crew handover to the ambulance cohort function who take over clinical responsibility of the patient, enabling the conveying crew to leave the hospital.
- Where patients may have transferred to a second vehicle due to shift change, the clock stop is the time the second ambulance crew handover the patient's care to either an ambulance cohort or to the care of the hospital.

Accountability and review

Colleagues in commissioning organisations responsible for ambulance contract management are asked to review the current contracting arrangements around Clock Start and Clock Stop recording and how cohorting is reported to ensure compliance with the national definitions.

Over the coming weeks, the AQI Data Specification will be updated to reflect the definitional collection of ambulance to hospital handover metrics, and we will commence consultation with stakeholders and implementation with ambulance services to ensure that key metrics are included in data submissions.

As we continue to progress through to implementation and publication of defined hospital handover metrics, systems should continue to monitor and review local handover data.

Royal United Hospitals Bath
NHS Foundation Trust

RUH Winter Plan Refresh 2023/24

Niall Prosser, Interim Chief Operating Officer

Version 3

The RUH, where you matter

Executive Summary

1. Trust Board agreed a bed plan for the year in April 23 which included the plan for 23/24 winter period. These slides build on the previously agreed plan.
    1. Previously agreed bed bridge identifying change in number of beds over previous years (development of day case unit, IPC works and opening mini PY).
    2. Included mitigations for 23/24, such as use of William Budd ward as a winter escalation ward
    3. Agreed plan cost £2.5m which was assumed to be offset against additional nationally available winter funding
2. A number of the key assumptions have changed since April that require Trust Board to agree a new approach for 23/24
    1. Access to William Budd is no longer achievable due to delays in Dyson Cancer Centre build
    2. Plan included using escalation beds (boarded beds, B36) as core beds to support the plan. These have been removed
    3. NHSE have now confirmed that there will be no winter funding available to support Trusts during 23/24 winter.
    4. There is an incentive opportunity of additional capacity if we meet certain thresholds
3. If the Trust withdraws the winter schemes previously agreed or doesn't identify new schemes the Trust is forecasting bed occupancy of over 105%. This will require utilisation unplanned escalation areas.
    1. Forecasting identifies this will cost an estimated minimum of £3.7m in additional costs or lost income.
    2. Significant clinical risk and patient safety concerns for ED, front door services and patients in our community
4. Trust has identified an updated winter plan, which needs renewed Trust Boards support
    1. Builds on the success the Trust has had recently, identifies new mitigations to support reduced bed occupancy to just below 95%. Individual schemes need further work and executive sign off
    2. Requires investment of £2.1m to deliver

Changes since April agreed plan

- Delays in access to the winter escalation ward

- Q1 of 23/24 has not seen significant COVID activity. Potential for this to return during Q3 or Q4. impact modelled at 25 beds. – New Variant 2.86 is causing great concern and the modelling of 25 beds may be too low.

- Recognition that boarded beds significantly impact on flow. Removed from plan as core bed base. Will only be utilised to support spikes in bed demand and limited in use.

- National letter (attached) outlines lack of winter funding available – but access to £150m capital funding if performance targets met.
    - 90% of ambulances offloaded within 30 minutes within Q3 and Q4 – RUH currently at 65% but averaging 36 minutes to offload
    - 80% 4 hour performance within Q4 – the RUH currently at 66.5% for Month 5
- Wiltshire Health and Care have requested that the RUH takes on the management of Chippenham and Trowbridge MIUs – impact currently being assessed, with further paper back to FPC/ Board

If we do nothing

Without the planned mitigations it is forecast that the Trust will have a bed occupancy above 100%. It is anticipated that this will lead too;

- Unplanned use of escalation areas such as day surgery suite, cath lab recovery, vascular lab and boarded beds

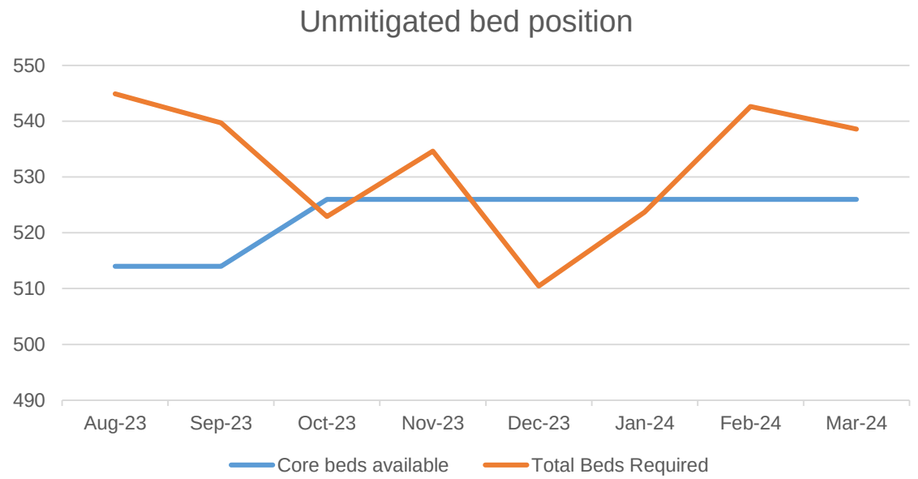
- Use of these areas will require unfunded agency nurses to support – calculated cost of £1.7m (November to March running of escalation)

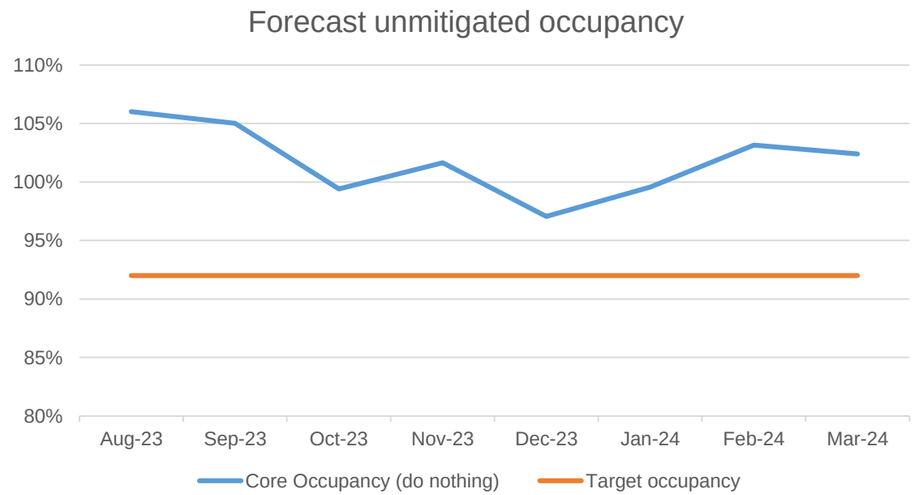
- Cancellation of elective activity due to failure to be able ring fence days surgery suite/ mini PY – lost elective income of £2m (loss of £400k per month from November to March).

- Significant delays in ambulance handovers due to lack of flow

- Significant safety concerns within ED and in the community as patients wait for ward beds to become available

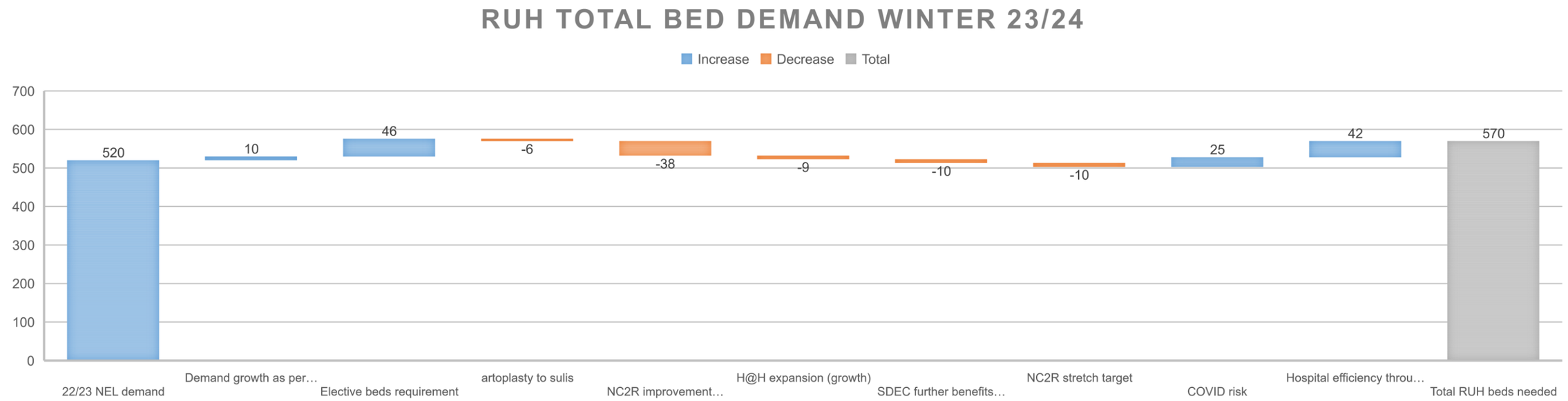
- Challenging working environment for staff leading to working experiences and associated impact

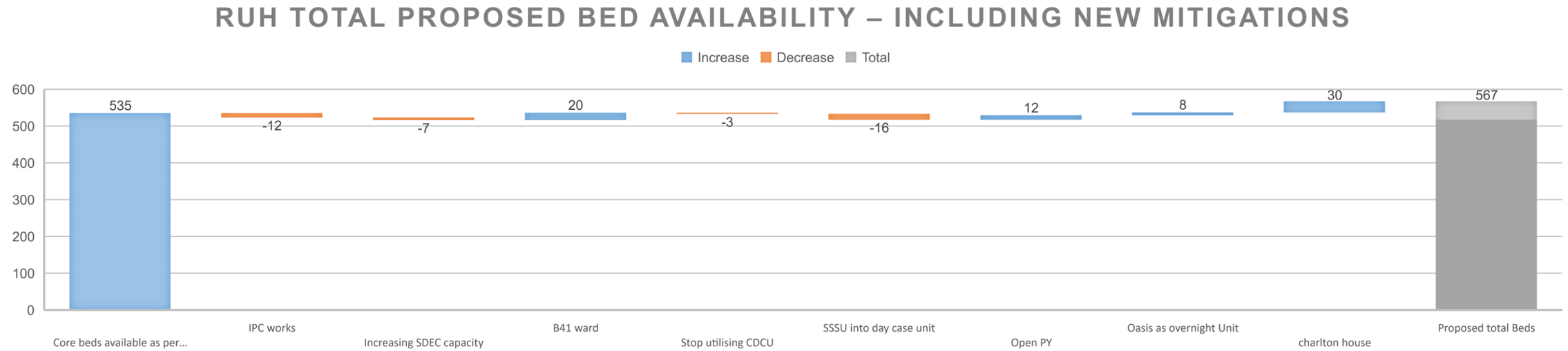




Note – December position impacted by Christmas period

Refreshed demand and capacity waterfall

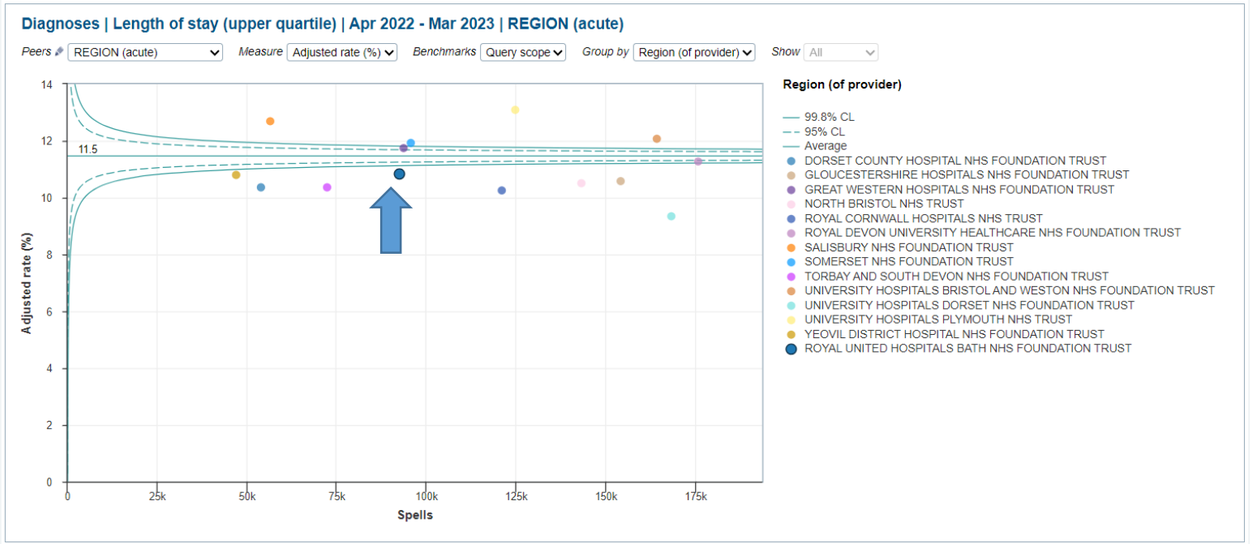




Can we go further/ faster

Feedback from the regional clinical advisor, Stevan Bruijns, on Urgent Care bundle implementation for NHSE southwest;

- "*This is a very impressive and ambitious plan. I'd be quite keen to have your permission to share with other providers as an example of good operational practice?"*
- *"Just reviewed Bath's UEC dataset. What a brilliant job you guys are doing"*
- *"Occupancy continues to drop. %NCTR still fairly high in region, but also showing a downward trend. Non elective LOS remains low compared to region. 0-day remains static, but 14-day and 21-day trending in the right direction."*
- *"Summary: Occupancy improvement is quite remarkable and suggests a consistent effort"*



We have an ambitious plan already which is focused on reducing admissions (SDEC, new ways of working) and reducing internal delays.

We have limited scope for improvement on LOS but continued opportunity to further reduce NC2R (current plan reduces to 80).

Potential to further improve how we operationally run the hospital on a day to day basis to support improved flow eg discharges earlier in the day.

National Letter (within the appendix) highlights 10 high impact interventions.

- First 3 (SDEC, Frailty, improve flow and length of stay) relate to acute services and are already a corner stone of our internal plans
- Remaining 7 relate to community services. These are already in place (Virtual Wards, Urgent Community Response, single point of access) or built into the systems plan for delivering the planned reduction in NC2R (community bed productivity, care transfer hubs, intermediate demand and capacity) or reduce demand (acute respiratory infection hubs) are being developed at the moment.

Refresh financial overview of the mitigations

		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	In year total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Adjustments to bed base	SSSU to be completely daycase	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(360.0)
	SDEC - acute medicine and frailty				11.0	11.0	16.5	16.5	27.5	27.5	33.0	33.0	33.0	208.9
	PY as a medicine ward													0.0
	Savings from closures/changes	**(30.0)**	**(30.0)**	**(30.0)**	**(19.0)**	**(19.0)**	**(13.5)**	**(13.5)**	**(2.5)**	**(2.5)**	**2.98**	**2.98**	**2.98**	(151.1)
Mitigations	Oasis / merged dicharge lounge							38.5	38.5	38.5	38.5	38.5	38.5	230.7
	Additional escalation as required (B41) and B36 in	99.9	145.8	90.4	101.7	101.7	101.7	101.7	101.7	101.7	101.7	101.7	101.7	1,251.3
	Site team review							0.0	12.0	18.0	23.8	23.8	23.8	101.3
	Medical team for medicine							0.0	25.0	25.0	25.0	25.0	25.0	125.0
	Weekend discharge team							0.0	0.0	0.0	0.0	0.0	0.0	0.0
	New ways of delivering CAHMs demand								12.0	12.0	12.0	12.0	12.0	60.0
	Charlton House								95.0	95.0	95.0	95.0	95.0	475.0
	Hot clinics in resp and cardiology							0.0	2.0	2.0	2.0	2.0	2.0	10.0
	Total Mitigations	**99.9**	**145.8**	**90.4**	**101.7**	**101.7**	**101.7**	**140.1**	**286.1**	**292.1**	**297.9**	**297.9**	**297.9**	2,253.3
	Total cost	**70**	**116**	**60**	**83**	**83**	**88**	**127**	**284**	**290**	**301**	**301**	**301**	2,102.3

Trust Board agreed a plan at a cost of £2.5m to support the annual bed plan, including winter. The refreshed plan reduces this cost by £0.4m.

A number of the schemes being identified are high risk (Red or Amber) of delivery, with the higher confidence schemes being focused on temporarily ensuring sufficient beds are available.

Conclusion

1. Significant risk to the RUH if we don’t do anything differently this winter including;
    1. Significant long waits for our patients within ambulance, in the community and within ED
    2. Reduction in elective income matching 22/23 levels of circa £2m
    3. Unplanned bed escalation will be required to support position. In 22/23 this was £1.7m

2. Mitigated NC2R position still means that, best case scenario, the RUH will be looking after between 55-80 NC2R patients at anyone time. System cant go further.

3. Regional team have assessed our plans and highlighted the strength in our delivery and ambition already built in

4. Have reduced the cost of the plan from £2.5m to £2.1m

5. New mitigations to be converted into operating plans to be signed off by relevant exec team to ensure meets EQIA

Ask of Board

1. Does the Board support the direction of travel for the refreshed Winter plan for 23/24?

2. Appetite for risk if system do not support funding for winter plan?

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item No:**	**14.1**
Date of Meeting:	**6 September 2023**		

Title of Report:	**Maternity and Neonatal Safety Report Quarter 1 2023/24**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author(s):	**Zita Martinez, Director of Midwifery**
Appendices	**Appendix 1.0 Insights report** **Appendix 2.0 Transitional and ATAIN Audit report**

1. Executive Summary of the Report

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

The Trust declared full compliance with Year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) in January 2023. MIS year 5 was launched during Q1 of 23/24, the service is evaluating the current position of compliance. Progress towards achievement will be reported in the coming quarters.

During Q1 of 23/24 there was a total of 1 perinatal death, the death was not supported for review via the Perinatal Mortality Review Tool (PMRT). There is currently one outstanding PMRT action relating to an Electronic Patient Record change request which is on-going.

One new referral was made to the Healthcare Safety Investigation Branch (HSIB) during Q1, which has been accepted for review. Full details are within this report.

This report outlines the Trust's current position for compliance with the 15 Immediate and Essential Actions (IEA) within the final Ockenden report of 2022. Work continues towards continued progression and completion of all actions.

Staffing levels are improving, the service has a strong retention and recruitment programme with a 100% Band 5 retention rate. The Clinical Facilitation Team has been extended to on boarding of the international midwifery recruits. The first three recruits joined the Trust during Q1 of 23/24. In June, the Midwifery Retention Team was awarded the Trust Team of the month award.

Continuity of Carer remain suspended except for the team caring for the most vulnerable families. The Homebirth and Community birth services in Chippenham recommenced full restoration of birth options to families. A homebirth lead midwife has been recruited to develop a dedicated home birth team. During Q1 there have been 65 community births of which 17 births were in Chippenham, 35 in Frome and 13 home births. The Director of Midwifery is leading engagement sessions to review models of care for community births.

Funding has been secured to create a Day Assessment Unit and Maternity Triage Unit; estate work is anticipated to commence in Q3 of 23/24.

Appendix 1 of this report contains the maternity and neonates 'Insights Report'. The East

Kent 'Reading the Signals', published in 2022 into failings within maternity services identified that 'it should be possible for individual Trusts to monitor and assess whether they have a problem'. Failure to listen and recognise the wider experience of staff and families was identified within the report as a contributor to poor care, experience and clinical outcomes. This report aims to collate the wide, and varied insights into maternity and neonatal services for cross correlation, thematic analysis, key areas of improvement and learning.

Appendix 2 contains the full Avoiding Term Admissions into Neonatal Units (ATAIN) report for Q1 of 23/24. During Q1 the ATAIN review meeting group identified 2 cases of avoidable admissions. Full details are within this report.

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.)

In Q1, Maternity and Neonatal services presented 1 new risk assessment which was approved for the risk register. 'RUH Maternity and Neonatal Risk Register assessment for the provision of maternity care to birthing people who do not identify as a female gender'.

This risk was shared with the Local Maternity and Neonatal System (LMNS) to be featured on their risk register as a System wide issue, no current maternity digital system is able to facilitate a pregnancy for a male patient profile.

During Q1, 3 risks were closed.

1768	Maternity redesign staffing impact	4
1763	Lack of AHP support - Dietician, Psychology, OT and Physio in the Neonatal Unit (NNU)	8
2013	Lack of adequate suturing lighting in birth rooms	4

Following receipt of new information at the end of Q1 from the Neonatal Operational Delivery Network regarding funding for Neonatal Allied Health Professionals, it is anticipated that risk 1763 may be re-opened. This is subject to a repeat risk assessment which is scheduled to be carried out in July.

All open risks Maternity and Neonates are listed below.

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1948	Obstetric ultra sound scan capacity	12
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	8

	2396	Obstetric theatre emergency call bells	12
	392	Obstetric and gynaecology workforce risk	15
	2417	Maternity triage	12
	2453	Lack of connectivity and IT facilities in Devizes health centre	8
	2467	Maternity workforce	12
	2481	Staff Entonox exposure in birthing environments	4
	2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	6
	2522	The Provision of maternity care to birthing people who do not identify as a female gender	8
	2483	Expiration of Maternity and Neonatal staff resources and guidelines	12

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

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

7.	References to previous reports
Previous monthly Perinatal Quality Surveillance reporting. Maternity and Neonatal Safety Report Quarter 3 - March 2023. Safer Staffing Report – August 2022. CNST Maternity Incentive Scheme – Year 4 declaration of compliance - December 2022. Maternity and Neonatal Safety Report Quarter 4 – July 2023	

8.	Publication
Public.	

9.	Sustainability
N/A	

10.	Digital
N/A	

Royal United Hospitals Bath
NHS Foundation Trust

MATERNITY AND NEONATAL QUARTER 4 2022/23 SAFETY REPORT

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

Maternity Safety Support Programme in place	Select Y / N	**N**

	April	**May**	**June**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓ see report	✓ see report	✓ see report
2. Findings of review of all cases eligible for referral to HSIB	✓ see report	✓ see report	✓ see report
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	✓ see report	✓ see report	✓ see report
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	✓ see report	✓ see report	✓ see report
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✗ see report	✗ see report	✗ see report
3.Service User Voice Feedback	✓ see report	✓ see report	✓ see report
4.Staff feedback from frontline champion and walk-about	✓	✓	✓
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓ Nil	✓ Nil	✓ Nil
6.Coroner Reg. 28 made directly to Trust	✓ Nil	✓ Nil	✓ Nil
7.Progress in achievement of CNST 10	✓	✗ New MIS standards released 30 May 23	✗
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment:			Work - 65% Treatment - 75% Staff Survey 2022
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours:			100% (GMC 2022)

1. REPORT OVERVIEW

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

2. PERINATAL MORTALITY RATE

The following graphs demonstrate how Royal United Hospitals Bath NHS Foundation Trust (RUH) is performing against the national ambition. There were no stillbirths in Q1, please refer to section 2.1.

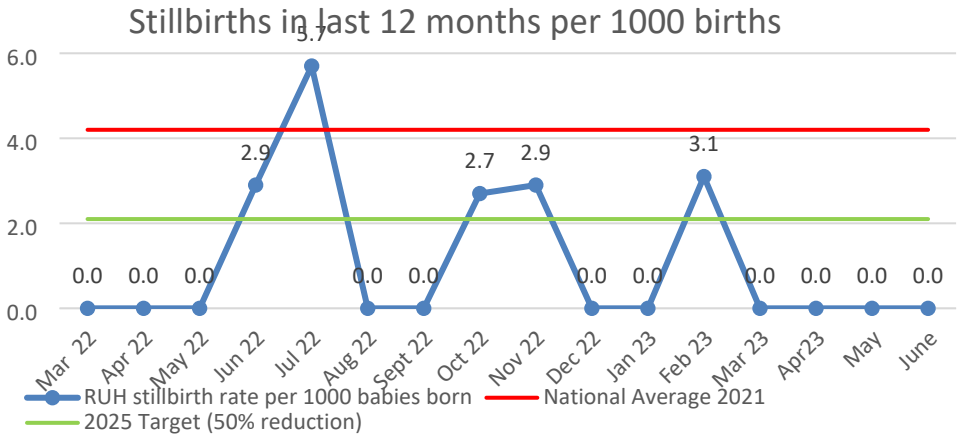


Figure 1. RUH NHS Trust Stillbirth rate per 1000 births over last 12 months

There were no reported neonatal deaths in Q1.

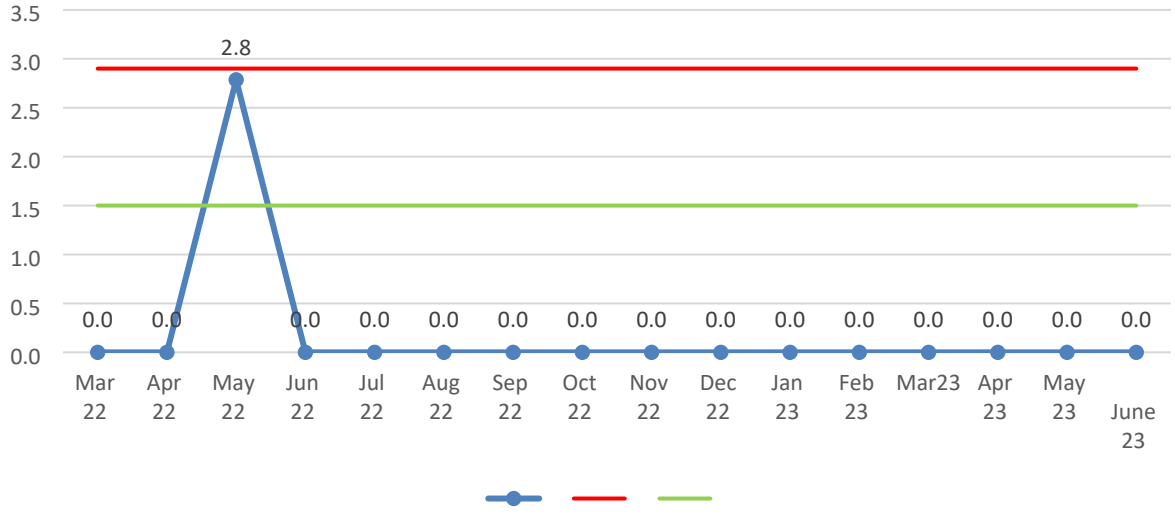


Figure 2. RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

2.1 PERINATAL MORTALITY SUMMARY FOR QUARTER 1 2023/24

2023/24 (excluding terminations for abnormalities)	Q1	Annual total 23/24
Stillbirths (>37 weeks)	0	0
Stillbirths(>24weeks-36+6weeks)	0	0
Late miscarriage (22+oweeks-23+6weeks)	0	0
Neonatal deaths	0	0
Total	**0**	**0**

Table 1. Perinatal Mortality Summary Quarter 1 2023/24

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

All perinatal deaths within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is a requirement of Safety Standard 1 of the NHSR Maternity Incentive Scheme year 5.

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

The RUH Electronic Patient Record records all stillbirths (24 weeks or greater gestation) and neonatal deaths. Births between 22-24 weeks are pulled manually and added to the data set submitted to MBRRACE-UK and are reported in figure 1. 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.

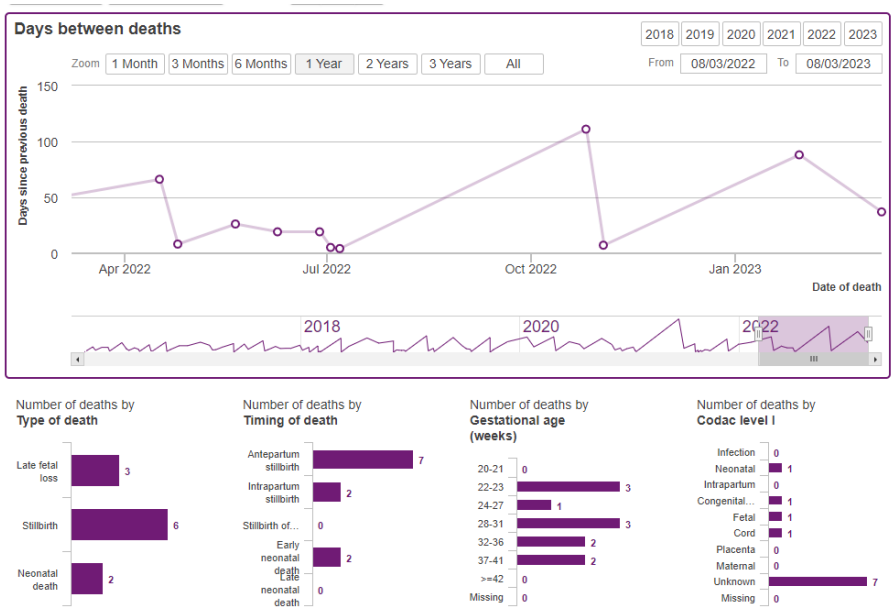


Figure 3. Reporting of RUH NHS Trust Deaths within Organisation.

There was one perinatal death in Q1 following a Medical Termination of Pregnancy this was reported to MBRRACE but was not supported for review via PMRT. Therefore, there are no published reviews via PMRT from Q1.

2.3 LEARNING FROM PMRT REVIEWS

Table 2 provides an update on the outstanding actions from reported cases in Q4 22/23 which were reviewed via PMRT. There is 1 current incomplete action which is on-going.

PMRT Action Plans Extract for Royal United Hospital Bath NHS Trust from reviews of deaths from 1/01/2023 to 30/06/2023						
Perinatal Case ID	Issue	Action plan text	Implementation text	Owner	Target date	Status
85900/1	It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	Added to checklist to improve documentation	Addition to checklist	Bereavement Lead Midwife	07/09/2023	Completed
86495/1	Parents were not asked if they are related at the booking appointment.	Digital Lead Midwife asked to request change when IT services are able to accommodate.		Digital Lead Midwife	07/07/2023	On-going
86495/1	This mother's progress in labour was not monitored on a partogram	Added to Safety Brief on Bath Birthing Centre. Ensure education to staff regarding importance of completion of partogram in labour even if fetal heartrate is not present.	Included in the content of the Bereavement study day	Bereavement Lead Midwife	31/05/2023	Completed

Table 2. Update on actions arising from Q4 22/23 PMRT reviews.

The cases from Q4 have been discussed at the PMRT meeting. The actions above were generated as incidental findings from the review process and were agreed as 'not relevant to the outcome' of the cases.

Of the PMRT cases from 22/23 aligned to the Saving Babies Lives Care bundle V2, 7.7% of cases (n=1) identified issues with the plotting of Symphysis Fundal Height Measurements to identify and appropriately manage Fetal Growth Restriction (FGR), however in this case it was not seen as causal to the outcome.

7.7% (n=1) of stillbirths were associated with reduced fetal movement management, this related to the provision of the reduced fetal movement leaflet in the mother's first language, this was not identified as causal to the outcome.

0% of the cases identified issues relating to the prevention, prediction, preparation and perinatal optimisation of pre-term birth

3. HEALTHCARE SAFETY INVESTIGATION BRANCH AND MATERNITY SERIOUS INCIDENTS

3.1 BACKGROUND

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

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

3.2 INVESTIGATION PROGRESS UPDATE

1 new referral was made to HSIB during Q1.

The case was a homebirth where the baby was born in poor condition requiring neonatal resuscitation at birth. The baby required transfer to a level 3 Tertiary Neonatal Intensive Care Unit for subsequent active therapeutic cooling. The baby has been identified as having MRI changes post cooling however it is not clear of the aetiology for these changes.

One HSIB report was returned in Q1.
There were two safety recommendations made to the Trust within this report. The findings from the report have been assessed for improvement and learning. HSIB identified in MI-0017511 that:

- 'The Trust to ensure that all staff are supported to summon immediate help when they are unable to reassure themselves of a baby's wellbeing if they are unable to hear the heart rate'
- The Trust should ensure that the investigations following an unexpected stillbirth are standardised and completed in line with national recommendations (Royal College of Obstetrics and Gynaecologists 2010).

In response to the recommendations, it has been identified that there is a lack of a Standard Operating Procedure relating to an inaudible fetal heartrate that has been previously normal within a care episode. This finding was shared within the LMNS Safety Forum and it has been recognised as an area of improvement across the System. A working party is being set up to agree key principles for the management and guidance provided to staff System wide.

The Trust Bereavement Midwife is supporting development of a 'Bereavement bloods profile' on Millennium to ensure the correct blood profiles are undertaken in the event of a perinatal death.

Table 3 identifies ongoing HSIB reviews into Q1. The outcomes of these reports will feature in future reports.

Ref	Details of Event	Date confirmed Investigation	External Notifications and Other Investigations
Ongoing			
N/A	N/A	N/A	N/A
New Referrals			
116486	Homebirth, baby born in poor condition requiring neonatal resuscitation at birth. Subsequent active therapeutic cooling and transfer to Tertiary Centre for ongoing care. MRI day 7 of life – MRI changes	10/05/2023	HSIB MI-026686 STEIS – awaiting from Central Risk Team

Table 3. HSIB referrals and ongoing investigations Quarter 1 2023/24

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY SERIOUS INCIDENTS

There were no new Serious Incidents reported during Q1.

There were 4 moderate harm events reported during Q4 which have not progressed to a Serious Incident review, all have received a local review, the multidisciplinary review team did not identify any acts or omissions in care casual to the event.

Ref	Details of Event	Review Response	External Notifications and Other Investigations
April			
115667	3/52 postnatal mother who birthed outside of the RUH was staying in Neonatal Unit (NNU) flats and became unwell – this was alerted to staff. A cardiac arrest call was made the mother transferred to Coronary Care Unit; a diagnosis of multiple pulmonary emboli (PE) was made. The mother was discharged after 3	MDT review conducted. Development of PEs deemed unavoidable from care perspective. Mother prescribed low molecular weight heparin by birth care provider; birth care provider informed of event. Incidental learning identified in relation to emergency care provided, and access into NNU parental flats. Learning being actioned and tracked via datix and Mat-Neo Action Tracker	

	days.		
115706	Baby fall from mother's lap in chair on postnatal ward. Subsequent fracture to the skull identified. Baby admitted to the NNU for observation. Currently at home with family.	MDT review conducted, risk of falls sticker in mother's notes to evidence staff discussion during the immediate postnatal period, audit 0ctober 22 indicate current compliance at 13.5% To review sticker and align to British Associate of Perinatal Medicine (BAPM) 2020 risk assessment for risk of falls. Noted signage around the ward environments could be stronger to raise awareness of the increased risk due to fatigue, sleep deprivation, reduced mobility and medications. Actioned to ward manager and leadership team midwife to begin quality improvement piece regarding parental information for the risk of baby falls in immediate postnatal period.	
May			
116544	Major Obstetric Haemorrhage (MOH) of 3034ml following a return to theatre for perineal haematoma excision and repair.	Counselled well about risks of prolonged 2nd stage, aware of risks but declined an Instrumental birth, episiotomy repaired by appropriate clinician. Co-incidental finding that oxytocin infusion not administered post-delivery, high risk of post-partum haemorrhage after prolonged 2nd stage. However blood loss was as a result of haematoma not uterine atony therefore not causal to outcome.	
June			
	Major Obstetric Haemorrhage (MOH) elective caesarean, 2 returns to theatre total WBL 5400mls. Mother transferred to Intensive Therapies Unit (ITU)	MDT review 30/06/2023. To look at the process of handover from Elective Lower Segment Caesarean Section (LSCS) to the ward – not contributory to the outcome. Care escalated in a timely manner with appropriate senior clinicians in attendance and care transferred to an appropriate setting onto ITU in response to the large blood volume lost. Consideration for radiological input. Haematology input obtained. Forward planning documented in notes.	

Table 4. Maternity and Neonatal Moderate harm Local reviews Q1.

4. CONTINUITY OF CARE

4.1 BACKGROUND

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

national Maternity Transformation Plan.

4.2 PROGRESS TO DATE

Maternity Continuity of Carer (MCoC) remains paused in line with national guidance. As staffing levels have improved, the service has commenced planning to achieve the commitment to reintroduce the MCoC pathway. The Community Matron, Transformation Midwife and community teams are working together to scope how this can be achieved. Antenatal and postnatal Continuity of Carer continues to be provided where possible, with vulnerable/at risk groups and those from Black Asian and Minority Ethnic groups being prioritised.

5. OCKENDEN UPDATE

5.1 OCKENDEN FINAL REPORT UPDATE – Q1 2023-2024

The Trust is not required to submit evidence of compliance, although this is monitored at speciality level and will be included in the Perinatal Quality Surveillance Tool from Q2.

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

6.1 SITUATION REPORT

Maternity training is specified in detail in the Maternity Training Needs Analysis. Compliance with fetal monitoring, neonatal resuscitation and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) during March of 2023 dropped to 83% (below the 90% standard) in response to a cancellation of March's PROMPT study day due to doctors in training industrial action.

During Q1 of 23/24, no training dates were cancelled. Training compliance continues to be monitored, noting the future dates for industrial action in Q2. Mandatory training dates will be paused during August of 2023 (Q2) in anticipation of optimum levels of annual leave being taken. To mitigate the risk, additional training dates have been made available during September, October, and November.

Sharing of local maternal and neonatal outcomes from serious incidents, near misses and never events are incorporated into training, and disseminated to staff in a variety of formats including: maternity newsletter, staff e-mails, staff safety briefings, patient safety 'Safety Catch' newsletter, Microsoft Teams RUH Maternity Team, case review posters with QR code links to full reports, and quality and safety whiteboards displayed in clinical areas with a 'Safety Hot Spot' of the month. Safety Hotspots are identified through service insights such as incidents, audit and, or family feedback.

A robust training trajectory has now been developed and a new monitoring and booking system is now in place to ensure current compliance is maintained and

continually improved.

The new Maternity Incentive Scheme (MIS) year five standards were released on 30 May 23. This includes the updated training core competencies standards. The services is currently assessing current compliance with 'Core Competencies version 2'.

6.2 TRAINING DATA

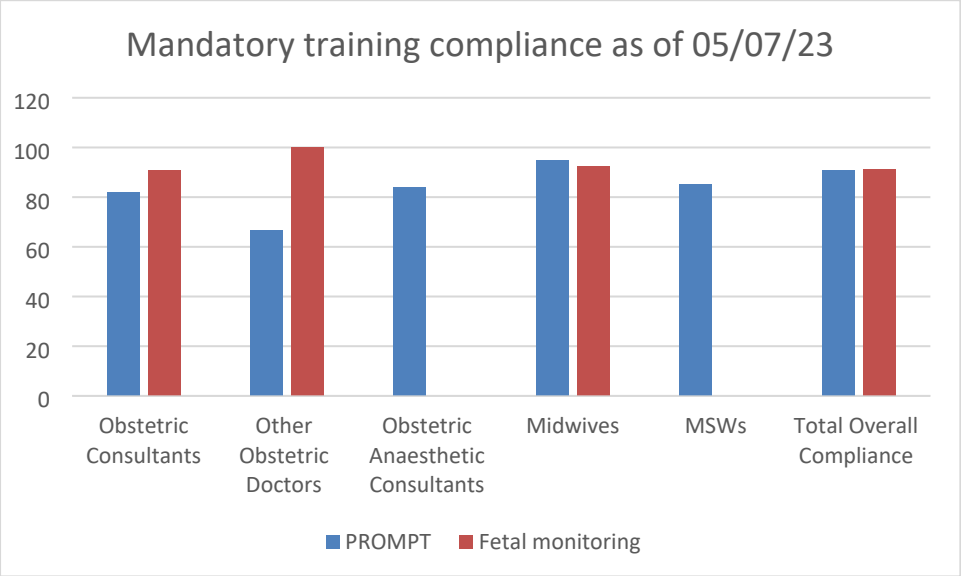
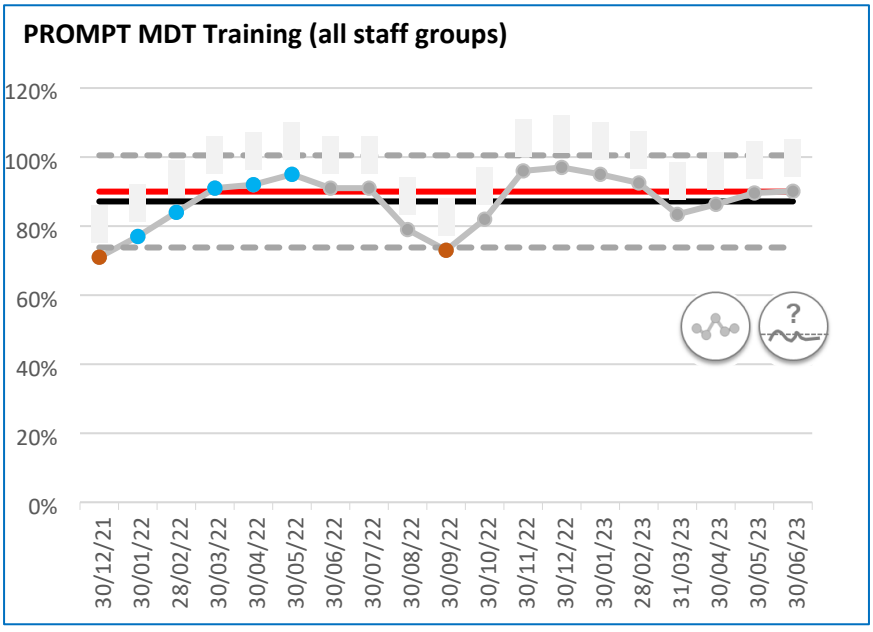


Figure 4. Prompt and fetal monitoring Training Compliance (%) by staff group Q1 2023/24



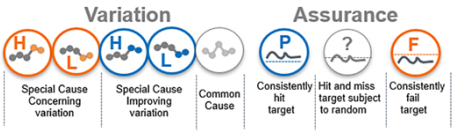
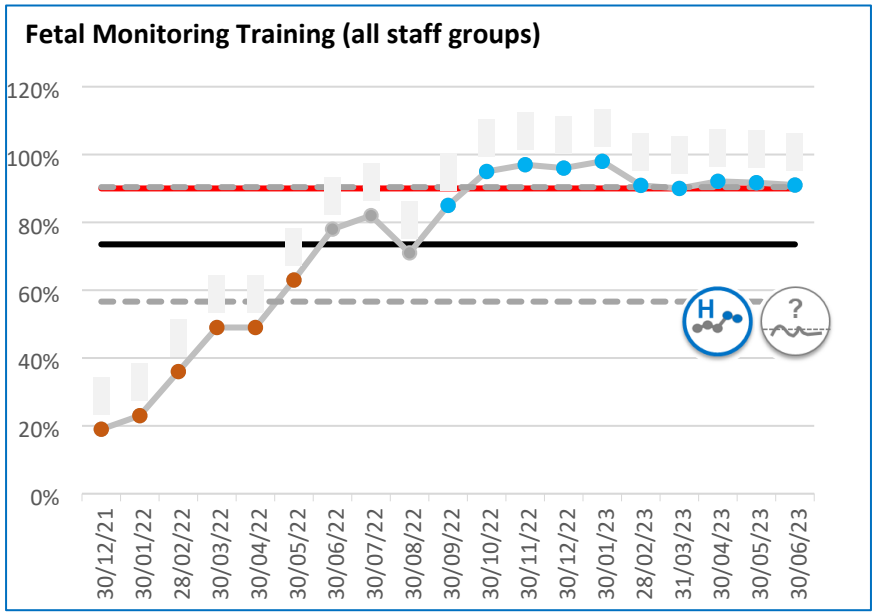


Figure 5. PROMPT compliance – all staff groups



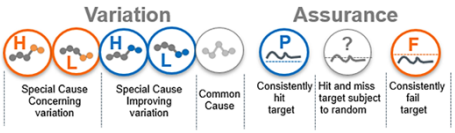


Figure 6. Fetal monitoring compliance – all Staff groups

7. BOARD LEVEL SAFETY CHAMPION MEETINGS

All staff are invited to attend monthly meetings held with the Chief Nurse and the Non-Executive Director (Board Level Safety Champions on 21 April, 18 May and 15 June). The meetings in Q1 were attended by members of the maternity and neonatal team from a range of areas, including community and specialist midwives.

Themes raised included:

- Recruitment updates, positive response to on-going recruitment to midwifery vacancies – first International midwives started in post during Q1.
- Positive response to self-rostering discussion from exit interviews feedback
- Community car permit issues
- Entonox emissions – risk assessment process in place for community services
- Discussions regarding homebirth team and models of care
- On call concerns

7.1 BOARD LEVEL SAFETY CHAMPION WALKABOUTS

The Board Safety Champions undertook walkabouts across Maternity Services: 20 April, 12 May and 5 June.

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

8. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q1 2023/24

The Clinical Negligence Scheme for Trusts released their Safety Standards for Year 5 on 30 May 2023 including a new Saving Babies Lives Version 3. The services is currently benchmarking compliance and have scheduled planning meetings

throughout Q2 to ensure action planning is undertaken and carried out in identified areas of low or non-compliance.

Updates will be completed and shared within Maternity and Neonatal Speciality Governance meeting, Board Level Safety Champions, and in subsequent report from Q2.

9. SAVING BABIES LIVES CARE BUNDLE V3

9.1 UPDATE

Saving Babies Lives version 3 was released on 30 May 2023. The bundle forms a requirement for implementation as Safety Action 6 (SA6) of the Clinical Negligence Maternity Safety Incentive Scheme year 5.

Version 3 has incorporated a new element 'Element Six: Management of pre-existing diabetes'.

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Risk assessment and surveillance for fetal growth restriction
- Element 3: Raising awareness for reduced fetal movements
- Element 4: Effective fetal monitoring during labour
- Element 5: Reducing pre-term birth
- Element 6: Management of pre-existing diabetes.

The Trust declared full compliance with all 5 elements of SBLv2 in January of 2023. The service is currently assessing current compliance for all elements of version 3, updates will be provided through Maternity Specialty Governance, and Maternity and Neonatal Safety Champion meetings.

The Trust awaits the launch of the national implementation tool to support evidence of compliance with MIS SA6. The required standard is:

1. Provide Assurance to the Trust Board and Integrated Care Board (ICB) that you are on track to fully implement all 6 elements of the SBLv3 by March 2024.
2. Hold quarterly quality Improvement discussions with the ICB, using the new national implementation tool once available.

It is of note that the percentages of compliancy within process and outcome indicator data sets have been removed from MIS SA6 but remain within the SBL v3 implementation tool.

10. SAFE MATERNITY STAFFING

10.1 MIDWIFERY STAFFING

As of 05 July 2023, the planned vs actual midwifery staffing was -11.74 whole time equivalent (WTE), (of which 1.6 WTE is maternity leave). This gives a substantive vacancy rate -10.14 WTE.

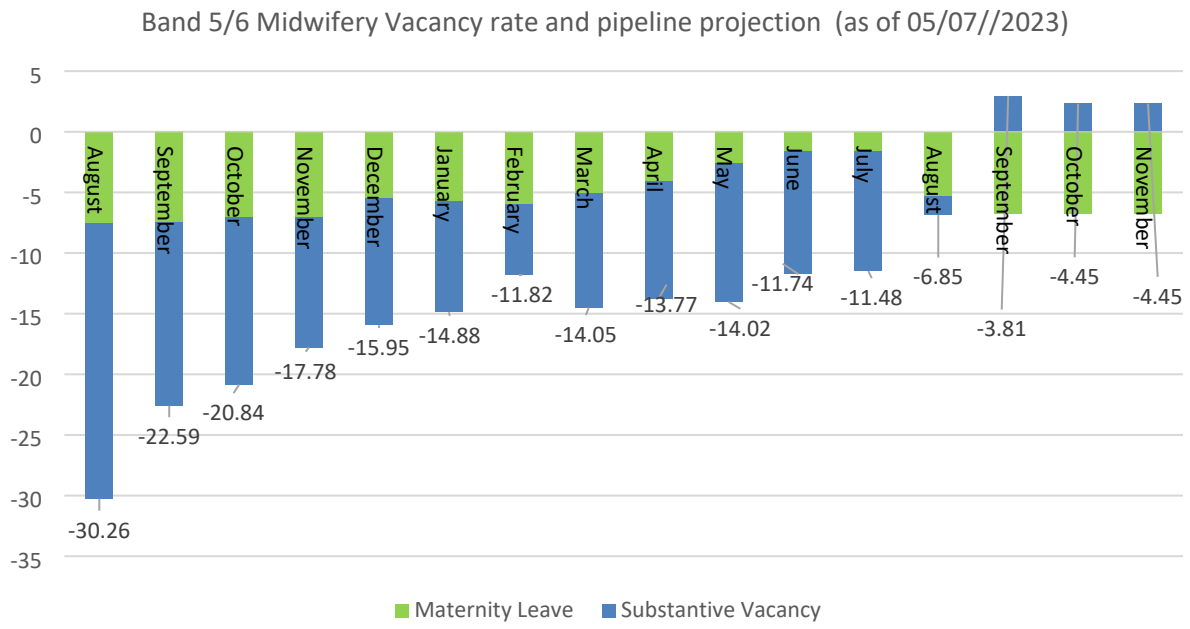


Figure 7. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness) 05 July 2023

Measure	Aim	Apr	May	Jun
Midwife to birth ratio	≤1:27	1:31	1:29	1:32
Midwife to birth ratio including bank	≤1:27	1:28	1:25	1:28
Supernumerary labour ward coordinator status	100%	100%	100%	100%
1:1 care not provided	0	0	0	0
Confidence factor in BirthRate+ recording	60%	83%	78%	69.4%

Table 5. Midwifery staffing safety measures

Following receipt of the Birth-rate+ report shared with board in June of 2023, the target midwife to birth ratio will be amended from Q2 23/24 to 1:24. This will lead to an anticipated decline in compliance to achieve the targeted midwife to birth ratio.

During Q1 we were joined by 3 international midwifery recruits. Their induction package has been developed by our recruitment and retention team to support their successful transition.

We have a robust staffing escalation policy, all exception reporting, analysis of utilisation of this policy, and next steps to ensuring progression towards safe staffing levels will be shared and reported on within the bi-annual board staffing paper.

10.2 OBSTETRIC STAFFING

Measure	Aim	Apr 23	May 23	June23
Consultant presence on BBC (hours/week)	≥90	98	98	98

	hours			
Consultant non-attendance (in line with RCOG guidance)	0	0	0	0
Twice daily MDT ward round	100%	100%	97%	93%

Table 6. Obstetric staffing safety measures

An Obstetric workforce review has been completed and has identified a risk within the current established funding of Obstetric Consultant posts. Currently there is a funded establishment for 9 Obstetric Consultants with a requirement for 11. The risk is mitigated by 2 locum posts which do not have recurrent funding. A risk assessment has been undertaken with action identified to mitigate the risk which will become live on the maternity risk register during Q2.

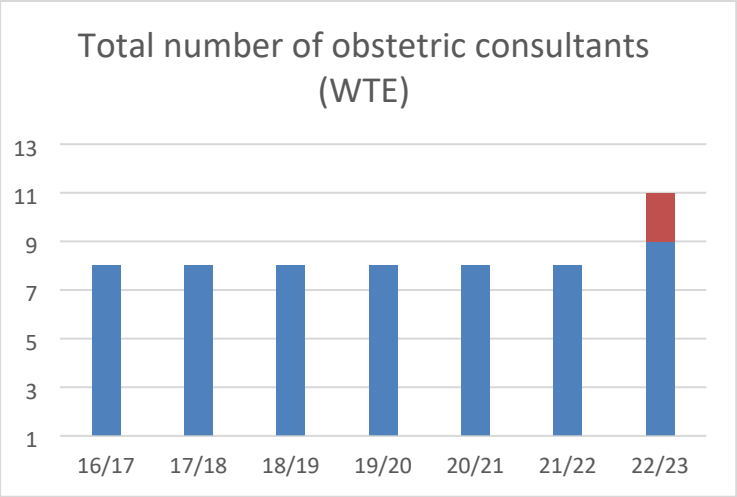


Figure 8: Total Number of Obstetric Consultants employed as of 11 July 23

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

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

	Apr 23	May 23	Jun 23
Number of formal compliments	1	1	1
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	5	2	5
Complaints	0	0	1

Table 7. Complaints and compliments Q1 23/24

One complaint was received in June, relating to the co-ordination and booking of an induction of labour, and the documentation of birthmarks at birth. The service is currently planning implementation of a neonatal body map to support staff accurately documenting any marks present at the birth. A new process for the organisation and management of the daily induction of labour list was launched during Q1 to mitigate the risk of lost information or accidental deletions.

There were no consistent commonalities identified between the PALS contacts received in Q1.
Themes from compliments related to the friendliness of midwives and staff.
.

12. SERVICE USER INSIGHTS FROM MATERNITY VOICES PARTNERSHIP PLUS

Co-production with Maternity Voices Partnership Plus (MVPP) has continued throughout Q1 on a range of antenatal information/birth options films.

13. QUALITY IMPROVEMENT PROJECTS / PROGRESS

13.1 MATERNITY TRANSFORMATION INCLUDING BETTER BIRTHS

Maternity transformation sets out to support implementation of The National Maternity Review (Better births, 2016), the NHS Long-Term Plan (2019) and the national Maternity Transformation Plan. Since 30 March 2023, all deliverables have been encompassed in the newly released Three Year Plan for Maternity and Neonatal Services (2023). Maternity and neonatal services have completed a period of review and benchmarking in relation to the deliverables in the plan.

In support of increasing clinical capacity in the acute unit, all routine planned care was relocated to community space in April 2023. Services are now taking place in Riverside and Mulberry Hub, providing care closer to home and easier to access.

A large focus of transformation work in Q1 has been related to the national requirement to implement personalised care and support plans to provide care that is personalised, shared decision making and informed consent and consistent evidence based information. In Q1 mandatory training was approved by the Nursing and Midwifery workforce group and will commence in September 2023.

Black Maternity Matters training commenced in Q1; seven members of staff are attending the programme delivered over a six month period with a focus on reducing health inequalities using Quality Improvement (QI) methods. The Transformation Lead has been appointed as QI lead for this project. There are a number of QI projects taking place including a pilot of a new translation app. Mandatory anti-racism training has also been approved and will commence for all maternity, obstetric and neonatal staff in September 2023. An Inclusion Midwife and performance audit co-ordinator have been appointed to support the health inequalities agenda.

The Perinatal Pelvic Health Service officially launched in Q1 and is now accepting referrals from professionals. The self-referral portal is in development and is due to launch in Q2, at which point the service will be fully established.

As part of the move to a new digital Electronic Patient Record (EPR) system and to meet national requirements a business case has been written for maternity and will be presented in Q2.

13.2 SAFEGUARDING

13.2.1 RAPID REVIEW IN WILTSHIRE

There was a rapid review request from the Wiltshire Safeguarding Vulnerable People Partnership (SVPP) in Q1. This review relates to the unexplained death of 5-week-old baby in the context of concerns about safe sleeping arrangements and parental neglect.

This case has however reinforced the importance of using a range of methods for sharing safe sleeping messages and the Review Group identified the value of using social media to share messages at pertinent times. For example, when parents are putting their babies down in the evening or in the run up to school holidays when families are more likely to be sleeping away from home and 'out of routine'.

13.2.2 SHARING INFORMATION REGARDING SAFEGUARDING

This is a planned pilot to gain any relevant safeguarding information about fathers of unborn babies from their General Practitioner (GP). The pilot will be for any women cared for by the Bath Lotus Team. This will involve attendance at the GP and Health Visitor (HV) meetings to share information.

13.2.3 SUDDEN UNEXPECTED DEATH IN INFANTS (SUDI) PREVENTION TASK AND FINISH GROUP

The Named Midwife has been part of a task and finish group looking at producing multi-agency guidelines and pathway for giving safe sleep advice to parents across BaNES Swindon and Wiltshire. The guidelines are currently in draft and will be shared once finalised. Going forward, there are plans to introduce a safe sleep risk assessment tool, to be used with families that have risk factors for SUDI.

13.2.4 DADS MATTER TOO

The Named Midwife has been a part of the focus group supporting this pilot in the West Wiltshire area that provides support workers for hard to engage fathers of unborn and babies under the age of one that have Children's Social Care involvement.
The programme is now a year old and there has been an evaluation carried out by Oxford Brookes. The findings are that the programme shows promise of positive impact and outcomes from the work done with these vulnerable families.
Going forward into the second year of the programme there will be no upper age limit for dads (previously was under the age of 30) and the programme will now cover the whole of Wiltshire.

14 INFANT FEEDING AND HEALTH IN PREGNANCY SPECIALIST SERVICES

14.1 INFANT FEEDING

The service continued to operate with the current funded establishment whilst awaiting response from the service review which identified additional resource to meet the Baby Friendly Initiative (BFI) requirements to meet BFI Standard 5 (Close, Loving relationships) in particular.

- 73 mother/baby pairs were offered specialist support

- 82.7% of all babies birthed were breastfed and the frenulotomy rate within tongue tie clinics was 2.8% this is below the recommended upper limit of 5% for frenulotomy rate as per NICE guidance.

A gap analysis identified a need to expand the infant feeding specialist team including the tongue-tie team, this was following identification that wait times for tongue tie assessments were increased. This is currently being recruited to.

14.2 HEALTH IN PREGNANCY

Smoking at time of Delivery (SATOD) across Wiltshire/BaNES was 4.8% which is below the national target of 6%. Smoking at time of booking also reduced slightly compared to the previous quarter to 9.4%.

Commissioned services for health promotion in pregnancy (Health In Pregnancy Service and The BLOOM Project) operated within usual staffing framework and both services were recommissioned albeit with a stepped reduction in funding from Wiltshire Council following the decommissioning of 'Maternal Healthy Me' (MHM) within the BLOOM project, which will cease to operate with effect from Q3 23/24.

The Tobacco Dependency Advisor (TDA) offered 1-1 care to women on site at the RUH (maternity inpatients and outpatients) for, on average, 15 hours per week.

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

The Professional Midwifery Advocates (PMAs) support staff through the A-EQUIP model. The model consists of five PMAs, totalling 0.5 WTE which is an increase from 0.2WTE prior to the restructure of the service.

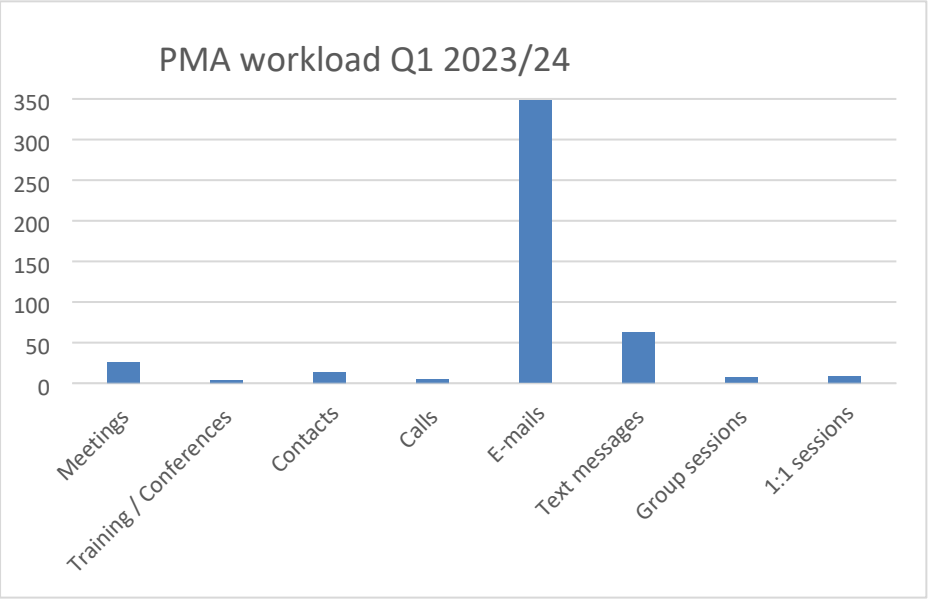


Figure 9: PMA workload

The team offer regular group reflections sessions in addition to individual support. In Q1, the themes were primarily focused on working conditions relating to community working patterns in particular ongoing concerns around the on call structure. The team

meet regularly with the senior midwifery leadership to discuss support, and action to address areas of concern.

16. AVOIDABLE ADMISSION INTO THE NEONATAL UNIT (ATAIN)

There were two recorded avoidable admission of a term babies to the Neonatal Unit in Q1 highlighted at the monthly MDT ATAIN review meetings.

One admission was identified as being avoidable, the delivery could have been expedited in response to a pathological cardiotocograph, with missed opportunities to undertake a septic screen during labour.

The second was identified as being avoidable within their neonatal care, as the baby had stabilised on admission to the Local Neonatal Unit (LNU) and did not need ongoing observations and could have immediately been reunited with its mother.

The relationship between the neonatal and midwifery teams continues to help facilitate enhanced care, particularly with plans of care and early interventions for high-risk babies e.g. assisting with thermoregulation and hypoglycaemia issues. This in turn helps to avoid admissions of the baby to the NNU.

This coordinated care was also highlighted as best practice on an occasion when the midwifery team completed all the observations on a baby as there were insufficient staff in the NNU to cover the Transitional Care Pathway (TCP) which avoided an unnecessary separation of the mother and baby.

16.1 TRANSITIONAL CARE PATHWAY

In Q1, 59% of the total number of admissions to the Neonatal Unit (97 babies*)* were cared for on the Transitional Care Pathway (TCP) for some or part of their admission. Out of this, 39% (64 babies) spent the entirety of their admission on the TCP.

No babies were identified as missed opportunity for TCP. The number of babies being cared for on the TCP is increasing each quarter, which demonstrates commitment to keeping mothers and babies together.

The TCP was staffed for 100% of shifts in Q1 which is an improvement and is reflective of the improvement on staffing levels.

Please see appendix 2 for the full Q1 ATAIN and TCP report.

17. SAFETY IMPROVEMENT PLAN

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

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

- Workforce

- Efficiency
- Safety
- Effectiveness
- Experience

Table 8 provides an update on the urgent required actions from the review.

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

Table 8. NHSE Action Plan – Key Areas for Action

18. RISK REGISTER

In Q1 Maternity and Neonatal, services presented one new risk assessment, which was approved for the risk register:

- 'RUH Maternity and Neonatal Risk Register Assessment for the provision of maternity care to birthing people who do not identify as a female gender'

Actions towards closing the gaps identified within the assessments, and mitigation of the risk, will be monitored through Speciality and Divisional governance with Trust Management Executive oversight to ensure the appropriate action is taken accordance with Trust framework outlined above.

All open risks within Maternity and Neonates are listed below.

During Q1 3 risks were closed.

1768	Maternity redesign staffing impact	4
1763	Lack of AHP support- Dietician, psychology, OT and Physio in the NNU	8
2013	Lack of adequate suturing lighting in birth rooms	4

Table 9: Closed risks in Q1

Following receipt of new information at the end of Q1 from the Neonatal Operational Delivery Network regarding the funding of the Neonatal Allied Health Professionals, it is anticipated that risk 1763 will be re-opened. This is subject to a repeat risk assessment which is scheduled to be carried out in July.

1734	Day Assessment Unit patient safety risk – area not compliant or fit for purpose	15
1948	Obstetric ultra sound scan capacity	12
2353	Replacement of ultrasound machine	4
2359	Maternity Information System IT support/capacity	8
2396	Obstetric theatre emergency call bells	12
392	Obstetric and gynaecology workforce risk	15
2417	Maternity triage	12
2453	Lack of connectivity and IT facilities in Devizes health centre	8
2467	Maternity workforce	12
2481	Staff Entonox exposure in birthing environments	4
2482	Assessment of minor and low harm Datix management in Maternity and Neonatal Division.	6
2522	The Provision of maternity care to birthing people who do not identify as a female gender	8
2483	Expiration of Maternity and Neonatal staff resources and guidelines	12

Table 10. Maternity and Neonatal Risk Register

19. RECOMMENDATION

The Quality Governance Committee is asked to receive and discuss the content of the report.

APPENDIX 1.

Report to:	**Quality Governance Committee**	**Agenda item No:**	
Date of Meeting:	**17 August 2023**		

Title of Report:	**Maternity and Neonatal Service Insights report Q1 23/24**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author(s):	**Zita Martinez, Director of Midwifery**
Appendices	**Nil**

1. Executive Summary of the Report

The East Kent 'Reading the signals' report of 2022 into failings within maternity services identified that 'it should be possible for individual trusts to monitor and assess whether they have a problem.' Failure to listen and recognise the wider experience of staff and families was identified within report as contributory to poor care, experience and clinical outcomes. This report aims to collate the wide, and varied insights into maternity and neonatal services at the RUH for cross correlation, and thematic analysis to identify key areas of improvement and learning.

This report considers insights received by Maternity and Neonatal services from the findings and issues raised within the Perinatal Mortality Review Tool (PMRT), findings and recommendations from reviews undertaken by the Healthcare Safety Investigation Branch (HSIB), learning identified from internal Serious Incident investigations, review of low and no harm incident reports, the Trust's legal and claims scorecard of 2022, feedback from the 'Birth Reflections' service, complaints, compliments and Patient Advisory and Liaison Services (PALS), feedback from the Maternity and Neonatal Voices Partnership Plus, results from the Care Quality Commission family survey, staff feedback received during Safety Champion walk-around, staff feedback to the Professional Midwifery/Nurse Advocacy (PMA/PNA) service and the Trust Freedom To Speak Up Guardian (FTSU).

This report identifies areas of commonalities and current actions being undertaken to delivery improvements to the services. The identified areas will be subject to continued monitoring to ensure progression and improvement via maternity and neonatal speciality governance. Where applicable challenges, or risks, to the service have been escalated to the maternity risk register.

The following brief summaries identify the current position relating to the areas identified for potential improvement.

The RUH is part of a national pilot for the provision of a perinatal pelvic health service. A specialist perinatal pelvic health midwife commenced in post during November of 2022, a specialist pelvic health physiotherapist commenced in December of 2022.

A quality improvement initiative was launched in Q1 of 23/24 specifically focused on the provision of intermittent auscultation during the second stage of labour in response to local clinical audit findings, and initial learning from a recent HSIB referral. On 30 May 2023, the national Saving Babies Lives Care Bundle version 3 was released, which encompasses the element of 'intrapartum fetal monitoring', recommendations and standards. Progress towards full implementation of all elements and recommendations of this package will be monitored via Specialty and Divisional governance.

A case cohort review is being undertaken looking at postpartum haemorrhage and pre-disposing risk factors, identification of risk, identification of the emergency, emergency management, and any modifiable factors to inform future improvements, if required, with an aim to reduce haemorrhage post birth.

Paper personalised care and support plans (PCSP) have been developed with key stakeholders including the Maternity and Neonatal Voices Partnership (MNVP) and service users and roll out will commence in September alongside personalised care and support plan training for staff. As part of the digital transformation, the aim is to digitalise the record.

The PCSP contains information regarding decision-making and informed choices including the application of the 'BRAIN' pneumonic (Benefits, Risks, Alternatives, Intuition, Nothing). The aims to empower birthing people through shared decision making with clinicians, during pregnancy, labour, and birth.

It is pleasing that the kindness and friendliness of our staff featured through feedback.

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.)**
Link identified to risk 2417 'RUH Maternity and Neonatal Risk Register Assessment Expiration of Maternity and Neonatal Staff Resources and Guidelines'. (High Risk 12)	

5.	**Resources Implications (Financial / staffing)**
The presentation of legal data alongside incidents, as within this report, is described within safety action 9 of the Maternity Incentive Scheme which carries both safety and financial implications.	

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

7.	**References to previous reports**
Previous monthly Perinatal Quality Surveillance reporting Maternity and Neonatal Safety Report Quarter 1 - July 2023 Maternity and Neonatal Insights Report, Q1 – Maternity and Neonatal Safety Champions, July 2023	

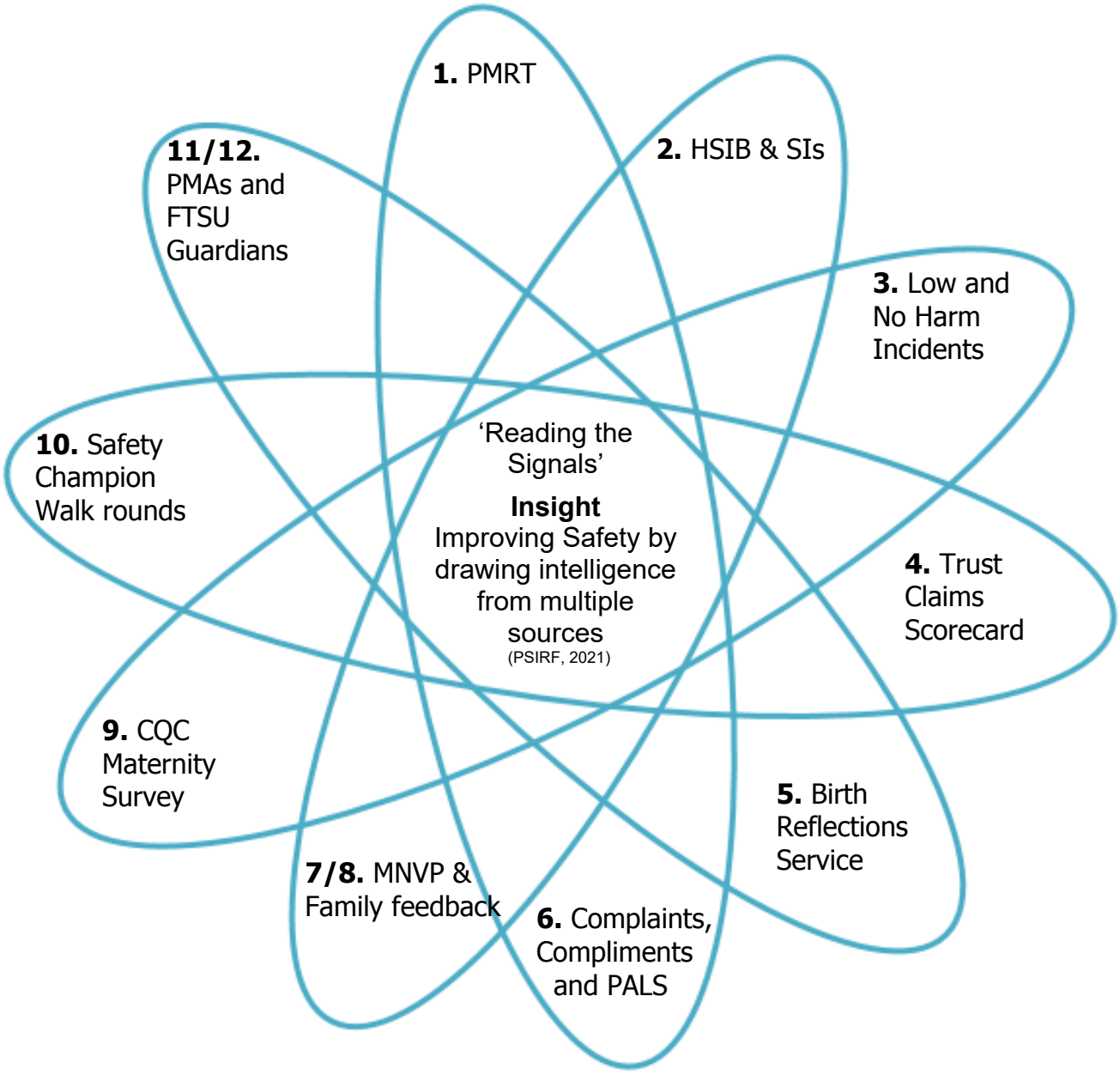
8.	**Publication**
Private	

APPENDIX ONE

REPORT OVERVIEW

'Reading the signals' report (Kirkup: 2022) from East Kent Maternity Services identified that 'it should be possible for individual trusts to monitor and assess whether they have a problem.' Failure to listen and recognise the wider experience of staff and families was identified within report as contributory to poor care, experience and clinical outcomes. It is acknowledged we have a large volume of information and feedback that can be difficult to collate to build a full picture of how our service looks, feels and provides care.

This report aims to draw upon the clinical insights across the Quarter, taking a thematic approach to identify commonalities or themes for the improvement, development and learning within our service.



1.0 PERINATAL MORTALITY REVIEW TOOLKIT (PMRT)

A retrospective review of the PMRT data for 22/23 has been undertaken to inform this first 'Insight Report' moving forwards this will be conducted Bi-annually. In 22/23, 7 deaths were eligible for a full PMRT review.

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
14	5	2	7	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
4	2	0	2	0

Table 1: PMRT outcomes

The issues have been sub categorised to enabler thematic review alongside other insights.

Category	Issue raised by PMRT	Total
Communication	2	**2**
Escalation		
Guidance		
Fetal Monitoring		
Clinical Oversight	3	**3**
Clinical Assessment	4	**4**
Triage		
Resuscitation		
Training		

Table 2: Issues identified by category

One perinatal death received care from RUH maternity services in Q1, did not require PMRT review as the baby was not born, nor died, within the RUH. No further cases were reported or reviewed via PMRT during Q1.

PMRT referrals	Total
Stillbirths <24/40	0
Late Loss >22<24	0
Neonatal Death	0
Total Perinatal Deaths	0

Table 3: PMRT referrals

2.0 HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND MATERNITY SERIOUS INCIDENTS (SI)

2.1 HSIB FINDINGS

HSIB provide findings and recommendations to the Trust for service learning and improvements;

I. Findings reflect information that was discovered through analysis of the evidence collected during the investigation.
II. Safety recommendations are made to organisations when the findings identified during an investigation are considered to be contributory to the outcome.

A review of the findings and recommendations made by during 22/23 identified nine recommendations and 19 findings, some sit within two or more categories, therefore the overall totals below may differ from those above:

Category	Findings	Recommendations	Total
Communication		3	**3**
Escalation	5	3	**8**
Guidance	7	1	**8**
Fetal Monitoring	1	2	**2**
Clinical Oversight		3	**2**
Clinical Assessment	3	1	**4**
Triage	1		**1**
Resuscitation	1		**1**
Training	1	1	**2**

Table 4: Review of findings by category for 2022/23

One finalised report from HSIB during Q1 of 23/24 contained two safety recommendations; as the care episode occurred within Q3 of 22/23 these recommendations are incorporated above.

One HSIB referral was made within Q1 of 23/24; this has been declared as a Serious Incident (SI). Initial internal review of the care identified findings that have been categorised and incorporated into the table 5.

2.2 SI FINDINGS

No further internal SIs were declared in Q1.

2.3 SI CLOSURES DURING Q1

Two final reports were approved during Q1, the findings and recommendations have been categorised, some sit within two or more categories, therefore the overall totals below may differ from those above.

Category	Initial review finding/ Term Of Reference (incomplete reviews as of Q1 23)	Recommendations	Total
Communication	1	3	**4**
Escalation			
Guidance		4	**4**
Fetal Monitoring	1		**1**
Clinical Oversight			
Clinical Assessment	0	3	**3**
Triage			

Resuscitation	1		**1**
Training	1		**1**

Table 5: the findings and recommendations have been categorised

3.0 INCIDENT REPORTS

During Q1 there were 478 Datix submitted.

	Maternity	Neonatal Intensive Care Unit	Obstetrics
Apr 2023	125	12	12
May 2023	129	13	14
Jun 2023	140	15	18

Table 6: Incidents recorded on Datix by reporting speciality

Of these, the largest contributors were:

Category of report	Total
Unexpected Re-admission (inclusive of readmission of baby to ward)	60
Post-Partum Haemorrhage >1500mls	37
Perineal Tear -3rd Degree	29
Shoulder Dystocia	29
Apgar Score <7 at 5 minutes	24

Table 7: Clinical reason reported as an incident on Datix

A thematic review of neonatal re-admissions was conducted and presented to Speciality Governance in Q4. This identified problems with data capture and data quality, with significant disparity noted between the number of re-admissions recorded on the Millennium digital system and the Datix system.

This has been further complicated with staff 'work-around' developed to improve flow on the Maternity ward, postnatal ward attenders are being recorded on millennium as an admission to enable a quicker turnaround of laboratory results.

This process has caused difficulties capturing robust data for neonatal re-admissions into Maternity Services from one system. An in depth review of both our maternal re-admissions and postpartum haemorrhage rates is in progress.

4.0 TRUST CLAIMS SCORECARD - OBSTETRICS

The Trust's latest scorecard correlates open and closed claims received by the Trust legal team for 2022. We anticipate a new scorecard between July and September of 2023.

Obstetrics accounted for 18% of claims but represented 65% of the value of Trust claims. The scorecard outlines the top five injuries and top five causes resulting in legal claims because of care.

This is listed as volume of claims and value of claims.

Claims by value:

Top 5 injuries by value for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Cerebral Palsy	4	54,128,094	13,532,024	8%	45%
2	Brain Damage	4	33,960,551	8,490,138	8%	28%
3	Hypoxia	1	13,150,000	13,150,000	2%	11%
4	Not Specified	1	13,090,000	13,090,000	2%	11%
5	Renal Damage/ Failure	2	1,217,239	608,619	4%	1%
Total Top 5 injuries by Volume for Obstetrics		**12**	**115,545,884**	**9,628,824**	**24%**	**97%**

Top 5 causes by value for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail / Delay Treatment	9	27,435,620	3,048,402	18%	23%
2	Fail To Monitor 2nd Stg Labour	4	27,310,232	6,827,558	8%	23%
3	Fail To Make Resp To Abnrm FHR	3	20,242,379	6,747,460	6%	17%
4	Fail To Warn-Informed Consent	2	13,886,053	6,943,027	4%	12%
5	Fail To Act On Abnorm Test Res	1	13,600,000	13,600,000	2%	11%
Total Top 5 causes by Volume for Obstetrics		**19**	**102,474,284**	**5,393,383**	**37%**	**86%**

Table 8: Claims by value

Claims by Volume:

Top 5 injuries by volume for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Unnecessary Pain	11	775,997	70,545	22%	1%
2	Psychiatric/Psychological Dmge	7	479,644	68,521	14%	0%
3	Adtnl/unnecessary Operation(s)	6	627,939	104,657	12%	1%
4	Brain Damage	4	33,960,551	8,490,138	8%	28%
5	Cerebral Palsy	4	54,128,094	13,532,024	8%	45%
Total Top 5 injuries by Volume for Obstetrics		**32**	**89,972,225**	**2,811,632**	**63%**	**75%**

Top 5 causes by volume for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail / Delay Treatment	9	27,435,620	3,048,402	18%	23%
2	Failure/Delay Diagnosis	8	1,709,206	213,651	16%	1%
3	Intra-Op Problems	6	292,853	48,809	12%	0%
4	Foreign Body Left In Situ	4	60,437	15,109	8%	0%
5	Fail To Monitor 2nd Stg Labour	4	27,310,232	6,827,558	8%	23%
Total Top 5 causes by Volume for Obstetrics		**31**	**56,808,348**	**1,832,527**	**61%**	**48%**

Table 9: Claims by volume

5.0 QUALITATIVE FAMILY FEEDBACK DATA

Areas raised:

5. Birth Reflections
Women shared their experience of informed consent during their care feeling scared or coerced into decision making.

6. Complaints (n=1)/PALS (n=7):

- Bladder Care during care and subsequent follow up n=2

7. Maternity & Neonatal Voices Partnership (MNVP) Dec- Feb 23:
• Having to repeat history to different clinicians
• Support with breastfeeding to 'hold breast' inconsistency with breastfeeding advice
• Partners feeling ignored by sonography
• Lack of adequate meals for mothers who have 'missed meal times'
• Women feeling they have to agree to a vaginal examination
• Neonatal Care Service user engagement

8. Friends and Family forms:
Of 447 responses 4 forms identified their overall care as poor and 3 identified as very poor.

From the comments on all of the forms submitted these have been evaluated irrespective of overall experience and the sentiments have been subcategorised. Of all comments of our services the following themes were top contributors to negative sentiments:

- Timeliness n=6
- Communication n=6
- Resources n=5

Positive Feedback:

5. Birth Reflections
Positive experiences of transferring to theatre post birth with birth partners and babies.

6. Themes from compliments:

- HIPS service
- Care during an Induction of Labour (IOL)
  - Staff interactions
  – Kindness, compassion and friendliness of staff.

7. Feedback from MNVP Dec-Feb 23:
• Timely appointments
• Friendly midwives
• Midwives Supportive of decisions made to formula feed from birth
• Women choosing to birth at home felt supported in their decisions
• Explanations for medical processes clearly explained
• Good communication when a caesarean became necessary

8. Friends and Family forms:
Of the 447 response s received in Q1 397 rated their overall care experience as very good and 40 rated their care as good

From the comments on all of the forms submitted these have been evaluated irrespective of overall experience and the sentiments have been subcategorised. Of all comments of our services the following themes were top contributors to negative sentiments:

- Staff attitudes and Behaviour n=246
- Care and Treatment n=132
- Communication n=94

Table 10: Summary of family feedback

6.0 CQC SURVEYS – The 2022 Maternity CQC survey identified the following:

Table 11: CQC service user feedback

In response to these findings the service as developed an action plan as outlined in table 12.

Areas for improvement	Actions
B8 – Antenatal Care During your antenatal check-up, did your midwives or doctor appear to be aware of your medical history?	Paper personalised care plans (PCP) to mitigate time needed for procurement of new IT system. Commence PCP training for all staff Risk assessment at every contact.
C4 - Your labour and birth Were you given enough information on induction before you were induced?	Co-production of personalised care plans guideline. Co-produced guidelines and updated information leaflets which are easily accessible.
C5 - Your labour and birth of your baby Before you were induced, were you given appropriate information and advice on the risks associated with an induction of labour?	Co-production of personalised care plans. Co-produced and updated information leaflets which are easily accessible.
D7 - Postnatal care Was your partner or someone close to you able to stay with you as much as you wanted during your stay in hospital?	All visiting restrictions during COVID-19 have been lifted and partners/support person is able to stay throughout the whole hospital journey.

F14 - Care after Birth Were you given enough information about your own physical recovery after the birth?	Update discharge guidelines and information leaflet which are easily accessible. Ensure appropriate discussion at every postnatal contact. Implementation of pelvic health service.

Table 12: Action plan in response to CQC survey results

7.0 BOARD LEVEL SAFETY CHAMPION WALKABOUTS

Maternity and Neonatal Safety Champions complete monthly 'walk-around' and virtual listening events open to all with Maternity and Neonatal staff to discuss any concerns or queries they may have within the service.

The themes include:

- Staff awareness of recruitment into midwifery and progression from previous low staffing
- Staff interests in a self-rostering model
- Difficulties in car parking in community
- Concerns regarding Entonox emissions in community birthing environments
- Implementation of the home birth team and prospective models of care.

8.0 FREEDOM TO SPEAK UP GUARDIANS

No contacts have been made to the FTSU Guardians from Maternity or Neonatal Services in Q1 of 23/24.

9.0 COMMONALITIES & THEMATIC ANALYSIS 'INSIGHTS'.

Review of the above insights into RUH Maternity Services has allowed for the collation of themes and commonalities to be identified and present areas for focus, further exploration, and potential improvements.

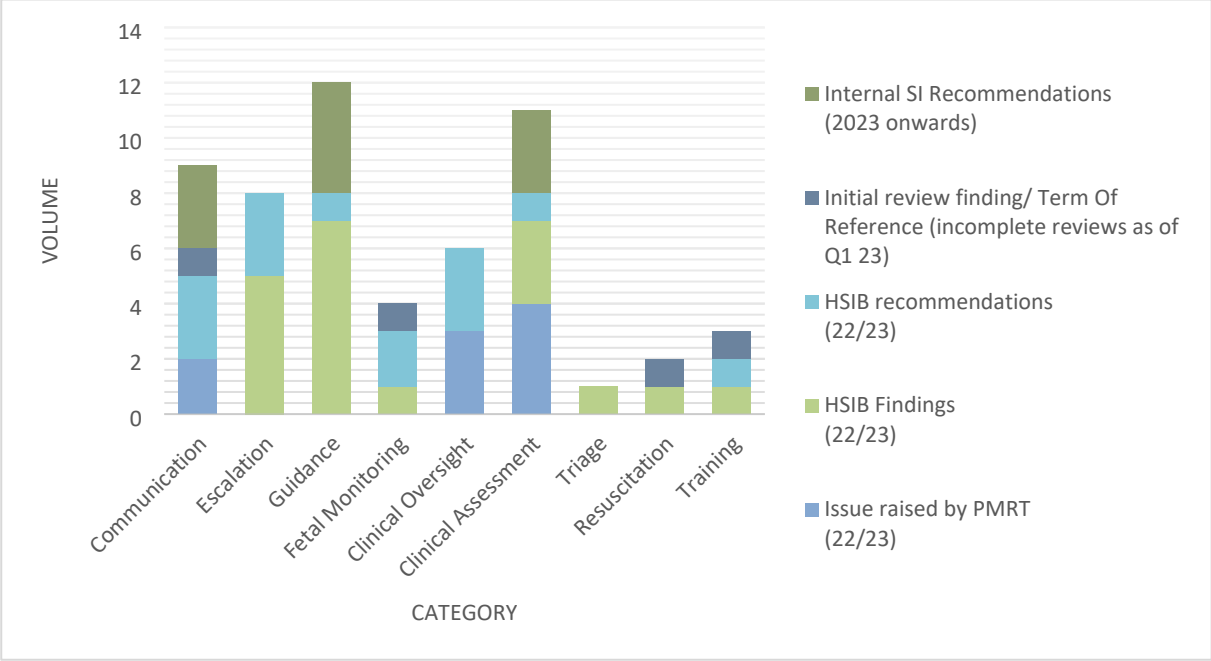


Table 13: Thematic and collated review of findings and recommendations by investigation route 22/23

Category	Issue raised by PMRT (22/23)	HSIB Findings (22/23)	HSIB recommendations (22/23)	Initial review finding/ Term Of Reference (incomplete reviews as of Q1 23)	Internal SI Recommendations (2023 onwards)	Total
Communication	2	0	3	1	3	**9**
Escalation	0	5	3	0	0	**8**
Guidance	0	7	1	0	4	**12**
Fetal Monitoring	0	1	2	1	0	**4**
Clinical Oversight	3	0	3	0	0	**6**
Clinical Assessment	4	3	1	0	3	**11**
Triage	0	1	0	0	0	**1**
Resuscitation	0	1	0	1	0	**1**
Training	0	1	1	1	0	**2**

Table 14: Identification of findings and recommendations by clinical category

When aligning the categories of recommendations and findings from case reviews in maternity and neonates from 22/23, the areas requiring improvement become clearer.

9.1 AREAS REQUIRING IMPROVEMENT

9.1.1 CLINICAL ASSESSMENT

Although identified as the top contributory category, further analysis of the individual findings, recommendations have shown a singular commonality within Symphysis Fundal Height Measurements within 2 HSIB findings and 1 PMRT issue raised. All other findings showed no commonalities.

Sub category of clinical assessment	Total n=11
Fundal Height measurements not plotted on a chart	3
Although indicated the mother was not offered infection screening for herself or her baby	1
Cabergoline was not given to supress lactation	1
The mother had a history of recurrent miscarriage but she did not receive appropriate pre-conception management	1
The Trust should ensure that the investigations following an unexpected stillbirth are standardised and completed in line with national recommendations (RCOG 2010).	1
The Mother was not reweighed at 36 weeks in line with local guidance	1
Decision for IOL	1
Provision of Intrapartum antibiotic prophylaxis	1
Mothers and their partners should be involved in all decisions regarding their care. These conversations should include a discussion of the options, risks, benefits and alternatives and should be clearly documented in the notes.	1

Table 15: Sub categories found within the clinical assessment category

We currently conduct 3 clinical audits featuring the measurement and plotting of SFH as an audit standard, these continue as part of the annual audit programme as per the Saving Babies Lives Care bundle V3. The latest audit results from Q4 of the reports for 22/23 are as follows:

	SFH measured	SFH Plotted on SFH chart	Referred for SFH abnormal	Normal Growth on USS	SGA identified
Abnormal SFH measurements x9	9/9	8/9	9/9	5	4
Normal SFH measurements x5	5/5	3/5	N/A	N/A X5 all normal SFH measurements	N/A
Totals x14	**100% 14/14**	**79% 11/14**	**100% 9/9**	**10**	**4**

Table 16: Findings of the SFH audit results for Q4 22/23

Risk Factor for SGA	Referred to Consultant Care	Aspirin indicated	SFH measured	SFH Plotted on SFH chart	Referral if SFH abnormal	Normal Growth on USS	SGA identified	Postnatal Stay of at least 3 days
Smoker x 1	1/1 (1/1 referred for smoking cessation.)	0/1 (previous SGA)	1/1	0/1	N/A	0	1	yes
Twin x 2	2/2.	2/2	N/A	N/A	N/A	2	0	yes
Low Pappa x 1	1/1	1/1	1/1	1/1	1/1	1	0	yes
BMI 17 x 1	N/A	N/A	1/1	1/1	N/A	Normal SFH measurements x1	0	Yes
No Risk Factors X2	N/A	N/A	2/2	2/2	1/1 1 x N/A	1 + 1 with normal SFH measurements	0	1/2
Totals x7	**100%**	**75%(3/4)**	**100%**	**80%(4/5)**	**100%**	**4 + 2 with normal SFH measurements**	**1**	**86% (6/7)**

Table 17: Audit findings from the Small for Gestational Age audit under the 3rd centile Q4 22/23

Risk Factor	Referred to Consultant Care	Aspirin if indicated	SFH measured	SFH Plotted on SFH chart	Referred if SFH abnormal	Normal Growth on USS	SGA identified
Raised/Low BMI x 6	5/5 health in pregnancy 1 N/A 5/5 Consultant care 1N/A	6 N/A	6/6	5/6	1/1 5 N/A	5 + 1 who had no USS N/A to referral(low BMI)	0
Smoker x 13	10/10 3N/A to smoking cessation see comments	6/7 3 x SGA 4 x twins	9/9 4 N/A twin	5/9 4 N/A twin	3/3 6 N/A as normal	9	4
Previous SGA x 2	2/2	2/2	2/2	2/2	2/2	0	2
Low Pappa x 2	2/2	2/2	2/2	2/2	N/A	2	0
Twin x4	4/4	4/4	N/A	N/A	N/A	2	2
IVF	1/1	N/A	1/1	1/1	N/A	1	0
PV Bleed in Early Pregnancy	1/1	N/A	1/1	1/1	N/A	1	0
Totals	**100% 25/25**	**93% 14/15**	**100% 21/21**	**76%16/21**	**100% 6/6**	**21**	**8**

Table 18: Audit findings from the Small for Gestational Age audit under the 10rth centile Q4 22/23

The findings of the 3 clinical audit reports indicate an overall good compliance with the measurement and plotting of Symphysis Fundal Height in line with current local and national guidance, and 100% for referral further review where SFH is as abnormal.

9.1.2 GUIDELINES

A significant number of clinical guidelines have expired or are near to expiry which is on the risk register, risk 2147, score 12. All actions towards improvement and mitigation of this risk will be monitored via the risk register.

As of 30 June 23, there are 29 guidelines, 9 standard operating procedures and 4 policies out of date. This is a 45% reduction since March 2023. It is anticipated this risk will be reduced if projections are achieved in the next 3-6 months, however this will require close monitoring.

9.2 Triangulation of qualitative and quantitative data

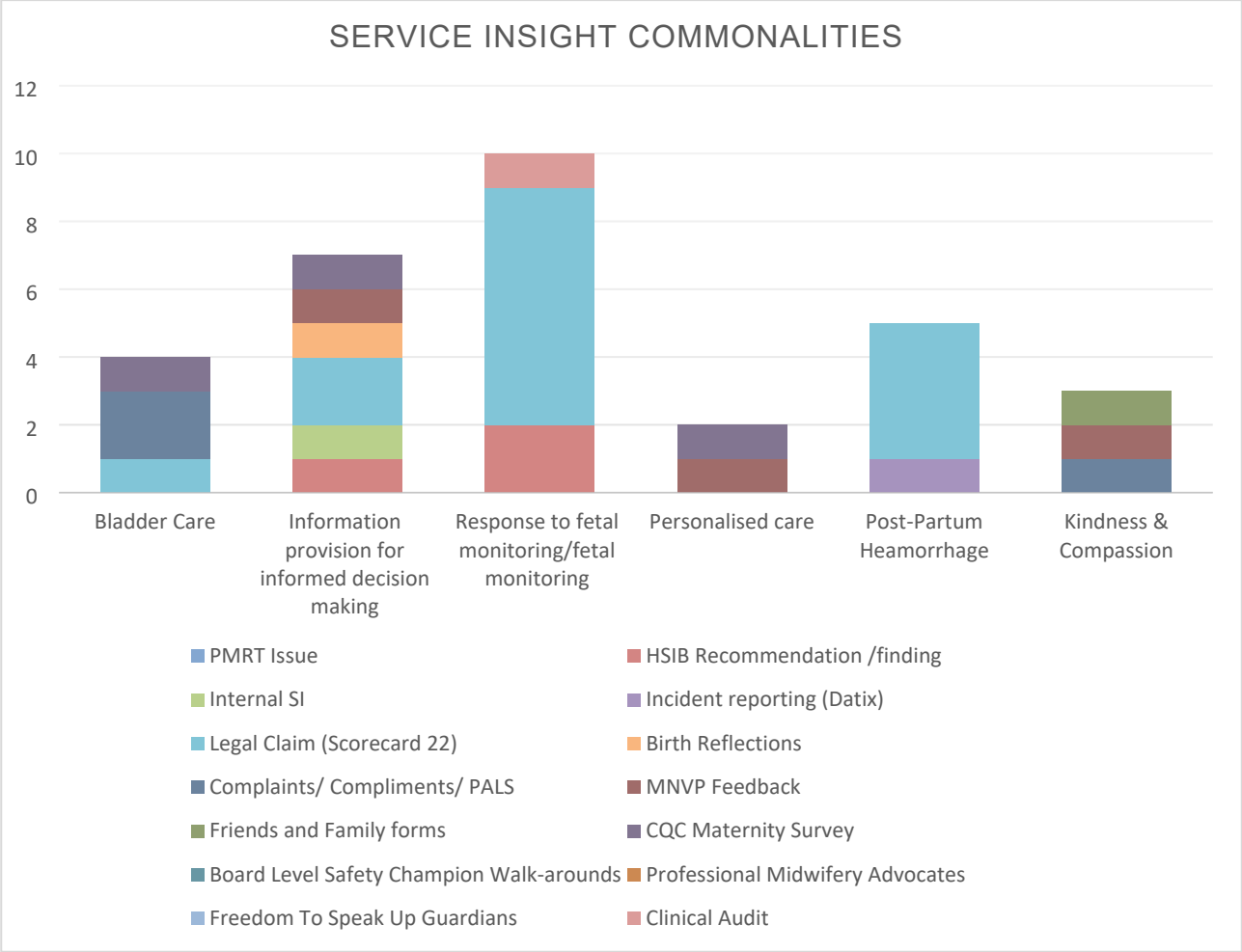


Table 19: Thematic and collated review of qualitative and quantitative service insights 22/23

9.3 AREAS REQUIRING IMPROVEMENT

9.3.1 BLADDER CARE

Bladder care issues fall under the remit of the perinatal pelvic health service, the RUH is part of a national pilot for the provision of a perinatal pelvic health service. A specialist perinatal pelvic health midwife commenced in post during November of 2022, a specialist pelvic health physiotherapist commenced in December of 2022. As part of their specialist roles they are reviewing bladder care provision and developing a bladder care policy with key stakeholders. The specialist midwife conducts a weekly ward round on our postnatal ward providing support and bedside training to midwives and identifying any potential areas for improvement within clinical practice. The services has recently procured two portable bladder ultra sound scanners (USS) to increase the access to bladder USS for women in maternity services.

9.3.2 RESPONSE TO ABNORMALITIES IN FETAL HEARTRATE/FETAL MONITORING

Fetal monitoring was identified in one HSIB recommendation, one incident finding, and internal clinical audit as an area for improvement. Fetal monitoring was identified within

seven claims featured within the 2022 claims scorecard; however, the dates of care within the scorecard range from 2012 to 2017. It is acknowledged that the opportunities and aspects of learning from these incidents may have been lost, as guidance, training requirements, and clinical practice regarding intrapartum fetal monitoring provision has changed since 2017. There is also a protracted period between birth and childhood diagnosis, which often precedes a legal claim.

Fetal monitoring has not been identified as a top contributory finding at RUH by HSIB; this is in contrast to the national theme in figure 1. Only one case identified fetal monitoring in 22/23, but it was not felt to have contributed to the clinical outcome.

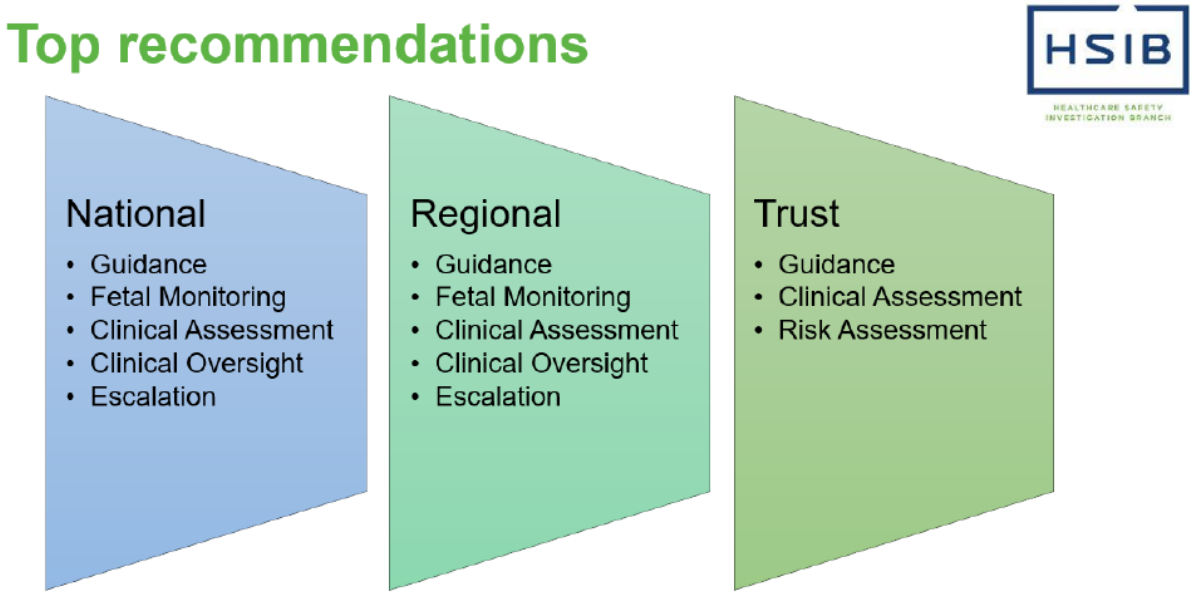


Figure 1: HSIB national thematic analysis featured within HSIB quarterly review for RUH Apr 23

A quality improvement initiative was launched in Q1 of 23/24, specifically focused on the provision of intermittent auscultation during the second stage of labour in response to our local clinical audit, and initial learning from a recent HSIB referral.

During Q1 of 23/24, the national Saving Babies Lives Care Bundle version 3 has been reviewed, which encompasses the element of 'intrapartum fetal monitoring', recommendations and standards. Progress towards full implementation of all elements and recommendations of this package will be monitored via Specialty and Divisional governance.

9.3.3 POST PARTUM HAEMORRHAGE

Postpartum haemorrhage was identified as a top contributor to local incident reports, on review of the 2022 claims scorecard, it identified that haemorrhages resulted in four claims within the varied categories of failure/delay treatment, inappropriate treatment and foreign body left in situ. The latest legal claim reported within the scorecard of 2022 relates to care in 2019.

It has been identified that the Trust is currently experiencing a higher-than-average rate of post-partum haemorrhage (PPH) in comparison to the national average. However, it is acknowledged that as a standard practice to weight all blood loss, unlike standard practice to estimate. This may account for the disparity when benchmarking against national averages, the higher-than-average rate is a shared finding with providers within Local Maternity and Neonatal Service (LMNS), all local providers weigh blood loss.

A case cohort review is currently taking place looking at the pre-disposing risk factors, identification of risk, identification of the emergency, emergency management, and any modifiable factors to inform future improvements, if required, with an aim to reduce haemorrhage post birth. Findings of this review will be shared within specialty governance, and the LMNS to report back via The LMNS to the South West Perinatal Quality Surveillance and Support Group (PQSSG)

9.3.4 PERSONALISED CARE

Paper personalised care and support plans (PCSP) have been developed with key stakeholders including the MNVPP and service users, roll out is scheduled for September, accompanied by staff training.

A working group has been established, following feedback to improve the user experience and reduce duplications. PCSPs will be used in conjunction with the birthing person's maternity record to ensure care is individualised.

9.3.5 INFORMATION PROVISION FOR INFORMED DECISION MAKING

The provision of all the information required for birthing people and their families to make informed decisions regarding their care, and what matters to them, is a legal obligation as outlined by the 'Montgomery ruling' of 2015. This ruling stated that 'patients can expect a more active and informed role in treatment decisions, with a corresponding shift in emphasis on various values, including autonomy, in medical ethics' (BMJ, 2017).

As part of the PSCP launch in September, the PCSP contains information regarding decision-making and informed choices including the application of the 'BRAIN' pneumonic:
B - Benefits
R - Risks
A - Alternatives
I - Intuition
N – Nothing

This is used to empower birthing people in shared decision making with clinicians, during their pregnancy, labour, and birth.

9.3.6 KINDNESS AND COMPASSION

It is pleasing to see that the kindness and friendliness of staff as a feature of feedback from the MNVPP received during December to February, formal compliments made to the service, and the Friends and Family form sentiment feedback during Q1. This feedback will be fed back to our teams via the Maternity Newsletter.

10. RECOMMENDATION

The Quality Governance Committee is asked to receive and discuss the content of the report.

Appendix 2.

Transitional Care Pathway and ATAIN Audit Q1 2023/2024

Contents

Executive Summary

Background

This audit has been completed to support 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

- Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising the separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.
- The pathway of care into Transitional Care (TC) has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care Board (ICB) quality surveillance meeting each quarter.
- The number of admissions to the neonatal unit that would have met TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues.
- 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.
- A data recording process for capturing existing transitional care activity, (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.) has been embedded. The data should capture babies between 34+0-36+6 week's gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.
- Analysis of staff/parent data captured via a questionnaire around satisfaction and quality and safety of care.
- Reviews of term admissions to the Neonatal Unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion evidence that progress with the action plan has been shared with the neonatal maternity safety champion, and Board Level Champion, LMNS and ICB quality surveillance meeting each quarter.
- Monthly reviews of unanticipated term admissions to the NNU to determine whether there were modifiable factors that could be addressed as part of an action plan.
- An audit trail is available which provides evidence that reviews of all term babies transferred or admitted to the NNU, irrespective of their length of stay.

A high-level review of the primary reasons for all admissions is completed, with a focus on the main reason(s) for admission through a deep dive, to determine relevant themes to be addressed. This is discussed at a monthly multi-disciplinary (MDT) ATAIN meeting.

Key findings

Standard	Compliance April 2023	Compliance May 2023	Compliance June 2023
Audit findings shared with neonatal safety champion	**100%**	**0 (Not in post)**	**0 (Not in post)**
The number of admissions to the Neonatal Unit (NNU) that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues	**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	**10**	**0**	**7**
% of shifts TCP nurse provided as per TCP staffing model	**100%**	**100%**	**99%**
TCP open	**100%**	**100%**	**100%**
Number of babies readmitted to neonatal unit from TCP	**0**	**0**	**1**
Avoidable term admissions 37+0 weeks gestation and above to the neonatal unit	**0**	**1**	**1**
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	1	**0**	**0**

Clinical Audit Report

Audit Findings

The findings of the audit demonstrates that there has been an improvement throughout the quarter in achieving and providing the correct staffing model for the Transitional Care Pathway service as staffing levels improve. Achieving the correct staffing model has been assisted by an increase in the number of babies cared for on the Transitional Care Pathway this quarter, providing the TCP nurse to have a full allocation of babies.

Transitional Care Audit Findings

- In Q1, 59% of the total number of admissions to the Neonatal Unit (NNU) (97 babies) were cared for on the TCP, for some or part of their admission. Out of this 39%, (64 babies) spent the entirety of their admission on the TCP.

- No babies were identified as missed opportunity for TCP. The number of babies being cared for on the TCP is increasing each quarter, which demonstrates commitment to keeping mothers and babies together.

- One baby in Q1 was relocated from the TCP to NNU due to mother not able to stay for the duration of admission due to home personal circumstances.

- The TCP achieved 100% staffing in Q1. This is an improvement on previous audits and shows the continuing improvement on staffing levels.

ATAIN Audit Findings

- This quarter has highlighted at the MDT ATAIN meeting, two avoidable admissions to the NNU. One of these babies were identified by the maternity MDT team as avoidable and the other identified by the paediatric team.

- One case identified a delivery could have been expedited in response to a pathological Cardiotocograph, with missed opportunities to have received a septic screen during labour.

- The second case was identified as avoidable as the baby had stabilised on admission to the LNU and did not need ongoing observations, therefore could have immediately been reunited with its mother. However the baby stayed in the LNU for 3 hours.

The cases have both highlighted learning that will be cascaded to the teams. Learning has been highlighted on Safety Briefs and Quality Board displays. In the maternity case, an amendment has been made to the current fetal monitoring guideline to support staff with care provision.

In Q1, all term admissions that have been admitted to the LNU and required non-invasive respiratory support are being reviewed. The review includes treatment, length of stay, and time of admission and discharge. The rationale is to identify what care changes can be made to expedite the repatriation of the baby to the care of their mother when it is clinically safe to do so. This will potentially involve increasing our use of the transitional care services.

In line with the Standard 3, reviews are carried out of all Neonatal Unit transfers or admissions regardless of their length of stay, including internal transfers within the RUH to the LNU. This includes Emergency Department and the Children's ward. In Q1, one baby was admitted to the LNU from the Children's ward with significant apnoea, fitting and subsequent diagnosis of meningitis. Following stabilisation with medication for the seizures, the baby was transferred back to the Children's ward. This was reviewed and agreed as an appropriate management plan.

When babies are admitted to the LNU, wherever possible, parents are offered a bed; this may not always be beside their baby, in parent accommodation adjoining the LNU.

Q1 Practice Improvements

- New-born Early Warning Trigger and Track (NEWTT2) charts and toolkit are due to be implemented on TC babies in Q2 2023-2024. The NEWTT2 chart and framework encompass parental concern to acknowledge the importance of the opinion of the family in addition to the wider multi-disciplinary team. This extended framework provides an escalation tool and a standard response and review tool for the multidisciplinary team to use jointly. The framework uses the PIER principles adopted by the National Patient Safety Improvement Programme. The total NEWTT2 score informs the escalation response including who is responsible, and the timing of a review and supports further escalation if required.

- With improved staffing and compliance to the staffing model for TCP, we have been able to facilitate more babies who require nasogastric tube (NGT) feeding. Six babies were cared for on the TCP requiring some nasogastric feeding; this is four more than last quarter. Discussion for plans to move to next phase of TCP in progress to support more babies requiring NGT support on TCP, reducing rates of separation of mothers and babies.

- The LNU now have a named link midwife for TCP to improve communication and collaborative working. Formation of a TCP working group in the process of being established. This group will be made up staff across all grades from neonatal unit, to work collaboratively with a maternity representative. Aim: To work together to implement change and improve and progress TCP service.

- Assessment of all term admissions requiring non-invasive respiratory support, ensuring their plan of care optimises their chances in being safely reunited with their mother as soon as clinically possible.

- During Q1, excellent practice was noted. A baby being nursed on the TCP who needed triple phototherapy for ABO incompatibility and bruising. Previously a baby with the clinical history of ABO incompatibility and bruising would have been admitted to the LNU for treatment, with input from the TCP nurse. However, the baby stayed with their mother and received all its necessary treatment under the TCP.

Neonatal Services Transitional Care and ATAIN Action Plan

Action	No	Details	Progress	Lead	Due	RAG status	Completion date
1. What do we Need? **Pathways of care into transitional care have been jointly approved by both neonatal and maternity teams.** The aim of the transitional care pathway is to minimise separation of resident mothers and their babies.							
There are care pathways for those babies who meet the criteria for the transitional care pathway	1.1	Pathways and criteria have been agreed by both maternity and neonatal teams	Completed when the transitional care pathway was established	Maternity and Neonatal Transitional Care Lead			Complete
Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice	1.2	Babies admitted onto the transitional care pathway have details recorded on the BadgerNet database. This database evidences that the baby has at least one element of the HRG XA04	Completed with each admission and validated by neonatal data clerk	Neonatal transitional care lead			Complete
2. What we need? **An explicit staffing model for the Transitional Care pathway** The staffing model needs to meet the BAPM staffing model for transitional care							
The neonatal rota provides an explicit	2.1	The rota allocates 1 neonatal nurse to care for 4 transitional care	Quarter 4 2022/2023 demonstrated compliance of the staffing model only 98% of the time.	Neonatal transitional care lead and Paediatri			com plete

staffing model for nursing care of the babies on the transitional care pathway		babies Staff vacancy factors, maternity and sick leave, are impacting on the ability to provide a nurse to the transitional care pathway at times	Staff recruitment has been successful into the B5 vacancies and by Summer 2023 we will be fully established on B5 and B4 Whenever possible the separation of mother and baby has been avoided. At times, this has meant that the TC nurse has had to care for babies on the TCP and babies on NNU. When we feel the safety of all the babies under our care maybe compromised, and we are unable to provide a safe staffing model to babies on the transitional care pathway, babies are brought to the neonatal unit and separated from their mother. Prior to separating the mother and baby the neonatal escalation policy will have been actioned and a datix submitted. This has not occurred in Q4	c Matron			

3. What we need? **The Transitional Care policy has been fully implemented and quarterly audits of compliance with the policy and guideline criteria are conducted.** Audit findings are shared with the neonatal safety champion on a quarterly basis							
Audit findings are shared with the neonatal safety champion on a quarterly basis.	3.1	Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions	Data is collected continuously Quarter 1 2023/2024 audit findings and the learning has been shared with the neonatal safety champion. A new nurse Consultant has been appointed and is now the neonatal safety champion.	Neonatal transitional care lead and Neonatal safety champion			

Report to:	**Public Board of Directors**	**Agenda item:**	**13.2**
Date of Meeting:	**6 September 2023**		

Title of Report:	**Bi-annual, Maternity and Neonatal Staffing Report**
Status:	**For discussion**
Board Sponsor:	**Antonia Lynch, Chief Nurse**
Author:	**Zita Martinez, Director of Midwifery**
Appendices	**None**

1. Executive Summary of the Report

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set their staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings.

This report gives a summary of all measures in place to ensure safe midwifery staffing; including clinical and specialist workforce planning, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus (BR+) Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, neonatal nursing and red flag incidents

BR+ is the only recognised national tool for calculating midwifery staffing levels. The Trust commissioned a full review in 2022 to meet Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST), Maternity Incentive Scheme (MIS); this report was published in April 2023. The report identified an increase in acuity and dependency across maternity services and therefore identified a need to increase establishments in clinical and non-clinical roles. This will require investment to meet year 5 of the Maternity Incentive Scheme. As a result of the change in acuity, the midwife to birth ratio will change in July from 1:28 to 1:24. Funding for an increase in establishment has not yet been sourced.

Bath and North East Somerset, Swindon and Wiltshire (BSW) Academy undertook a workforce planning review for the Local Maternity and Neonatal System (LMNS) in March 2023. The headroom for qualified midwives was reviewed, taking into consideration the statutory and mandatory training requirement, sickness, annual leave and maternity leave. The recommendation to the Local Maternity and Neonatal System was a headroom requirement of 28% for all midwives. The Trust's current headroom is 20% built into the funded establishment.

Over the past 12 months, maternity staffing has improved; by September 2023 there will be no substantive vacancies for band 5 and 6 midwives. There is a significant reduction in turnover and demonstrates stabilisation in the service.

Monthly audit of supernumerary status of the labour ward co-ordinator and 1:1 care in labour highlights a high level of compliance.

2. Recommendations (Note, Approve, Discuss)

To 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). Trust to support Birth plus report 2022	

4.	Risk related to staffing (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)	
392	Obstetric and gynaecology workforce risk	15
2417	Maternity triage	12
2467	Maternity workforce	12
1763	Lack of AHP support- Dietician, psychology, OT and Physio in the NNU	8
1768	Maternity redesign staffing impact	4
1948	Obstetric ultra sound scan capacity	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.	

	References to previous reports/Next steps
MIS combined Maternity and Neonatal Safety report, Q4 22-23 MIS combined Maternity and Neonatal Safety report, Q1 23-24 BirthRate + report data from 2022, presented 2023 Perinatal Quality Surveillance Tools, January – June 2023 MIS Year 4 Board declaration paper, January 2023	

8.	Freedom of Information
Public.	

BI-ANNUAL MIDWIFERY, MATERNITY 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) requirements.

1.2 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings.

2.0 Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including clinical and specialist workforce planning, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, neonatal nursing and red flag incidents

3.0 Birth rate Plus Workforce Planning

3.1 Birth Rate Plus (BR+) is the only recognised national tool for calculating midwifery staffing levels, the Trust commissioned a review in 2022 to meet Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST), Maternity Incentive Scheme (MIS). MIS established 10 Safety Actions to support safer care, Trusts that demonstrate achievement of all 10 Safety Actions recover the additional 10% of the maternity contribution charged under the scheme plus a share of the monies paid in to the scheme by the hospitals that did not achieve.

4.0 Maternity Incentive Scheme

4.1 Safety Action 5 - To demonstrate an effective system of midwifery workforce planning to a required standard.

i. Complete a systematic, evidence-based process to calculate midwifery staffing establishment
ii. Trust Board to evidence midwifery staffing budget reflects establishment as calculated in above
iii. In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BR+ or equivalent calculations
iv. Where Trusts are not compliant with a funded establishment based on BR+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls
v. The plan to address the findings from the full audit or table top exercise of BR+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners

4.2 The April 2023 report evidenced a variance between the current funded establishment and required clinical and non-clinical establishment (specialist midwives) to support safe staffing at the RUH. These findings are summarised in the table below:

Clinical and Non-clinical variance from current establishment.

Current Funded Clinical, Specialist, Management wte	% Uplift	Birthrate Plus wte	Variance wte
190.10	20%	202.03	-11.93
190.10	24%	211.01	-20.91
190.10	28%	220.70	-30.60

Table 1: Funded establishment vs the gap analysis required to uplift the establishment based on 20, 24 and 28% headroom

4.3 There is an ongoing maternity business case, which incorporates the BR+ findings; currently there is no identified funding stream to support an uplift in establishment. If funding is not identified, the Trust will not achieve compliance with year 5 of the Maternity Incentive Scheme.

4.4 The headroom for qualified midwives was reviewed by the BSW Academy in conjunction with the Directors of Midwifery across the Acute Hospital Alliance. Taking into consideration the statutory and mandatory training requirement, sickness, annual leave and maternity leave, the analysis recommended to the Local Maternity and Neonatal System that a headroom of 28% was required for all midwives; RUH currently has a headroom of 20% built into the funded establishment.

4.5 The Ockenden Final report advised maternity services, as part of effective workforce planning review, minimum staffing levels (to include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave).

4.6 The increase in establishment is influenced by a number of local and national drivers;

i. Increase of women and birthing people's complex needs
ii. Increase of cascade of interventions due to national ambition to reduce poor outcomes
iii. The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes all have an impact upon the required midwifery input
iv. Transitional care is now provided on the ward rather than in neonatal units.
v. Safeguarding needs require significant input, which put higher demand on the workload
vi. Reduced antenatal admissions and shorter postnatal stays requires sufficient community midwifery resource

vii. Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and midwifery support roles

viii. Triage covers a 24-hour period, seven days per week, with two midwives throughout the 24-hour period and an additional midwife for 24 hours per day is required to provide effective telephone triage

ix. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians

x. Cross border, activity impacts on community resources

xi. The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation; consequently, more women are meeting their midwife earlier. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss.

4.7 In addition to these posts, consideration needs to be given to recommendations from national reports such as Ockenden and MIS concerning new roles required to support safer high quality maternity services, for example the inclusion of Consultant Midwife posts.

5.0 Recruitment and retention

5.1 Over the past 12 months maternity staffing has improved; by September 2023 we will have no substantive vacancy for band 5 and 6 midwives. The BR+ has evidenced a need for an uplift in establishment, once funded we will actively recruit into these vacancies.

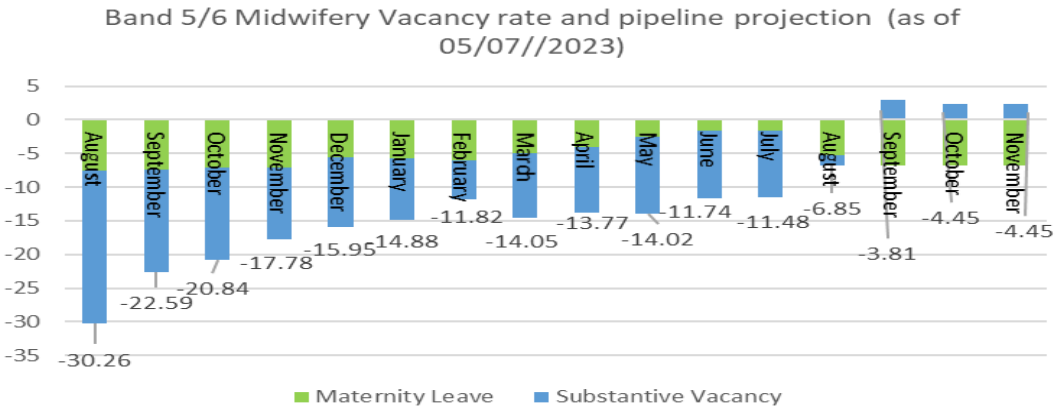


Figure 1: Band /6 midwifery vacancy rate and pipeline projection

5.2 Over the past 12 months, the service has had an active recruitment campaign, including national and local advertising, successful recruitment of eight Internationally Educated Midwives, two Nurses undertaking the nurse to midwife MSc conversion course.

5.3 The success of the retention team has supported 100% retention of our Newly Qualified Midwives (NQM) who commenced in August 2022.

5.4 The table below details the number of midwives who have left the maternity service since January 2023. This is a significant reduction in turnover and demonstrates stabilisation in the service.

Month	Band 5 Leavers	Band 6 Leavers
January 23	0	0
February 23	0	1.31
March 23	0	0
April 23	0	0
May 23	0	1
June 23	0	0
Total	0wte	2.31wte

Table 2: Midwifes leaving the Trust by month

6.0 Fill rates

6.1The chart below highlights the improved midwifery fill rates during over the past 6 months. There is a slight decrease in June 2023 rate; this is due recent appointments of midwives into specialist midwifery roles and NQM undertaking a 3-month placement into the community.

Month	Day qualified %	Night qualified %
Jan 2023	90.4%	95.9%
Feb 2023	90.9%	90.1%
March 2023	89.9%	85.1%
April 2023	83.7%	82.6%
May 2023	93.3%	93.1%
June 2023	88.2%	89.8%

Table 3: Fill rates by day and night

7.0 Escalation

7.1The service continues to monitor staffing on a daily basis; the improved staffing in the acute maternity unit has reduced the requirement to redeploy community midwives between January and May. However, in June there has been an increase in redeployment due to acuity and complexity in the acute setting.

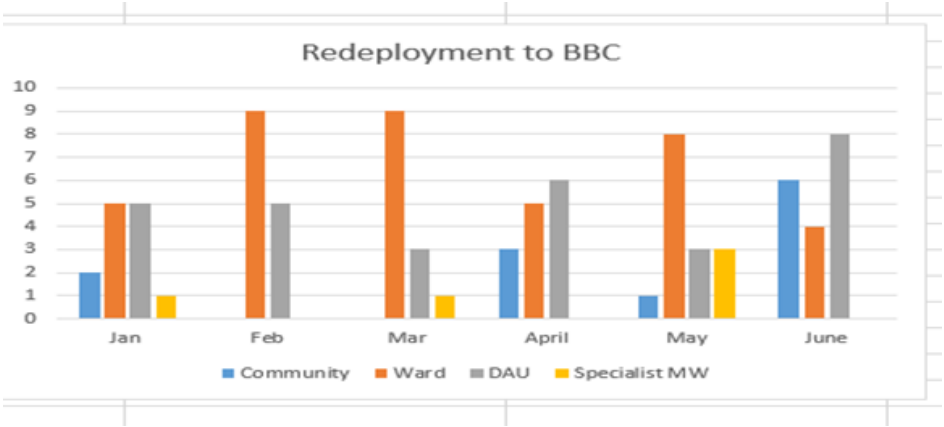


Table 4: Redployment encounters from community sites to the Bath Birthing Centre

7.2 When staffing is less than optimum, the following measures are taken to maximise staffing into critical functions to maintain safe care for the women and their babies in line with the Maternity Escalation Policy:

- Request midwifery staff undertaking specialist roles to work clinically
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained
- Activate the on call midwives from the community to support labour ward
- Request additional support from the on call midwifery manager
- Liaise closely with maternity services at opposite sites to manage and move capacity as required (mutual aid)

7.3 Although the staffing position has stabilised over the past 6 months, there is an on-going requirement for out of hours on call support within the service. 73 hours of midwifery on call hours have been used in the last 6-month period to support activity and acuity within the acute unit.

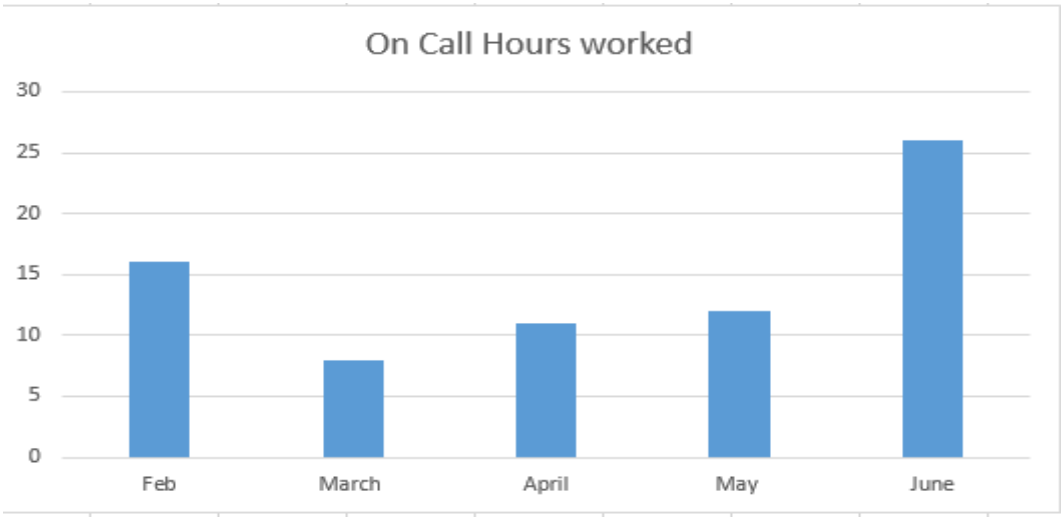


Table 5: On call hours used to provide safe midwifery care

8.0 Birth to Midwife ratio

The birth to midwife ratio was previously calculated by Birth Rate + as 1:28 and the compliancy is reported in table 6.

The birth to midwife ratio has been increased following the latest BR+ report to 1:24, and this standard will be introduced in July 2023.

Month	Target	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023
Birth to midwife ratio	1.28	1.33	1.28	1.31	1:31	1:29	1:32

Birth to Midwife ration (including bank)	1.28	1.30	1.25	1.29	1.28	1.25	1.28

Table 6: Compliance with the midwife to birth ratio

9.0 BR+ Live Acuity Tool

9.1 The BR+ Acuity Tool is utilised to assess 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatal care. It is a measure of 'acuity' and the system is based upon the clinical indicators used in the well-established BR+ workforce planning system.

9.2 The BR+ classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one to one care in labour for all women and increased ratios of midwifery time for women in the higher needs categories.

9.3 Availability of a supernumerary labour ward co-ordinator (LBW) is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support and guidance to clinical staff and able to manage activity and workload through the labour ward without having a caseload to manage or a labouring woman. Compliance for the past 6 months is demonstrated in table 7.

	Number of days per month	**Number of shifts per month**	**Compliance**
January 2023	31	62	99%
February 2023	28	58	99%
March 2023	31	62	97%
April 2023	30	60	100%
May 2023	31	62	100%
June 2023	30	60	100%

Table 7: Compliance with the supernummary labour ward coordinator

9.4 Table 7 identifies an improvement in staffing from April 2023. Review of incidents and outcome data provided assurance that the three months when 100% compliance was not achieved and did not require the LBC to provide 1:1 care in labour or negatively impact on safe care.

9.5 Women in established labour are required to have one to one care and support from an assigned midwife to ensure the safe, high quality provision of care. If there is an occasion where one to one care cannot be achieved then this will prompt the labour ward co-ordinator to follow the course of actions, which may be clinical or management actions or following the escalation policy.

Table 8 outlines compliance for the past 6 months

	Jan	Feb	March	April	May	June
1:1 in established labour- Bath Birth Centre	100%	100%	100%	100%	100%	100%

Table 8: Compliance with one to one care in established labour

10.0 Neonatal nursing staffing

10.1 The neonatal service has recently recruited to the Nurse Consultant post, this role provides clinical leadership within the unit, and this post was vacant from April to June. We have recruited into the B7 vacancy with anticipated start date in September. There is an active recruitment plan to address outstanding vacancies, the table below represents Neonatal WTE staffing vacancy for this period.

Neonatal Staffing Quarter 2 April – June 23.

Month	Band 5	Band 6	Band 7
April 23	**-2.34 WTE**	**-2.67 WTE**	**-0.52 WTE**
May 23	**-2.34**	**-2.67**	**-0.52**
June 23	**-2.34**	**-2.67**	**-0.52**
Total	**-1.34**	**-2.67**	**-0.12**

Table 9: Neonatal Staffing Q1

10.2 Neonatal nursing staffing

10.3 All ITU and HDU patients should be cared for by a nurse who is Qualified in Speciality (QIS) trained, for special care babies it is best practice if nurses are QIS trained although standards can still be met if supervised by a QIS nurse. The unit also requires one QIS trained nurse in charge and one for Traditional Care on each shift. The target is for 70% of the nursing staff to be QIS trained. The current QIS compliance is 63% with 3.4WTE starting their QIS training in September and December which would increase our QIS to 72%.

The following table represents the neonatal nursing staffing provision based on patient acuity in line with British Association of Perinatal Medicine (BAPM) service specifications over the review period. This demonstrates a stable position over the last 6 months.

BAPM SERVICE SPECIFICATION FOR NEONATAL NURSING STANDARDS

MONTH	DAY SHIFT	NIGHT SHIFT
JANUARY 2023	93.6%	87.1%
FEBRUARY 2023	89.3%	92.8%
MARCH 2023	100%	100%

APRIL 2023	96.7%	100%
MAY 2023	100%	100%
JUNE	96.7%	86.7%

Table 10: BAPM service specification for Neonatal Nursing Standards

10.4 Allied Health Professional Neonatal staffing

The BAPM standards also recommend integrating allied health professionals (AHP) within the neonatal service to enhance service provision to optimise short and long-term neurodevelopment and mental health of infants and their families; this is advocated in the Neonatal Critical Care Report (2019).

The Neonatal AHP staffing for this period is as below.

BAPM recommendations	Hours Funded by Operational Delivery Network funds	Total hours provided within Trust
0.8 WTE Physiotherapist	0.2 WTE	0.2 WTE
0. 7 WTE Dietitian	0.2 WTE	0.3 WTE
0. 8 WTE SALT	0.2 WTE	0.2 WTE
0. 9 WTE Psychology	0.2 WTE	0.4 WTE
0.8 WTE Occupational Therapy	0.3 WTE	0.3 WTE

Table 11: The Neonatal AHP staffing for this

The Division are reviewing the gap in funding and WTE provision.

11.0 Recommendations

Maternity services are a high-risk specialism where 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.

1. The Trust to support the findings of the current BR+ report for both clinical and non-clinical midwifery and maternity funding stream.
2. Evidence of an agreed plan and timescales to ensure midwifery staffing budget reflects the new BR+ establishment report findings.
3. The senior maternity leadership team to continue to support a robust recruitment process.
4. The Trust to continue to seek funding for all externally funded posts.

5. The Trust to continue to seek funding for the additional clinical midwifery posts, senior specialist midwife and non-clinical leadership.

6. Continue to work towards compliance with British Associate of Perinatal Medicine standards for Neonatal Medical and Nursing staff.

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

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**16**
Date of Meeting:	**6 September 2023**		
Title of Report:	**Alert, Advise and Assure Report – People Committee**		
Status:	**For discussion**		
Author:	**Paul Fairhurst, Non-Executive Director and Chair of the People Committee**		

Key Discussion Points and Matters to be escalated from the meeting

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

- The Guardian of Safe Hours Annual Report: the Committee noted that the Trust is compliant with the terms and conditions of the 2016 junior doctors' contract; and noted the progress made across many fronts regarding implementation of the contract. However, the Committee also noted concerns around the gaps in real time data, in part due to perceived cultural resistance to submission of exception reports which resulted in many potential exceptions going unreported. Greater triangulation and more work around the health and wellbeing issues for staff were required to be integrated within the report.

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

- Making A Difference: Committee members had some concerns around the very low response rates to the survey and that therefore it did not provide a reliable picture as to real time issues and trends (including burnout). The Committee discussed the potential of a future digital solution which would make the survey completion quicker, easier and more readily available to more staff.

ASSURE: Inform the board where positive assurance has been achieved

- The NHS Long Term Work Plan was presented. The Committee was assured by the in-depth assessment of the LTWP and the high level of alignment between LTWP and the RUH People Plan. Given that alignment and the potential for revisions to the LTWP (including in the event of a change of government), the Committee was content that the primary focus is on delivery of the RUH People Plan whilst maintaining a watching brief on any significant evolution of or changes to the LTWP that would require the Trust to stop, start or change any of our plans.
- The RUH People Plan Dashboard was discussed and the Committee were informed that this would be split into divisional data; issued KPIs; with monitoring and governance arrangements established.

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

- The committee discussed the Board Assurance Framework (BAF) risks 4& 5 which related to the People Committee noting that there no risk ratings had yet been added to both BAF risks;

- The Committee noted that the BAF did not capture workforce supply risk (which was within the 2022/23 BAF): The Trust could suffer significant staffing risks as a result of the limited supply of healthcare professionals in the national NHS workforce market. This would be added to the Board Assurance Framework.

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

- The committee were informed of some excellent improvements within the portering and cleaning teams who had worked hard to empower staff and drive cultural change which had resulted in a positive impact on the morale of the team and hopefully will support recruitment and retention and lead to performance improvements.
- *You Matter Strategy*: Basics Matter: the committee praised the excellent work undertaken by the team to identify, plan and begin to implement improvements to staff 'basics' of food and drink, gym, rest areas, accommodation and much more support, whilst noting that there is still much to do.
- The *Talent Acquisition Strategy* was discussed and the Committee were very pleased with the exceptional progress that had been made to progress with staffing development.

APPROVALS: Decisions and Approvals made by the Committee

- The Committee approved changes made to the Terms of Reference (ToR). The Committee agreed additional changes, including to add a responsibility to gain assurance regarding alignment between the People Plan and the Transformation Programme. The ToR will come back to the next meeting for approval before submission to the Board.
- The Committee had agreed to increase the number of meetings to six a year and these would be aligned with the Board meeting dates to ensure a clear approvals process and allow streamlined and timely upward reporting;
- The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) with action plans for the year from August 2023 were approved by the Committee (whilst noting ongoing issues and areas of focus, including barriers to representation and progression, and bullying and harassment affecting global majority colleagues; and the significant level of non-declaration of disability),

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

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**6 September 2023**		

Title of Report:	**RUH People Plan update**
Status:	**For information**
Board Sponsor:	**Alfredo Thompson, Director for People and Culture**
Author:	**Jane Dudley, Deputy Director for People and Culture**
Appendix:	**Delivering the RUH People Plan - update slides, July 2023.**

1. Executive Summary of the Report

The RUH Board agreed the RUH People Plan in July 2022, and it was agreed that the Board would receive regular updates on this significant programme of work.

The slide pack at Appendix 1 provides an overview of:

- The People Plan – with the main elements of Capacity, Capability and Culture.
- The Programme of work being developed to underpin delivery.
- Progress and next steps.
- Risks and how these can be mitigated and managed.

Context

The RUH vision is the 'You Matter' strategy, a core element of which is that 'people are at the heart of everything we do; our strategic aim for the 'People We Work With' is:

- Demonstrating our shared values with kindness, civility and respect all day every day.
- Taking care of and investing in teams, training, and facilities to maximise our potential.
- Celebrating our diversity and passion to make a difference.

Our key measure is 'Percentage of staff recommending the RUH as a place to work'.

Feedback from the 2022 Staff Survey indicated people gave broadly 'above average' feedback about their experience of working at the RUH; however, our aspiration is to be at, or near, the very best.

In 2022 62% of the circa 3000 people who replied to the annual Staff Survey indicated that they would recommend the RUH as a place to work; the intention of the People Plan is to raise that percentage year-on-year, both by increasing the number and diversity of people responding to the survey, and by increasing the proportion of people who feel able to recommend the RUH as a place to work.

Whilst it is not yet possible to measure the outcomes of work that has been done since the last update to Board, below please find high level summary of key achievements:

1. **Vacancy levels** – these have increased because of new funding and all 120 international nurses' recruitment vacancies have been filled. We are expecting the last cohort to arrive in November 2023.

2. **Mandatory training compliance** - The launch of the new digital platform has been well received with 3,838 colleagues accessing the platform. This has led to 8,511 courses completed resulting in a 1.3% increase in compliance.
3. **Agency reduction** - focus on stopping the use of Off Framework Agency has led to Estates and Facilities now using 'Framework' only agencies
4. **Staff Experience:** We have seen an increase in overall staff engagement score from 6.63 (April 2023) to 6.75 (August 20230. This has been largely due to an increase in staff motivation (6.89 compared to 6.72); Involvement Score (6.75 compared to 6.68) and Advocacy Score (6.62 compared to 6.47).
5. **Equality, Diversity and Inclusion:** The launch of our Positive Action Development programme, Routes to Success, has been well received by our Global Majority colleagues. The programme has been designed for anyone from a Global Majority background currently working in band 5/6 role. We funded 18 spaces and received over 53 applicants. This demonstrates the need and desire to develop our People. We have also seen an increase the percentage of staff reporting experiencing discrimination at work from a manager/team leader or colleague (17% compared to 13%). We expect this to increase as we build awareness of discrimination and create a culture where it is safe to raise concerns.

2. Recommendations (Note and Discuss)

The Board is asked to note progress against the agreed People Plan, the risks to delivery, and how these risks are being mitigated and managed.

3. Legal / Regulatory Implications

Workforce issues have many legal and regulatory implications; of particular significance are the employment law aspects relating to equality of opportunity.

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

Workforce risks are captured in the corporate risk register and BAF.

5. Resources Implications (Financial / staffing)

Workforce is the biggest cost associated with delivery of services; workforce costs constitute a high proportion of financial turnover. The People Plan is designed to support improvements in productivity, aligned with the Transformation Programme, and to demonstrate improvements in efficiency in the RUH workforce.

Delivery of the People Plan requires leadership from across the RUH; this effort is underpinned by the People Directorate. The work to improve how the People Directorate itself functions is well underway, using resources agreed by the Executive Team. Evaluative work will underpin the benefits realisation and return on investment analysis.

6. Equality and Diversity

There are significant challenges regarding equality, diversity, and inclusion for all RUH staff – the People Plan seeks to address these challenges by setting out a five-year programme of improvement, underpinned by an Equality Impact Assessment each year, through the Equality Delivery System (EDS) and Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap analysis and the National Staff Survey.

7. References to previous reports/Next steps

The Board received and agreed the RUH People Plan in July 2022. The intention is to give regular updates, twice a year.

8.	Freedom of Information
The RUH People Plan has elements which are of significant sensitivity, particularly regarding workforce risk, and so this up-date report is made to a private session of the Board.	

9.	Sustainability
The behaviour of our workforce can support our approach to environmental sustainability.	

10.	Digital

There are significant opportunities for the RUH Workforce to make better use of digital opportunities and this plan is designed to support delivery of the RUH Digital Strategy. Examples of this include:

- Digitalising the recruitment process and temporary staffing processes.
- Digital support to the whole workforce through the introduction of a ‘People Hub’.
- The RUH Learning Management system, ‘LearnTogether’.

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Delivering the People Plan

Update briefing for the RUH Board
6th September 2023

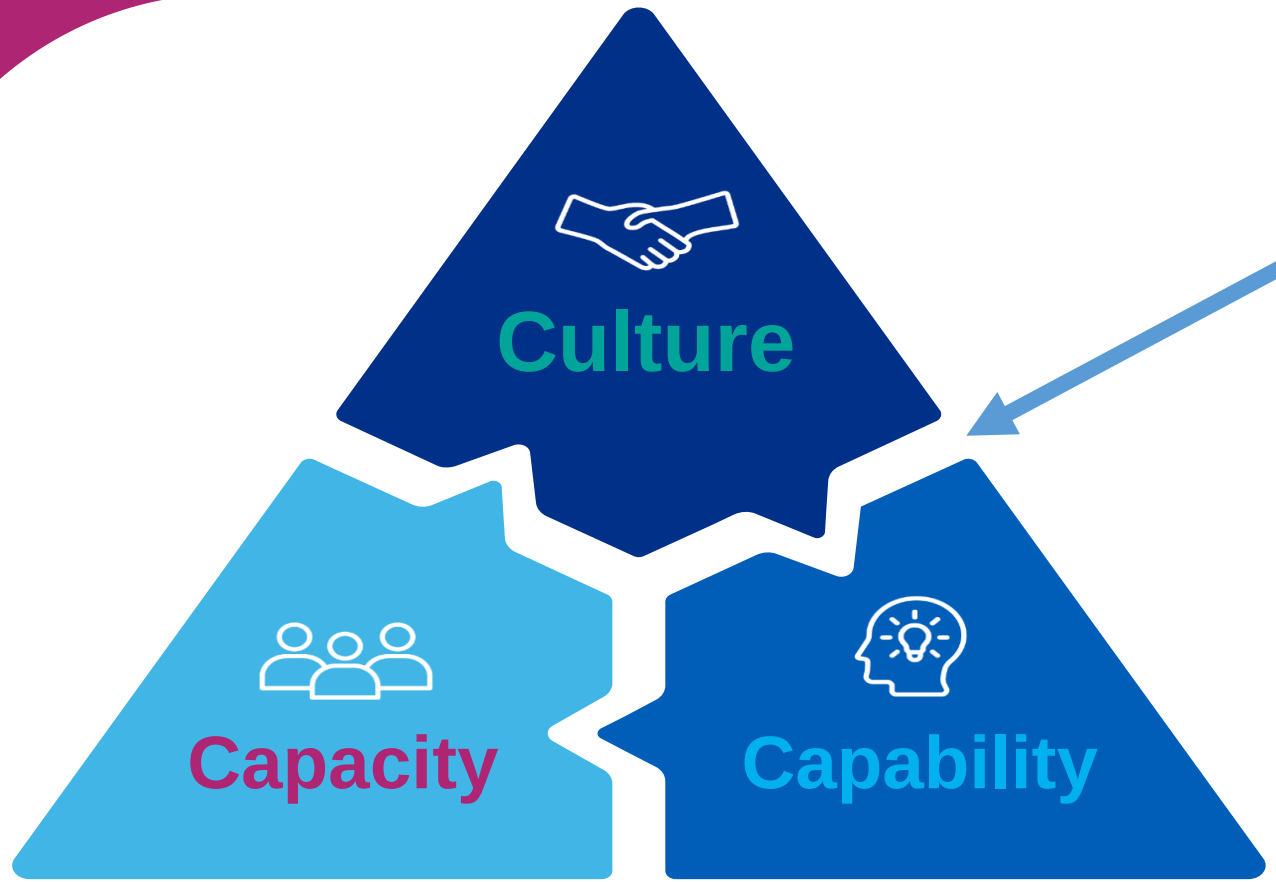
Alfredo Thompson,
Director for People and Culture

The RUH, where you matter

Background

- The Board agreed the new **RUH People Plan** in July 2022 and agreed to receive regular updates.
- Our strategic aim for the '**People We Work With**':
  - Demonstrating our shared values with kindness, civility and respect all day every day.
  - Taking care of and investing in teams, training, and facilities to maximise our potential.
  - Celebrating our diversity and passion to make a difference.

RUH People Plan



NHS Long Term Workforce Plans

TRAIN: Increasing 'new workforce' through training.

RETAIN: Encouraging people to stay in the NHS.

REFORM: Improving productivity.

Restorative Just & Learning /Civility & Kindness

User friendly people processes

The RUH, where you matter

The people we work with

Progress with the RUH People Plan

This Board update covers two main elements of progress:

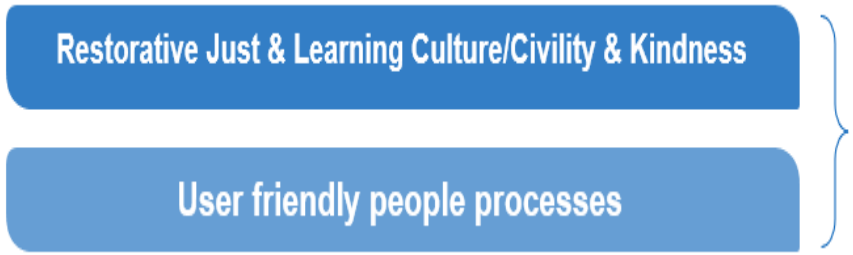
1. ‘Enabling’ actions.
2. Programme updates.

‘Enabling’ Actions

- Since the last up-date (January 2023) significant progress has been made with ‘re-orientating’ the People Directorate to deliver the People Plan.
- The People Directorate has worked in a reactive way, to-date, most colleagues have been focused on reacting to workforce gaps and problems, rather than taking anticipatory and/or preventative action.
- Changes to the structures are designed to change how the Directorate functions, ensuring that the whole team is improvement-oriented:
- Progress:

1. The current People Directorate teams received proposals for change in April and were involved in co-designing the new structures and ways of working.
2. An Outcome Report was issued in May and work is underway to make the changes.
3. The People Directorate now has **four teams aligned to the People Plan**.

This team leads on overall Programme Management approach and on ‘partnering’ through Divisional People Partners



Led by Associate Director:
- Matt Foxon (commencing in September 2023

Programme 1: User Friendly Processes

- Redesign:
  - Recruitment
  - Induction/On Boarding
  - Appraisals
  - On Line Learning
  - Bank Booking process

Programme 2: Restorative Just & Leaning Culture/Civility & Kindness

- Kindness and Civility week
- Benchmark review of formal employment cases per 1000 employee (4:1000)

Led by Associate Director:
- Ben Padfield

Programme 3: Staff Experience and Engagement

- Launched RUH's Culture and Leadership Programme
- Launched 'Getting Basics Right' programme
- Launched updated 'Behaviours Framework'

Programme 4: Diverse and Inclusive

- Launched EDI Board development sessions
- Launched RUH Positive Action Development Programme
- Re-launch of staff networks each with an Executive SRO

Programme 5: Compassionate leaders

- Launched 'You Matter: Leadership Development Programme' aimed at Divisional Triumvirates and Corporate Deputies

Programme 6: Health & Wellbeing

- Scoping and approval of investment into Burnout reduction programme
- Continued focus on NHS Health Checks
- Robust Financial Support offer
- Better understanding of Occupational Health productivity

Programme 7: Maximising potential

- Launched our new digital Learning Management Platform: Learn Together
- New Leadership Framework for all levels of the organisation
- Refocus on Clinical Skills

Programme 8: Workforce Planning

- Recruited new Workforce Planner
- Agreed to fund 'Calderdale Model' aligned to BSW Workforce Transformation methodology

Led by Associate Director:
- Helen Back

Capacity
New ways of working and delivering care

Programme 9-
Maximising collaborative working across BSW / BNSSG

- Collaborative coaching for five Chief People Officers across BSW
- Collaborative scoping exercise for transforming People Services

Programme 10-
Recruitment, values-based selection, on-boarding and a supported first year

- Digital Talent Acquisition
- Improved Time to Hire measures
- Redesigned Induction and On-Boarding Process

Programme 11-
Temporary Staffing

- Reduction of Agency spend collaborative work across BSW
- Redesigning RUH Bank Service
- Joined Locum's Nest National Collaborative Bank

Led by Associate Director:
- Eugenie Mellon

Programme Approach

- Since the last up-date (January 2023) significant progress has been made with developing the ‘Programme’ approach to deliver the People Plan.
- The eleven programmes of work are defined, and most are showing tangible progress. Each will have:
  - Project Plans to underpin.
  - Key Performance Indictors (KPIs) – tracked at Board (through the Integrated Performance Report (IPR), People Committee (People Committee Dashboard), Performance Review Meeting (PRM), and at Divisional level (with drill-down to service / team level as required).
  - Benefits realisation plans and evaluation mechanisms; to track the impact of People Plan delivery.
- At present, because the Programme Architecture is still being developed most Programmes are showing as **‘Amber’** or **‘Red’**.

People Plan elements– Programme Level	Programme RAG - July 2023
1. User friendly people processes, including 'getting the basics right'.	Amber – project plans being prepared. KPIs being confirmed. Benefits realisation required.
2. Restorative, Just & Learning / civility and kindness.	Amber – project plans being prepared. KPIs being confirmed. Benefits realisation required.
3. **Culture** – Employee experience and engagement.	Amber – project plans being prepared. KPIs being confirmed. Benefits realisation required.
4. **Culture** – Employee equality, diversity & inclusion (EDI).	Red – project plans developed. KPIs give cause for concern. Benefits realisation required.
5. **Culture** – Compassionate leaders.	Amber – project plans being prepared. KPIs being confirmed. Benefits realisation required.
6. **Capability** – Employee health and wellbeing.	Amber – project plans being prepared. KPIs being confirmed. Benefits realisation required.
7. **Capability** – Employee learning and development.	Amber – project plans being prepared. KPIs being confirmed. Benefits realisation required.
8. **Capability** – Workforce Planning.	Red. Project plans not yet initiated.
9. **Capacity** – Improvement through collaboration.	Green. Collaboration underway. Not anticipated to have early impact on RUH KPIs.
10. **Capacity** – Talent acquisition to optimise capacity.	Amber – project plans being prepared. KPIs being confirmed. Benefits realisation required.
11. **Capacity** – Enhancing temporary staffing and minimising agency usage.	Amber – project plans being prepared. KPIs being confirmed. Benefits realisation required.

Programme highlights and exception reports.

People Plan Programmes	Programmes Highlights and Exception Reports
1. User friendly people processes, including 'getting the basics right'.	**What is going well:** • We are making better use of technology to streamline and improve processes and are developing plans for further digitalisation, whilst recognising the need for a 'human voice' to resolve some issues. • We have defined the 'basics' including hydration, food, access to rest spaces, access to changing facilities, access to exercise facilities and we are making progress on all of these, in collaboration with the Strategy and Estates and Facilities Directorates. **What needs to be improved:** • The pace of change for the 'basics'; we need to have all the fundamental things that make the RUH a good place to work, in place for everyone, as soon as we can.
2. Restorative, Just & Learning / civility and kindness.	**What is going well:** • We have promoted kindness and civility and have another 'civility week' coming up soon. • Our Restorative, Just and Learning work is well underway; the team use the R,J & L approach and paperwork for new HR Case Work and are refining it as new challenges arise. **What needs to be improved:** • Our R,J & L policies are not quite fully developed – work is underway. We have had many very serious challenges to address during 2023. • We need processes to evaluate the impact of R, J & L.

Programme highlights and exception reports.

People Plan Programmes	Programmes Highlights and Exception Reports
3. **Culture** – Employee experience and engagement.	**What is going well:** • People have been engaged in the work to refresh the RUH 'Values and Behaviours' Framework and the values and behaviours have been highlighted by the Executive Team. We have identified new resources. **What needs to be improved:** • Our quarterly 'Making a Difference' surveys show stable but disappointing feedback regarding what proportion of staff say that they would recommend the RUH as a place to work. It is necessary to view the Making a Difference Survey results with caution as the quarterly survey receives a poor level of response. 61% of those who responded to the 2022 Staff Survey agreed that they would recommend the RUH; work is required to improve this percentage.
4. **Culture** – Employee equality, diversity & inclusion (EDI).	**What is going well:** • We are delivering training to improve EDI awareness and are communicating our intent to improve. **What needs to be improved:** • Our networks are not yet sufficiently well developed to ensure that the diverse voices, of the whole RUH workforce, are heard. We have some particularly worrying 'hotspots' of discrimination.
5. **Culture** – Compassionate leaders.	**What is going well:** • Work is underway with 'cohort zero' (reports to the Executive Team) and we are preparing to form a 'Culture Team', drawn from across the RUH. **What needs to be improved:** • Even some senior leaders (cohort zero) articulate a diminished view of the importance of leadership

Programme highlights and exception reports.

People Plan Programmes	Programmes Highlights and Exception Reports
6. Capability – Employee health and wellbeing.	**What is going well:** • We are focusing on employee burnout (as a response to the Staff Survey) and how to prevent burnout and support colleagues who are struggling. This is also to improve sickness rates. **What needs to be improved:** • Our 'Dignity at Work' Programme requires a higher profile / wider support to achieve improvements in how we report and tackle violence towards staff.
7. Capability – Employee learning and development.	**What is going well:** • The 'LearnTogether' platform has been launched and is working well. **What needs to be improved:** • Our clinical skills training requires significant enhancement to manage risk. We anticipate collaborating across the Acute Hospitals Alliance (AHA).
8. Capability – Workforce Planning.	**What is going well:** • We submitted a quantitative workforce plan for 2023/24 **What needs to be improved:** • Our Divisions and Directorates have little meaningful engagement in strategic Workforce Planning at present. Our workforce reports significant concerns about whether there are 'enough people to do the job' in many teams at the RUH, despite comparatively low levels of vacancies.

Programme highlights and exception reports.

People Plan Programmes	Programmes Highlights and Exception Reports
9. **Capacity** – Improvement through collaboration.	**What is going well:** • We are collaborating about people policy development, international recruitment and have agreed a range of further topics to be explored. **What needs to be improved:** • Partnership working requires significant capacity and the People Directorate team are focused within the RUH at present; there is a need to plan for resource into collaboration.
10. **Capacity** – Talent acquisition to optimise capacity.	**What is going well:** • We are designing 'end-to-end' roles for talent acquisition, such that our team supports people through from attraction to the RUH to the culmination of a successful first year at the RUH. Some talent acquisition (recruitment) KPIs have improved. **What needs to be improved:** • We are yet to see sustainable improvements in all KPIs; some need more work, particularly in partnership with recruiting managers.
11. **Capacity** – Enhancing temporary staffing and minimising agency usage.	**What is going well:** • Greater collaboration between the People Directorate teams for substantive and temporary staff. **What needs to be improved:** • Use of off-framework agency is a particular concern; both cost and quality of service. • The Staffing Solutions team have been overstretched and under-resourced.

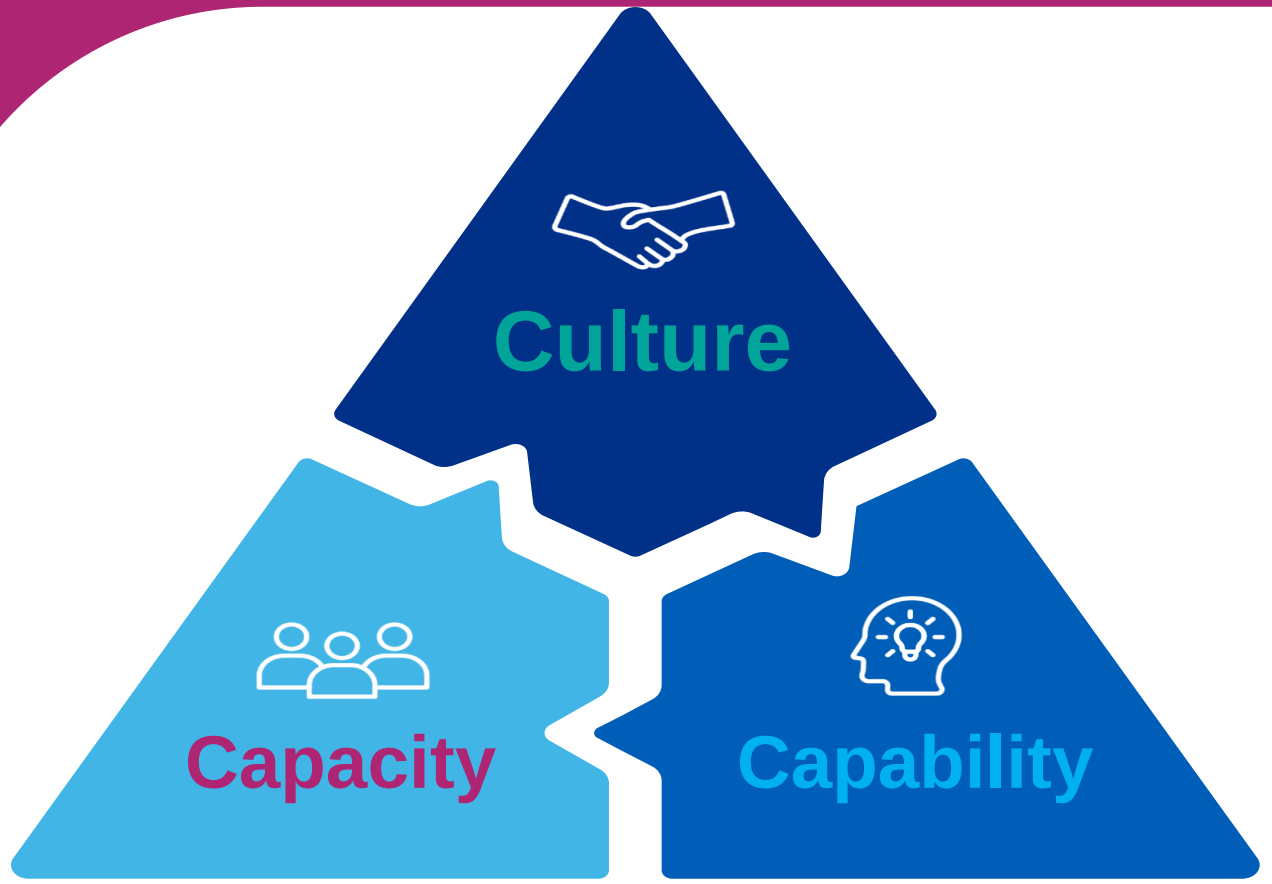
Recruitment KPIs: example of the successes and challenges.

Stage	Trac Code	KPI	KPI Owner	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	KPI Average
Trust vacancy rate %			Workforce Information	6.5%	5.0%	5.7%	4.50%	3.70%	2.70%	2.50%	2.10%	1.90%	5.70%	TBC	
Trust vacancy rate WTE			Workforce Information	347.27	267.23	307.26	245.4	198.9	145.4	136.2	114.3	102.8	319.7	TBC	
Number of live recruitment campaigns			Recruitment & Medical Staffing Teams	61	220	269	212	200	182	173	213	252	204	264	
Time to approve	T1A	3 days	Divisions	1	4.8	4.2	4.1	3.8	5.8	3.8	5.1	5.8	6.9	5.3	4.6
Time to advertise	T1B	2 days	Recruitment & Medical Staffing Teams	0.1	1.5	3.3	1.1	0.9	1.7	2.5	3.3	2.3	2.8	1.6	1.9
Time to shortlist	T4	3 days	Manager	1.9	4	6.4	7.4	7.2	10.4	7.7	7.1	9.9	9.7	8.3	7.3
Time to invite to interview	T5	2 days	Recruitment & Medical Staffing Teams	0.2	0.7	0.8	0.3	0.5	1.4	0.7	0.4	0.3	0.2	0.4	0.5
Time to update interview outcomes	T5B	1 day	Manager	0.5	1.5	2.3	2.7	3.1	3.2	3.4	3.4	3.8	3.2	3.8	2.8
Time to issue offer	T6	2 days	Recruitment & Medical Staffing Teams	1.5	4	7.4	6.4	10.3	5.6	5.1	2.3	4.3	4.8	2.8	5.0
Time to accept offer	T6A	2 days	Candidate	1.2	1.6	1.9	2.6	3.7	3	3.9	3.5	1.8	2.6	3.6	2.7
Time to complete pre-employment checks **excludes M&D staff*	T11	20 days	Recruitment Team		14.6	21.3	27.3	26.3	22.9	21.6	19.7	23.6	26	26	22.3
Time to complete starter paperwork **excludes M&D staff*	TSDR1	5 days	Candidate	1.2	3.2	2.6	2.7	4.4	3.4	5.3	4.3	2.7	5.8	5.8	3.3

Successes: we got down to 1.9% vacancies at the end of 2022/23 – however, the figure has risen because of new posts added. 'Time to invite to interview' has been consistently good.

Challenges: 'Time to approve' is affected by concerns about deficit. 'Time to update interview outcomes' is a managerial task, which requires further work. 'Time to issue offer' sits with the recruitment team and requires further work.

Summary - RUH People Plan



Restorative Just & Learning /Civility & Kindness

User friendly people processes

The RUH, where you matter

The People Plan provides a coherent, achievable and measurable framework within which we can deliver a great place to work – that people at the RUH feel able to recommend.

Crucially, research and evidence shows that people who are thriving in their workplace deliver better care.

Whilst the timeframe for this programme of work spans several years – good progress is being made.

The RUH People Plan is entirely compatible with and will support the RUH to respond to the NHS Long Term Workforce Plan.

The Board, People Committee, Divisions and Teams will receive regular up-dates on KPIs and trends.

The people we work with

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**18**
Date of Meeting:	**6 September 2023**		

Title of Report:	**WRES and WDES Annual Report 2023**
Status:	**For Information**
Board Sponsor:	**Alfredo Thompson Director for People and Culture**
Author:	**Emma Baker-Gaunt, Head of Equality, Diversity and Inclusion**
Appendices	**Appendix 1: WRES Report** **Appendix 2: WDES Report**

1. Executive Summary of the Report

This paper outlines performance against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) with action plans for the year from August 2023

WRES

Throughout the WRES report, we have followed the national WRES team for consistency and used Black and Minority Ethnic (BME). We are in the process of reviewing the language we use to highlight inequity between staff.

The WRES comprises nine standards against which we are required to assess performance:

- Four standards cover the comparison of White and Black and Minority Ethnic staff metrics held within the Electronic Staff Record (ESR).
- Four standards cover the comparison of white and Black, Asian and minority ethnic staff responses within the annual NHS staff survey results for 2022.
- One standard covers an assessment of whether our Board ethnicity is representative of the Trust's whole workforce.

Within the RUH our data has shown that we have made progress with our representation across the organisation and at Board level. Now, 20% of the people we work with are from a Black and Minority Ethnic background. Whilst we have seen progress in representation the data highlights that within agenda for change clinical roles, there is a disparity between representations from band 5 – 6 roles, and very low representation at more senior roles band 8a and above, indicating the presence of a barrier to career progression.

This year's data also highlights that reducing bullying and harassment is a priority area for the RUH to focus over the next 12 months. The data speaks to a culture of bullying with at least a quarter of staff experiencing bullying and harassment from another member of staff and indicates a much more challenging and hostile experience for Black and Minority Ethnic staff where the experience of harassment, bullying or abuse from patients or other staff has increased significantly, increasing year on year and is now 10% greater than their white peers. When it comes to bullying and harassment from their manager or team leaders the results are more than 3 times higher for our Black and Minority Ethnic staff (19% compared to 6%).

In our 2022 WRES report, we highlighted the “spiral of positivity” in best performing trusts out lined by Professors Michael West and Jeremy Dawson, where “the greater the proportion of staff from a black Asian or minority ethnic background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction. The experience of black Asian and Minority ethnic staff is a very good barometer of the climate of respect and care for all within NHS trusts”.

Addressing the disparity in difference for our staff has a substantial impact for the people we care for, the people we work with and the people in the community and is vital to creating an environment where everyone matters.

WDES

Throughout this report, we have followed the national WDES team and used capital ‘D’ when referring to Disabled staff. This is a conscious decision, made to emphasise that barriers continue to exist for people with long-term conditions.

The WDES comprises ten metrics against which the Trust is required to assess its performance:

- Three standards cover the comparison of Disabled and non-disabled staff metrics held within the Electronic Staff Record (ESR)
- Five standards cover the comparison of staff with and staff without disabilities responses within the annual NHS staff survey results for 2019
- One standard looks at the staff engagement score for staff with and without disabilities.
- One standard covers an assessment of whether our Board is representative of the overall staff within the RUH.

From the data we can see that overall, we have good engagement with our Disabled staff, as well as good representation at board level. We have relative equity in both appointment from shortlisting and feeling there is equal opportunities for career progression. Three quarters of disabled staff have adequate adjustments to enable them to do their work. However, there are 25% that are not getting the tools and support they need, and it may be that this impacts on our Disabled staff feeling less valued (36% compared to 46%) and a greater pressure to come to work compared to their non-disabled colleagues (28% compared to 17%).

Disabled staff are also more likely to experience bullying, harassment and abuse in the workplace from all sources. Whilst positive progress has been made in the reducing the experience of bullying and harassment from line managers and team members last year (down from 21% to 14%), there has been an increase this year, and it is still nearly double the percentage of disabled staff are experiencing bullying and harassment compared to non-disabled staff. To address this, we have made the percentage of staff experiencing discrimination at work a breakthrough objective for the organisation. This makes it a key focus for all areas of the organisation to reduce and improve staff experience, reporting progress regularly to the executive teams via our performance review meetings.

The main caveat for the results in this year's report is the stark difference in the percentage of staff declaring a disability on ESR compared to the percentage of staff declaring a long-term illness or condition via the staff survey. It is very likely that the 4% representation is not accurate, as we have over 21% declaring a long-term condition via the staff survey. This may be an indicator that as an organisation we have not yet created a disability inclusive environment. The Advisory, Conciliation and Arbitration Service (ACAS) have identified the common reasons someone may not tell an employer that they are disabled or might have a disability are that they do not realise their condition is a disability, they may not think of themselves as disabled, they may be worried about how their employer might react or they may not want anyone to know.

This lack of declaration has a big impact on how we review and interpret the data about the experience our Disabled staff are having. As a result, the next 12 months we will collaborate with our Disabled staff to better understand how to encourage staff to share their disability with us, so that we can improve the overall experience for all Disabled staff and ensure we are consistently providing a fair, equitable and supportive environment, where everyone's work is valued.

2.	**Recommendations (Note, Discuss)**
Public	

3.	**Legal / Regulatory Implications**

Statutory obligation under the Equality Act 2010 to publish information to demonstrate compliance with the public sector equality duty (PSED) at least annually and is further required to publish the results of the annual WRES and WDES data collection and subsequent action plans.
It is a legal obligation to that our policies and practices should not discriminate on the grounds of:

- Age
- Gender reassignment
- Being married or in a civil partnership
- Being pregnant or on maternity leave
- Disability
- Race including colour, nationality, ethnic or national origin
- Religion or belief
- Sex
- Sexual orientation

Our data shows that we have practices in situ which could lead to discrimination on the grounds of race. We have a legal duty to act on these.

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)**
Strategic priority 2 on the BAF.	

5.	Resources Implications (Financial / staffing)

Alongside the opportunity cost of people's time to support initiatives to deliver positive action and WRES and WDES actions, the People Directorate has improved the resources available through a new post reporting to the Head of EDI and through a secondment to the team. Likewise, non-pay resources have been made available to support more EDI training.

Further resource implications will be assessed during the 2024/25 planning round and EDI work to address the WRES and WDES actions will link across to the RUH Transformation Programme, led by the Chief Medical Officer.

6.	Equality and Diversity

The Equality, Diversity, and Inclusion (EDI) agenda for the RUH workforce is a key element of the RUH People Plan (Programme Four).
The reports propose actions suggest positive action to support the organisation to reduce the inequalities detailed in the WRES and WDES.

7.	References to previous reports/Next steps

- Fusion leads - complete
- Diversity and Inclusion Steering Group -complete
- People Committee
- Public Board in September 2023

8.	Freedom of Information

Private for discussion with the People Committee. Public documentation will be submitted to Board in September 2023

9.	Sustainability

The RUH workforce has significant potential to have a positive impact on the RUH approach to environmental sustainability, including its commitment to achieve net zero carbon status by 2030; this is particularly an issue for the overall RUH People Plan, including Programme Four (EDI).

10.	Digital

The People Plan aligns to the RUH Digital Strategy; every opportunity will be used to improve use of digital solutions throughout the eleven People Plan Programmes.

NHS
Royal United Hospitals Bath
NHS Foundation Trust

WRES Report

Workforce Race Equality Standard
Financial Year: 2022-23

Date: July 2023

The RUH, where you matter

Introduction to WRES

Workforce Race Equality Standard (WRES) uses data to highlight the experiences of the workforce based on race against 9 key indicators. It requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract. As an NHS provider, we are expected to show progress against a number of indicators of workforce equality. In the 2022 NHS WRES Report, Dr Navina Evans commented:

“Evidence increasingly suggests an association between staff experience and patient outcomes, meaning there is not just a moral case for improving the experience of our colleagues from minority communities and backgrounds – it also benefits patients, productivity and performance. For example, the percentage of staff believing that their trust provides equal opportunities for career progression or promotion (WRES indicator 7) is a predictor of higher levels of patient satisfaction.”

Within the RUH our data has shown that we have made great progress with our representation across the organisation and at Board level. Now, 20% of the people we work with are from a Black and Minority Ethnic background. This is great not just for us, but for the people we care for and the people in our community, as we know this representation enables us to continue to strive for the highest quality of care.

However, whilst we have seen progress in representation there is much more we can do. Over the next 12 – 24 months we will be focussing our actions on equal career progression, in particular for our colleagues working clinically in band 5 – 6 roles. As well as bringing in initiatives to reduce the percentage of staff who experience harassment, bullying or abuse from any source whilst at work.

At the RUH we are committed to creating the conditions to perform at our best, celebrating our diversity and passion to make a difference and within this report we outline the tangible actions we plan to take to achieve this.

Cara Charles-Barks
Chief Executive

Alfredo Thompson
Director of People and Culture

A note on language:

Throughout this report, we have followed the national WRES team for consistency and used Black and Minority Ethnic (BME). However as an organisation we are in the process of reviewing the language we use to highlight inequity between groups.

RUH indicator trends 2017 – 2023

Royal United Hospitals Bath NHS Foundation Trust

	WRES Indicator		RUH Results: Financial Year							Trend
			16/17	17/18	18/19	19/20	20/21	21/22	22/23	
1	Percentage of black and minority ethnic (BME) staff		10%	10%	11%	13%	14%	16%	20%	
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.88	1.4	1.73	1.93	1.91	1.5	1.5	
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		2.89	1.44	1.94	1.64	1.1	1.1	1.74	
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff		0.89	0.86	0.99	0.81	0.83	0.4	0.53	
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME	27%	28%	29%	29%	28%	31%	38%	
		White	28%	28%	25%	26%	25%	28%	27%	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	27%	31%	29%	29%	29%	31%	34%	
		White	23%	24%	25%	25%	22%	24%	23%	
7	Percentage of staff believeing that trust provides equal opportunities for career progression or promotion	BME	68%	56%	67%	68%	74%	41%	51%	
		White	90%	88%	88%	88%	89%	57%	59%	
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	17%	20%	14%	14%	17%	19%	19%	
		White	6%	6%	6%	6%	5%	6%	6%	
9	Percentage difference between the organisations' Board voting membership and its overall workforce		-10%	-10%	-11%	-6%	0.70%	4%	4%	

Our improvements and 2023/24 focus

2022/23 improvement

Indicator 1: Percentage of BME staff in the organisation

Celebration: The percentage of black and minority ethnic staff has doubled since 2017. Our increased representation includes welcoming new colleagues with international careers. This provides the people we care for with a rich diversity of experience helping us to provide the highest quality of care.

Indicator 9: Board representation

Celebration: The board is the most representative of the workforce with a change from -10% in 2017 to 4% in 2023. Increased representation at board level signifies the RUH's commitment to ensuring a wide range of voices, experiences and communities are heard and part of the decision making processes for the hospital.

Priority focus and objectives

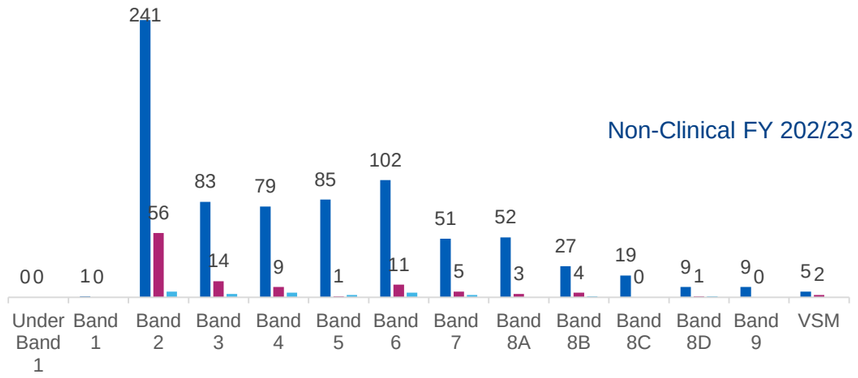
Indicator 5,6 & 8: The percentage of staff experiencing harassment, bullying or abuse from patients/relatives, staff and managers over the last 12 months.

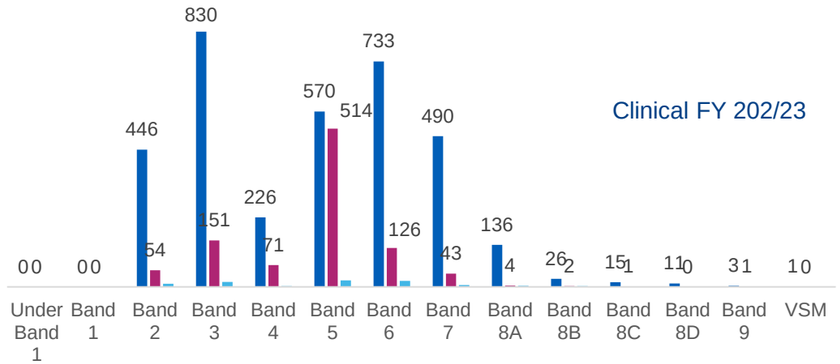
Objective: 15% decrease in percentage of BME staff experiencing bullying, harassment or abuse from patients, staff and managers by March 2025.

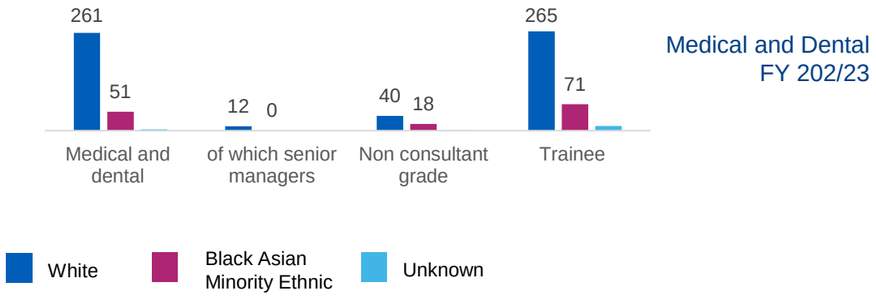
Indicator 1 & 7: Representation of BME staff across all bands and percentage of staff believing the Trust provides equal career progression

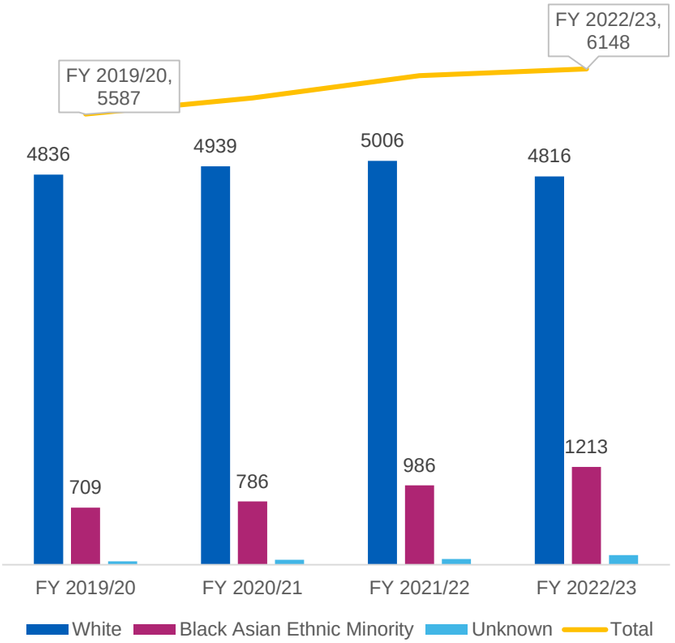
Objective1: Increase BME representation in clinical roles at bands 6 – 8a by October 2024
Objective 2: Increase percentage of staff believing the Trust provides equal career progression to 60% by October 2024

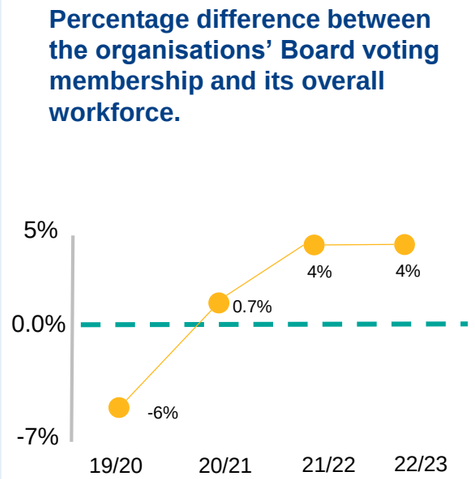
Understanding the impact of our processes











There has been a year on year increase in the percentage of Black and Minority Ethnic within the RUH. This year showing a rise to 20% of the total workforce. The greatest representation is in clinical roles. Non-clinical roles have much less representation overall and the majority of representation in the lower bands (1-4). The steady increase in representation clinically over the last 4 years has been supported by recruitment of internationally educated nurses. However, the data indicates that there is a disproportionate representation of Black and Minority Ethnic staff at band 5 that drastically drops. Whilst there is an almost 50/50 split in representation at band 5, this drops significantly at band 6, with white staff within the roles rising from 52% at band 5 to 83% at band 6. International recruitment will have had an impact, but we would have expected to see the career progression of those nurses recruited 3 years ago increasing the representation at band 6 and we have not. This is why we have taken an action to review our recruitment processes and bring in positive action programmes to support the development and representation of our Black and Minority Ethnic staff into Middle/ Upper bandings and leadership roles.

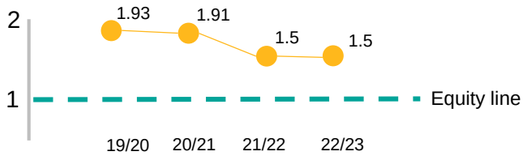
Understanding the impact of our processes

Relative likelihood of appointment from shortlisting:

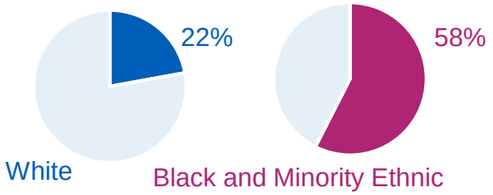
White

Black and Minority Ethnic

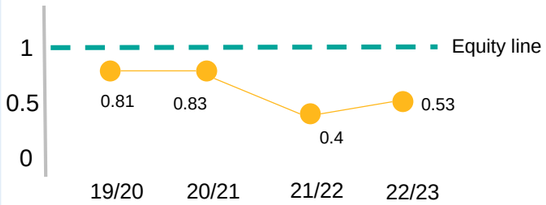
Relative likelihood of White staff being appointed from shortlisting compare to Black and Minority Ethnic staff :



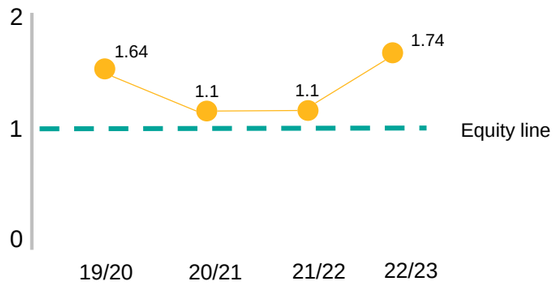
Likelihood of staff accessing non-mandatory training and CPD:



Relative likelihood of White staff accessing non-mandatory training and CPD compared to Black Asian Minority Ethnic staff:



Relative likelihood of Black and Minority Ethnic staff entering the formal disciplinary process compared to White staff:



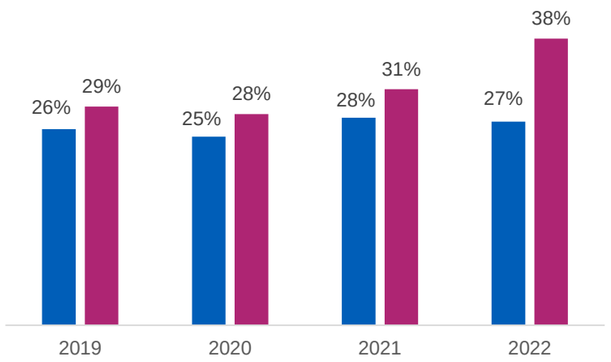
The relatively likelihood of white applicants being appointed from shortlisting compared to Black and Minority Ethnic applicants has stayed the same in 2023 compared to 2022. For every 20 white applicants shortlisted, 8 will be appointed, whereas for every 20 Black and Minority Ethnic applicants shortlisted, only 5 will be shortlisted. This indicates that there is a real need to challenge the support, guidance and processes that we use to recruit across the organisation. In particular to look at how this indicator links with the lack of representation present at band 6 and above clinically and from band 3 and above in non-clinical roles. It is also important that we consider the impact of bias within our recruitment processes and as a result have developed actions to fully review and implement de-biasing techniques within our recruitment approach. The likelihood of staff accessing non-mandatory training and CPD is greater fro those in Black and Minority Ethnic staff than white staff. For this we have to review what types of courses, and if there is a greater uptake, why are we not seeing that reflect in career progression across the organisation

There has been a sharp increase in the relative likelihood of Black and Minority Ethnic staff entering the formal disciplinary process compared to white staff. The figures overall are relatively low within the organisation and so have an impact on the results. However there is a need for greater understanding of informal and formal processes and how we as an organisation measure and monitor the application of our processes. The HR team will be looking at how we ensure equity and fairness within our processes to prevent our Black and Minority Ethnic staff entering processes disproportionately.

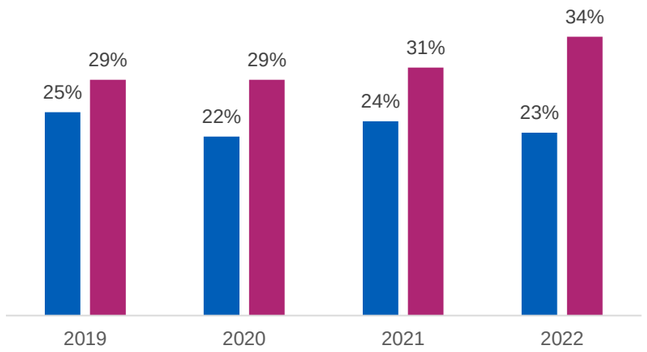
Understanding the experience of our staff

White Black and Minority Ethnic

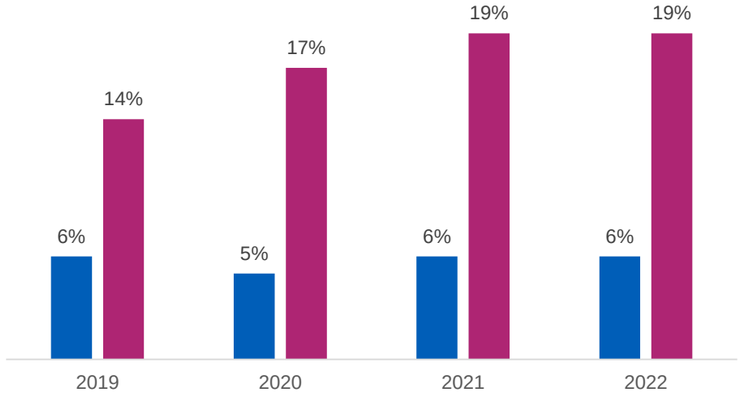
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months:



% of staff who experienced harassment, bullying or abuse from other staff in the last 12 months:



% of staff who personally experienced discrimination at work from a manager, team leader or other colleagues:

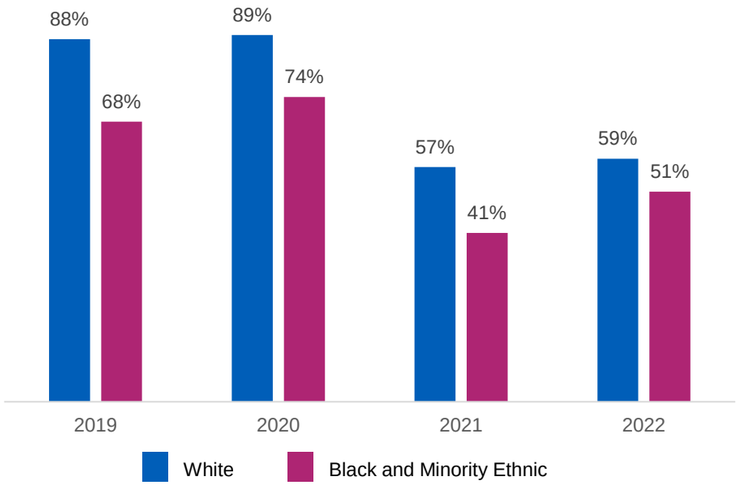


This data is taken from the NHS Staff Survey in 2022. The experiences for staff has remained consistent with around a quarter of staff experiencing bullying, harassment or abuse from patients and other staff. However over the last 2 years there has been a steep rise in experience for Black and Minority Ethnic staff that is greater than for white staff. We have seen the difference in experience grow from 4% in 2019 to 10% in 2022. This correlates with the 7% increase in overall representation of Black and Minority Ethnic staff within the organisation and indicates that as an organisations, whilst we have increased our diversity we have not yet managed to create a truly inclusive environment.

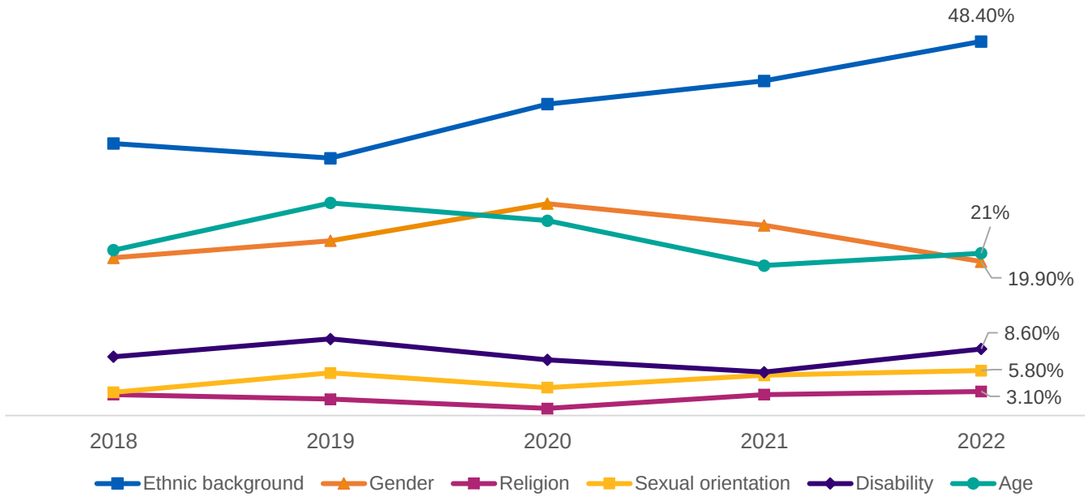
This is further evidenced in the relationship between teams and line managers, with a third more Black and Minority Staff experiencing discrimination at work from team members or a manager than their white colleagues and as a result we have made the experience of discrimination a break-through objective for the organisation over the next 12 months. Putting it as a priority area of focus for all divisions to be improved and reported on through our performance review meetings.

Understanding the experience of our staff

% of staff who believed that the trust provided equal opportunities for career progression or promotion:



The grounds on which staff identified their experience of discrimination was based on at the RUH:



From the NHS Staff Survey we can see that overall there has been a decline in how colleagues feel about the provision of equal opportunities to career progression. There has been a positive 10% increase for Black and Minority Ethnic staff. This may be as a result of the positive action programmes already provided that are beginning to create and overall increase in the feeling of equal opportunities. The overall drop will be considered within the full review of recruitment processes, with the aim to increase the overall percentage, whilst remaining the relative equity in experience.

The discrimination graph particularly highlights a distinct difference between the grounds on which staff feel their experience of discrimination was. In particular 48% was on the grounds of ethnicity and steeply rising year on year, where others such as gender have seen a decline or have remained similar year on year such as sexual orientation and religion. This is why as an organisation we have prioritised discrimination in the workplace within our RUH strategy and are starting with challenging racism within the RUH and working towards becoming and Anti-racist organisation.

Action Plan

= 2023/24 priority areas of work

Indicator requirements	Action to address	Led by / Sponsored by	Delivered by
1: Increased representation across clinical roles in band 6-8a.	• All divisions with driver measures to improve representation at higher bands. • Positive Action Development Programme for 22 staff band 5 – 6 across clinical roles, focussed in areas where there is high BME representation within lower bands and low representation in higher band roles. Launch date September 2023	Lead: Head of EDI &HR Business Partners Sponsors: Divisional Directors	• September 2023 • March 2024
2: Increased chance of appointment for BME candidates compared to White	• Full review of end to end recruitment process to highlight opportunities to remove bias. • Run a pilot approach of adjusted process in FaSS and Medicine. Take learning from BSW Inclusive Recruitment Project and apply to processes. • Improved Inclusive Recruitment e-Learning for all hiring managers.	Lead: Recruitment lead, Head of EDI Sponsor: Associate Director for Talent Acquisition	• November 2023 • January 2024 • September 2023
3: Reduced likelihood of entering formal disciplinary process for BME staff	• Bespoke HR training to help HRBPs understand bias within HR process • Review of approach to formal and informal processes and adjust accordingly • Develop a dashboard to indicate discrepancy in real time across informal and formal processes and identify any areas where there is greater likelihood of discrimination	Lead: HR Business Partners Sponsor: Associate Director for Partnering and Programmes	• October 2023 • January 2024 • March 2024
4: Greater understanding of access to CPD and cause of increased disparity	• Full review of CPD uptake and A3 to understand the differentiation in completion of non mandatory CPD	Lead: Head of Learning and Development Sponsor: Associate Director for Capability	• January 2024
5: Reduction of staff experiencing harassment and bullying from public	• Introduction of Dignity at Work (red card) policy for patients and visitors • Deliver resources and training to all staff on identifying and challenging discrimination from patients	Lead: Security Manager and Head of EDI Sponsor: Chief Nurse	• December 2023 • March 2024
6: Reduction in staff experiencing harassment and bullying from staff	• Build resources and training to all staff on identifying, challenging and reporting abuse into induction, preceptorship and all development programmes within the RUH • Introduce a new reporting system to make reporting of experiences of harassment and bullying from staff easier • Re-develop bullying and harassment policy to change approach to racism raised within the organisation and embed early prevention across all areas with active allyship.	Lead: Head of EDI Sponsor: Deputy Director for People and Culture	• January 2024 • March 2024 • December 2023

Action Plan

= 2023/24 priority areas of work

Indicator requirements		Action to address	Led by / Sponsored by	Delivered by
	7: Increased belief in equitable access to career progression	• Indicator 7 will be used as a measure to monitor the success of actions in indicator 1. • Easy access career development pathways and guides for potential career steps to be created as part of RUH retention improvement programme	Lead: HR change manager Sponsor: Associate Director for Capability	• March 2024
⚠	8: Significant decrease in BME staff experiencing discrimination compared to white staff from managers	• New reporting system to allow for reporting of line manager discrimination outside of direct management (see action for indicator 6) • Diversity indicators developed in ward accreditation process and within speciality and division score cards to hold leaders to account on the experience of their teams • Focussed training developed and delivered for key areas where experiences are highest	Lead: Head of EDI Sponsor: Associate Director for Culture	• March 2024 • October 2024 • February 2023
	9: Sustained representation at board level	• Board development sessions to embed the importance of role modelling and sustained representation at senior levels across the organisation	Lead: Head of EDI Sponsor: Director for People and Culture / CEO	• October 2023

NHS 75

Royal United Hospitals Bath

NHS Foundation Trust

The RUH, where you matter

Royal United Hospitals Bath
NHS Foundation Trust

WDES Report

Workforce Disability Equality Standard
Financial Year: 2022-23

Date: July 2023

The RUH, where you matter

Introduction to WDES

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. It requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract. As an NHS provider, we are expected to show progress against a number of metrics of workforce equality. In the 2021 NHS WDES Report, Professor Em Wilkinson-Brice highlighted:

“The fundamental principles set out in the People Promise provide the grounds for an inclusive environment for all our staff, in which the voices of Disabled staff are heard and listened to, in which Disabled staff feel recognised and valued, and will be supported to achieve their full potential.”

This year’s WDES results highlight that we have sustained and improved equity in appointment from shortlisting for Disabled and non-disabled candidates, giving us confidence in our processes for recruitment. Our efforts to ensure our Board represents our staff has also seen a positive improvement with a greater representation on the voting board than within our wider organisation. We have also seen year on year our staff engagement between non-disabled and disabled colleagues has stayed the same. All of this shows that our efforts to ensure the voice of Disabled staff is working.

However, there is still so much we need to do. In particular to ensure staff feel valued, recognised and can come to work free from discrimination. Our focus over the next 12 months will include increasing the percentage of Disabled staff who feel that their work is valued, addressing the discrimination Disabled staff face from staff and managers compared to their non-disabled colleagues, and challenging leaders to think about reasonable adjustments with flexible work so that no Disabled member of staff feels pressured to come to work when they are not well enough.

We have also identified that there is a key risk with our WDES data. Whilst our staff survey declaration of a long term condition indicates that 21% of staff have a long-term health condition or illness, our ESR data informs us only 4% of staff have a disability. In addition over 16% of staff are logged as ‘unknown’, with no progress made in the last 2 years. Over the next 12 months we want to understand what stops our colleagues from sharing their disability and raising the profile of the benefits, so that we can make sure our actions and initiatives are truly meeting the needs of the people we work with.

Cara Charles-Barks
Chief Executive

Alfredo Thompson
Director of People and Culture

A note on language:

Throughout this report, we have followed the national WDES team and used capital ‘D’ when referring to Disabled staff. This is a conscious decision, made to emphasise that barriers continue to exist for people with long-term conditions.

RUH indicator trends 2019 – 2023

Royal United Hospitals Bath
NHS Foundation Trust

WDES Metric			RUH Results: Financial Year					Trend
			18/19	19/20	20/21	21/22	22/23	
1	Percentage of disability declaration	Disabled	3%	4%	4%	4%	4%	
		Non-disabled	72%	75%	77%	80%	80%	
		Unknown	24%	21%	19%	16%	16%	
2	Relative likelihood of Disabled staff compared to non-disbaled staff being appointed from shortlisting across all posts		NA	1.52	1.60	1.27	0.97	
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.		0.00	0.00	0.00	0.00	0.00	
4a	i: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients	Disabled	31%	34%	29%	33%	35%	
		Non-disabled	26%	24%	24%	27%	27%	
	ii: from managers	Disabled	21%	18%	16%	14%	16%	
		Non-disabled	12%	11%	10%	11%	9%	
	iii. From other colleagues	Disabled	26%	32%	24%	25%	27%	
		Non-disabled	18%	17%	17%	18%	18%	
4b	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Disabled	38%	45%	37%	46%	44%	
		Non-disabled	41%	46%	40%	40%	42%	
5	Percentage of Disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion.	Disabled	49%	48%	52%	52%	54%	
		Non-disabled	57%	58%	59%	56%	59%	
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled	33%	31%	31%	25%	28%	
		Non-disabled	19%	20%	20%	22%	17%	
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled	37%	28%	43%	38%	36%	
		Non-disabled	48%	50%	51%	45%	46%	
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work		NA	NA	NA	NA	75%	
9a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	Disabled	6.70	6.70	6.90	6.70	6.70	
		Non-disabled	7.10	7.10	7.20	7.10	7.00	
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce		17%	21%	16%	13%	-4%	

WDES overview

From the data we can see that overall we have good engagement with our Disabled staff, as well as good representation at board level. We have relative equity in both appointment from shortlisting and feeling there is equal opportunities for career progression. Three quarters of disabled staff have adequate adjustments to enable them to do their work. However, this also shows us there are 25% that are not getting the tools and support they need, and it may be that this impacts on our Disabled staff feeling less valued (36% compared to 46%) and a greater pressure to come to work compared to their non-disabled colleagues (28% compared to 17%) .

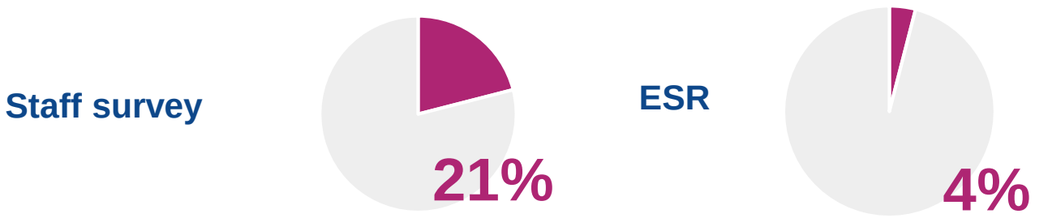
Disabled staff are also more likely to experience bullying, harassment and abuse in the workplace from all sources. Whilst positive progress has been made in the reducing the experience of bullying and harassment from line managers and team members last year (down from 21% to 14%) , there has been an increase this year, and it is still nearly double the percentage of disabled staff are experiencing bullying and harassment compared to non disabled staff. To address this we have made the percentage of staff experiencing discrimination at work a break through objective for the organisation. This makes it a key focus for all areas of the organisation to reduce and improve staff experience, reporting progress regularly to the executive teams via our performance review meetings.

The main caveat for the results in this years report is the stark difference in the percentage of staff declaring a disability on ESR compared to the percentage of staff declaring a long term illness or condition via the staff survey. It is very likely that the 4% representation is not accurate, as we have over 21% declaring a long term condition via the staff survey. This may be an indicator that as an organisation we have not yet created a disability inclusive environment. The Advisory, Conciliation and Arbitration Service (ACAS) have identified the common reasons someone may not tell an employer that they are disabled or might have a disability are that they do not realise their condition is a disability, they may not think of themselves as disabled, they may be worried about how their employer might react or they may not want anyone to know. This lack of declaration has a big impact on how we review and interpret the data about the experience our Disabled staff are having. As a result, the next 12 months we will collaborate with our Disabled staff to better understand how encourage staff to share their disability with us, so that we can improve the overall experience for all Disabled staff and ensure we are consistently providing a fair, equitable and supportive environment, where everyone's work is valued.

Staff engagement score of Disabled staff compared to non-disabled staff.

6.7	7.0
Disabled	**Non-disabled**

% of staff declaring long term condition or illness on staff survey compared to ESR declaration rate



Our improvements and 2023/24 focus

2022/23 improvement

Metric 2: Relative likelihood of appointment from shortlisting

Celebration: Progressive movement toward equity (1.0) between Disabled and non-disabled colleagues. Dropping from 1.6 in 20/21 to 0.97 in 22/223.

Actions: Share learning of what has worked well and apply some the processes and benefits to other areas where there is still inequity in shortlisting and appointment.

Priority focus and objectives

Metric 1: Percentage of disability declaration

Objective 1: Increase disability declaration by at least 5% by March 2024
Objective 2: Decrease percentage of unknown staff by at least 5% by March 2024

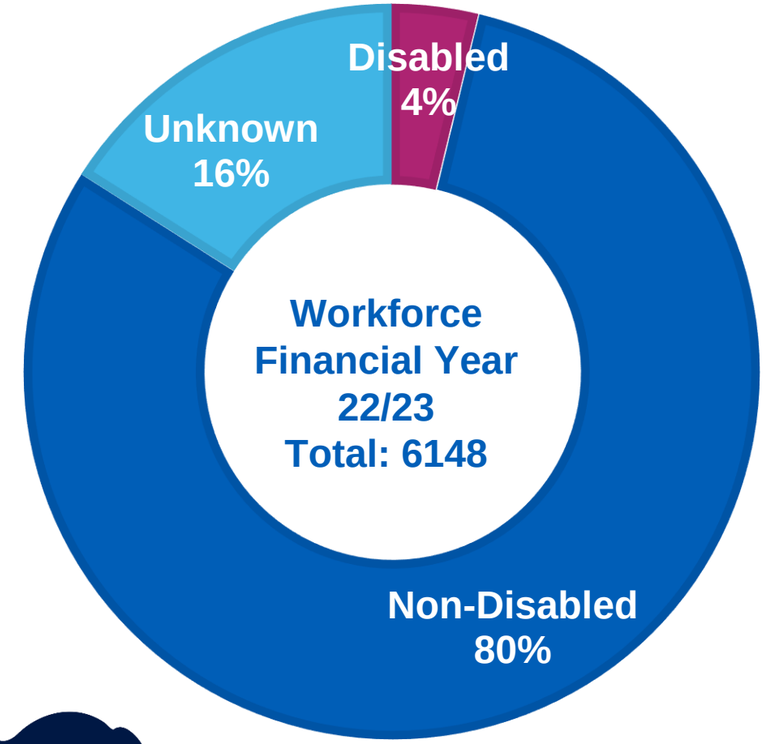
Metric 4a ii&iii: experience of bullying, harassment or abuse form managers or other colleagues

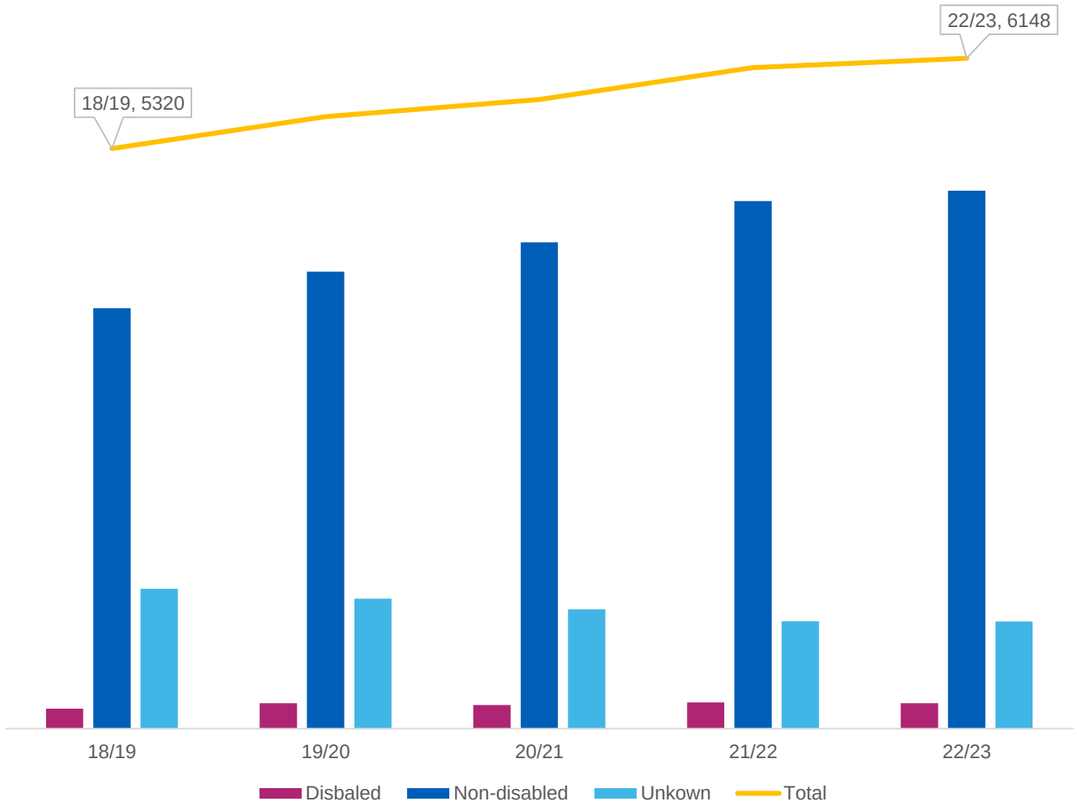
Objective: Half the percentage difference of Disabled staff experiencing bullying, harassment or abuse compare to non-disabled staff by October 2024

Metric 6: Percentage of Disabled staff that have felt pressure from their manager to come to work, despite not feeling well enough

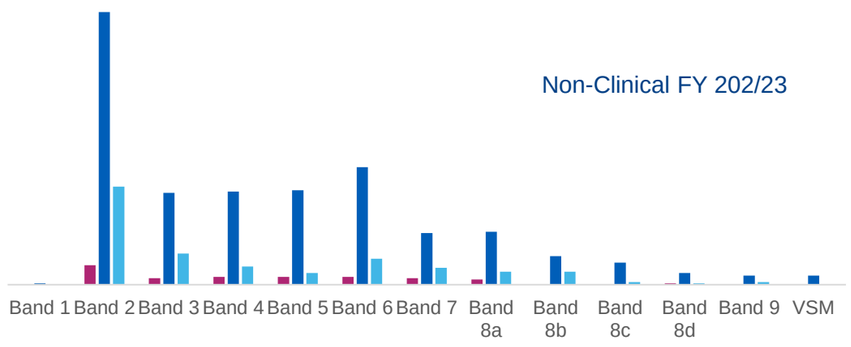
Objective: 10% reduction in the percentage of staff who feel pressured to come to work by October 2024

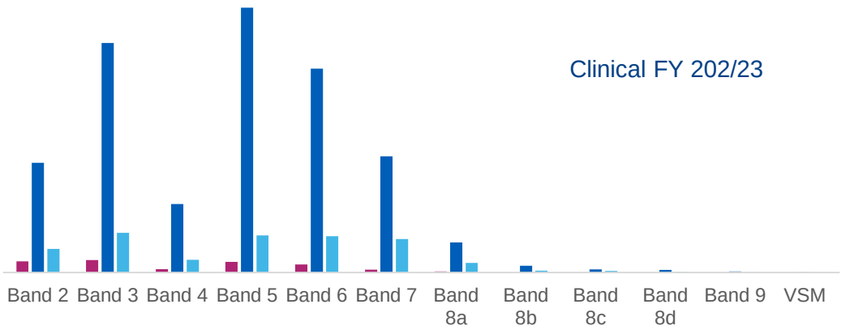
Our Workforce Disability Equality Data

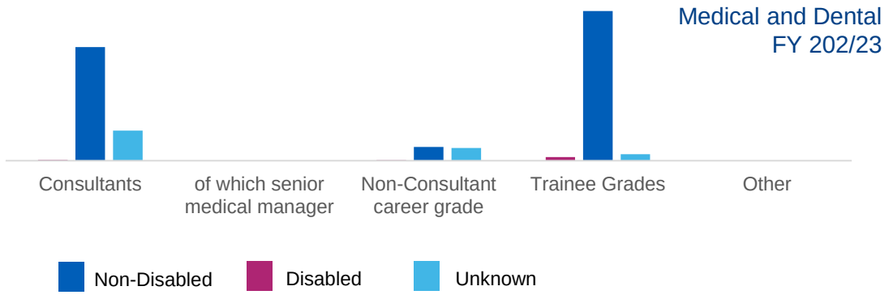




Understanding the impact of our processes







Relative likelihood of appointment from shortlisting:

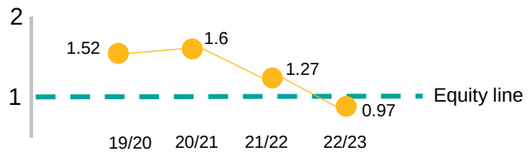
36%

Non-Disabled

35%

Disabled

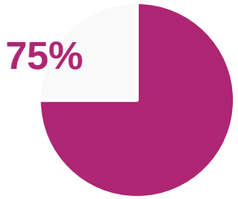
Relative likelihood of Disabled staff compared to non-disabled staff being appointed to from shortlisting



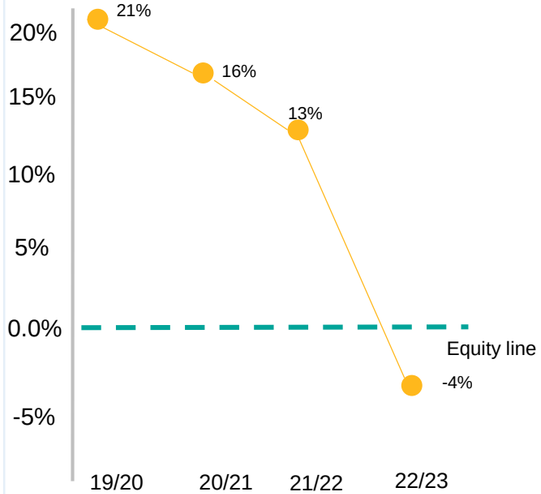
Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process

19/20	20/21	21/22	22/23
0.0	0.0	0.0	0.0

Percentage of Disabled staff saying their employer has made adequate adjustment to enable them to carry out their work



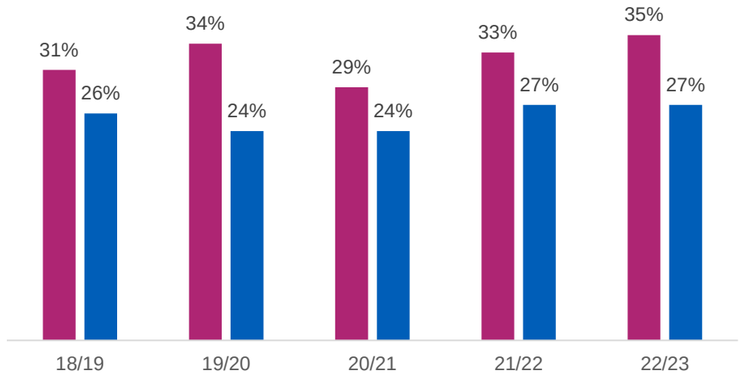
Percentage difference between the organisations' Board voting membership and its overall workforce (Disabled staff)



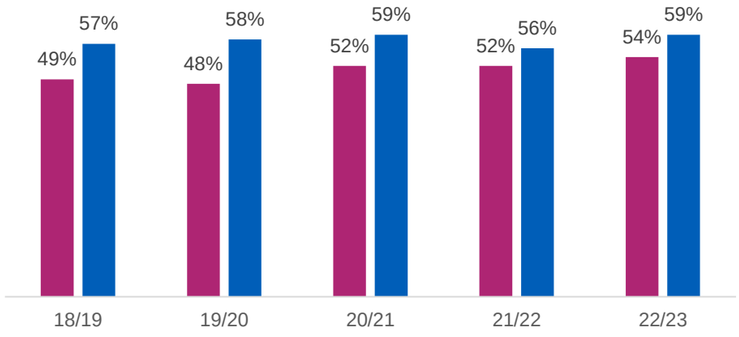
Understanding the experience of our staff

Disabled Non-disabled

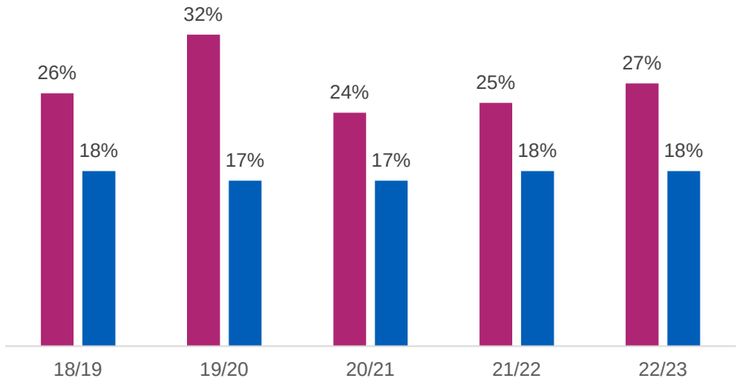
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months:



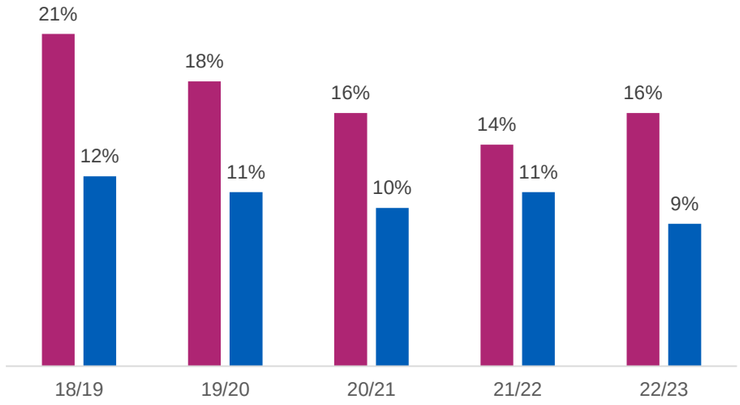
% of staff who believed that the trust provided equal opportunities for career progression or promotion:



% of staff who experienced harassment, bullying or abuse from other staff in the last 12 months:



% of staff who personally experienced discrimination at work from a manager or team leader :



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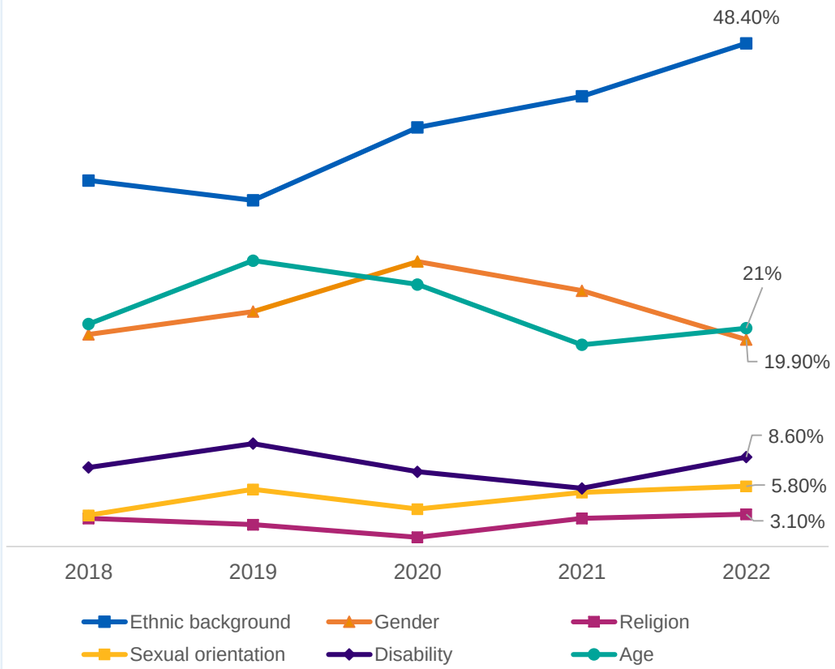
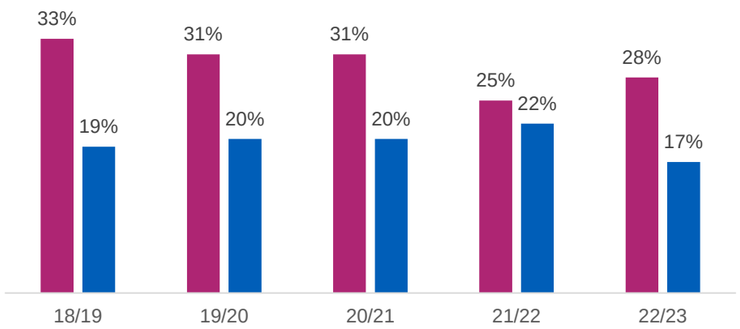


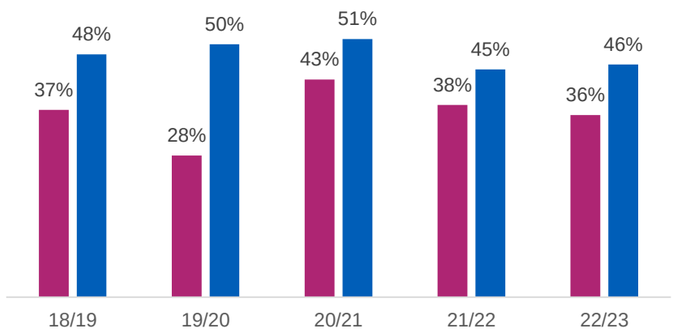
Understanding the experience of our staff

Disabled Non-disabled

% of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough:



% of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.



Action Plan

⚠ = 2023/24 priority areas of work

	Metric requirements	Action to address	Led by / Sponsored by	Delivered by
⚠	Metric 1: Increase disability declaration by at least 5% by March 2024 Decrease percentage of unknown staff by at least 5% by March 2024	• Re-launch Equal Abilities Network to promote engagement and uptake of campaigns developed by and for Disabled people we work with • Disability sharing campaign designed to increase awareness of support, reasonable adjustment and help aid declaration of disability. • Revie how ESR data is captured and what routes may already exist for updating declaration of disability or long term health condition.	Lead: Head of EDI Sponsor: Associate Director for Culture	March 2024
	Metric 2: Sustained approach to ensure equity of appointment is maintained	• Review parts of process that are working and apply to other recruitment processes. • Review what needs to be continued to ensure ongoing equity achieved	Lead: Recruitment Lead Sponsor: Associate Director for Talent Acquisition	July 2024
	Metric 3: Understand why the metric has remained at 0.0 year on year	• Review data capture approach and how metric is measured, adjust and change to ensure accuracy of data if necessary	Lead: HR Business Partners Sponsor: Associate Director for Programmes and Partnering	May 2024
⚠	Metric 4a (i,ii,iii): Half the percentage difference of Disabled staff experiencing bullying, harassment or abuse compare to non-disabled staff by October 2024	• Build resources and training to all staff on identifying, challenging and reporting abuse into induction, preceptorship and all development programmes within the RUH • Introduce a new reporting system to make reporting of experiences of harassment and bullying from staff easier • Re-develop bullying and harassment policy to change approach to racism raised within the organisation and embed early prevention across all areas with active allyship. • Diversity indicators developed in ward accreditation process and within speciality and division score cards to hold leaders to account on the experience of their teams • Focussed training developed and delivered for key areas where experiences are highest	Lead: Head of EDI Sponsor: Associate Director for Culture / Deputy Director for People and Culture	October 2024
	Metric 5: Increase awareness of career opportunities within the organisation	• Develop collaboration between learning and development / organisational development team and Equal Abilities Network to develop a project that highlights career development opportunities for Disabled staff.	Lead: Head of L&D / Head of EDI Sponsor: Associate Director for Capability	October 2024
⚠	Metric 6: 10% reduction in the percentage of staff who feel pressured to come to work by October 2024	• Review of reasonable adjustment guidance for managers • Review flexible working and supporting attendance policy to ensure equitable and inclusive approach to supporting Disabled staff	Lead: HR Business Partners (support from Head of EDI) Sponsor: Deputy Director for People and Culture Associate Director for Programmes and Partnering	May 2024

Action Plan

⚠ = 2023/24 priority areas of work

Metric requirements		Action to address	Led by / Sponsored by	Delivered by
	Metric 7: Increase percentage of staff who feel the organisation values their work	• Collaborate with communications and HR transformation to ensure Disabile staffs experiences are included within retention work stream, as well as reward and recognition work streams	Lead: HR change manager Sponsor: Associate Director for Capability	October 2024
	Metric 8: Continue to increase adequate adjustment(s) enabling staff to carry out their jobs	• Review reasonable adjustment processes to improve user experience • Develop guidance and signposting for managers to raise awareness and build in provision from on boarding and through appraisal processes.	Lead: HR change manager / Head of EDI Sponsor: Associate Director for Capability / AD for Culture	May 2024
	Metric 9b: Improve activities and provision of engagement opportunities for Disable staff	• Re-launch Equal Abilities Network • Develop communication plan for key Disability events throughout the year • Increase engagement in the NHS Staff Survey, actively encouraging Disabled staff	Lead: Head of EDI Sponsor: Associate Director for Culture	October 2023
	Metric 10: continue to promote representation across the board.	• Continue board development sessions focussed on EDI and key issues across all key governance locations	Lead: Head of EDI Sponsor: Director for People and Culture	January 2024

NHS 75

Royal United Hospitals Bath

NHS Foundation Trust

The RUH, where you matter

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	19
Date of Meeting:	6 September 2023		

Title of Report:	Freedom to Speak Up Update 2022
Status:	For Discussion and Noting
Board Sponsor:	Alfredo Thompson, Director for People and Culture
Author:	Helen Back, Associate Director Learning and Culture Parmi Perera, Freedom to Speak Up Guardian
Appendices	App 1: PRN00719_Letter re Verdict in the trial of Lucy Letby_180823

1. Executive Summary of the Report

This report provides an update on the progress that the Trust continues to make, this progress includes engaging with the External Guardian's Service to conduct a formal review of our current service alongside formalising the Associate Guardian role, to ensure there is no break in service in period of leave.

One of the actions already identified internally – but is an approach used by the external Guardian's Office - is the creation of an Organisational SLA, which provides a very clear framework or escalation and response times where a guardian does not feel they are getting the engagement needed from the organisation.

These steps, with others, will support our new FTSU guardian, associate guardian and champions continue to drive the service forward in the best way possible.

The FTSU team, have responded to all recent CQC requests, whilst working with the National Guardian's Office to ensure compliance with the need to maintain anonymity for those who have spoken to the FTSU team.

A number of listening events have taken place over the June and July 2023, to support the identification of actions that could support improvements in specific clinical areas. These have raised concerns around confidentiality, a specific action is being addressed around re-education of confidentiality for those in leadership positions. The FTSU team will continue to embed this message

This report explores the most recent data around concerns that have been raised and also the feedback around staff not feeling safe to raise issues and steps that have been taken to increase visibility of the service.

Finally, this report looks at the progress made against the FTSU vision and strategy highlighted in the annual Report.

2. Recommendations (Note, Approve, Discuss)

Strategic Workforce Group/the board is asked to:

- Discuss and note the Freedom to Speak Up update

- Note the links to ED&I – the 2023 NHS Equality, diversity and inclusion improvement plan references FTSU – stating
  Boards should ensure concerns raised about race/religious discrimination are dealt with in a proactive, preventative, thorough and timely manner, including encouraging diversity in Freedom to Speak Up Guardians.
- Contribute to the debate around the creation of a speaking up culture within the Trust especially in light of the Lucy Letby case
- Note that the Trust has commissioned an external review of the FTSUG service and speak up culture

3. Legal / Regulatory Implications

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

- NHS contract (2016/17) requirement to nominate a Freedom to Speak Up Guardian.
- National NHS Freedom to Speak Up raising concerns (whistleblowing) policy (2016)
- NHS Constitution: The Francis Report emphasises the role of the NHS Constitution in helping to create a more open and transparent reporting culture in the NHS which focuses on driving up the quality and safety of patient care.
- Public Interest Disclosure Act 1998: The Act covers all workers including temporary agency staff, individuals on training courses and self-employed staff who are working for and supervised by the NHS.
- Enterprise and Regulatory Reform Act 2013: The Act introduces a number of key changes to the Public Interest Disclosure Act targeted at strengthening protections for whistleblowers.
- The Bribery Act 2010: This guidance is targeted at helping employers ensure that their local policies and procedures are in line with the legislation and, most importantly, are tied into whistleblowing arrangements.
- Health Service Circular 1999/198 "The Public Interest Disclosure Act 1998: Whistleblowing in the NHS": The Health Service circular requires every NHS trust to have robust policies and procedures in place which enable staff to raise concerns in compliance with the Public Interest Disclosure Act and remains in force.
- PAS 1998 Whistleblowing Arrangements Code of Practice

On 18th August 2023, the Trust received the letter entitled “Verdict in the trial of Lucy Letby” from NHS England. The Board has been asked to ensure it has proper governance and oversight on the following:

NHS England Requirement	Trust Process	Governance	Frequency
All staff have easy access to information on how to speak up	• Freedom to speak up eLearning subject is ‘Essential’ training for all new starters. The current compliance rate is 76.23% and on target to deliver	Reviewed at People Committee	Monthly as part of Stat and Mand training

	85% by next summer		
Relevant departments, such as HR, and FTSUG are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme	• Actively promoted through the HRBPs and FTUSG network	People Committee	Quarterly Reports
Approaches to mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and those who work unsocial hours and may not always be aware of have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.	• Executive and NEDs "Go See" programme – Day and Night visits • FTSUG service is comprised of 14 multi-cultural; profession & grades • FTSUG service operates 24/7 • Monthly Virtual All Staff Briefs • Weekly Q&A sessions – anonymous feedback possible • Monthly meeting between FTSUG, Chief Executive and Director for People & Culture	People Committee; Executive Team meetings	Consistent feedback
Board seek assurance that staff can speak up with confidence and that whistle-blowers are treated well	• Freedom to Speak Up Guardian reports • Senior Independent Director in place • Independent review of our FTSUG currently being undertaken by 'The Guardian Service'	People Committee and Board reports	Quarterly Reports
Boards are regularly reporting, reviewing and acting upon available data	• Freedom to Speak Up Guardian Reports • Regular monthly meetings between FTSUG, Chief Executive and Director for People and Culture	People Committee	Monthly Meetings Quarterly Reports

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)**
The implementation of effective practices ensuring that staff are able to raise concerns and are protected when they do will ensure that the Trust guards against	

legal claims against it. Failure to develop and implement the requirements of the legal and regulatory framework requirements may lead to reputational and finance losses.

Development and maintenance of the Freedom to Speak Up agenda is one of the key control measures for the management of BAF 2 (shortages in the supply of registered healthcare professionals).

5.	Resources Implications (Financial / staffing)

6.	Equality and Diversity
The Raising Concerns Policy complies with the Public Sector Equality Duty 2023 NHS Equality, diversity and inclusion improvement plan references FTSU – stating *Boards should ensure concerns raised about race/religious discrimination are dealt with in a proactive, preventative, thorough and timely manner, including encouraging diversity in Freedom to Speak Up Guardians*.	

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

8.	CQC Domains
Safe: Effective: Caring: Responsive: Well-led	

9.	Freedom of Information
Public	

1. Purpose

The purpose of this report is to update Strategic Workforce/Trust Board on Freedom to Speak up (FTSU) activities at Royal United Hospitals Bath NHS Foundation Trust (RUH) over the last quarter (Quarter 1 01st April 2023-30th of June 2023), providing information on the nature of the concerns raised including relevant internal data.

2. Background

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

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

Similar to staff being encouraged to speak up and raise concerns, leaders and managers are also encouraged to actively listen to these concerns and action/escalate matters respectively.

The National Guardian's Office (NGO) is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC and NHSI/E. Freedom to Speak Up and Raising Concerns supports our Trust's vision:

- **For the people we work with**, creating the conditions to perform to our best – living by our values, investing in our teams and supporting diversity.

The Trust Vision for Freedom to Speak Up is:

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

The FTSU Guardian is also responsible for submitting quarterly date to NGO as follows:

Q1 (2023/24): Opens Monday 10th July 2023 and closes on Monday 7th August 2023

Q2 (2023/24): Opens Monday 9th October 2023 and closes on Monday 6th November 2023

Q3 (2023/24): Opens Monday 8th January 2024 and closes on Monday 5th February 2024

Q4 (2023/24): Opens Monday 8th April 2024 and closes on Tuesday 7th May 2024

Guardians will be able to add or amend data from 2022/23 during the reconciliation period, which will run alongside the Q4 window.

A Freedom to Speak Up Guardian has been in place at the RUH since October 2016. The service has been supported by two Associate guardians in an interim period before Parmi Perera, the new FTSU guardian came into post in June 2023.

The FTSU Service currently has previously trained 13 FTSU Champions. However, since taking over the FTSU Guardian role in June 2023, there are plans to refresh training and introduce a formal agreement for champions to ensure they continue to work in accordance to NGO Guidelines.

3. Update on FTSU

3.1 FTSU Champions

Having discussed the roles, responsibilities and remits of FTSU Champions with NGO, FTSU Guardian at Trust has been advised to await further guideline updates by NGO. FTSU Guardian is currently updating the champion list with a structured plan to ensure FTSU Champions are working within their remits. FTSU Champions will also be asked to complete annual refresher training with FTSU Guardian and NGO.

3.2 FTSU Data

Overall FTSU continues to be a busy service with staff accessing the service from a range of job roles, bands and areas in the organisation. This data will be summarised below.

Confidence in raising concerns has marginally declined at the improving in the organisation. Our 2022 Staff Survey data shows whilst we remain above average – we have seen a drop in confidence in both raising concerns and confidence in organisation taking action. This matches the national picture, where the highest performing organisations have also seen a decline from 2021.

4. Embedding FTSU into the culture of the RUH

Continued work is being taken forward to promote and maintain an open and transparent culture across the Trust, ensuring that all members of staff feel safe and confident to speak up about issues that concern them. Parmi Perera and Catherine Gideon (Associate Guardian) have increased visibility – ensuring presence in clinical areas – both during the working day, at night, and some cover at weekends. It is worth noting, the current establishment does not support 24/7 cover – but the team have worked flexibly to ensure visibility of the service for all staff and the aim is to continue to do so.

FTSU have worked with the Senior nursing team, to ensure communications have reached all areas about the new FTSU guardian team and how they can support. The team are mindful they do not seek to have all concerns come to them, so are working with managers to create an open culture where speaking up is encouraged.

The RUH has commissioned an independent provider, The Guardians' Service, to conduct a review of the service to ensure we are applying best practice, and strive to create a culture where staff feel safe to raise concerns.

Work is underway to include Freedom to Speak up into the ward accreditation programme at bronze, silver and gold level.

FTSU training is available to new starters, inductions and project search workers in different formats to ensure training is accessible to all staff, including those who do not have access to computers/ e learning. There is a FTSU e-training for senior leaders, 'Follow Up', which FTSU is hoping to introduce in the year.

FTSU is present on the Patient steering group to support triangulation Patient safety concerns. FTSU Guardian is awaiting meeting with Interim Quality Programme Director to discuss methods of triangulating concerns from various sources as a mean of being vigilant to trending themes.

FTSU also meets with senior leaders to feedback on occurring themes, review trends on 'Open cases' and/or any high risk cases, cases escalated to directorate and also to discuss support going forward.

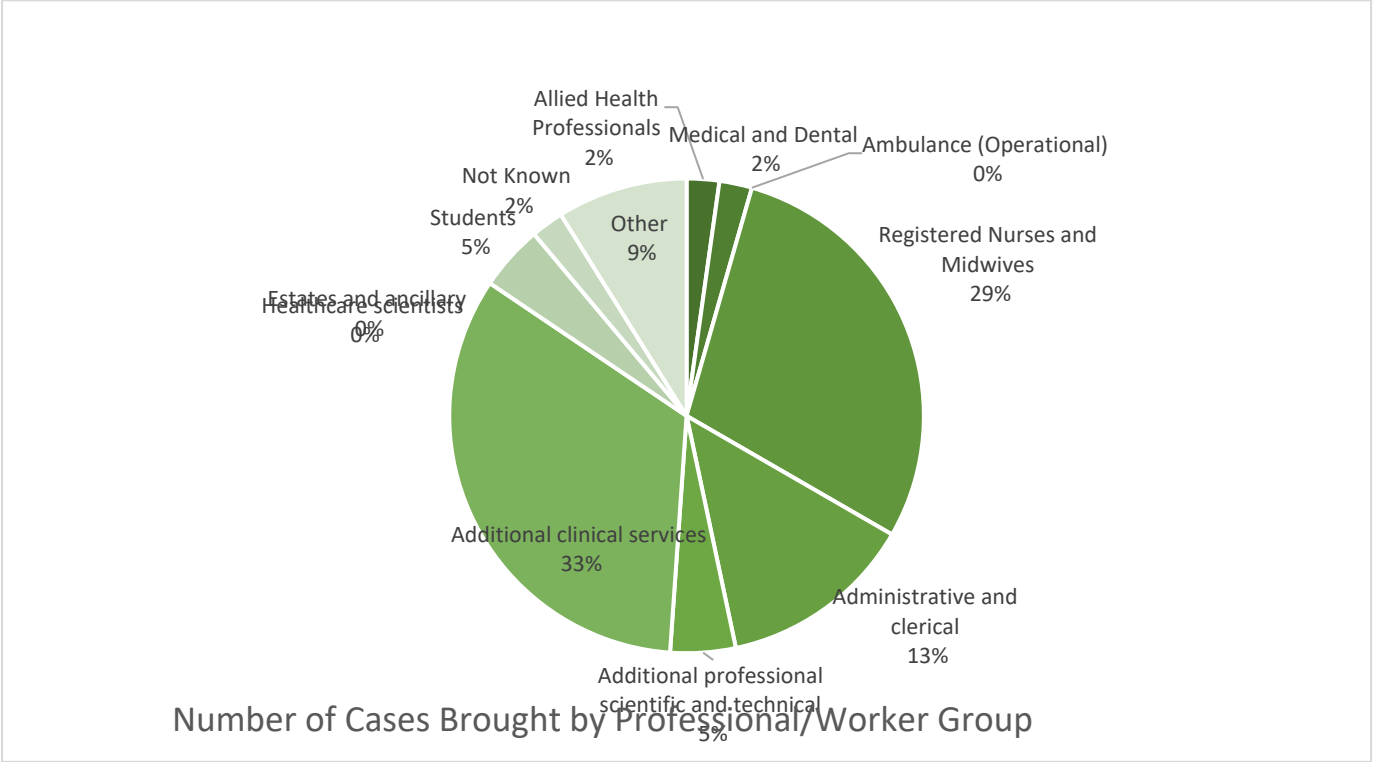
Regular updates of themes and trends are given to all divisions at board, this will continue as part of a quarterly rolling programme.

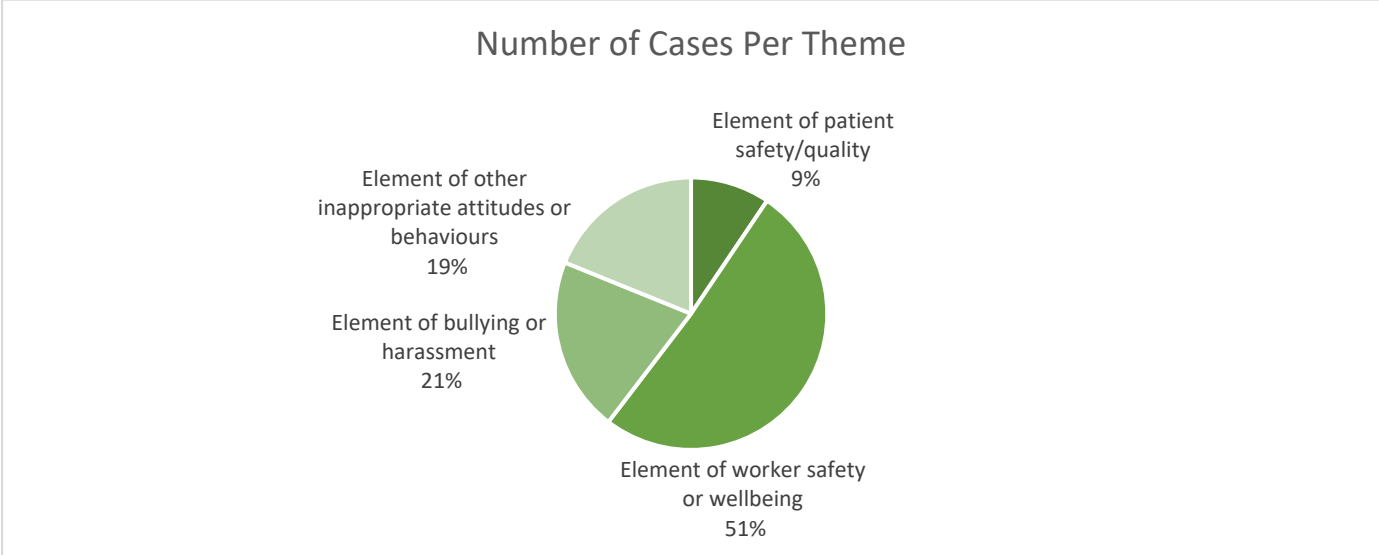
FTSU information is sited within the Trust's leadership programmes.

October 2023 is the 'FTSU Speaking Up' month and there is hope of raising awareness especially for night and weekend staff.

5. 2023-2024 Q1 Data

Size of organisation	Medium (between 5000-10,000 workers
Region	South West
Number of cases brought to FTSU Guardian(s)	45



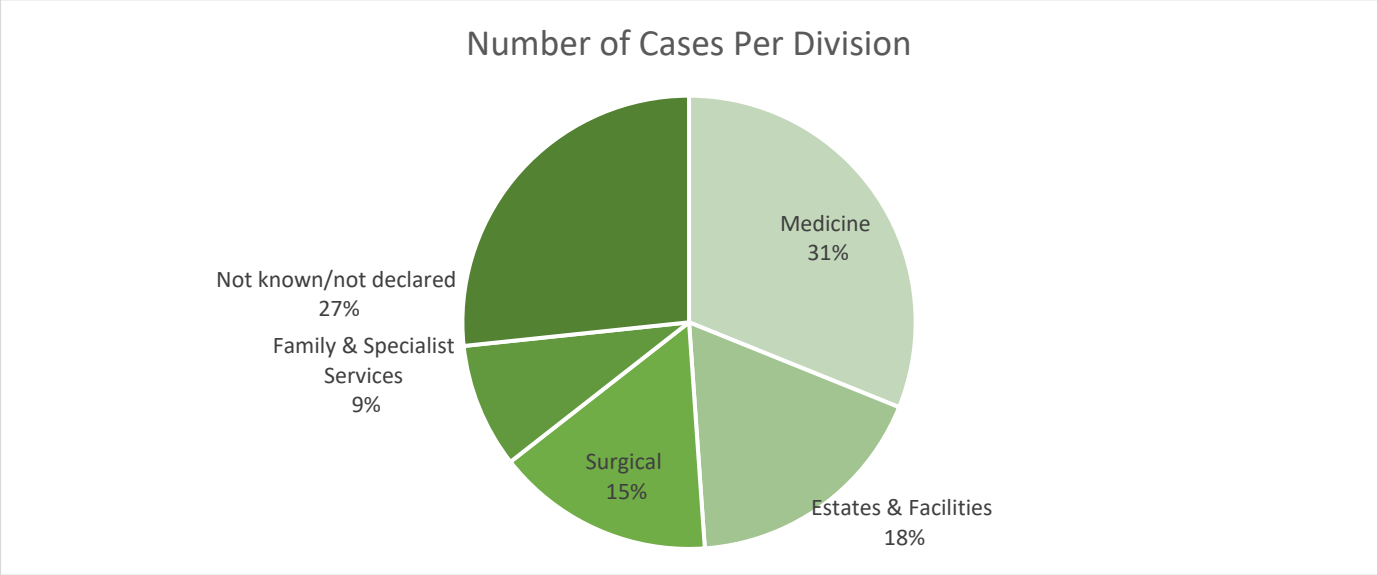


Please note: FTSU concerns are recorded per NGO Guidelines themes of Patient Safety/Well-being, Worker Safety/Well-being, Inappropriate Attitudes and Behaviours and Bullying & Harassment. However, if a case has more than 1 theme, all themes are recorded and reported accordingly.

FTSU also takes into account and reports the following:

Number of cases raised anonymously	2
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated	1

FTSU records the following information but is not required to submit the following to NGO.

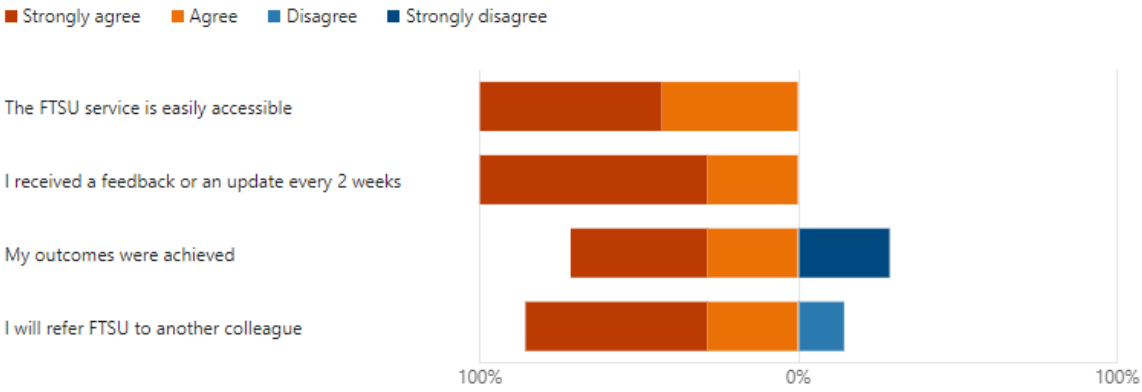


6. FTSU User Feedback

FTSU asks users to fill out a feedback form once their case has closed. The feedback summary is below: Please note the following are extracted screenshots from the feedback form. The numbering of sections do not relay to rest of report.

1. Based on your experience, please rate

More Details



7. Given your experience, would you speak up again?

More Details

Yes	5
No	2
Maybe	0

ID ↑	Name	Responses
1	anonymous	I needed advice on whether to complete a datix or not for something that happened on a ward (from a bank shift) , but I think that wasn't understood, and was asked if I needed help speaking to my manager from my department (which is outpatients). I just wanted some advice, but all I was told was " I do not have the clinical knowledge to advise you regarding this."
2	anonymous	Really helpful understanding and caring
3	anonymous	as soon as the senior leaders were informed i was removed from my ward having done nothing wrong
4	anonymous	Kind and understanding. Pro-active and professional. Issue has been resolved.
5	anonymous	I first spoke to [redacted] who then arranged a meeting with [redacted] passed on my concerns to Para. You have all been incredibly supportive and helpful, and Para, I very much appreciate that you are taking this further.
6	anonymous	The support was good and I felt confident it was treated seriously.
7	anonymous	The support of speak up guardian gave me a confidence and the feeling of protection against potential retaliations form my colleagues/ managers

12. Please suggest any areas for FTSU Service improvements.

6 Responses

ID ↑	Name	Responses
1	anonymous	Being clear on what services you offer/ What you can do vs. what you can't, because if something happens in a clinical area, to be told Freedom to speak up team aren't clinical so can't advise, isn't helpful...Also i dont have more than 1 role, but in order to complete this form I still had to answer Q4?
2	anonymous	FTSU is a valuable service however senior leaders should take time to reflect and learn when procedures are not followed.
3	anonymous	Ensure intranet up to date with details of champions and guardians and their contact numbers.
4	anonymous	It's an excellent service!
5	anonymous	My concerns where raising the issue could have caused problems for others and this caused me some angst. Understanding this is about solving problems and improvement and getting this message through more widely is important.
6	anonymous	outreach to the employees perhaps by visiting the wards and having a little chat about with them / create awareness sessions

10. What are the barriers for you to speak up and how can we help you overcome them?

7 Responses

ID ↑	Name	Responses
1	anonymous	I have no barriers
2	anonymous	Confidence
3	anonymous	unfortunately FTSU are unable to help me, but i thank them for their support
4	anonymous	Initially it was hard to get hold of someone to speak to as intranet wasn't up to date with who to contact. There was no FTSU guardian in post at the time of raising my concern, although, this has now been resolved.
5	anonymous	I decided to speak up after having several meetings with my managers that didn't resolve the issues, so fortunately I knew about Speak Up due to it being included in my Induction.
6	anonymous	It was a relief and caused anxiety building up to contact, I would advise anyone don't do what I did and wait speak up with confidence if you have something troubling you and you are not confident in responses you have received from line management.
7	anonymous	When I raised my complaint, the fear of retaliation was a realistic concern. However, the guardian ensured my protection by offering me the option of anonymity and sincere support in protecting me during the complaint procedure. That in fact was backed up by the head of the hospital and therefore was empowering. The knowledge about the existence of service was also a barrier. I was aware of the Speak Up service from another NHS trust. Increasing knowledge about service will be a good idea. During one of my inductions, in another trust, I had a separate face-to-face seminar with their speak-up guardian, and although short and simple, this little session really lodged in my memory and became very empowering when things went wrong.

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**20**
Date of Meeting:	**6 September 2023**		

Title of Report:	**Gender Pay Gap Report**
Status:	**For Information**
Board Sponsor:	**Alfredo Thompson Director for People and Culture**
Author:	**Emma Baker-Gaunt, Head of Equality, Diversity and Inclusion**
Appendices	**Appendix 1: Gender Pay Gap Report**

1. Executive Summary of the Report

The Trust has a legal duty to publish Gender Pay Gap information yearly by 30th March each year for the previous calendar year. We collected our data on 31st March 2022. The gender pay gap looks at both the mean and median average. We believe the median average is a more representative measure of the pay gap because it is not affected by outliers (a few individuals at the top or bottom of the range). Key findings are:

- The median pay gap between our male and female medical staff has increased further, continuing to be in favour of men. Male employees in medical staff group are earning an average of £12.20 per hour more than their female colleagues. This is an increase of £2.52 compared to the 2021 median average.

- The medical and dental staff group is the only pay group that has an almost 50/50 split in representation. All other levels are majority female.

- This year has also seen a sharp increase in the gender pay gap across bonus payments with an 18.43% gap favouring men when looking at the median average bonus payments between male and female employees. This is a significant increase from parity (no gap) in 2021.

- A decrease of the median pay gap for the Trust overall, favouring women with female employees paid 1.31% more on average than male. Last year's gap was 2.49% favouring women.

The Trust recognises that more work needs to be done to address the inequalities experienced by female employees. Our current reporting cycle means we are working with data that is 12 months prior. We will change the reporting cycle of our gender pay gap for March 2023, so that the report is released in the same year of the results, so that actions can be implemented before the next reporting date.

Additionally, there is very little understanding clarity of where the gap is greatest within medical staffing and the causes of the widening gap. We intend to use the A3 quality improvement methodology to understand the root cause of the difference in

gender pay gap for medical staff. This will inform targeted and focussed measures, led by the senior leaders within the medical teams to address the top contributing areas to the widening gap. The goal is that by 2024, the NHS staff survey results see an increase in the percentage of female staff that recommend the RUH as a place to work and feel satisfied with the level of pay, alongside a reduction in the gender pay gap for medical and dental staff.

2.	Recommendations (Note, Approve, Discuss)
The Board of Directors is asked to note the information provided in this report.	

3.	Legal / Regulatory Implications
The Trust has a legal duty to publish the data, both on its website and on the government's gender pay gap reporting website	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The Gender Pay Gap is on the Trust Register, recognising the potential reputational impact of the published data.	

5.	Resources Implications (Financial / staffing)
The work of the A3 could lead to actions that have a financial impact, the amount and what level is unknown and therefore unable to quantify at this point.	

6.	Equality and Diversity
Gender is one of the nine protected characteristics under the 2010 Equalities Act. The People committee oversees work on equality issues. There is currently an inequity between male and female employees in pay. Specifically in the Medical and Dental Staffing Group.	

7.	References to previous reports
N/A	

8.	Freedom of Information
Public	

9.	Sustainability
N/A	

10.	Digital
N/A	

Appendix 1

Royal United Hospitals Bath
NHS Foundation Trust

Gender Pay Gap Report 2021/22

Executive Summary

As an organisation employing more than 250 staff the Trust is required under the Equality Act 2010, to publish information on its gender pay audit.

This report sets out the 2022 gender pay gap in comparison to 2021 data, the results from the NHS staff survey data around pay, alongside acknowledgements and actions for the Trust to address its gender pay gap.

Mirroring the NHS as a whole, 76.49% of our workforce is female. Female employees outnumber male employees at most levels of the organisation, except for within our medical and dental workforce where the split is approximately 50/50.

Our data for this year's report was collected on 31st March 2022.

Key findings:

- The median pay gap between our male and female medical staff has increased further, continuing to be in favour of men. Male employees in medical staff group are earning an average of £12.20 per hour more than their female colleagues. This is an increase of £2.52 compared to the 2021 median average.

- The medical and dental staff group is the only pay group that has an almost 50/50 split in representation. All other levels are majority female.

- This year has also seen a sharp increase in the gender pay gap across bonus payments with an 18.43% gap favouring men when looking at the median average bonus payments between male and female employees. This is a significant increase from parity (no gap) in 2021.

- A decrease of the median pay gap for the Trust overall, favouring women with female employees paid 1.31% more on average than male. Last year's gap was 2.49% favouring women.

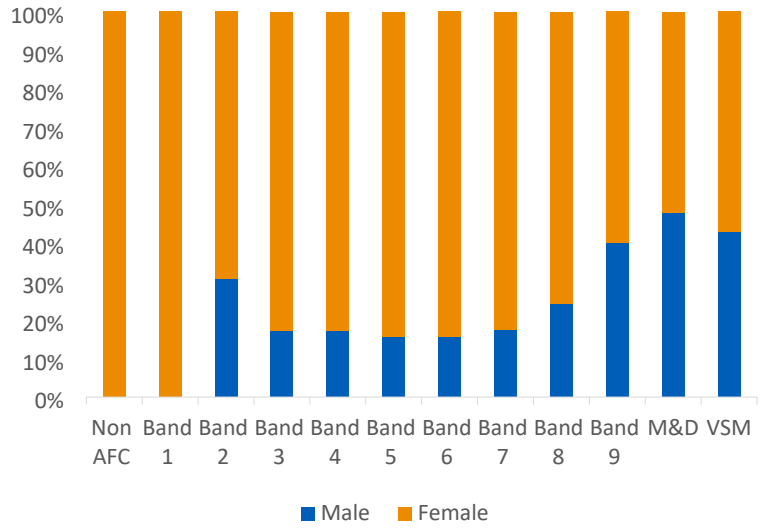
- A big lift in the median average and mean average bonus payments for non-medical staff rising from 19.29% to 45.66% (Median) and 11.93% to 53.64%(Mean) in favour of women.

Royal United Hospitals Bath
NHS Foundation Trust

Our results - 31st March 2022 snap shot

At all levels the largest majority of employees are female. Our Medical and Dental group has an almost 50/50 split, with 52.1% female and 47.9% male.

Percentage of male and female staff employed by pay band as at 31st March 2021



Quartile	Male %	Female %
Lower	22.4%	77.6%
Lower Middle	25.0%	75.0%
Upper Middle	16.2%	83.8%
Upper	30.4%	69.6%

Figure 1: Bar graph indicates percentage of male and female staff employed by pay band as at 31st March 2021

There has been little movement from 2021 to 2022 in terms of percentage of men/women in each band and the quartiles, except for in Band 1 which is now 100% female with no male representation (down from 50%). With an employee currently at Band 1, the Trust is unable to become a real living wage employer and we are working to change this.

Gender pay gap as a Mean Average

What is the 'Mean'?

The mean is the average hourly wage. It is calculated by adding up all the pay of all male employees and dividing it by the number of male employees. The same is then done for all the female employees.

The mean gender gap is the difference between the average hourly earnings of male full-pay employees and female full-pay employees.

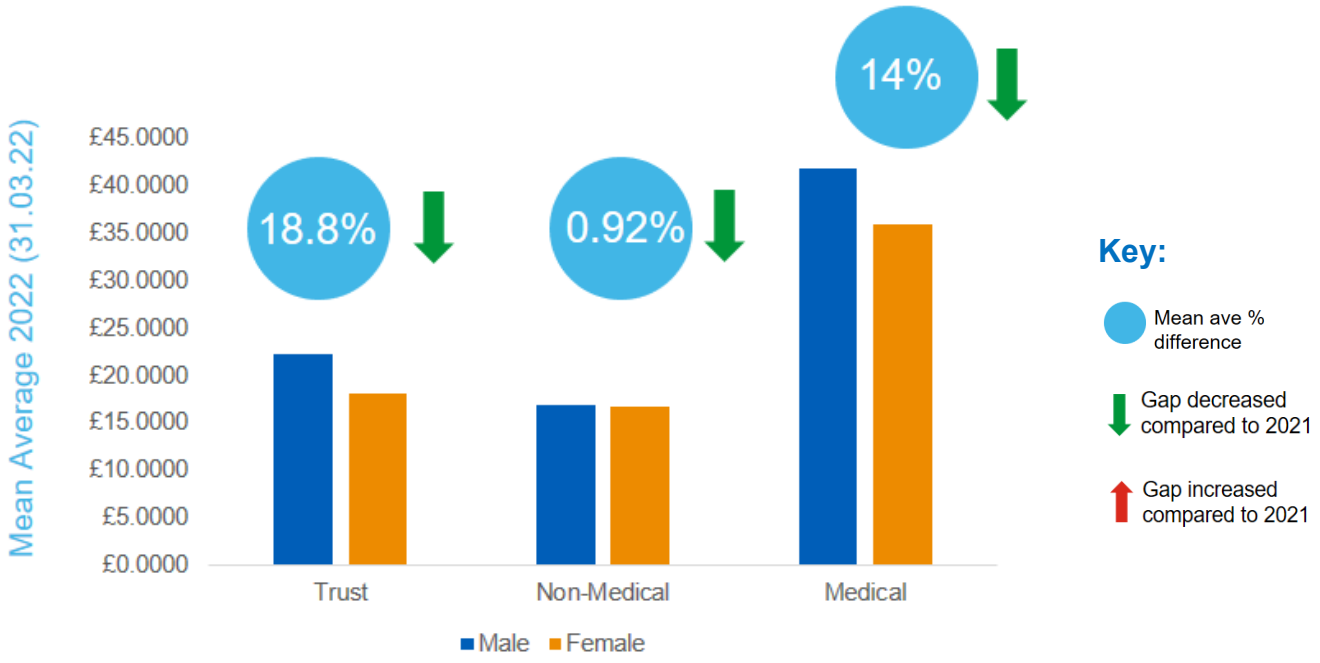


Figure 2: Bar graph showing the mean average pay by gender. Compares Trust overall, non-medical and medical staff.

Gender	Male 2021	Female 2021	Male 2022	Female 2022	% difference 2021	% difference 2022
Trust	£21.97	£17.36	£22.19	£18.01	21.03%	18.83%
Non-Medical	£15.60	£15.95	£16.83	£16.67	-2.24%	0.92%
Medical	£45.30	£36.02	£41.74	£35.88	20.48%	14.03%

On average men earn £4.18 per hour more than women. When medical staff are removed, this decreases to 16p an hour more. Men in the medical workforce earn on average £5.85 per hour more than women, a better position than last year where men in the medical workforce earnt £9.28 per hour more than women.

Gender pay gap as a Median Average

What is the 'Median'?

The median pay gap is the difference between the midpoints in the ranges of hourly earnings of male and female employees. It takes all salaries in the sample, lines them up in order from lowest to highest, and picks the middle salary. We believe this is a more representative measure of the pay gap because it is not affected by outliers – a few individuals at the top or bottom of the range.

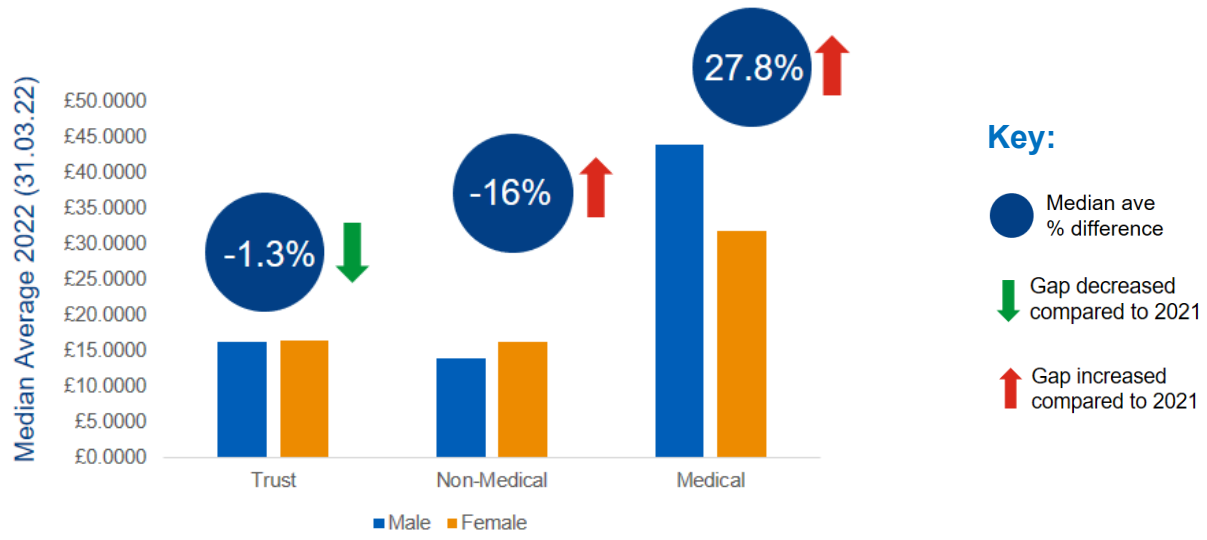


Figure 3: Bar chart represents the median average pay by gender. Compares Trust wide, non-medical and medical staff.

Gender	Male 2021	Female 2021	Male 2022	Female 2022	% difference 2021	% difference 2022
Trust	£15.28	£15.66	£16.19	£16.41	-2.49%	-1.31%
Non-Medical	£12.99	£14.92	£13.89	£16.13	-14.84%	-16.09%
Medical	£43.49	£33.81	£43.90	£31.70	22.25%	27.79%

Whilst pay has increased across the Trust, the median percentage difference has decreased. It still reflects a slight average median gap favouring women, with female employees earning on average 21p per hour more than men. This is not reflected in medical pay where there has been further increase in the gap favouring men, who are paid on average £12.20 per hour more than women.

When considering non-medical staff women are paid more than men, with this gap also increasing compared to 2021, with an average of £2.24 more per hour.

Bonus gender pay gap as mean and median average

As an NHS organisation the pay elements we have that fall under bonus pay criteria are, Local Clinical Excellence Awards, (LCEA), paid to Consultants and performance bonuses paid to the Executive Directors

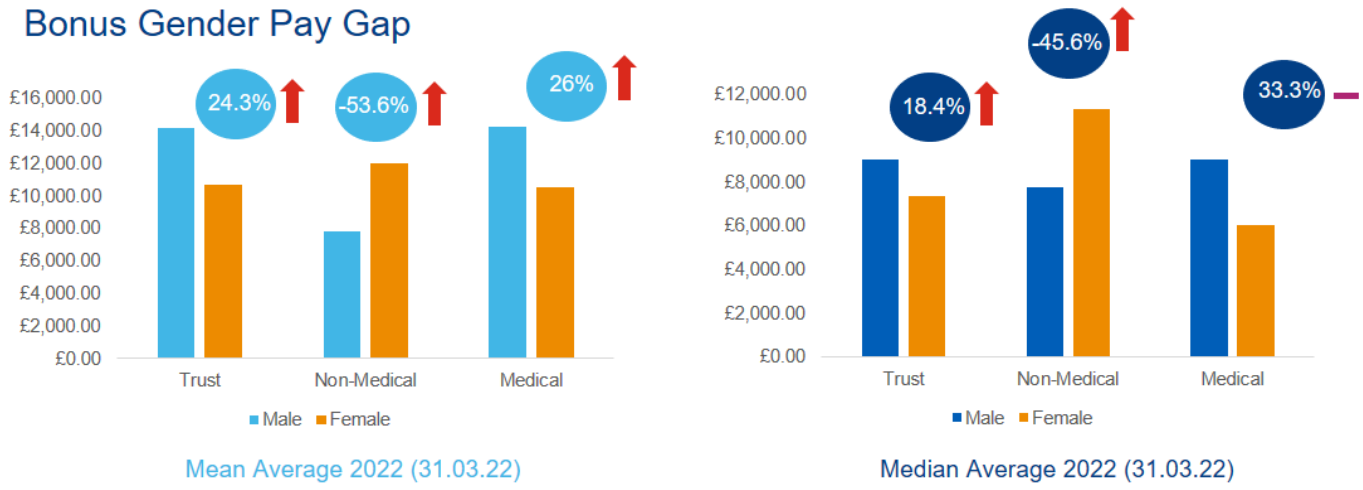


Figure 4: Two bar graphs showing the bonus gender pay gap by Trust, Non-medical and Medical staff groups.

Key:

Mean ave % difference

Median ave % difference

Gap decreased compared to 2021

Gap increased compared to 2021

Bonus payments for non-medical staff have changed significantly, as highlighted in previous reports this figure can fluctuate given the small numbers of executives who receive bonuses, a change of just one person leaving a post and another filling it who is of a different gender can have a significant impact.

The gender pay gap for bonuses for the Trust overall have increased, both in the mean and median average difference. Last year as a Trust we hit parity for the first time since gender pay gap reporting began with a bonus median percentage difference between male and female employees of 0%, however this year the gap has increased substantially to an 18.43% difference favouring men. The greatest difference however, has been seen in non-medical staff group where the median gap has increased from 19.29% to 45.66% in favour of female employees.

Proportion of males and females receiving a bonus payment

Gender	Male 2021	Female 2021	Male 2022	Female 2022	% difference 2021	% difference 2022
Trust	4.10%	0.54%	3.59%	0.49%	3.56%	3.10%
Non-Medical	0.07%	0.07%	0.06%	0.07%	0.00%	-0.01%
Medical	18.93%	6.67%	17.34%	6.53%	12.26%	10.81%

As with 2021, the proportion of staff receiving bonuses has remained largely static, with a continuing trend towards an overall improvement in all scores.

Satisfaction with reward male and female comparison

Survey Question: NHS Staff Survey 2022 results	Male	Female	Statistically significant?
Percentage satisfied with recognition for good work	61%	54%	Yes
Percentage satisfied with extent organisation values my work	52%	42%	Yes
Percentage satisfied with level of pay	31%	24%	Yes
Percentage satisfied with opportunities for flexible working patterns	56%	55%	No
Percentage would recommend organisation as place to work	67%	62%	Yes

Overall our 2022 staff survey results show that of the employees who responded, our female staff are significantly less satisfied with the recognition they receive for good work, the extent they feel the organisation values their work and with the level of pay they receive. Our survey also indicated our female employees are significantly less likely to recommend the RUH as a place to work.

Final comments and actions

The greatest discrepancy in gender pay gap is within our medical and dental staff group. This has been a known issue, identified in a national report in 2020 “Independent Review into Gender Pay Gaps in Medicine” by Professor Dame Jane Dacre. However we have seen minimal change over the year, and this year a further worsening of the gap. Some actions from the 2021 report looked to address the inequality between male and female medical and dental staff but have not provided the expected results.

The Trust recognises that more work needs to be done to address the inequalities experienced by female employees. Our current reporting cycle means we are working with data that is 12 months prior. We will change the reporting cycle of our gender pay gap for March 2023, so that the report is released in the same year of the results, so that actions can be implemented before the next reporting date.

Additionally, there is very little understanding clarity of where the gap is greatest within medical staffing and the causes of the widening gap. We intend to use the A3 quality improvement methodology to understand the root cause of the difference in gender pay gap for medical staff. This will inform targeted and focussed measures, led by the senior leaders within the medical teams to address the top contributing areas to the widening gap. The goal is that by 2024, the NHS staff survey results see an increase in the percentage of female staff that recommend the RUH as a place to work and feel satisfied with the level of pay, alongside a reduction in the gender pay gap for medical and dental staff.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**21**
Date of Meeting:	**6 September 2023**		
Title of Report:	**Alert, Advise and Assure Report – Finance and Performance Committee**		
Status:	**For discussion**		
Author:	**Nigel Stevens**		

Key Discussion Points and Matters to be escalated from the meeting

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

- **Meeting discussed at length the 3 year break even improvement plan. A representative from BSW joined this element. The meeting concluded:**
  - **The structured approach was welcome**
  - **Board and FPC need to focus on forecasts not historical – this should drive the work**
  - **Critical to embed culture change**
  - **Committee recognised the huge challenge and the significant ramp up in second part of the plan, with options yet to be defined**
- **Winter Plan a significant concern and needs urgent Board review. Lack of central winter funding is a major concern**

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

- **Monthly operational performance report demonstrated much hard work and growing improvement but steep mountain to climb**
- **Managing and improving productivity will be a key to success**
- **Finance challenges in year remain a concern with a number of additional cost pressures in view**

ASSURE: Inform the board where positive assurance has been achieved

- **Assurance on operational improvements and the plans for continuing the current positive trend**

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

- **FPC covered most of the risks in one form or another**

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

- **Nil**

APPROVALS: Decisions and Approvals made by the Committee

- **Approved new laundry contract**

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

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	21.1
Date of Meeting:	6 September 2023		

Title of Report:	RUH 3 Year Plan and Improvement Programme: Deep Dive on Programme Approach
Status:	For discussion
Board Sponsor(s):	Andrew Hollowood, Chief Medical Officer Libby Walters, Director of Finance and Deputy CEO
Author(s):	Rhiannon Hills, Director of Transformation / Rachel Hambly, Programme Director, Financial Improvement Programme Libby Walters, Director of Finance and Deputy CEO
Appendices	None

1. Executive Summary of the Report

Each organisation is required to achieve a financial break-even position on an annual basis and return to a recurrent breakeven position in the next 3 years which is by 2025/26. The RUH has a breakeven plan in 2023/24 which requires the delivery of a £23.5 million savings programme and on achievement of the 2023/24 plan will enter 2024/25 with an underlying deficit of £32 million.

As per the Finance Strategy previously agreed the RUH are planning to return to financial breakeven by 2026/27 and this is to be delivered predominantly through the Improvement Programme. In order to accelerate the return to financial balance the revised proposed plan is to achieve this in 3.5 years so that the RUH is in a breakeven position by half way through 2026/27. The paper highlights these plans.

The delivery vehicle for financial recovery is the Improvement Programme. Initially, the programme is focussing on delivery of the 2023/24 £23.5m target and £28m stretch target but is now shifting focus to the development of a 3-year rolling programme. The programme objective is to ensure that the Trust is maximising resources to provide top decile performance for patient care, attracting and retaining great staff and delivering within financial resources in alignment with the Trust Strategy.

This paper provides a deep dive into the governance, processes and structure of the Improvement Programme, delivery to date and plans for future years.

2. Recommendations (Note, Approve, Discuss)

It is recommended that the Board of Directors:

- Note and discuss the 3 year recovery plan and the progress being delivered though the Improvement Programme

3. Legal / Regulatory Implications

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

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

In line with the Risk Assessment Framework :

The Trust fails to deliver its financial plan which leads to the Trust having a Single Oversight Framework rating of three or higher, representing a material level of financial risk. This results in a lack of confidence from the Trust's commissioners and the regulator and increases the level of scrutiny which utilises significant resources and can damage the reputation of the Trust. A significant number of financial risks are being managed and these are set out in the paper.

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 are being overseen by the Improvement Programme Steering Group to ensure the impact on clinical services is considered. The impact on health inequalities will be considered as part of this process.	

7.	References to previous reports
Monthly Integrated Performance Report Financial Strategy, FPC, 26th June 2023 This report was discussed at the Finance and Performance Committee on the 30 August 2023.	

8.	Freedom of Information
Public	

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

10.	Digital
Not applicable	

RUH Improvement Programme

Deep dive on the programmes approach: Defining Clinical Benefits
August 2023

1.0 Improvement Programme Background

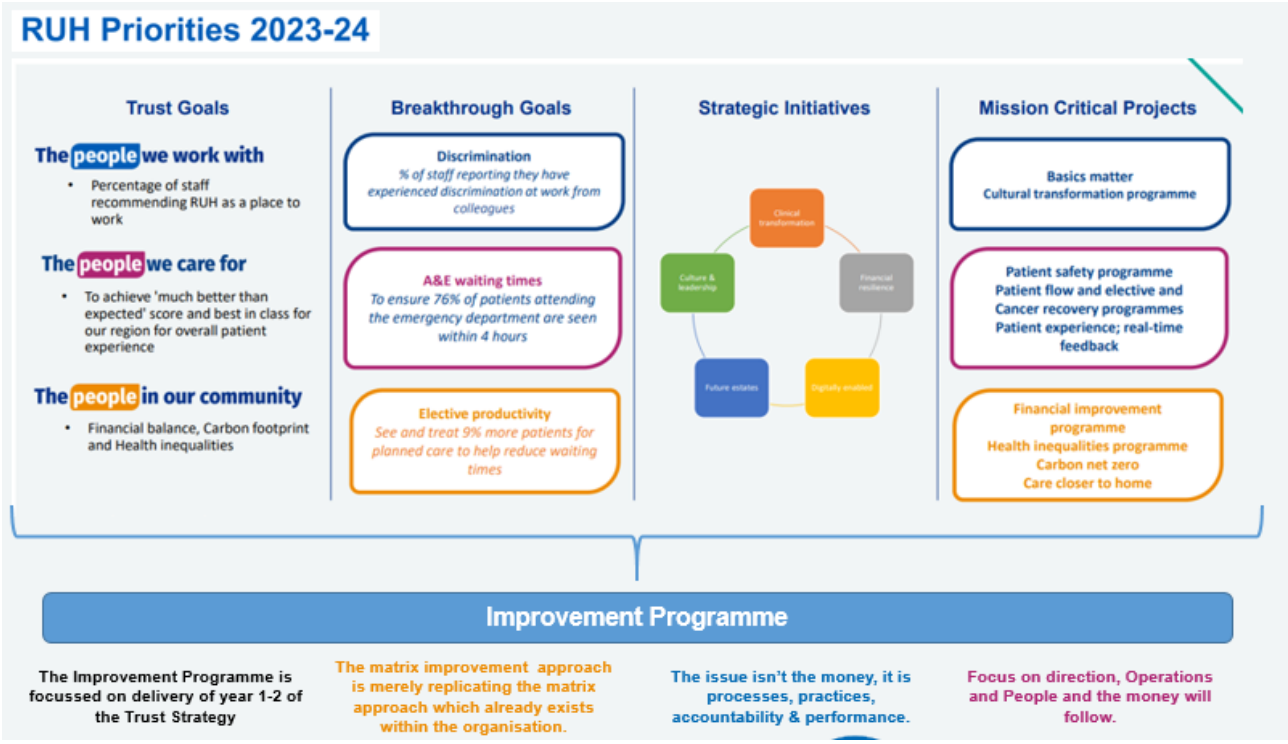
Each organisation is required to achieve a financial break-even position on an annual basis and return to a recurrent breakeven position in the next 3 years, which is by 2025/26. The RUH has a breakeven plan in 2023/24 which requires the delivery of a £23.5 million savings programme and on achievement of the 2023/24 plan will enter 2024/25 with an underlying deficit of £32 million.

As per the Finance Strategy previously agreed the RUH are planning to return to financial breakeven by 2026/27 and this is to be delivered predominantly through the Improvement Programme. In order to accelerate the return to financial balance the revised proposed plan is to achieve this in 3.5 years so that the RUH is in a breakeven position by half way through 2026/27.

The delivery of financial stability forms part of the wider Trust Strategy and the Improvement Programme is focussed on delivery of Years 1 and 2 of the strategy and development of plans for following years.

The programme runs in tandem with other key Trust activities and initiatives to achieve the wider Trust goals. These include the five core strategies: Clinical Transformation, Digitally Enabled, Culture and Leadership, Future Estates and Financial Resilience.

Figure 1: Delivering the Trust Strategy



It is recognised that in order to change the way we work, improve the experience for our staff and patients and delivery operational and financial benefits, this will require a holistic approach focusing on changing culture, innovation, focus on deliver, getting the basics right and ensuring the right team are in place to support transformational change.

The Trust has identified a number of opportunities to improve our processes, practices, accountability & performance to support the delivery of our financial position. These include;

- Seeing more elective patient within our current capacity
- Ensuring patients are seen in the correct setting which reduces patients in hospital beds
- Attract and retain staff to reduce reliance on high cost temporary workforce
- Investing in digital to improve the efficiency of services
- Pursing commercial opportunities
- Moving our 2 intensive care units onto one footprint
- Better use of our estate
- Reducing overheads
- Getting better value from the products we buy
- Reducing harm
- Redesigning our clinical services
- Improving the value of our current operational models

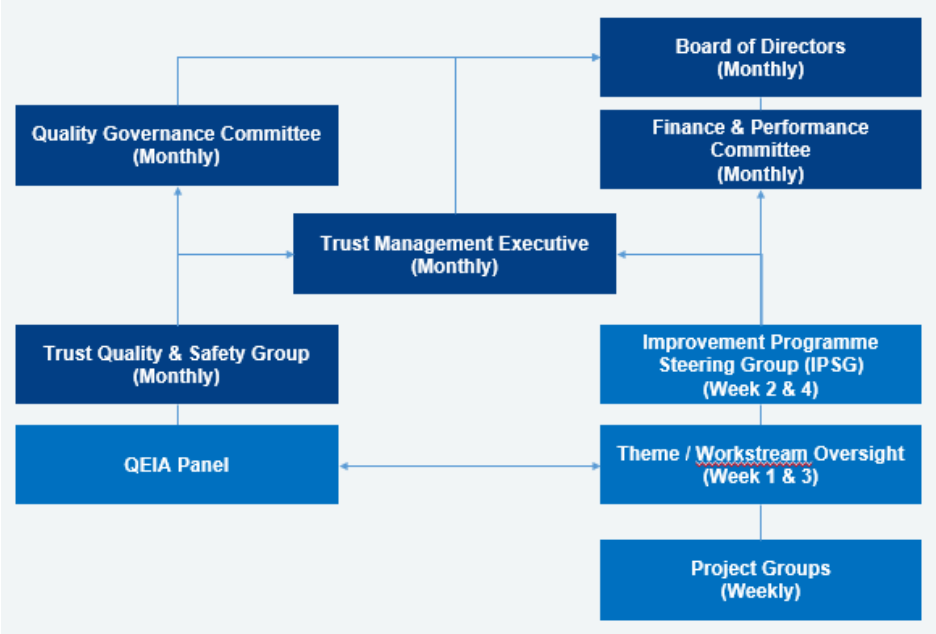
The Improvement Programme has been designed to cover projects across all of these areas supported by a dedicated team to ensure delivery and benefits realisation.

2.0 Programme Governance Structure

The RUH Improvement Programme was established in April 2023, formally commencing in May 2023. The programme is now in its 20th week of reporting for the FY 2023/24.

The programme is being overseen by the Improvement Programme Steering Group (IPSG), chaired by the Chief Medical Office. The Group reports into the Trust Management Executive (TME) and Financial & Performance Committee (FPC).

Figure 2: Meeting Governance Structure



The Programme has been set up against six overarching Themes. Under each of these themes sit a number of Workstreams. Beneath these are individual Projects.

Figure 3: Themes and Workstreams Matrix

Theme	Productivity & Efficiencies	Workforce	Cost Control & Management	Estate Management	Income	Divisional Schemes
Workstreams	1.1 Theatres	2.1 Nursing & Therapies Staffing	3.1 Pharmacy & Medicines Management	4.1 Estates & Facilities	5.1 Commercial Opportunities	6.1 Medicine
	1.2 Outpatients	2.2 Medical Staffing	3.2 Procurement, Inventory Management & Contracts	4.2 Portering	5.2 Private & Overseas Patients	6.2 Surgery
	1.3 Patient Flow	2.3 Admin & Clerical / Non-clinical			5.3 Elective Income (ERF)	6.3 FASS
	1.4 Radiology	2.4 Central HR			5.4 Clinical Coding & Best Practice Tariffs	6.4 E&F
	1.5 Pathology	2.5 Direct Engagement			5.5 Commissioner Income	6.5 Corporate
	1.6 Sulis Elective				5.6 Contract Income	

2.1 Programme Roles & Responsibilities

Each Workstream has an Executive Lead, a SRO, Clinical / Operational Lead, Operational / Improvement Manager, Project Manager, Finance Lead, BI Lead and other specialist support (as required).

Under each Workstream exists a number of Improvement Projects. Each project will subsequently also have a Project Lead, Clinical / Operational Lead, Operational / Improvement Manager, Project Manager, Finance Lead, BI Lead and other specialist support, dependent on the specific project.

There are some further Divisional Projects which are identified as also requiring support from the Improvement Team as well as a number of projects being led within the operational divisional teams.

Figure 4: Programme Roles & Responsibilities

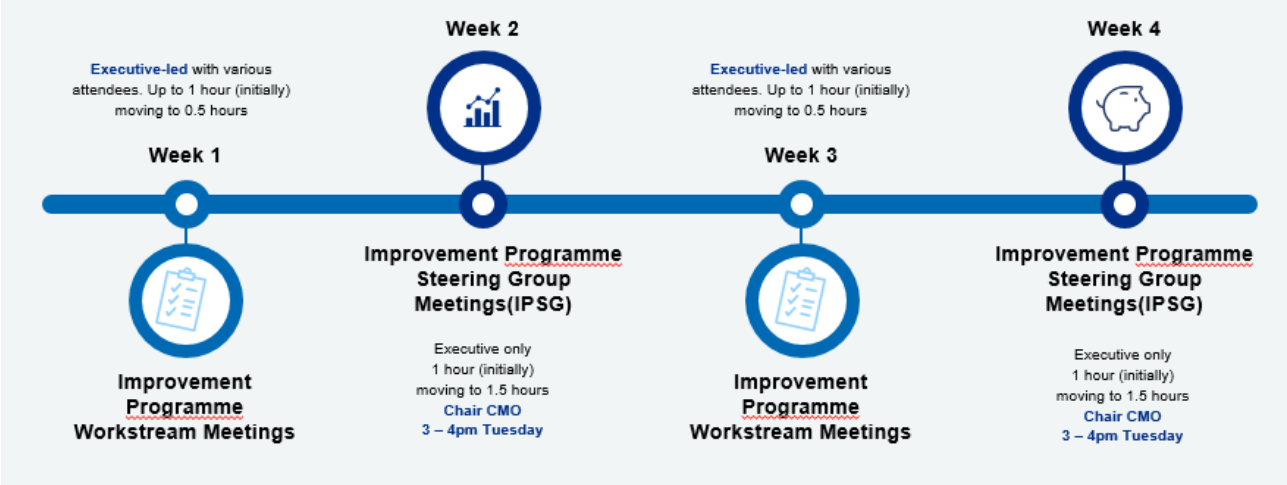
Role	Description
Executive Lead / SRO (Accountable)	Strategic programme oversight, assurance, and problem resolution.
Divisional / Department Lead (Responsible)	Operational leadership of the programme and weekly oversight.
Workstream Lead (Responsible)	Day-to-day programme leadership and management - The person selected by the division / department to lead the workstream.
Finance Lead (Consulted)	Financial input comprising financial analysis, budget categorisation, verification of financial benefit and reporting of actual and forecast information (Usually the relevant finance manager)
People Team Lead (Consulted)	HR / Workforce input comprising assessment of any HR impact from the proposed workstream projects and verification of WTE benefit, reporting of actual and forecast workforce information (Usually the relevant HR Business Partner)
Improvement Team Lead (Responsible)	Project identification and delivery support, oversight, assurance, wider-alignment and programme documentation management and completion.
Clinical Lead (Consulted)	Provision of clinical input, insight and alignment into project and its objectives.
Estates & Facilities Lead (Consulted)	Provision of Estates & Facilities input, insight and alignment into project and its objectives.
IT Lead (Consulted)	Provision of ICT input, insight and alignment into project and its objectives.

2.2 Meeting Rhythm

The programme is Executive-led, overseen by the Chief Medical Officer. An Improvement Programme Steering Group (IPSG) is held on the second and fourth Tuesday of every month in which progress against the workstream's respective forecast plan is overseen, risks are raised and discussed and new opportunities are approved to commence.

In weeks one and three, Executive-led Workstream meetings take place to drive project activities, remove blocks and support teams to deliver change. The workstream meetings also support and facilitate the continuous generation of new ideas and opportunities.

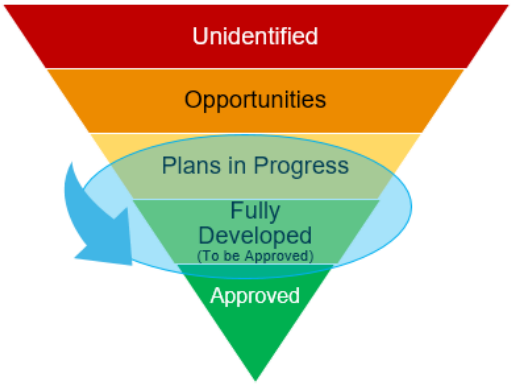
Figure 5: Meeting Structure & Rhythm



2.3 Project Approval Process

The workstream meetings also support and facilitate the continuous generation of new ideas and opportunities.

Figure 6: Process for generating projects



- There should be a disproportionate number of **unidentified "ideas"** coming out of each Workstream
- When an **unidentified "idea"** is worked up with a calculated benefit, it becomes an **"opportunity"**
- For a project to move from **"plans in progress"** to **"fully developed"** and thus ready for review at IPSG, it must go through the QEIA process.

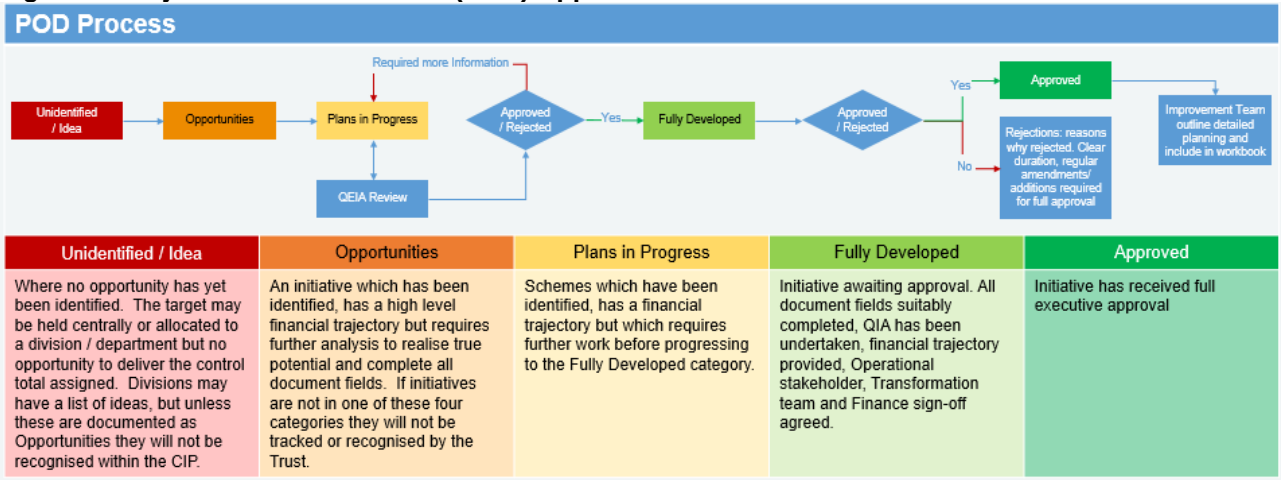
As new ideas for projects are developed, Project Outline Documents (PODs) are completed which set out a brief summary of the proposed project, scope and project deliverables (quality, performance and financial) as well as any resources required to support the project.

2.4 Quality Equality Impact Assessment (QEIA)

As part of the initial scoping exercise, a Quality Equality Impact Assessment (QEIA) Form is also completed which assesses the impact of any proposed change on Quality, Patient Experience, Patient Safety, Clinical Effectiveness, Patient Flow, Productivity, Innovation and Performance and Workforce Effectiveness. It also assesses any impact to protected characteristics – Disability, Age, Race, Religion or Belief, Sexual Orientation, Pregnancy or Maternity, Gender, Carers and Gender Reassignment.

Quality Equality Impact Assessments (QEIAs) are completed by the Workstream team and Improvement Team Lead collaboratively. When complete, these are then reviewed by the Chief Nurse, Chief Medical Officer and Director for People and Culture. QEIAs need to be approved prior to a POD being submitted to IPSG for approval to proceed to a live project.

Figure 7: Project Outline Document (POD) Approval Process



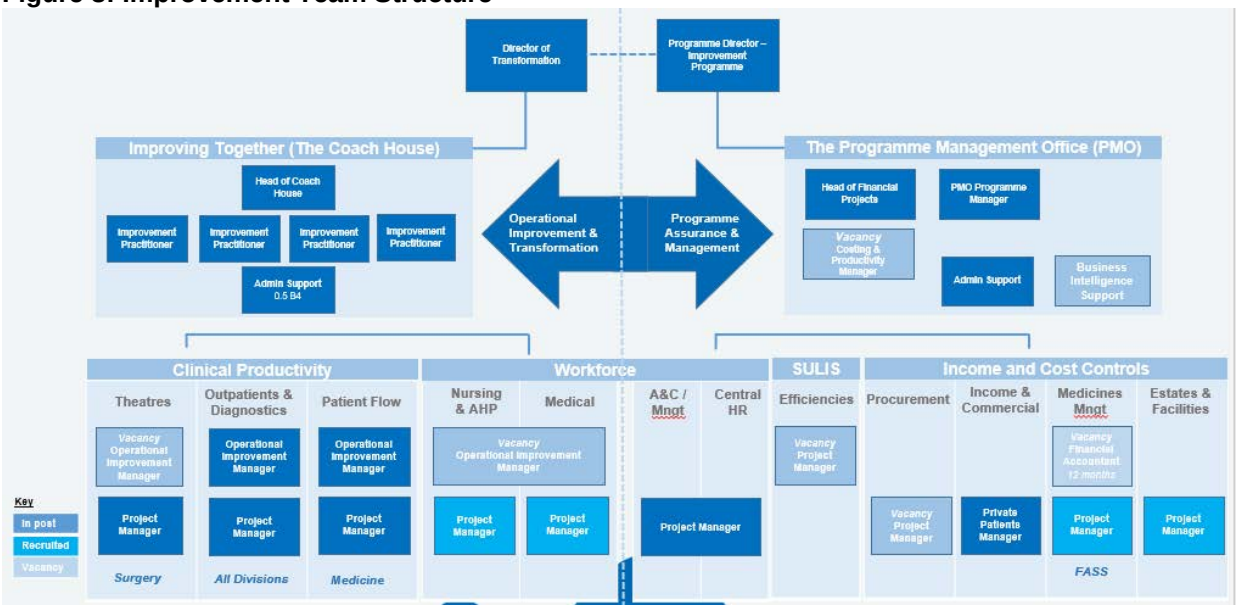
2.5 Improvement Team Resource

The 'Improvement Team' was established in May 2023 and is led by the Director of Transformation and Programme Director, Financial Improvement Programme. External resource was initially recruited into the programme to support the scoping of background / current states and to identify initial opportunities within each of the respective thematic areas of the programme.

The team has developed over the last three and a half months to comprise of 5.0 WTE Project Managers and 2.0 WTE Operational Improvement Managers, 1.0 WTE Programme Management Officer and 0.8 WTE Programme Administrator.

A further 4.0 WTE Project Managers were appointed in the latest round of interviews at the beginning of August and interviews are set to take place for further appointment of Operational Improvement Mangers in September 2023. There are 5.0 WTE Vacancies remaining to be filled at which point the team will be up to full establishment.

Figure 8: Improvement Team Structure



2.5 Programme Management Office (PMO)

The programme is being supported by a Programme Management Office (PMO). The Programme PMO Team are responsible for ensuring that there is sufficient grip in each of the workstreams, feeding into the Programme Level and IPSG. They oversee the 3 Year rolling programme plan and keep track of the delivery against targets for the Programme and workstreams. The Head of Financial Projects insures that there is a tight grip on financial delivery, ensuring that savings are evidenced and removed from budgets.

Weekly Highlight Reports are submitted by the Workstream Project Leads to update on process, actions and next steps. They also provide details on project benefits against each of our people groups.

2.6 Improving Together Coach House

The Coach House team also form part of the Improvement Team. As well as having responsibility for training, coaching and facilitating staff trust wide in implementing the behaviours, tools and routines of Improving Together. As subject matter experts on the Improving Together methodology, they also provide guidance on the practical application of the tools and routines and coaching on the behaviours that enable a culture of continuous improvement within the programme and support particular projects as and when appropriate.

2.6 Workstream Benefits

Each workstream is reporting against a number of KPIs. A dashboard is currently in development to automate the process by which these KPIs will be routinely measured at programme-level against their respective baselines/against their target forecasts.

The key benefits for each workstream are currently categorised against the Trust's people groups to ensure alignment with the Trust goals/wider strategy: the people we care for, the people we work with and the people in our community.

2.7 Risk and Issues

Risks and issues are tracked at Project and Workstream level and review at fortnightly Workstream meetings. High risks and risks to delivery are reported into the Improvement Programme Steering Group (IPSG) via the Executive Lead for each workstream and the PMO office maintains an overarching Programme Risk and Issues log.

Currently, the biggest risk is of non-delivery of target leading to the Trust not making financial balance – this risk is being mitigated by:

- The introduction of the £28m stretch target above the £23.5m required for financial balance
- Strong project management and programme management
- Weekly oversight of delivery for all workstreams
- Focus on delivering the projects underway in the first instance to ensure money is released before moving on to more ideas so as not to spread the team too thinly
- Consultant staff still in post whilst team recruitment is complete

3.0 Programme Delivery to date

The programme is on track and delivering above trajectory for M4. We have delivered £3.98m year to date against a stretch target of £2.1m. A total of £16.28m of schemes have been confirmed to deliver this financial year against the stretch target of £28.1m. Work is continuing to develop further PODs against the remaining target.

Workstreams are beginning to release savings although there is still further work to do ahead of a significant rise in trajectory in Month 8 where our stretch trajectory requires delivery of £4.8m to be released each month going forward to Month 12.

Figure 9: Monthly Delivery and Forecast

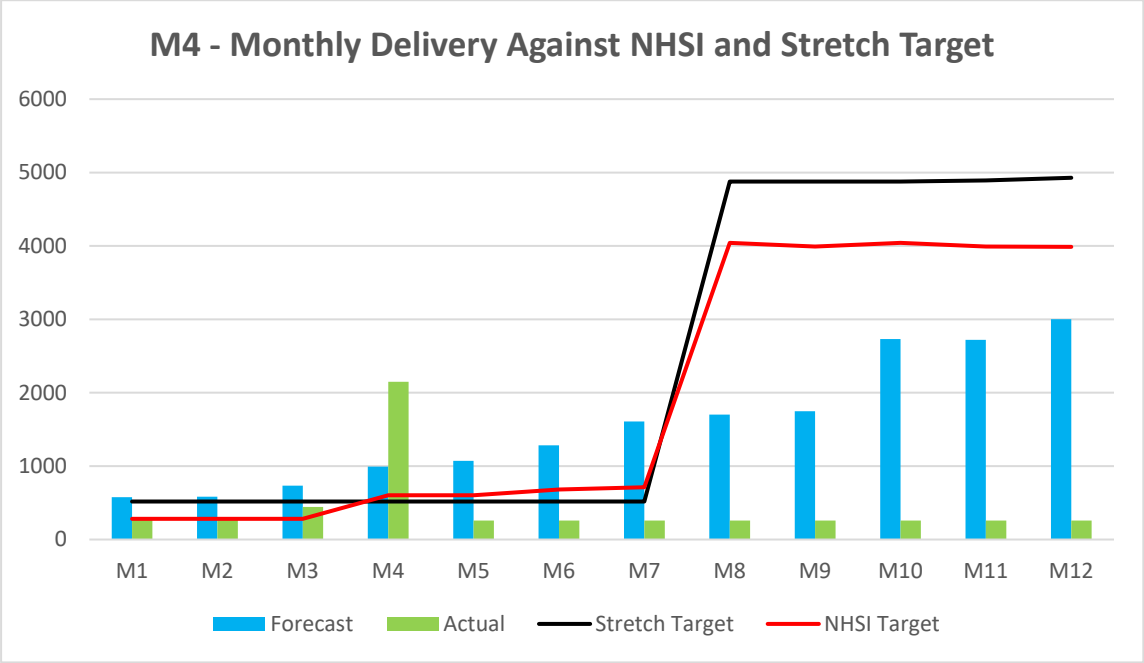
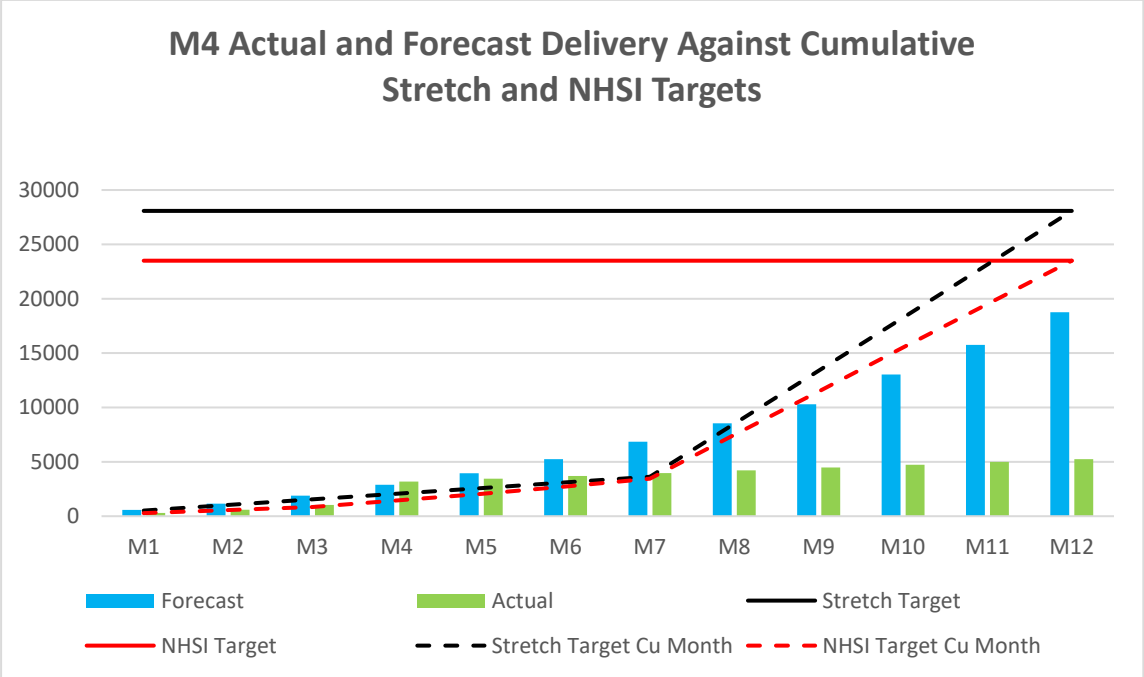


Figure 10: Cumulative Delivery and Forecast



Each Programme of work is developing run rates to provide assurance on where and when the financial savings will be delivered. The table below highlights this for the £16.3m of schemes identified to deliver so far this financial year. Work continues to developed run rates for each of the schemes.

Figure 11: The table below highlights the forecast run rate of each scheme

Accumulative													
	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12	Total
QIPP Delivered													
1_Divisional QIPP	£125	£226	£368	£1,129	£1,242	£1,355	£1,469	£1,582	£1,695	£1,808	£1,922	£2,035	£2,035
2_Productivity and Efficiency	£0	£0	£91	£167	£281	£394	£508	£621	£735	£848	£1,067	£1,380	£1,380
3_Workforce	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
4_Cost and Control Management	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
5_Estates & Facilities	£0	£0	£0	£1,136	£1,136	£1,136	£1,136	£1,136	£1,136	£1,136	£1,136	£1,136	£1,136
6_Income Commercial	£21	£27	£36	£53	£53	£53	£53	£53	£53	£53	£53	£53	£53
7_Income Clinical	£47	£95	£183	£272	£361	£449	£538	£627	£715	£804	£893	£981	£981
Total Delivered	**£193**	**£347**	**£678**	**£2,758**	**£3,073**	**£3,388**	**£3,704**	**£4,019**	**£4,334**	**£4,650**	**£5,070**	**£5,585**	**£5,585**
NHSE Plan	**£282**	**£564**	**£846**	**£1,448**	**£2,050**	**£2,732**	**£3,445**	**£7,487**	**£11,479**	**£15,521**	**£19,513**	**£23,500**	**£23,500**
Still to Deliver	£89	£217	£168	-£1,310	-£1,023	-£656	-£259	£3,468	£7,145	£10,871	£14,443	£17,915	£17,915
Forecast Plans to Deliver													
1_Divisional QIPP	£0	£0	£0	£0	£0	£86	£228	£413	£597	£782	£966	£1,178	£1,178
2_Productivity and Efficiency	£0	£0	£0	£0	£188	£376	£564	£877	£1,638	£2,558	£3,499	£4,309	£4,309
3_Workforce	£0	£0	£0	£0	£0	£100	£200	£430	£660	£890	£1,120	£1,350	£1,350
4_Cost and Control Management	£0	£0	£0	£0	£0	£0	£57	£113	£170	£226	£283	£339	£339
5_Estates & Facilities	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£153	£153
6_Income Commercial	£0	£0	£0	£0	£18	£37	£55	£73	£128	£206	£284	£362	£362
7_Income Clinical	£0	£0	£0	£0	£46	£152	£329	£506	£683	£1,533	£2,384	£3,234	£3,234
Total Forecast to deliver	**£0**	**£0**	**£0**	**£0**	**£253**	**£750**	**£1,432**	**£2,411**	**£3,875**	**£6,194**	**£8,536**	**£10,925**	**£10,925**
Delivered and Forecast to deliver	**£193**	**£347**	**£678**	**£2,758**	**£3,326**	**£4,138**	**£5,136**	**£6,430**	**£8,209**	**£10,844**	**£13,605**	**£16,511**	**£16,511**
NHSE Plan	**£282**	**£564**	**£846**	**£1,448**	**£2,050**	**£2,732**	**£3,445**	**£7,487**	**£11,479**	**£15,521**	**£19,513**	**£23,500**	**£23,500**
Still to identify	£89	£217	£168	-£1,310	-£1,276	-£1,406	-£1,691	£1,057	£3,270	£4,677	£5,908	£6,989	£6,989

4.0 Return to Financial Sustainability

The Improvement Programme is the approach and methodology for the Trust to return to a balanced finance position. The Trust has an underlying deficit of £32 million and the Finance Strategy outlines the plan to return to financial balance by 2026/27. The table below highlights the trajectory for returning to financial balance as agreed in the Finance Strategy.

Figure 12: Original RUH Potential Recovery solution set 2023-27:

Delivery programme:	23/24 £m	24/25 £m	25/26 £m	26/27 £m
Transactional efficiency	10.0	10.0	10.0	10.0
Constrain use of system growth		3.0	3.0	4.0
Recovery Programme: UEC de-escalation => costs saved		0.5	0.5	1.2
Recovery Programme: elective productivity => margin	2.4	4.7	1.6	2.1
Retrench 20-23 pay-bill cost growth		0	4.1	5.2
Recovery Programme: Other recurrent savings	11.1			
Total Recovery Plan	23.5	18.2	19.2	22.5
Recurrent remaining delivery gap:	-32.0	-22.0	-12.2	0

There is now a requirement to return to a recurrent balanced finance position by 2025/26 and a balanced position including the use of non-recurrent sources by 2024/25; which is earlier than the plan in the Finance Strategy. The Finance Strategy set out a high level summary of opportunities based on benchmarking data and prioritises which identified up to £90 million of opportunities. This high level summary of areas will be the focus for the Improvement Programme over the next 3 years. The plans will be accelerated in order to return to finance balance sooner. The table below highlights the revised recovery plan over a 3.5 year period. Savings will need to be accelerated further if a return in 3 years is required, but at the present time this does not feel to be achievable.

Figure 13: RUH Proposed Recovery solution set 2023-27:

Delivery programme:	23/24 £m	24/25 £m	25/26 £m	26/27 £m
Transactional efficiency	10.0	10.0	10.0	10.0
Constrain use of system growth		3.0	3.0	4.0
Recovery Programme: UEC de-escalation => costs saved		0.5	0.5	0.0
Recovery Programme: elective productivity => margin	2.4	4.7	1.6	0.0
Retrench 20-23 pay-bill cost growth		1.8	5.1	0.0
Recovery Programme: Other recurrent savings	11.1	2.4	2.0	1.0
Total Recovery Plan	23.5	22.4	22.2	15.0
Recurrent remaining delivery gap:	-32.0	-17.8	-4.8	0

The opportunities that are the focus of the Improvement Programme are highlighted in the table below.

Figure 14: Efficiency opportunities

Theme	Workstream	2024/25	2025/26	2026/27	2027/28	Cumulative total
Productivity & Efficiencies	Elective Recovery & Productivity	£2.60	£0.00	£0.00	£0.00	**£2.60**
	Sulis Recovery	£2.10	£1.60	£1.60	£0.00	**£5.30**
	Non Criteria to Reside	£0.50	£0.50	£0.70	£0.70	**£2.40**
	ICU model	£3.10	£0.00	£0.00	£0.00	**£3.10**
	Diagnostics	£0.00	£0.00	£0.50	£0.00	**£0.50**
	Urgent care	£0.00	£0.00	£0.50	£0.60	**£1.10**
Workforce	Temporary workforce	£1.10	£0.60	£0.60	£0.00	**£2.30**
	Workforce efficiencies	£0.60	£0.30	£0.30	£0.00	**£1.30**
	Corporate services	£0.00	£0.50	£0.30	£0.00	£0.80
Cost Control & Management	Procurement	£1.60	£0.00	£0.00	£0.00	**£1.60**
Estate Management	Estates	£0.00	£0.50	£0.30	£0.00	**£0.80**
System Integration /	Clinical Services Review	£0.00	£4.20	£4.30	£2.20	£10.70
	Digital	£0.30	£0.30	£0.20	£0.20	£1.10
Income	Commercial opportunities	£0.50	£0.30	£0.30	£0.60	**£1.60**
	Growth contribution	£3.00	£3.00	£4.00	£4.00	**£14.00**
Other	Reducing harm	£0.00	£0.40	£0.40	£0.40	£1.10
	Sub-total transformation projects	**£15.40**	**£12.20**	**£14**	**£8.70**	**£50.30**
Divisional Schemes	Operational QIPP	£10.00	£10.00	£10.00	£10.00	**£40.00**
	Total	**£25.00**	**£22.00**	**£24.00**	**£18.70**	**£90.00**

Cumulative efficiencies	£25.40	£47.40	£71.40	**£90.00**

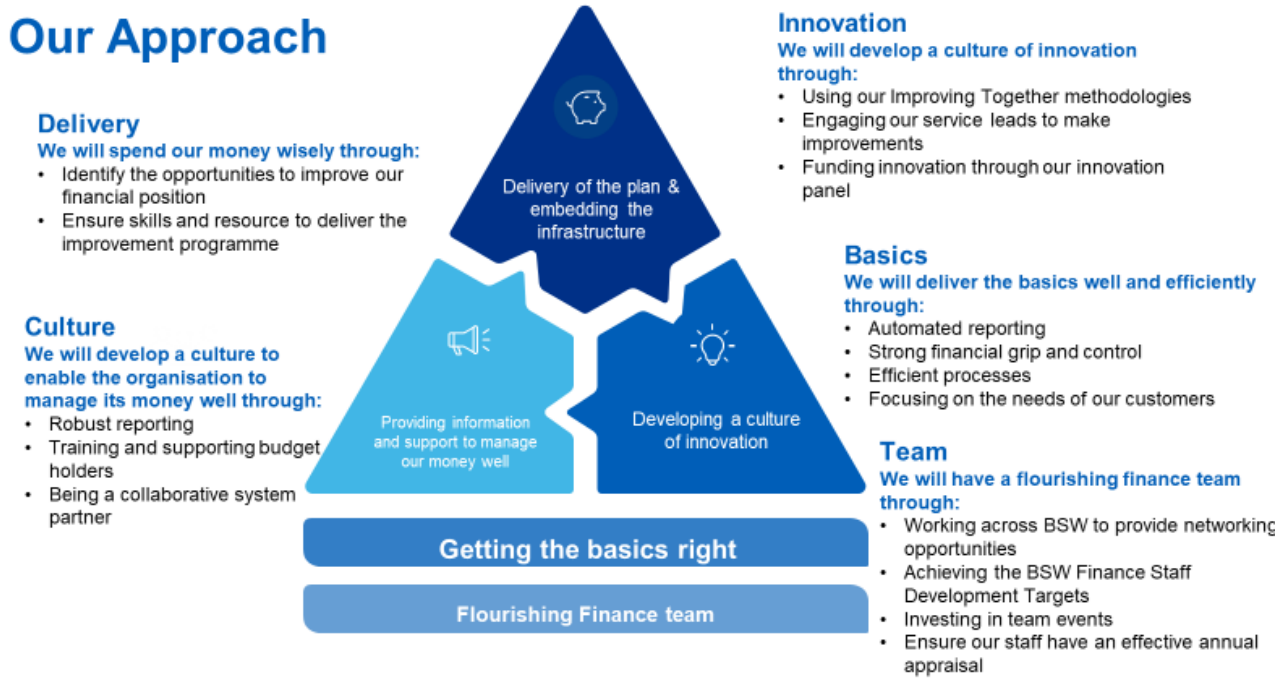
5.0 Finance Strategy

The delivery of the Improvement Programme is one area of focus in terms of returning to financial balance. It also runs alongside the other priorities of the finance strategy which are focussed on:

- Developing a culture to enable the organisation to manage its money well;
- Developing a culture of innovation;
- Ensuring we deliver the basics well and efficiently; and
- A flourishing finance team.

The diagram below summaries the overall finance strategy approach.

Figure 15: Outline finance strategy



6.0 Clinical Strategy

The Improvement Programme will be aligned to the clinical strategy. This will include productivity and efficiency across clinical services (top decile performance), reduction in clinical variation and improved care as well the consideration about disinvesting in services This will be led by the Acute Hospital Alliance Clinical Strategy workstream to delivery our ambition of a left shifting appropriate services away from the acute hospital setting.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**22**
Date of Meeting:	**6 September 2023**		
Title of Report:	**Alert, Advise and Assure Report from the Non-Clinical Governance Committee**		
Status:	**For discussion**		
Author:	**Sumita Hutchinson, Non-Executive Director and Chair of the Non-Clinical Governance Committee**		

Key Discussion Points and Matters to be escalated from the meeting

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

The Committee discussed the digital strategy focusing on the governance perspective with AHA and the delivery of the EPR and core services. Key concerns to escalate to board:

- The levels of digital maturity of the three different organisations with the RUH lagging; risk of the Trust not being fit for the future if insufficient progress is not made with regard to digital advancement;
- Potential to impede the progress of other programmes due to the significant capital already input in to the EPR programme

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

- The Committee received the 2022/23 Annual Sustainability Report; further assurances were sought to ensure that the Trust was performing against the goals it had set out in the 2020 strategy as not all been addressed in the report; the NCGC requested further information on how they could support with the development of the Green Plan.

- Annual security report. The committee sought further assurance that the trust are doing everything they can to support staff and colleagues who are subject to violence and aggression at work. In particular, to support those that are disproportionately impacted, from diverse backgrounds.

- Catering update. The committee sought a better understanding on why the trust score was lower as compared to other trusts for PLACE. The committee also sought further information on the connection between sustainability and the trust food and nutrition report.

ASSURE: Inform the board where positive assurance has been achieved

- The Committee received the Quarterly 2022/23 Incidents and Litigation Reports and gained positive assurance;
- The Committee received the 2022/23 Annual Health and Safety Compliance Report and were positively assured;

- The Committee received the 2022/23 Site Security and Safety Annual Report and reasonably assured;
- The Committee received the 2022/23 Annual Estates Return Collection (ERIC) Submission and were positively assured;
- The Committee received the Emergency Preparedness, Resilience & Response (EPRR) Annual Report & Future Planning and were reasonably assured;

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

- The committee discussed the Board Assurance/ Framework (BAF) risks 9, 10 and 11. Changes to the wording of a number of risks were proposed to improve clarity and understanding.

- No new risks were identified

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

- Facilities transformation: Cleaning services: Committee members were very impressed by the staffing changes within the cleaning team; this had boosted staff morale and also empowered staff to improve working practices and strengthen team working

APPROVALS: Decisions and Approvals made by the Committee

- The Committee agreed that BAF risks relating to digital, cybersecurity and sustainability should be shared with the Audit and Risk Committee for oversight.

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

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	23
Date of Meeting:	6 September 2023		

Title of Report:	**Annual Review of Directors' Interests, Fit and Proper Persons Test and Board of Directors Code of Conduct**
Status:	**For Approval**
Board Sponsor:	**Alison Ryan, Chair**
Author:	**Roxy Milbourne, Deputy Head of Corporate Governance**
Appendices	**Appendix 1: Fit and Proper Person Test** **New guidance available here:** NHS England Fit and Proper Person Test Framework for board members **Appendix 2: Summary of CQC Guidance on Compliance** **Appendix 3: Annual Self Declaration Form**

1. Executive Summary of the Report

This report sets out details of the interests currently declared by members of the Board of Directors, and reminds the Board of the need to adhere to the Seven Principles of Public Life (the "Nolan Principles").

The Board of Directors undertakes an annual review and declaration that Board Members continue to meet the requirements of the CQC's Fit and Proper Persons Test as set out in appendices 1 & 2. All Board members have completed and signed their self-declarations confirming that they continue to meet the requirements of the Test.

2. Recommendations

The Board of Directors is asked to:

1. Approve the Register of Directors' Interests;
2. Agree to continue to abide by the Seven Principles of Public Life; and
3. Confirm that members of the Board of Directors continue to meet the requirements of the Fit and Proper Persons Test;

3. Legal / Regulatory Implications

All members of staff are required to declare relevant interests and for members of the Board of Directors: these must be declared or referred to in the Trust's Annual Report. The requirements of the Fit and Proper Persons Test for Executive and Non-Executive Directors are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

None

5. Resources Implications (Financial / staffing)

N/A

6. Equality and Diversity

N/A

7.	References to previous reports
This is an annual report presented to the Board of Directors.	

8.	Freedom of Information
This is a public Board paper.	

Review of the Board of Directors Declared Interests; the Nolan Principles of Public Life; and Fit and Proper Persons Test Declaration

1. DECLARATIONS OF INTEREST

Background

The Trust's Declarations of Interest Policy requires all staff to declare relevant interests which are recorded on a central register of interest. Additionally, all "Decision Making" staff (which includes Directors, all staff at band 8D and above and those with substantial budgetary responsibility) are required to make an annual declaration of interests, which are published on the Trust website.

It is good practice for the Board of Directors to receive and review the interests declared by its members at least once a year for approval, and these are presented below.

Board of Directors Declared Interests

The following interests have been declared by the members of the Board of Directors, and they have been approved, either by the Chair or in the case of the Chair's interests, by the Senior Independent Director:

Surname	First Name	Role	Declared Interest
Charles-Barks	Cara	Chief Executive	• Member of the Advisory Panel of Nourish - an organisation that promotes healthy eating and nourishment for those going through illness or medical treatment. (Ceased 31/03/23) • Visiting Professor in the Faculty of Health and Applied Sciences at the University of the West of England. • Deputy Chair of NHS Quest, a leadership/development provider. • Son working on the Staff Bank within the People Directorate. (Ceased 16/08/23)
Durbacz	Antony	Non-Executive Director	• Board member at LiveWest. • Governor at Crispin school. (Ceased 31/07/23) • Independent Governor at Bath Spa University. • Daughter is a specialist trainee in Obstetrics and Gynaecology in the Severn Deanery.
Fairhurst	Paul	Non-Executive Director	• Trustee of Designability (UK Charity). • Trustee of Back-Up (UK Charity).
Foster	Joss	Director of Strategy	• Complaints Panelist for the Dental Complaints Service. • Investor in Veloscient Ltd (An organisation developing a platform to facilitate structured data capture for a range of markets including healthcare).
Fox	Paul	Non-Executive Director	• Paid employment at Bath Spa University. (Ceased 30/06/23) • Member of UKRI Financial Sustainability Research Committee. • Governor at Wiltshire College & University Centre. • Treasurer of Liberal Democrat History Group. • Treasurer Western Counties Liberal Democrats.

Surname	First Name	Role	Declared Interest
			• Member of the Chartered Institute of Public Finance and Accountancy. • Wife is registered with the NHS bank and could occasionally work at the RUH. • Wife is employed by University Hospitals Bristol NHS Foundation Trust.
Hollowood	Andrew	Chief Medical Officer	• Director of Andrew Hollowood Ltd; FH Intuition Ltd; Boomsatsuma Creative Arts Education Company. • Wife is a General Practitioner at Hartcliffe Surgery, Bristol.
Hutchison	Sumita	Non-Executive Director	• Volunteer for the Save the Soil movement. • Non-Executive Director at Gloucestershire Health and Care NHS Foundation Trust.
Johnson	Brian	Director of Estates & Facilities	• Director of Estates at Salisbury NHS Foundation Trust.
Lynch	Antonia	Chief Nurse	• Spouse is a Matron at Great Western Hospitals NHS Foundation Trust.
Morley	Hannah	Non-Executive Director	• Member of the Charter Society of Physiotherapists. • Member of Canadian Alliance Physiotherapy. • Member of College of Physiotherapy, British Columbia. • I am employed by Aneurin Bevan University Health Board as a Senior Planning and Service Development Manager. • Member of the Royal Society of Arts. • Member of the Health and Care Professions Council.
Orpen	Ian	Non-Executive Director	• Investor in tem.energy who operate a platform to connect suppliers of renewable energy with businesses.

Surname	First Name	Role	Declared Interest
Prosser	Niall	Interim Chief Operating Officer	• Brother is a specialty manager within the surgical division.
Ryan	Alison	Chair	• South West Regional Chair for Organ Donation, part of NHS Blood and Transplant (unremunerated).
Stevens	Nigel	Non-Executive Director	• Strategic Advisor and minority shareholder in Route Konnect (a software start up operating in the data analysis sector). • Chair, Transport Focus - a public funded watchdog. • Owner and sole-trader, Raybarrow Consulting - management consultancy.
Thompson	Alfredo	Director for People and Culture	• Attends Locum's Nest Special Interest Group meetings. Locum's Nest is a private organisation that the Trust uses to book Medical Locums.
Walters	Libby	Director of Finance	• Husband is on the Radiology portering bank. • Daughter holds a bank portering contract with the RUH.

2. THE NOLAN PRINCIPLES OF PUBLIC LIFE

The Committee on Standards in Public Life devised the Seven Principles, often referred to as the Nolan Principles, following its report into the standards of behaviour in public life in May 1995. The report identified that public life was more rigorously scrutinised than in the past, and that people in public life were not always as clear as they should have been about where the boundaries of acceptable conduct lay.

The 7 principles of public life apply to anyone who works as a public office-holder. This includes people who are elected or appointed to public office, nationally and locally, and includes all people appointed to work in health, education, social and care services.

All public bodies are required to have Codes of Conduct incorporating the Seven Principles and provide internal systems for maintaining standards which should be supported by independent scrutiny.

The Trust demonstrates this through:

- The Board of Directors' Code of Conduct;
- The Declarations of Interest Policy and Employee Code of Conduct;
- Completion of a register of interests as described above;
- An annual review of interests declared by the Board of Directors;
- Periodic reminders of the need to be open about relevant interests; and
- Conducting the majority of its business in the public domain to ensure transparency and openness.

The seven principles are:

Selflessness
Holders of public office should act solely in terms of the public interest.

Integrity
Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

Objectivity
Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability
Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness
Holders of public office should act and take decisions in an open and transparent

manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

Honesty
Holders of public office should be truthful.

Leadership
Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Details of the Fit and Proper Test are set out in Appendix 1 to this report. All Members of the Board Directors have self-declared that they continue to meet the requirements of the Test.

Recommendations
The Board of Directors is asked to:

1. Approve the Register of Directors' Interests;

2. Agree to continue to abide by the Seven "Nolan" Principles of Public Life; and

3. Confirm that each member of the Board of Directors continues to meet the requirements of the Fit and Proper Persons Test;

4. Consider whether any ongoing checks (such as updated DBS checks) should be undertaken to provide evidence that Directors continue to meet these requirements.

Appendix 1 - FIT AND PROPER PERSON TEST

The Health and Social Care Act (Regulated Activities) Regulations 2014 regulation 5 places a duty on NHS providers not to appoint a person or allow a person to continue to be a director under certain circumstances. Providers must not appoint an individual to an executive or non-executive director post unless the individual:

- is of good character;
- has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;
- is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
- has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
- none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual (see below).

The regulation state that in assessing whether a person is of good character, the matters considered must include:

- Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence;
- Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Part 1 of Schedule 4 of the regulations lists categories of persons who are prevented from holding the office of Director, including:

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40);
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment;

- The person has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

It is the responsibility of the Chair to discharge the requirement placed on the provider, to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

All members of the Board of Directors have signed an annual self-declaration form in 2023 and the organisation is compliant with the newly published framework published on 2nd August 2023. The new guidance available here: NHS England Fit and Proper Person Test Framework for board members

(https://www.england.nhs.uk/wp-content/uploads/2023/08/PRN00238-i-kark-implementation-fit-and-proper-person-test-framework-2-aug-2023.pdf)

The Head of Corporate Governance will prompt directors to update their declaration annually, and will raise any issues with the Chair or Senior Independent Director as appropriate.

Checks are carried out on all new appointees to the Board (including DBS, bankruptcy and disqualified director checks, and confirmation of qualifications) and this evidence is held by the Head of Corporate Governance.

Appendix 2 – Summary of CQC Guidance on meeting the FPP Regulation

Component of the regulation:	Providers must have regard to the following guidance:
5(1) This regulation applies where a service provider is a body other than a partnership	This regulation applies to all providers that are not individuals or partnerships.
5(2) Unless the individual satisfies all the requirements set out in paragraph (3), a service provider must not appoint or have in place an individual— (a) as a director of the service provider, or (b) performing the functions of, or functions equivalent or similar to the functions of a director.	For NHS bodies it applies to executive and non-executive, permanent, interim and associate positions, irrespective of their voting rights. The requirement will also apply to equivalent director posts in other providers, including trustees of charitable bodies and members of the governing bodies of unincorporated associations. Where a local authority is a provider, the regulations will not apply to elected members as they are accountable through a different route.
5(3)(a) the individual is of good character	When assessing whether a person is of good character, providers must follow robust processes to make sure that they gather all available information to confirm that the person is of good character, and they must have regard to the matters outlined in Schedule 4, Part 2 of the regulations. It is not possible to outline every character trait that a person should have, but we would expect to see that the processes followed take account of a person's honesty, trustworthiness, reliability and respectfulness. If a provider discovers information that suggests a person is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter. Where a provider considers the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the provider's reasons should be recorded for future reference and made available.
5(3)(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,	Where providers consider that a role requires specific qualifications, they must make this clear and should only appoint those candidates who meet the required specification, including any requirements to be registered with a professional regulator. Providers must have appropriate processes for assessing and checking that the candidate holds the required qualifications

	and has the competence, skills and experience required, (which may include appropriate communication and leadership skills and a caring and compassionate nature) to undertake the role. These must be followed in all cases and relevant records kept. We expect all providers to be aware of, and follow, the various guidelines that cover value-based recruitment, appraisal and development, and disciplinary action, including dismissal for chief executives, chairs and directors, and to have implemented procedures in line with the best practice. This includes the seven principles of public life (Nolan principles).
5(3)(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employe	This aspect of the regulation relates to a person's ability to carry out their role. This does not mean that people who have a long-term condition, a disability or mental illness cannot be appointed. When appointing a person to a role, providers must have processes for considering their physical and mental health in line with the requirements of the role. All reasonable steps must be made to make adjustments for people to enable them to carry out their role. These must be in line with requirements to make reasonable adjustments for employees under the Equality Act 2010.
5(3)(d) the individual has not been responsible for, been privy to, contributed to or facilitated, any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and	Providers must have processes in place to assure themselves that a person has not been responsible for, privy to, contributed to, or facilitated any serious misconduct or mismanagement in the carrying on of a regulated activity. This includes investigating any allegation of such and making independent enquiries. Providers must not appoint any person who has been responsible for, privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity. A director may be implicated in a breach of a health and safety requirement or another statutory duty or contractual responsibility because of how the entire management team organised and managed its organisation's activities. In this case, providers must establish what role the director played in the breach so that they can judge whether it means they are unfit. If the evidence shows that the breach is attributable to the director's conduct, CQC would expect the provider to find that they are unfit. Although providers have information on when convictions, bankruptcies or similar matters are to be considered 'spent' there is no time limit for considering serious misconduct or responsibility for failure in a previous role.

5(3)(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.	A person who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 must be subject to a check by the Disclosure and Barring Service (DBS). Providers must seek all available information to assure themselves that directors do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1. Robust systems should be in place to assess directors in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. In addition, where a director meets the eligibility criteria, providers should establish whether the person is on the children's and/or adults safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act. If a provider discovers information that suggests an individual is unfit after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter.
5(6) Where an individual who holds an office or position referred to in paragraph (2)(a) or (b) no longer meets the requirements in paragraph (3), the service provider must— **(a)** take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and **(b)** if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question	Providers must assess and regularly review the fitness of directors to ensure that they remain fit for the role they are in. Providers must determine how often to review fitness based on the assessed risk to business delivery and/or to the people using the service posed by the individual and/or role. Providers must have arrangements in place to respond to concerns about a person's fitness in relation to Regulation 5(3) and (4) after they have been appointed to a role, which either they or others have identified, and providers must adhere to these arrangements. Providers must investigate, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, they must take proportionate, timely action. Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to people who use the service.

Appendix 3

Executive Directors and Non-Executive Directors – Self Declaration Form

On 20 November 2014 the Care Quality Commission (CQC) published guidance on the fit and proper person requirements which apply to all NHS providers. These regulations support ensuring the accountability of directors of NHS bodies and outline the requirements for robust recruitment and employment processes for board level appointments. As part of the assurance against the new Fit and Proper Person requirements for existing board members, you are required to complete the following self-declaration on an annual basis, sign, date and return.

Have you got the qualifications, competency, skills and experience which are necessary for the office or position or work for which you are employed / engaged?	☐ YES	☐ NO
Are you able by reason of health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the office or position or work for which you are employed / engaged?	☐ YES	☐ NO
Have you been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying on a regulated activity or providing a service elsewhere, which if provided in England would be a regulated activity?	☐ YES	☐ NO
Have you been the subject of any of the following: • Undischarged bankruptcy or a being a person whose estate has had sequestration awarded in respect of it and who has not been discharged. Subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order to like effect made in Scotland or Northern Ireland or elsewhere in the world. • A moratorium period under a debt relief order applied under Part VIIA (debt relief orders) of the Insolvency Act 1986. • A composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it. • Included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland or elsewhere in the world. • Prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment (for example, under Companies or Charities legislation).	☐ YES	☐ NO

Have you been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence?	☐ YES	☐ NO
Have you been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals?	☐ YES	☐ NO
Have you ever been found not to be a fit and proper person for the purposes of Regulation 5, of the Health and Social Care Act 2008 (Regulated Activities) Regulations, namely the requirements to: • Be of good character • Have the qualifications, skills and experience necessary for the relevant position • Be capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010 • Not have been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider • Not be prohibited from holding the relevant position under any other law e.g. Under the Companies Act or the Charities Act	☐ YES	☐ NO

I hereby agree that the above is accurate.

Name: Position:

Signed: Date:

Please return completed declaration forms to the Head of Corporate Governance