Bundle Public Board of Directors 5 March 2025

0 Agenda
- 0.0 - DRAFT Public BoD Agenda Mar 25 v2.0 - 04.03.25

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

2 Written Questions from the Public

3 Minutes of the Board of Directors meeting held in public on 15 January 2025
- 3.0 - DRAFT Public BoD Minutes Jan v1

4 Action List and Matters Arising
- 4.0 - Public BoD Action List Jan 25 v1.0 - 17.01.25

5 Governor Log of Assurance Questions and Responses (for information)
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6 Items discussed at Private Board

7 Patient Story
- 7.0 - Patient Story cover sheet to Board of Directors 5.3.25 v1

8 CEO and Chair's Report
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9 Integrated Performance Report
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10 Item Withdrawn

11 Quality Assurance Committee Upward Report
- 11.0 - QAC Upward Report Feb 2025

12 People Committee Upward Report
- 12.0 - Jan 25 PC Upward Report v2

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- 13.0 - Annual Health and Safety Report 2324 V7

14 Finance and Performance Committee Upward Report and Terms of Reference for Ratification
- 14.0 - Finance Upward Reporting 30.01.25 and 25.02.25
- 14.1 - Finance and Performance Committee ToR - Jan 25

15 Charities Committee Upward Report
- 15.0 - Charities Committee Upward Report - Feb 25

16 Non-Clinical Governance Committee Terms of Reference for Ratification
- 16.0 - NCGC ToR - Jan 2025

17 Mineral Hospital Assets Update
- 17.0 - Mineral Hospital Assets v1.1 - 26.02.25

18 Board Sub-Committee Terms of Reference Update
- 18.0 - Risk - Sub-Committees ToR - 27.02.25

19 Group Chair Proposal
- 19.0 - Group Joint Chair - 27.02.25
- 19.1 - Appendix 1 Guide to the appointment of Joint Chair Nov-24 Draft V1.0
- 19.2 - Appendix 2 Joint Chair and Local Lead NED Tasks and Assumptions_V1.0

20 Maternity Incentive Scheme Sign Off / Clinical Negligence Scheme for Trusts
- 20.0 - MIS board report Year 6

20.1 - MIS_SafetyAction Jan 2025.xlsx Declaration Form
20.2 - MIS-Year-6-guidance
20.3 - RUH 24-25_MIS Year 6_Final issued 22-01-25 (003).pdf - KPMG audit

21 Any Other Business

Royal United Hospitals Bath
NHS Foundation Trust

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS OF THE ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST WEDNESDAY 5 MARCH 2025, 13:00 – 16:00 VENUE: PAVILION FUNCTION ROOM, KINGSWOOD SCHOOL UPPER PLAYING FIELDS, BATH, BA1 9BH

Item	Item	Presenter	Enc.	For
OPENING BUSINESS				
1.	Chair's Welcome, Introductions, Apologies and Declarations of Interest: Paran Govender, Toni Lynch	Alison Ryan, Chair	Verbal	-
2.	Written questions from the public		Enc.	I/D
3.	Minutes of the Board of Directors meeting held in public on 15 January 2025		Enc.	A
4.	Action Log		Enc.	A/D
5.	Governor Log of Assurance Questions and Responses (For Information)		Enc.	I
6.	Items discussed at Private Board		Verbal	I
7.	Patient Story	Jason Lugg, Deputy Chief Nursing Officer	Pres.	I/D
8.	CEO and Chair's Report	Cara Charles-Barks, Chief Executive	Enc. / Verbal	I
9.	Integrated Performance Report	Jon Lund, Interim Chief Finance Officer	Enc.	I/D
The People We Care For				
10.	Item withdrawn			
11.	Quality Assurance Committee Upward Report	Simon Harrod, Non-Executive Director	Enc.	I/D
The People We Work With				
12.	People Committee Upward Report	Paul Fairhurst, Non-Executive Director	Enc.	I/D
The People in Our Community				
13.	Annual Health and Safety Compliance Report	Jason Lugg, Deputy Chief Nursing Officer	Enc.	I/D
14.	Finance and Performance Committee Upward Reports and Terms of Reference for Ratification	Antony Durbacz, Non-Executive Director	Enc.	I/D
15.	Charities Committee Upward Report	Sumita Hutchison, Non-Executive Director	Enc.	I/D

16.	Non-Clinical Governance Committee Terms of Reference for Ratification	Sumita Hutchison, Non-Executive Director	Enc.	A
Governance				
17.	Mineral Hospital Assets Update	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	I/D
18.	Board Sub-Committee Terms of Reference Update	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	A
19.	Group Chair Proposal	Nigel Stevens, Senior Independent Director	Enc.	A
20.	Maternity Incentive Scheme Sign Off / Clinical Negligence Scheme for Trusts	For Information and Publication	Enc.	I
CLOSING BUSINESS				
21.	Any Other Business	Alison Ryan, Chair	Verbal	-
Date of Next Meeting: Wednesday 7 May 2025, 13:00 – 16:00 Pavilion Function Room, Kingswood School Upper Playing Fields, Bath, BA1 9BH				

Key:

A – Approval	Enc – Paper enclosed with the meeting pack
D – Discussion	Pres– Presentation to be delivered at the meeting
I – Information	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, 15 JANUARY 2025, 13:00 – 16:00
VENUE: PAVILION FUNCTION ROOM, KINGSWOOD SCHOOL, UPPER PLAYING FIELDS, LANSDOWN ROAD, BATH, BA1 9BH

Present:

Members

Christopher Brooks-Daw, Chief of Staff
Cara Charles-Barks, Chief Executive
Antony Durbacz, Non-Executive Director
Paul Fox, Non-Executive Director
Jocelyn Foster, Chief Strategic Officer
Paran Govender, Chief Operating Officer
Andrew Hollowood, Interim Managing Director
Simon Harrod, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Jon Lund, Interim Chief Finance Officer
Antonia Lynch, Chief Nursing Officer
Alison Ryan, Chair

In attendance

Simon Andrews, Associate Chief Nurse, Workforce and Education
Kheelna Bavalia, Interim Chief Medical Officer (from 1st February 2025)
Matthew Foxon, Deputy Chief People Officer
Roxy Milbourne, Interim Head of Corporate Governance
Zita Martinez, Director of Midwifery for Family and Specialist Services
Clare Park, Obstetric Lead
Public Governors
Sarah Richards, Interim Chief Medical Officer
Constance Rowell, Deputy Director of Nursing (shadowing the Chief Nurse)
Charlotte Sampson, Healthcare Support Worker
Catherine Soan, Executive Assistant *(minute taker)*

BD/25/01/01 Chair's Welcome, Introductions, Apologies and Declarations of Interest:

The Chair welcomed everyone to the meeting. Apologies had been received from Alfredo Thompson, Chief People Officer, Hannah Morley, Non-Executive Director, Nigel Stevens, Non-Executive Director and Paul Fairhurst, Non-Executive Director.

BD/25/01/02 Written questions from the public

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

BD/25/01/03 Minutes of the Board of Directors meeting held in public on 6 November 2024

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

BD/25/01/04 Action List and Matters Arising

There were no actions on the action log.

BD/25/01/05 Governor Log of Assurance Questions and Responses
The Governor Log was presented to the Board for information, it had been shared with the Council of Governors at the beginning of December.

The Board of Directors noted the Governor Log.

BD/25/01/06 Item Discussed at Private Board of Directors meeting.
The Chair provided an overview of the topics discussed at the Private Board of Directors meeting, mainly focussed on finance and operational pressures.

The high volume of patients coming in to hospital over recent weeks contributes to financial pressure as it reaches the stage where we don't have the premises or staff to treat people without pausing elective care, which we receive payment for. This was a national issue. The Private Board had discussed the impact this had on the end of year financial position.

BD/25/01/07 Staff Story
The Chair welcomed Simon Andrews, Associate Chief Nurse, Workforce and Education and Charlotte Sampson, Registered Nurse to the meeting to present the staff story.

The Associate Chief Nurse, Workforce and Education, introduced Charlotte Sampson, who shared her career journey with the Board of Directors. The story told of Charlotte's experience in becoming a Registered Nurse. Prior to nursing, her career had been in childcare, someone had said to her that she'd be suited to healthcare and she applied for a job as a Bank Healthcare Assistant in February 2017.

In June 2017 Charlotte gained a substantive post on the Medical Short Stay Unit which she really enjoyed it and it wasn't long before she wanted to further develop her career in nursing. Her manager, Health Jeffcoat saw her potential and encouraged her to apply for a Trainee Nursing Associate apprenticeship which she began in March 2018. Charlotte described how it was tough but she loved it and everyone at the Trust was very supportive. At that time, it was only the second cohort of the apprenticeship and due to the Covid pandemic there was a break in learning for 4 months and when it began again, it was online learning.

In March 2021, Charlotte received her pin as a qualified Registered Nurse Associate. She had to have a year in practice before becoming a band 5. She gained a lot of experience and when she reached band 5, she was ready to take next step. In September 2022 she commenced a Registered Nurse Degree apprenticeship programme. Unfortunately during Charlotte's first week of induction her mother passed away but with the support from everyone around her, she fully qualify as a Registered Nurse in April 2024.

Charlotte acknowledged the pressure on her family who were very supportive and the apprenticeship had given her the skills in practice, she could see the difference between those who undertook an apprenticeship to those who had studied at university. Charlotte described how she felt lucky to have had the apprenticeship opportunity.

Since qualifying as a Registered Nurse, Charlotte had taken on another new role as an Infection Control Nurse, joining the team in September in a dual role . Charlotte was now thinking about undertaking a masters and had an aspiration to be a band 6 Sister. She

thanked the RUH for the apprenticeship opportunity, had she not been able to do that she felt she would not be where she is today.

The Chair thanked Charlotte for sharing her career journey, which had kicked off the new year to a fantastic start. The Associate Chief Nurse, Workforce and Education added that Charlotte's story demonstrated the ability of apprenticeships and experience as well as her hard work and dedication. Charlotte is sharing her story with colleagues and would welcome the opportunity to share it to other groups.

Antony Durbacz, Non-Executive Director asked how many people were moving through the apprenticeship scheme. The Associate Chief Nurse, Workforce and Education advised that he was interviewing this week for Registered Nurse degree apprenticeships for internal and external placements. Ward Sisters also 'talent spot' and support colleagues with applying for apprenticeships.

The Chief Nursing Officer thanked the nursing workforce and education team for their support with the programme.

The Chief Executive was keen to explore other opportunities for encouraging young people in our community. The Associate Chief Nurse, Workforce and Education advised that we were working with the Midsomer Norton Schools Partnership, capturing young people straight from school and we now have more people interested that we do places. The Chief Nursing Officer added that attracting people to apprenticeships wasn't the challenge, the limitation was with the funding to backfill staff on apprenticeships.

The Board of Directors thanked Charlotte for sharing her inspirational journey.

BD/25/01/08 CEO and Chair's Report

The Chief Executive acknowledged the challenges the organisation had experienced over winter and the goals to improve patient access to our services. As an organisation, the RUH was focussed on ensuring patients were not waiting unnecessarily for treatment. We are awaiting the NHS planning guidance that sets out what we are required to do across the year. We expect the guidance to lay out the expectation to return to the 18 week standard. We are doing well but have a few patients waiting over 65 weeks for specialist conditions, the number of people waiting over 52 weeks was minimal. Other expectations of the guidance was the requirement to improve the experience of patients in urgent care and to ensure a breakeven position.

The Chief Executive was appointed as the Group Chief Executive at the beginning of November, it was early days for the group model with Salisbury and Great Western but key collaboration priorities were being mapped out and a Board Seminar for all three Boards takes place next week to progress and design how we work together.

From an RUH perspective, the organisation had a number of critical incidents in recent weeks relating to the pressure in the hospital. The country had been challenged with the high levels of Flu in the community and access to community services.

The organisation was making improvements on diagnostic performance with over 1000 new appointments being available per month. In terms of cancer performance, we have returned our position to below the regional tiered position and have a trajectory to return to the national position. We continue to be challenged financially, although we have

achieved more than planned to reduce our underlying deficit. Next year will be challenging and it was important for collaboration within the Group model to look at what we can do together to reduce duplication.

A date for the opening of ICU was expected soo, it had been delayed due to obtaining parts for the air ventilation system. The Chief Executive thanked RUHX and the Friends of the RUH for the funding for the new ceiling pendants in the ICU. The Chief Executive commented that once complete, the ICU will be phenomenal with exceptional space for family and staff.

The RUH's maternity team had received some pleasing feedback in the CQC's 2024 Maternity Survey which was a great testament to the team who are a leading light nationally.

The Chair highlighted the one-day seminar of SW NHS Leaders looking at the 10 year plan to achieve the Governments "three shifts" for the NHS.

Antony Durbacz, Non-Executive Director congratulated those involved with the improved performance in referral to treatment, diagnostic and cancer performance.

Paul Fairhurst, Non-Executive Director had submitted a question via the Chair on digital transformation and the requirement of the NHS to make elective care appointments available through the NHS app. The Chief Executive advised that BSW had been selected as an early adopter of the programme and will be the leading system for the South West. The NHS Federated Data Platform offers a range of opportunities, driving productivity and improvement, from a national perspective there is money available to support digital transformation.

The Board of Directors noted the update.

BD/25/01/09 Integrated Performance Report

The Interim Managing Director presented the report and highlighted:

Workforce

The vacancy rate and level of staff sickness remains low and is within national targets. Work was ongoing to address the low staff appraisal rate. Mandatory Training levels continue to be above where we expected it to be. The new case management system, Halo, was coming on board to direct staff to a self-service approach.

Quality

The quality of care patients receive is excellent but we continuously strive to do better. The level of pressure ulcers continues to be low, some wards have not had a pressure ulcer for 11 years. Falls data remains in a good position, the number of patients who don't fall was over 98%.

Infection Control

107 patients in the organisation today were affected by infection, this has an impact on bed closures, due to the nature of the ward environment we can't manage the spread of infection as well as we'd like.

Patient support
Divisions were focussing on patient support as part of their breakthrough objectives. Levels of Flu peaked on 6th January but we started to see an increase before Christmas. The Trust called a critical incident in mid-December that lasted 3-4 days. We worked hard with community partners to reduce the number of non-criteria to reside patients and also opened C16 as an admission area. Despite our actions, we saw a reduction in 4 hour performance. This difficult period eased over Christmas but we were back into critical incident within the first 2 weeks of January. The data shows an improvement in caner performance, diagnostics and elective recovery for November which was above plan. However, we expect to see a reduction in the December data.

Finance
The Interim Chief Financial Officer advised that the data within the report is at the end of November. We now have the December data and saw a further deterioration in our finances, with a deficit of £2.5 million. We need to take further action to improve this.

Achieving the objective set for the integrated care system by the end of the financial year was challenging. We are undertaking some targeted work to understand the impact of the operational pressures over winter, i.e. having to cancel elective operating and increases in pay expenditure due to sickness and escalation capacity. Recovery actions were focussed on maximising elective income for the remainder of the year and the opportunities the Sulis Elective Orthopaedic Centre will bring to support capacity. The Trust will continue to bare down on pay costs by holding vacancies and reducing agency costs.

The Chief Operating Officer commented that expected attendances in December was accurate but the acuity of patients was greater than expected and more patients required beds primarily due to Flu but also respiratory, chest pain and MSK being top contributors. We were able to manage demand as length of stay was less than expected and the wards supported discharges well. The South Western Ambulance Service NHS Foundation Trust team have described an unprecedented demand over winter.

Sumita Hutchison, Non-Executive Director referred to the 41 new complaints received in October, which was the highest number received in one month during the year. She asked if we understood what the reason behind the increase was. The Chief Nursing Officer responded that it was the continued trend that caused concern but communication was a theme. We liaise with many partners across BANES, Wiltshire and Swindon and the processes in each area have are varied. We have a quality improvement programme as we know we don't always get it right but we do have good governance in place.

Antony Durbacz, Non-Executive Director referred to the improved staff sickness position and asked what the targeted interventions were that had supported this. The Deputy Chief People Officer responded that as a trial, particular teams had received increased support with sickness cases in terms of workflow and policy adherence. This greater wraparound support helped line managers and the people team has a driver measure to take what we learnt and share it, as well as making it more sustainable. We have brought in Halo and provided HR support to all managers with the aim of ensuring colleagues are referred to Occupational Health in a timely manner. As part of the driver, we will be doing more intervention on MSK, which is the third highest impact on figures.

Paul Fox, Non-Executive Director asked what proportion of sickness was long term. The Deputy Chief People Officer responded that the number of long term sickness approximately matched short term sickness and will include this metric in the IPR in future.

Action: Deputy Chief People Officer

The Board of Directors noted the update.

BD/25/01/10 MIS Combined Maternity and Neonates Quarterly Report Q2

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

Four perinatal deaths (excluding medical termination of pregnancies) were reported in quarter 2, this was below the national rate. One neonatal death had been declared as a patient safety incident investigation. There were no maternity and neonatal safety investigations in month.

The next steps for progression towards full compliance of the Maternity Incentive Scheme were outlined, the organisation was in a strong position, there was evidence of compliance with a funded establishment based on BirthRate+ calculations. A new risk on the risk register was the compliance of neonatal nurses holding a recognised qualification in the specialty (QIS), this had deteriorated following staffing re-locations and retirements, to below the British Association of Perinatal Medicine (BAPM) standard of 70%. There was a full action plan towards recovery and mitigation of the non-compliance. Some nurses were in training at the moment. The availability of training was a national issue. The Board of Directors noted compliance that the neonatal unit meets the BAPM national standards of medical staffing.

The Board of Directors noted the update against the work on the Maternity and Neonatal Service Insights Report 2023/24.

The Chief Operating Officer referred to the data on still births and neonatal deaths and noted that the numbers are varied, she asked if this was something of concern. The Obstetric Lead advised that other Trust's with a similar population have clusters such as this. No commonalities had been found through internal reviews, we are on a downward trajectory and assured that we have robust processes in place to ensure no harm.

Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Board of Directors had been identified and was being implemented.

Progress with the maternity and neonatal culture improvement plan was being monitored and any identified support being considered and implemented.

The Board of Directors noted the update.

BD/25/01/11 Midwifery and Neonatal Bi-Annual Staffing Report

The Director of Midwifery and Obstetric Lead provided an overview of the Maternity and Neonates Quarterly report and highlighted the strong position in terms of funding to birthrate establishment. We have recruited significantly and sickness had stabilised. The Labour Ward Lead had managed to remain as supernumerary. The challenge was recruiting neonatal nurses.

The Getting it Right First Time (GIRFT) report recommends we should increase our transitional care service to at least 8-beds based on the current birth rate. A review of current staffing was in progress to consider expansion of transitional care bed provision.

There was a large number of fixed term secondment roles in the Neonatal Unit which will not continue following cease of fixed term funding from the Neonatal Operational Delivery. The team was considering how this risk was mitigated.

Sumita Hutchison, Non-Executive Director praised the team on the improved staffing levels, noticing the change on a recent walkaround.

The Chief Strategic Officer referred to Qualified in Speciality (QIS) staff training and asked how long it would take for us to achieve the national target 70% compliance rate. The Director of Midwifery responded that there was a national resource issue and it was unclear but there was mitigation in place Advanced Neonatal Nurse Practitioners. She added that we struggle to recruit to that role and were looking at succession planning.

The Board of Directors noted the update.

BD/25/01/12 Annual Nursing Establishment Review

The Chief Nursing Officer presented the key report following the annual Nursing and Allied Health Professional Establishment review that took place between December 2023 and June 2024.

The Trust was over establishment for registered nurses due to recruitment for the Day Surgery pathway and William Budd moving to the Dyson Cancer Centre, as well as preparing for the new ICU. In addition we have created 24/7 band 6 Sisters due to safety considerations. The recruitment of Healthcare Support Workers (HCSW) was ongoing and we were looking to create a new programme to attract, recruit and retain HCSW's. What came out of the establishment reviews was the changing dependency of patients in relation to enhanced care i.e. patients with a mental health condition alongside a physical condition. An enhanced care team had been recruited to improve the safety and quality of care provision.

The Chief Nursing Officer advised that it was the first time data had been included on the Allied Health Professional workforce, there was no validated workforce tool on which to benchmark this data. The data needed some cleansing but it will become more sophisticated.

The hospital had successfully supported a considerable number of students and learners in clinical practice and we have enhanced our support on this. We have also undertaken some analysis around staffing levels and the impact on patient outcomes. We have found that infection control data was more difficult to associate with staffing levels in part because of lack of side rooms. We are looking to improve the efficiency of rosters to ensure the resources we have are used effectively.

The primary aim for the establishment review was to assess the hospital current establishments against the principles of Safe Staffing across inpatient wards, Theatres, and the Emergency Department, and to determine if investment was required to deliver Safe Staffing. In ED there was a validated tool to assess staffing which we will undertake

more comprehensively and undertake a review of Theatres to ensure the staffing was fit for purpose in terms of meeting the elective recovery trajectory. The establishment review continually evolved and Quality Board had recommended a bi annual review.

Sumita Hutchison, Non-Executive Director asked where the funding had come from for the enhanced care team. The Chief Nursing Officer responded that we have always had funding available for temporary staffing to support patients who had mental health conditions but temporary staff didn't always provide meaningful intervention. We felt it was better to convert this into a team of staff who could better meet the needs of these patients. We topped up the funding as an invest to save initiative.

Simon Harrod, Non-Executive Director congratulated the organisation on the pressure ulcer data which was really good compared to other hospitals in the Group model. He asked if this was down to the quality of staff and staffing levels. The Chief Nursing Officer responded that it was the quality of leadership, training and staffing levels that had led to this. We will be sharing our learning with other Trusts in the Group.

Antony Durbacz, Non-Executive Director referred to the nursing cohort not covered by the report. The Chief Nursing Officer advised that the review focusses on inpatient nursing as this is where most harm occurs but we have an aspiration to undertake a review in outpatients (measuring harm differently). Antony Durbacz, Non-Executive Director asked how we accelerate this and the Chief Nursing Officer responded that she had asked NHSE for some methodology and feedback from exemplar Trusts who had undertaken a review of outpatients. The Chief Operating Officer commented that it was important to understand the demand for clinics to ensure we have the skill mix right to get the best result.

The Chief Nursing Officer commented that we can use our research to determine Safe Staffing but at any one time there are things that impact the delivery of safe care for example the acuity of patients. We have twice daily safe staffing meetings so intelligence from colleagues is shared.

The Chair added that she had recently met a Consultant who wanted to work with us because our staffing levels had improved and it was very gratifying that our past reputation was no longer our reputation. She suggested that the work the Chief Nursing Officer and team had done on this should be used as an exemplar for other Trusts.

The Board of Directors noted the report.

BD/25/01/13 Winter Update
Nothing further to discuss.

BD/25/01/14 People Committee Upward Report
The Board of Directors noted the People Committee Upward report.

BD/25/01/15 Strategic Priorities Q3
The Chief Strategic Officer presented the paper on the progress made in quarter 3 towards delivery of our You Matter Trust Strategy. The feedback from the Board of Directors on the level of transparency on what was on track was now clearly outlined within the paper to give a balanced picture. The challenge in the last quarter was getting the balance right between strategic and capacity constraints which had been growing.

The Board of Directors noted that reasonable progress had been made and that the Council of Governors will be presented with the A3's in March.

Paul Fox, Non-Executive Director requested an update on the corporate services review and the Chief Strategic Officer advised that the people team were leading the work to look at how we can work differently, more efficiently. The Chief Executive added that there were benefits of running our corporate services together but there were a number of corporate services to consider how they could be redesigned.

Paul Fox, Non-Executive Director asked if that programme of work would benefit from Non-Executive Director input and this was welcomed by the Chief Executive who suggested a more in-dept conversation at the combined Board to Board meeting next week.

The Board noted the update.

BD/25/01/16 Non-Clinical Governance Committee Upward Report

Sumita Hutchison, Non-Executive Director provided a verbal update of the Non-Clinical Governance Committee which met yesterday, the Committee noted that a new Digital Strategy was expected this year and the Committee discussed visibility around the clinical versus corporate systems, whereby more resource was put into the clinical aspect. The Electronic Patient Record gave long term benefits but it was felt that we needed more short term benefits from digital. There was recognition that there had been some constraint on transformation monies from NHSE which added to the level of risk.

The Committee had good assurance in relation to cyber and data security. The Data Security Protection Toolkit for 2024-25 having transitioned into the aligned Cyber Assessment Framework was providing challenges in meeting some of the standards expected in relation to cyber assurance. This was a national issue and the Non-Clinical Governance Committee was assured this was being managed.

The new Estates Strategy was under development and when finalised will be presented to the Board for approval.

The Non-Clinical Governance Committee was assured that the actions from the Facilities Improvement Programme were being managed effectively and funding was being put into roles within the team to maintain improvements.

The Interim Managing Director referred to the clinical, digital and estates strategies and questioned whether it was beneficial to move forward with those strategies as a Trust or delay to bring together under the Group model. The Chief Executive envisaged that the Group would have an overarching strategy document, contained within that would be a section relating to each organisation outlining what is needed to meet the Group's ambition and maximise opportunities. The Chief Financial Officer agreed and felt that the strategies were needed in the interim to be sighted on what each organisation in the group is working on to seek out joint opportunities, recognising that the electronic patient record impacted many of the shared pathways.

The Board of Directors noted the update.

BD/25/01/17 Charities Committee Upward Report and Terms of Reference for ratification

The Board approved the updated Terms of Reference for the Charities Committee.

BD/25/01/18 Audit and Risk Committee Upward Report

Paul Fox, Non-Executive Director presented the upward report from the Audit and Risk Committee meeting in December. He highlighted that the number of overdue internal audit actions had increased and the number of internal audit reports rated amber/red (sustainability, pay controls and procurement). He outlined the reasons behind this and the plans to address as contained within the report. The Committee was assured by the understanding and controls on these. The External Auditor's Annual Report 23/24 concluded that there was no significant weakness in the Trust's arrangements in respect of Financial Sustainability.

The Committee received a report on the Trust's Grip and Control arrangements. While satisfied that these were comprehensive, the Committee identified the risk that the grip in control was so effective it might be having adverse consequences.

The Chair commented that she felt the Audit and Risk function improves every year.

The Board of Directors noted the update.

BD/25/01/19 Board Assurance Framework (BAF) Summary Report

The Interim Head of Corporate Governance advised that the BAF was presented to the Board for information. The risks had been discussed and approved by the Executive Team, with the full BAF being discussed and approved at the Private Board of Directors meeting in December 2024. The Board sub-committees regularly review their respective risks and the summary report will be presented to Board on a quarterly basis.

The Chief Executive requested that the sub-committee reports to Board provide a summary of what we are doing to mitigate the risks in the BAF.

Action: Non-Executive Directors

The Chief Executive requested that as the BAF is a public document, a summary of what it is and how the organisation uses it should be included in the paper each month.

Action: Interim Head of Corporate Governance

The Chief Executive suggested that the Board receive the BAF earlier in the agenda in future to triangulate it with the sub-committee reports.

Action: Interim Head of Corporate Governance

BD/25/01/20 Any Other Business

There was no other business.

The Meeting closed at 15.32

Agenda Item: 4

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY, 15 JANUARY 2025

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB608	**Integrated Performance Report** Deputy Chief People Officer to include a metric around long term sickness in the IPR.	**25/01/09**	**January 2025**	**March 2025**	Long term absence information included in the countermeasure summary under sickness absence rate. **To close**	**Deputy Chief People Officer**
PB609	**BAF Summary Report** Non-Executive Director to ensure that the sub-Committee reports to Board summarised of what was being done to mitigate the risks in the BAF.	**25/01/19**	**January 2025**	**May 2025**		**Non-Executive Director**
PB610	**BAF Summary Report** Interim Head of Corporate Governance to include a summary of what the BAF is and how the organisation uses it in the report going forward.	**25/01/19**	**January 2025**	**May 2025**		**Interim Head of Corporate Governance**
PB611	**BAF Summary Report** Interim Head of Corporate Governance to bring the BAF forward on the agenda in future to triangulate it with the sub-Committee reports.	**25/01/19**	**January 2025**	**March 2025**	The BAF Summary Report will be taken before the Board Committee Upward Reports at the next meeting. **To close**	**Interim Head of Corporate Governance**

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**5**
Date of Meeting:	**5 March 2025**		

Title of Report:	**Governor Log of Assurance Questions and Responses**
Status:	**For Information**
Board Sponsor:	**Alison Ryan, Chair**
Author:	**Roxy Milbourne, Interim Head of Corporate Governance**
Appendices	**None**

1. Executive Summary of the Report

This report provides the Board of Directors with an update on all questions on the "Governors' log of assurance questions" and subsequent responses. The Governors' log of assurance questions is a means of tracking the communication between the Governors and the Non-Executive Directors (NEDs). Governors are required to hold the NEDs to account for the performance of the Board and this is one way of demonstrating this.

No new questions have been raised since the last report was presented in January 2025 and there are currently no open questions.

2. Recommendations (Note, Approve, Discuss)

The report is presented for information.

3. Legal / Regulatory Implications

None

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

There are no risks on the risk register.

5. Resources Implications (Financial / staffing)

There are no resource or financial implications.

6. Equality and Diversity

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

7. References to previous reports

January 2025.

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

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**5 March 2025**		

Title of Report:	**Patient Story**
Status:	**For discussion**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Sharon Manhi, Lead for Patient and Carer Experience** **Julie Jackson, Senior Sister** **Trauma & Orthopaedics/Trauma Assessment Unit**
Appendices	**None**

1. Executive Summary of the Report

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

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

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

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

The story

Eileen's story – experience of Emergency care and the Trauma Assessment Unit (TAU)

Eileen is in her late 70's and lives in Keynsham with her husband Phil.

In this film, Eileen shared her experience of attending the Trauma Assessment Unit and reflected on an earlier visit to the Emergency Department. In January this year, Eileen woke up with severe pain in her arm. Eileen contacted her GP Practice and was given an appointment that morning. Her GP called the on-call trauma and Eileen was advised to attend the Trauma Assessment Unit (TAU) later that morning.

Eileen was very relieved to be seen so promptly and said that after a thorough assessment and pain relief, the clinical team diagnosed a rupture of her elbow muscle. An ultrasound scan was booked for the following day. Eileen said that the care she received was very professional and that the staff co-ordinated her scan appointment with a scan her husband was also having the next day.

Background and context

The RUH opened its Trauma Assessment Unit in January 2020 to patients waiting for Trauma and Elective Hand Surgery. This was in response to increased strain on existing infrastructure.

TAU relocated to a purpose-built unit in late 2022 in a position within close proximity of the fracture clinic and plaster room. Within the unit there is a purpose-built procedural room with formal air exchange. This means it is appropriate for both trauma and elective hand operating in line with published British Society for Surgery of the Hand (BSSH) guidance for operating outside of main theatres.

The Trauma Assessment Unit (TAU) provides care to patients with complex injuries and conditions that need specialist orthopaedic input and treatment. The on-call team can accept referrals to the unit from GP practices, minor injuries units and the Emergency Department for assessment and investigation if deemed appropriate for the unit. The department is open from 7am to 8pm seven days a week and the team undertake trauma procedures and some elective procedures.

The following are examples of feedback received from patients and their families:

"Staff were very informative of procedure which made me feel calm and relaxed throughout"

"I was treated extremely well, and every step of the process was explained as it was happening"

"I was given clear and detailed information regarding the procedure, including the benefits and risks"

Next steps

- The film will be shared widely with staff across the Trust
- Continued focus on increasing the number of procedures (trauma and elective) that can safely be undertaken in the unit
- The unit are trialling a hand pump for patients requiring 24-hour intravenous antibiotics which will means that for suitable patients this will eliminate the need for an overnight stay.

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

3.	Legal / Regulatory Implications
The Equality Act 2010 requires organisations to make reasonable adjustments to ensure that people with disabilities or other conditions are not at an advantage. The Care Act 2014 recognising the equal importance of supporting carers and the people they care for. The Health and Care Act 2022 introduced a statutory requirement that regulated service providers ensure that their staff receive training on learning disability and autism which is appropriate to the persons role	

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

5.	Resources Implications (Financial / staffing)
A business case has been submitted for the antibiotic hand pump	

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

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

8.	Freedom of Information
Public.	

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	8
Date of Meeting:	5 March 2025		
Title of Report:	Chief Executive Officer Report		
Status:	For Information		
Board Sponsor:	Cara Charles-Barks, Chief Executive Officer		
Author:	Helen Perkins, Senior Executive Assistant to Chair and Chief Executive		
Appendices	None		

1. Executive Summary of the Report

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

Updates included in this report are:

Chief Executive's Report

- National / System
- NHS Staff Survey Results
- Group Development
- Board to Board Development
- Leadership Team: Managing Directors
- Resources and Transitional Support
- Partnership Agreement and Joint Committee Establishment
- System working engagement series
- Operating Model/Structures
- Corporate Service Collaboration
- Governance & Accountability Framework
- Shared Electronic Patient Record (EPR)

Chair's Report

- Contract Approvals undertaken through Chair's Action
- Board Meeting Dates 2025/26

Local (RUH)

- Operational
- Finance: BSW ICS Financial Performance & RUH Financial Performance
- Maternity Incentive Scheme (MIS)
- RUH Researchers set their sights on Study Success
- Team GB Olympian swaps the running track for the hospital ward
- New fundraising campaign to help bring cancer care to Frome
- EPRR team receives full compliance rating
- Congratulations to our Occupational Health team
- RUH Membership
- Use of Trust Seal
- Consultant Appointments

2.	Recommendations (Note, Approve, Discuss)
The Board is asked to note the report.	

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

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
Strategic and environmental risks are considered by the Board on a regular basis and key items are reported through this report.	

5.	Resources Implications (Financial / staffing)
A significant amount of time is being taken by the Improvement Team to support the recovery programme.	

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

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

8.	Freedom of Information
Private	

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

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

Chief Executive Officer's Report & Chairs Report

Chief Executive's Report

1. National/System

Amanada Pritchard, Chief Executive NHS England, announced her decision to step down from her position at the end of the financial year. Sir James (Jim) Mackey will be the Transition CEO of NHS England, working closely with Amanda for the next month before taking up post formally on the first of April. Sir Jim Mackey will step in on a secondment basis, with a remit to radically reshape how NHS England and Department of Health and Social Care (DHSC) work together.

2. NHS Staff Survey results

The 2024 NHS Staff Survey results will be published at 9.30am on Thursday 13 March on the Staff Survey Coordination Centre website. Further to receiving local data, each organisation will receive its local benchmark report under embargo provisionally at the end of February.

3. Group Development:

January and February have seen the foundations start to form, putting us in a good place to significantly move forward over the next 12 months.

Board to Board Development:

We had our first of our Board-to-Board development day in January, providing us time for Board members from GWH, RUH and SFT to meet, continuing to develop relationships, and to reflect on the collective challenges and opportunities we have ahead.

We explored our national and BSW context, our Group strategic response and planned areas of focus. The day was supported by a session on Group Governance Development, led by Browne Jacobson, a legal firm which is supporting us with some of this work currently. The remainder of the day saw teams reflecting on opportunities, values, behaviours, and the culture we aim to foster.

Leadership Team: Managing Directors

The recruitment process for our three Managing Directors is well-underway. We had planned to hold interviews in February; in collaboration with the three Chairs across the Group we decided to allow more time in the recruitment process and now aim to interview in March/early April.

Resources and Transitional Support:

We have received funding from the NHSE South West Region for transitional support for our Group development, and a tender exercise is underway to identify a partner. We expect the selected partner to start with the Group in March. Early focus will be on planning our Group Design Phase – including work on our operating model and organisational design.

Partnership Agreement and Joint Committee Establishment:

A task and finish group of executives and non-executives met in late January. Supported by Browne Jacobson colleagues, the legal and policy context for provider Groups were set out, followed by a series of examples of how other groups around the NHS have

established themselves. There is no off-the-shelf model for our BSW Hospitals circumstances. The working party met again in February to consider the potential Joint Committee role in scenarios related to likely priorities in BSW – strategy and group mobilisation, financial sustainability and successful EPR implementation and benefits realisation. We are aiming to confirm Terms of Reference for the Joint Committee in March.

System working engagement series with Councils of Governors
In January, supported by colleagues from our Legal Advisors Browne Jacobson, we held a series of local Governor discussion sessions focused on system working and group leadership and development. A further development session for all three Governor teams is planned for March.

Operating model/structures
Work to establish our new operating model will begin in earnest in March, supported by the transitional team. We will establish Improving Together, Organisational Design, Organisational Development and change management as essential complementary components for successful development of BSW Hospitals Group. We plan to finalise our operating model by September.

Corporate Service Collaboration
Corporate service collaboration will be an important part of our operating model, identifying opportunities to work at scale and align processes. Executive colleagues are planning our approach in readiness for arrival of transitional support to help with more detailed design and implementation. We are aiming to agree our corporate services model by September.

Governance & Accountability Framework
In parallel, our Trust governance leads and company secretaries have begun meeting weekly to identify opportunities for collaboration, alignment and avoidance of duplication.

Shared Electronic Patient Record (EPR)
We are now in the 'Engage' stage which runs through to March 2026. This includes the build, testing and training for EPR. Our EPR Joint Committee met on 29 January. Our implementation team is well established.

Chair's Report

1. Contract Approvals undertaken through Chair's Action

Since the last Board I have approved the raising of one purchase order for greater than £1m each, under delegated Chair's action due to urgent need to raise purchase orders to ensure services are provided before 31st March. In line with Standing Financial Instructions, I am reporting this to the Board of Directors. The Contract Recommendation Report is available via the Chief Finance Officer.

The purchase order related to Capital equipment and 7 year maintenance contracts for the replacement of the trust's Endoscopes for the Gastroenterology and Respiratory Departments awarded to Olympus Keymed Group Ltd. The capital cost is £3,536,544 and is funded by additional Public Dividend Capital allocation provided by NHS England. The 7 year maintenance cost is £2,231,700 and funded by existing revenue budgets. The

maintenance delivers a recurrent revenue saving and the nee scopes will provide a productivity benefit compared to current practise due to the quicker sterilisation turnaround times and lower downtime.

I was advised by Chief Finance Officer to approve on recommendation of Medicine Division and Trust procurement and finance teams.

I am assured that the recommended contract is consistent with the business case approved by the Board in December 2024. I am assured that the Procurement process followed and decision for Direct Award via NHSSC framework is appropriate.

2. Board Meeting Dates 2025/26

At the Board meetings of the Great Western Hospitals NHS FT, Royal United Hospitals Bath NHS FT on 22 July 2024 and Salisbury NHS FT on 5 September 2024 each Board of Directors approved the Case for Change to move to a Group model.

Following the move to the BSW Hospitals Group model and consultation with Board members, it is proposed that minor changes are made to the Board cadence to implement three 'all Board' seminars per year (all three boards joining together for a seminar).

The following dates have been identified by the BSW CoSec team and will follow the pattern of one seminar date to be allocated to each Trust on their set date (this means that each Trust will be required to change two Board dates in 25/26) and will be hosted by that Trust. The dates for 2025/26 have been proposed as follows:

Host Organisation	**All Board Seminar Date**
Royal United Hospitals	Wednesday 4th June 2025
Salisbury Foundation Trust	Thursday 2nd October 2025
Great Western Hospitals	Thursday 12th February 2026

The only change for the RUH that is required is in terms of the Board and seminar date in October 25 and February 26 to align with SFT and GWH and the potential addition of a local seminar in August.

The Board is asked to approve the above changes to Board meeting and seminar dates and structure in 2025/26.

Local

1. Operational

Ambulance handover

In January, the Trust lost a total of 2,597 hours in ambulance handovers, a decrease from the previous month (2,965). The percentage of ambulance handovers completed within 30 minutes decreased for January to 30% compared to previous month (33%) against the national standard of 95%.

4 Hour Performance

The RUH 4-hour performance in January 2025 was 68.9% and 60.5% on the RUH footprint (unmapped), an improvement on December 2024 (63.6% and 54.7%

respectively). Non-admitted performance was 74.2%, which was an increase against the performance for December (67.1%). Admitted performance was 31%, which was also improved from December (28.2%). Improved senior staffing within CED helped with this, along with more consistent senior staff in ED overnight.

Non-Criteria to Reside
During January, the Trust had an average of 102 patients waiting who had no criteria to reside, which was an increase of 15.7 to the previous month (the system target remains 55).

Referral to Treatment
In January, the Trust achieved an RTT performance of 60.2%. For waiters > 65 weeks, the Trust saw a decrease in January from 15 to 9 patients. There were 3 patients waiting > 78 weeks at the end of January (3x Ophthalmology – awaiting corneal transplant surgery).

Elective Recovery
M10 delivered 128% of 19/20 activity and 104% against the 24/25 plan, generating £322k of additional income against plan.

Cancer
In December 28-day performance improved, achieving 72.6% and above the 70% tiering threshold for the third consecutive month. 62-day performance recovered in December, achieving 71.8% against the national 70% target. This performance has been driven by improvements in Breast (as per recovery trajectory following the increased diagnoses and consultant sickness in late summer), and Colorectal (using capacity at Sulis for non-complex procedures).

Diagnostics
In January, 62.50% of patients received their diagnostic within the 6-week target against an in-month target of 77.97%, despite delivering 2,061 additional diagnostic tests across all modalities. Increased demand for urgent and suspected cancer continues to impact on available capacity for routine diagnostics, as does unplanned staff sickness.

2. Finance:

BSW ICS Financial Performance
The organisations in the BSW Integrated Care System must collaborate to develop Revenue and Capital Financial Plans with a view to achieving breakeven against allocations each year. The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to its pre-pandemic levels.

The BSW System developed a financial plan with a deficit of £30m, of which RUH was £5.3m. This was accepted by NHS England and £30m deficit support funding has been provided and performance is now measured against a breakeven plan.

At Month 10 the Integrated Care System is at an adverse variance to plan of £16.3m
The Trust has agreed with ICS partners and NHSE Regional Team to formally declare a deficit of £14.9m at Month 10 and given full commitment that every effort will be made to deliver this forecast. The Board of Directors received a full forecast at the meeting last month

This reported position has been agreed as acceptable to NHS England Regional team is anticipated to result in:

- no formal escalation under NHS System Oversight Framework
- no repayment of deficit in future years, in line with NHSE business rules, taking account of the ICS being funded below target allocation

RUH Financial Plan (The RUH position for NHS performance purposes includes RUH Foundation Trust and fully consolidated Sulis financial position)
The RUH breakeven plan is underpinned by £22.7m of non recurrent revenue financial support from commissioners, £5.3m of deficit support funding from NHSE and £7.1m of NHSE funding for revenue consequences of strategic capital investment. The financial plan for the year requires full delivery of a £36.6m Savings Programme, which has been phased to recognise progressive reduction in costs and increases in income over the year. Delivery of this plan is supported by an Improvement programme with 3 workstreams focussing on (1) Clinical Operational Service Transformation (2) Paybill Reduction and (3) Cost Control and Commercial Income. Achieving the financial plan is an RUH Breakthrough Objective for 2024/25

Revenue Financial Performance – Month 10
At Month 10 the RUH is at a deficit position of £9.0 million, which is £9.0 million adverse to the breakeven plan year to date; and £0.1m adverse to the forecast outturn trajectory

The key drivers of this variance are:

- £10.4m net of non pay and operating income budget overspends, of which c£1m is one off in nature. Clinical Supplies and Consumables remain a challenge to the budget. Worked WTE continues to reduce but is higher than budgeted trajectory. Pay is over spent by £1.1m, £0.5m relating to under funding of pay awards and £0.6m from pressures on wards.

Savings of £26.4m have been delivered to date (72% of annual target in 83% of the financial year), including £14.4m of pay savings against budget, and the benefit of Elective Recovery Fund Income and operating margin of 60%.

Risks and Actions Required
A do nothing different trajectory of cumulative year to date performance would lead to an £11.8m deficit, which would be £11.8m adverse to the breakeven plan.

In order to deliver £9.0m deficit the following key actions are required:

- Sustain current financial position and savings delivery, including current vacancies
- Additional paybill savings through bank controls and holding vacancies
- Additional ESRF income through improved coding and data capture and additional activity in February and March
- Non Pay cost reduction in line with savings plans for Procurement and Medicines optimisation
- Sulis financial recovery and mitigation to Endoscopy Van forecast cost pressure

3. Maternity Incentive Scheme (MIS)

In February 2025, the Board of Directors (a meeting held in private), approved for the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution declaring full compliance with the Maternity Incentive Scheme. The CEO signed to confirm that:

i) The Trust Board were satisfied that the evidence provided demonstrated achievement of the 10 Safety Actions to meet the required Safety Actions' sub-requirements as set out in the 10 maternity Safety Actions.

ii) There were no reports covering either year 2023/24 or 2024/25 that related to the provision of maternity services that could subsequently provide conflicting information to the declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/MNSI investigation reports etc.)

iii) There were no reports covering an earlier time-period that may prompt a review of previous MIS submissions.

In addition, the CEO appraised the Accountable Officer (AO) for the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (ICS) of the MIS Safety Actions' evidence and declaration form. The CEO and AO both signed the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Board declaration was sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2025 and 3 March 2025.

The paper presented to the Board of Directors by the Director of Midwifery and the Obstetric Clinical Lead is attached to the agenda for noting and publication on the Trusts public facing website.

4. RUH Researchers set their sights on Study Success

The Maternity and Paediatric research teams at the Trust are celebrating recruiting their 1,000th young participant to a major study, which uses an infra-red camera to screen for congenital cataracts in newborn babies.

Funded by the National Institute for Health and Care Research (NIHR), the DIvO (Digital Imaging versus Ophthalmoscopy) study is a two-year UK clinical study which aims to find out if digital imaging is a more accurate method of detecting cataracts in newborn babies than the current technique using an ophthalmoscope (a medical eye torch).
The RUH is one of a number of sites supporting the DIvO study.

5. Team GB Olympian swaps the running track for the hospital ward

A Team GB Olympian who took centre stage at last year's Olympic Games in Paris has temporarily put down her fencing sword and picked up her stethoscope to begin a new role at the Trust.

Kerenza Bryson who represented Great Britain in the women's modern pentathlon, started as a new resident doctor at the RUH in December.

As if being a doctor and a professional athlete wasn't enough to keep her busy, Kerenza is also an Army Reservist with 165 Port and Maritime Regiment, Royal Logistic Corps.

6. New Fundraising Campaign to help bring Cancer Care to Frome

Bath Cancer Unit Support Group (BCUSG) has launched a fundraising campaign to support a new RUH Cancer Treatment Centre, which will be based in Frome. The new facility will ensure more patients can receive Cancer care closer to home.

The RUH is planning to open a Systemic Anti-Cancer Treatment (SACT) Centre in Frome Medical Centre. SACT is the use of drugs to treat or control cancer, which includes chemotherapy, immunotherapy, hormonal therapy and targeted therapy.

The centre will not just benefit patients living in Frome, but also those from neighbouring towns and villages such as Shepton Mallet, Warminster and Westbury.

The BCUSG aims to raise £64,000 by the end of March 2025 to support with renovations and set-up costs. The new treatment centre is scheduled to open later this year and will care for up to five patients at a time.

7. Emergency Preparedness, Resilience and Response team receives full compliance rating

The RUH's Emergency Preparedness, Resilience and Response (EPRR) function has achieved, for the first time as a Trust, a full compliance rating with the national 2024 Core Standards.

This really is a fantastic achievement and reflects the continuous hard work and commitment shown by everyone in our emergency planning team, working with our staff. The full compliance rating was achieved following a thorough review from BSW Integrated Care Board, which included face to face meetings and the submission of detailed reports outlining our emergency planning strategies.

The ICB particularly praised the Trust for, among other things, the learning it had taken from the major security incident that took place in February 2024 and running training exercises and supporting wider multi-agency events.

8. Occupational Health Team Accreditation

I am delighted to inform you that the Trust has been awarded the SEQOHS (Safe, Effective, Quality, Occupational Health Service) accreditation as of 18th February 2025.

This prestigious recognition is a testament to our unwavering commitment to excellence in occupational health services.

I would like to extend our heartfelt gratitude to Julie Stone for her exceptional leadership throughout this journey. Her dedication and vision have been instrumental in achieving this milestone. This accreditation not only highlights our adherence to the highest standards but also reinforces our commitment to the well-being of our staff and patients. It is a proud moment for all of us, and I am confident that we will continue to uphold these standards in the future.

9. RUH Membership

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

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

10. Use of Trust Seal

The Trust seal was used on the 14th February for the lease in relation to the updated lease of the shop and café at the Royal United Hospitals Bath NHS Foundation Trust, between the Trust and League of Friends.

11. Consultant Appointments

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

Dr Elizabeth Williams, Speciality Trainee (Year 8) at the Trust, was appointed as a Consultant in Emergency Department and Intensive Care Unit on 13th January 2025. Dr Williams will commence her new role on 7th July 2025.

Dr Andrew Virr, Locum Consultant at the Trust, was appointed as a Consultant in Emergency Medicine on 27th January 2025. Dr Virr commenced his new role on 1st March 2025.

Dr Daniel McLernon-Billows, Bank Specialty Trainee at the Trust, was appointed as a Consultant in Emergency Medicine on 27th January 2025. Dr McLernon-Billows will commence his new role on 2nd June 2025.

Dr Rebecca Oliver, Speciality Trainee (Year 7) at the Trust, was appointed as a Consultant in Haematology on 19th February 2025. Dr Oliver's start date has yet to be confirmed.

Dr Arvinda Chippagiri, Locum Consultant at the Trust, was appointed as a Consultant in Urology on 22nd January 2025. Dr Chippagiri commenced his new role on 3rd February 2025.

Mr Ayman Ali, Locum Consultant at the Trust, was appointed as a Consultant in Urology (with interest in Robotic Surgery) on 22nd January 2025. Dr Ali's start date has yet to be confirmed.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**5 March 2025**		

Title of Report:	**Integrated Performance Report (January 2025 Data)**
Status:	**For noting**
Board Sponsor:	**Paran Govender, Chief Operating Officer** **Jon Lund, Interim Chief Finance Officer** **Toni Lynch, Chief Nursing Officer** **Alfredo Thompson, Chief People Officer**
Author:	**Tom Williams, Head of Financial Management** **Rob Eliot, Lead for Quality Assurance** **Matt Foxon, Deputy Chief People Officer** **Operational Team**
Appendices	**Appendix 1: Integrated Performance Report** **Appendix 2: Trust Scorecard**

1. Executive Summary of the Report

The report provides an overview of the Trusts Performance for the period up to and covering January 2025, aligned to our True North Pillars and breakthrough objectives agreed for the year.

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

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

Finance

BSW Integrated Care System

- The organisations in the BSW Integrated Care System must collaborate to develop Revenue and Capital Financial Plans with a view to achieving breakeven against allocations each year. The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to its pre-pandemic levels.
- The BSW System developed a financial plan with a deficit of £30m, of which RUH was £5.3m. This was accepted by NHS England and £30m deficit support funding has been provided and performance is now measured against a breakeven plan.
- At Month 10 the Integrated Care System is at an adverse variance to plan of £16.3m (see slides 13 & 14 for further details)
- The Trust has agreed with ICS partners and NHSE Regional Team to formally declare a deficit of £14.9m at Month 10 and given full commitment that every

effort will be made to deliver this forecast. The Board of Directors received a full forecast at the meeting last month

	GWH	SFT	RUH	ICB	TOTAL
FOT	1.4	-15.7	-9.0	8.4	-14.9

- This reported position has been agreed as acceptable to NHS England Regional team is anticipated to result in:
    - no formal escalation under NHS System Oversight Framework
    - no repayment of deficit in future years, in line with NHSE business rules, taking account of the ICS being funded below target allocation

Revenue Financial Performance – Month 10 (see slides 4-12 for further details)

- At Month 10: the RUH is at a deficit position of £9.0 million, which is £9.0 million adverse to the breakeven plan year tio date; and £0.1m adverse to the forecast outturn trajectory
- The key drivers of this variance are:
    - £10.4m net of non pay and operating income budget overspends, of which c£1m is one off in nature. Clinical Supplies and Consumables remain a challenge to the budget. Worked WTE continues to reduce but is higher than budgeted trajectory. Pay is over spent by £1.1m, £0.5m relating to under funding of pay awards and £0.6m from pressures on wards.
- Savings of £26.4m have been delivered to date (72% of annual target in 83% of the financial year), including £14.4m of pay savings against budget, and the benefit of Elective Recovery Fund Income and operating margin of 59%.

Risks and Actions required

A do nothing different trajectory of cumulative year to date performance would lead to an £11.8m deficit, which would be £11.8m adverse to the breakeven plan. Savings achieved would be £31.2m. In order to deliver £9.0m deficit the following key actions are required:

- Sustain current financial position and savings delivery, including current vacancy level
- Additional paybill savings through bank controls and holding vacancies
- Additional ESRF income through improved coding and data capture and additional activity in February and March
- Non Pay cost reduction in line with savings plans for Procurement and Medicines optimisation
- Sulis financial recovery and mitigation to Endoscopy Van forecast cost pressure

Capital and Balance Sheet Position – Month 10 (see slides 15-17 for further details)

- Total capital expenditure is £38.1m at Month 10, which is £10.7m behind plan

due to delays in both the SEOC and EPR programmes
- The closing cash balance for the Group was £31.9m which is 16.0% higher than the plan due to the capital delays, however cash balances are decreasing in line with I&E deficit.

Workforce

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

- Staff-in-post in January 2025 was 5547.9 WTE, a decrease from M9s 5565.5
- The pay bill increased from £28.2min M9 to £28.3m in M10
- The vacancy rate increased to 2.83% in M10
- Agency spend as a proportion of the total pay bill increased from 0.47% in (M9) to 0.81% (M10) keeping us well within the local target of 3.5% and the national target of 3.2%.
- Rolling turnover decreased to 8.36% (from 8.43% in M9) a continued positive variance against a target of 11.00%.
- The target percentage figure for Appraisal completion is 90%; Appraisal rate is consistently in the low 80s, currently 80.81%
- Mandatory Training compliance continues to be narrowly above target at 86.74%.

The priorities within our People agenda will continue the work around pay efficiencies, management of sickness absence and improving appraisal compliance.

A 2025/26 Strategic People, Culture and Leadership Plan and a draft is going to the March 2025 People Committee.

Countermeasures are being taken to improve the key standards:

Sickness absence rate

Short term
- Communications campaign focussing on ‘keeping yourself well at work this winter’. Encouraging staff to wear face masks, clinell wipe touch points, get their covid and flu jabs and follow good IPC practices
- Using Allocate reports for real time sickness management, planning to move this data across to Halo.

Long term sickness
- The People Hub is supporting managers with 141 long term sickness cases.
- MSK campaign undertaken by Wellbeing Outreach Lead in Cleaning and ED nursing and interventions implemented
- Reviewing and developing the staff physiotherapy service
- Workplace adjustments and Working with Cancer working groups

exploring ways to improve the support for staff with long term health conditions and workplace needs. These are key contributors to improving organisational wellness management.

- Life MOT questionnaire project being conducted by Wellbeing Outreach Lead in Cleaning to identify what areas we can provide additional support to staff in (e.g., financial wellbeing, accommodation/housing, caring responsibilities, work-related issues etc.)
- Departmental stress risk assessments to be conducted in ED, Maternity and Radiology in line with the new Wellbeing at Work Policy to address structural issues that increase the risk of stress, burnout, and mental health issues.
- Levels of stress, anxiety and depression are decreasing but still too high – tools and resources developed for managers to assess and address issues (including team-based solutions, proactive intervention from EAP and culture teams)
- Charitable funds used for wellbeing specialist to focus on high pressure areas for worry, stress and burn-out.

Appraisal

Despite showing an improvement over the last 12 months, the appraisal rate remains consistently below the target (currently 9% below). A proposal is currently being developed to explore the feasibility of an appraisal window for the next financial year. A revised Appraisal Policy is now awaiting ratification, and Divisional People Partners have started a concerted campaign to support managers to appraise colleagues whose appraisals are out of date.

Agency Spend and Bank Rate

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

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

Recruitment

Workforce controls remain in operation to support a sustainable workforce for the future. This includes all corporate posts and any clinical post above Band 7 to be subject to additional scrutiny at ICB level to support financial recovery.

Mandatory Training

Task and Finish group (with clinical representation) in place to ensure recovery

of resus compliance and monitoring of safety outcomes.

Quality

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

The Quality Report routinely reports on agreed performance measures and patient safety priorities.

Updates:

Pressure Ulcers
There have been 5 pressure ulcers reported in December: One category 3 pressure sacral ulcer and three category 2 pressure ulcers over three clinical areas. There was also one category 2 medical device related pressure ulcer on a patient's nose in the Intensive Care Unit. All cases are being reviewed, emergent themes related to inconsistent application of skin assessments and repositioning of patients**.**

Falls
In December, 98.2% of patients admitted to the RUH did not sustain a fall whilst in our care. There were 4 reported falls that resulted in moderate harm to patients. The incidents occurred on 4 different wards (1 medical and 3 surgical) and resulted in hip fractures. Huddles have been completed for these incidents to identify opportunities for learning. Where appropriate a further review will be completed and presented to the review panel. Any actions formulated are then included in the falls work plan to ensure improvement work is planned and completed.

Infection Prevention and Control Update
There were 7 cases of Clostridiodes Difficile Infection (CDI) reported in December. This is 73 cases against our target threshold of 75. The cases have been widespread across the Trust.

There were 16 cases of *E. coli* infection reported during December, resulting in 70 cases against our threshold of 82. Urinary focus accounts for 29 cases and is the Trust's major contributor in cases of *E. coli*. Benching has shown that we are currently mid-table across the South-West. The Infection, Prevention and Control team are contributing to a workstream to support accurate completion of fluid charts.

Incidences of Avian flu have been reported by UKHSA in the East Midlands, front door service have been made aware.

Patient Support and Complaints
In December, the Trust received 27 new complaints, which is one less than the

complaints received in November (n=26).

The number of complaints reopened each month remains low with the majority of contacts satisfied with the outcome/response. One complaint was reopened in December. 61% (Target 90%) of complaint responses were closed within the timeframe agreed with the complainant. The response rate in December across the Clinical Divisions was 58% in Medicine. Surgery was 66% and Family and Specialist Services 50%. (2/4 complaints).

Early resolution (within 14 days) was achieved in 69% of all complaints and concerns (Target 75%).

Maternity Update

- Midwife to birth ratio remains stable
- Neonatal Unit (NNU) qualified in speciality (QIS) rate has reduced. This is due to the southwest operational delivery network (SWODN) contacting all providers to ensure only patient facing nurses are included in calculation. Anticipate compliance to standard by Q2 2025 following 4 nurses gaining QIS qualification
- Advanced Neonatal Nurse Practitioners (ANNP) vacancy remains. There is a national shortage of ANNPs therefore the decision to advertise to tier 2 made. Further mitigations being discussed if unable to recruit to tier 2
- Meeting with Birthrate Plus (BR+) ongoing to ensure red flags are in line with Bath, North East Somerset, Swindon and Wiltshire (BSW) reporting
- Training with BR+ also planned for January 2025 to ensure accurate capture of inpatient acuity, and to set new staffing requirements following implementation of Leadership and Culture QI project
- 1 antenatal stillbirth at 23+5, no care issues identified. Will receive full perinatal mortality review report
- 1 neonatal death due to a metabolic disorder. No care issued identified
- MIS year 6 – compliance with SA6 and SA8 confirmed. KPMG audit underway
- Review of triangulation of feedback process underway to ensure themes and action are identified linked to Trust values.

<u>Operational Performance</u>

<u>Ambulance Handover</u>

- In January, the Trust lost a total of 2,597 hours in ambulance handovers, a decrease from the previous month (2,965).
- The percentage of ambulance handovers completed within 30 minutes decreased for January to 30% compared to previous month (33%) against the national standard of 95%.
- SWASFT shared some data with RUH, and it does show an overall increase for ambulance handovers in 15-30mins, 30-60mins with a

concurrent reduction in those ambulance handovers in 90-120mins, 2-3hrs, 3-4hrs and 4-8hrs, which is positive.

4 Hour Performance

- The RUH 4-hour performance in January 2025 was 68.9% and 60.5% on the RUH footprint (unmapped), an improvement on December 2024 (63.6% and 54.7% respectively).
- Non-admitted performance was 74.2%, which was an increase against the performance for December (67.1%).
- Admitted performance was 31%, which was also improved from December (28.2%).
- Improved senior staffing within CED helped with this, along with more consistent senior staff in ED overnight.

Non-Criteria to Reside (NC2R)

- During January, the Trust had an average of 102 patients waiting who had no criteria to reside, which was an increase of 15.7 to the previous month (the system target remains 55)

Referral to Treatment (RTT)

- In December 2024, the Trust achieved an RTT performance of 60.2%
- For waiters > 65 weeks, the Trust saw a decrease in January from 15 to 9 patients
- There were 3 patients waiting > 78 weeks at the end of January (3x Ophthalmology – awaiting corneal transplant surgery)

Cancer (December performance)

- 28-day performance improved, achieving 72.6%, above the 70% tiering threshold for third consecutive month
- 62-day performance recovered in December, achieving 71.8% against the national 70% target.
- Performance driven by improvements in Breast (as per recovery trajectory following the increased diagnoses and consultant sickness in late summer) and Colorectal (using capacity at Sulis for non-complex procedures)

Diagnostics

- 62.50% of patients received their diagnostic within the 6-week target against an in-month target of 77.97%, despite delivering 2,061 additional diagnostic tests across all modalities
- Increased demand for urgent and suspected cancer continues to impact as does unplanned staff sickness

Elective Recovery

- M10 delivered 128% of 19/20 activity and 104% against the 24/25 plan, generating £322K of over delivery against plan

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

3.	Legal / Regulatory Implications
Trust Single Oversight Framework.	

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

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

6.	Equality and Diversity
N/A	

7.	References to previous reports/Next steps
Standing agenda item.	

8.	Freedom of Information
Public	

9.	Sustainability
None identified.	

10.	Digital
None identified.	

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report

February 2025 (January 2025 data)

The RUH, where you matter

Trust Priorities 2024/25

Royal United Hospitals Bath NHS Foundation Trust

The people we care for

The people we work with

The people in our community

Trust goals

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

Breakthrough goals 24/25

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

Discrimination
% of staff reporting they have experienced discrimination at work

Making best use of available resources
Delivery of financial plan

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

Trust-wide projects

- **Patient Safety Programme -** Quality Management System, Patient Safety Incident Response Framework, Paperless Inpatients
- **Atrium Redesign**
- **Patient Experience Programme** - DrDoctor Patient Platform, Website
- **Clinical Estate -** One ICU, Maternity DAU, Dyson Cancer Centre Benefits Realisation
- **Community Services Tender**
- **Elective & Cancer -** Community Diagnostic Centre & Sulis Elective Orthopaedic Centre
- **Foundations Programme** – Basics Matter & People Hub
- **Workforce Plan**
- **Employee Experience & Engagement –** Joy at Work, Employee Recognition
- **Restorative, Just & Learning Culture**
- **Equality, Diversity & Inclusion Programme** – Positive Action & Dignity at Work
- **Leadership Development Programme**
- **Health Inequalities Programme** – Preventative services, Anchor Plan
- **Estate Decarbonisation**
- **Financial Improvement Programme** – Clinical productivity, Pay Bill, Income and cost controls
- **Single EPR**
- **Acute Hospital Alliance reset** – Clinical and Corporate Services

Business Rules

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

Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 10

The people in our community

The RUH, where you matter

1. Executive Summary

BSW Integrated Care System

- The organisations in the BSW Integrated Care System must collaborate to develop Revenue and Capital Financial Plans with a view to achieving breakeven against allocations each year. The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to it's pre-pandemic levels.
- The BSW System developed a financial plan with a deficit of £30m, of which RUH was £5.3m. This was accepted by NHS England and £30m deficit support funding has been provided and performance is now measured against a breakeven plan.
- At Month 10 the Integrated Care System is at an adverse variance to plan of £16.3m (see slides 13 & 14 for further details)
- The Trust has agreed with ICS partners and NHSE Regional Team to formally declare a deficit of £14.9m at Month 10 and given full commitment that every effort will be made to deliver this forecast. The Board of Directors received a full forecast at the meeting last month

	GWH	SFT	RUH	ICB	TOTAL
FOT	1.4	-15.7	-9.0	8.4	-14.9

- This reported position has been agreed as acceptable to NHS England Regional team is anticipated to result in:
  no formal escalation under NHS System Oversight Framework
  no repayment of deficit in future years, in line with NHSE business rules, taking account of the ICS being funded below target allocation

Revenue Financial Performance – Month 10 (see slides 4-12 for further details)

- At Month 10: the RUH is at a deficit position of £9.0 million, which is £9.0 million adverse to the breakeven plan year tio date; and £0.1m adverse to the forecast outturn trajectory
- The key drivers of this variance are:
  - £10.4m net of non pay and operating income budget overspends, of which c£1m is one off in nature. Clinical Supplies and Consumables remain a challenge to the budget. Worked WTE continues to reduce but is higher than budgeted trajectory. Pay is over spent by £1.1m, £0.5m relating to under funding of pay awards and £0.6m from pressures on wards.
- Savings of £26.4m have been delivered to date (72% of annual target in 83% of the financial year), including £14.4m of pay savings against budget, and the benefit of Elective Recovery Fund Income and operating margin of 59%.

Risks and Actions required

A do nothing different trajectory of cumulative year to date performance would lead to an £11.8m deficit, which would be £11.8m adverse to the breakeven plan. Savings achieved would be £31.2m.
In order to deliver £9.0m deficit the following key actions are required:

- Sustain current financial position and savings delivery, including current vacancy level
- Additional paybill savings through bank controls and holding vacancies
- Additional ESRF income through improved coding and data capture and additional activity in February and March
- Non Pay cost reduction in line with savings plans for Procurement and Medicines optimisation
- Sulis financial recovery and mitigation to Endoscopy Van forecast cost pressure

Capital and Balance Sheet Position – Month 10 (see slides 15-17 for further details)

- Total capital expenditure is £38.1m at Month 10, which is £10.7m behind plan due to delays in both the SEOC and EPR programmes
- The closing cash balance for the Group was £31.9m which is 16.0% higher than the plan due to the capital delays, however cash balances are decreasing in line with I&E deficit.

2. Executive Scorecard

	Performance Indicator	Description	Target		Baseline	Actual 2024/25									
			Performing	Under Performing		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Sustainability Tracker Metrics	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	£0	£0m	(£0.08m)	(£1.50m)	(£0.61m)	(£0.63m)	(£1.88m)	(£2.11m)	(£4.24m)	(£6.27m)	(£8.96m)
	Forecast delivery of Group financial plan	Forecast variance from year to date plan	<=0	>0	(£5.30m)	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	(£9.00m)
	Group delivery of Plan	Total year to date financial performance	<=0	>0	(£5.30m)	(£2.26m)	(£4.06m)	(£6.50m)	(£6.59m)	(£7.76m)	(£1.88m)	(£2.11m)	(£4.24m)	(£6.27m)	(£6.96m)
	Value of Forecast QIPP Unidentified	Forecast performance against plan	< = £5m	> £5m	£0m	£2.86m	£2.86m	£2.86m	£2.81m	£2.81m	£2.81m	£2.81m	£0.00m	£0.00m	£0.00m
	Delivery of QIPP against plan	Performance against plan	<=100%	>100%	100.0%	100.0%	98.0%	96.1%	99.2%	95.2%	89.2%	97.0%	100.5%	93.8%	91.9%
	Reduction in agency expenditure	Agency costs as a % of total pay costs	<= 3%	> 3%	3.0%	1.2%	1.2%	0.3%	1.0%	1.0%	1.0%	0.8%	1.1%	0.5%	0.8%
	Sickness against plan	Actual levels of sickness against average pre-pandemic levels	<= 4.1%	> 4.1%	4.5%	4.5%	4.5%	4.4%	4.9%	4.6%	4.4%	4.6%	5.2%	4.6%	5.0%
	Net impact of high cost drugs and devices	Total expenditure and income against plan for high cost drugs and devices (YTD)	<=0	>0	£0	(£0.1m)	(£0.6m)	(£0.8m)	(£1.2m)	(£1.1m)	(£1.7m)	(£1.5m)	(£2.2m)	(£2.0m)	(£2.2m)
	Increase productivity	Implied productivity based on financial and operational performance (Quarterly)	>=3%	3%	-7%	-23%	-23%	-23%	-23%	-23%	-13%	-13%	-13%	-12%	-9%
	Elective recovery	In Month Performance against planned levels of activity (Value based)	>= 100%	< 100%	n/a	112%	113%	109%	106%	105%	105%	114%	112%	101%	104%
	Non elective activity	In Month Performance against planned levels of activity (Value Based)	<= 102%	> 102%	n/a	119%	142%	116%	120%	112%	113%	112%	107%	109%	110%
	Delivery of capital programme	Variance from year to date planned capital expenditure (Internally Funded Schemes)	-5%	<5%	n/a	67.3%	51.9%	69.7%	65.7%	61.8%	51.8%	63.7%	66.2%	63.2%	76.9%
	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+ or - 5%	><5%	n/a	0	0	0	0	0	0	0	0	0	0
	Delivery of planned cash balance	Variance from year to date planned cash balance	- 10%	<10%	n/a	8.8%	25.6%	24.50%	38.7%	40.0%	17.4%	64.9%	41.6%	30.2%	16.0%

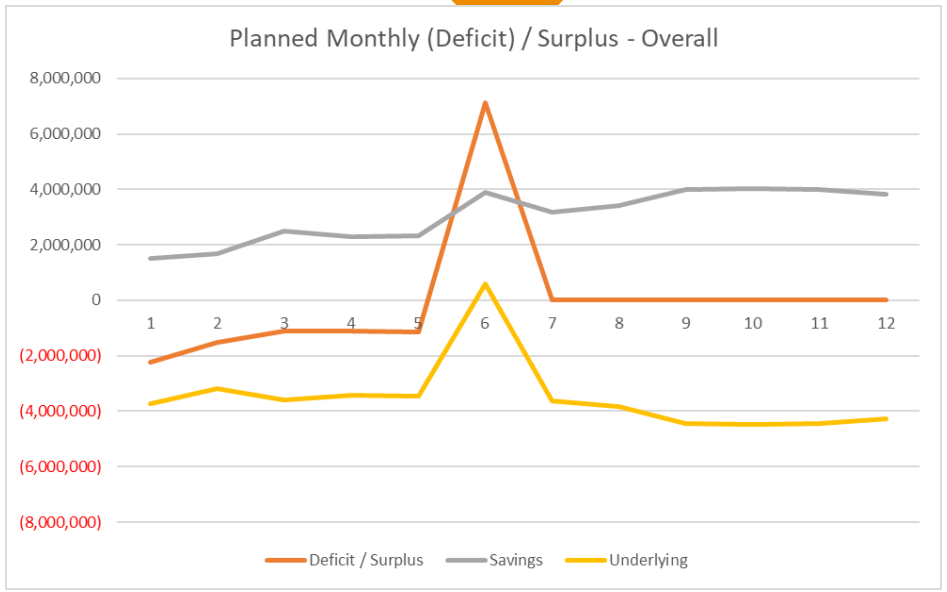
3. Overall Revenue Position

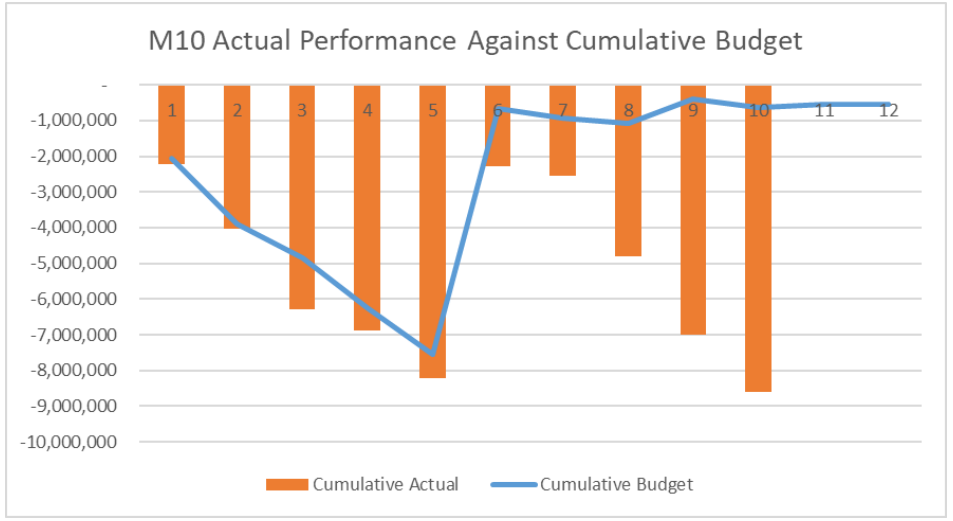
At Month 10 the Group is at a deficit position of £9.0million which is £9.0million adverse to a breakeven plan.

The Planned Monthly (Deficit) / Surplus graph shows the phased budget over the year. This shows the base case deficit around £3.5 million per month with savings recovering this position and a gradually increasing rate. This graph has been updated to include the £5.3m system recovery funding.

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

A do nothing trajectory of cumulative year to date performance would lead to an £11.8m deficit, which would be £2.8m adverse to a planned £9.0m year end deficit. With 2 months remaining savings delivery is required to step up by approx. £1.3m per month for the remainder of the year to the forecast delivery.





4. True North | Breakeven position

Statement of Comprehensive Income Period to 202410	RUH						Sulis						Group Adjustment						Total Group Position					
	202410			YTD			202410			YTD			202410			YTD			202410			YTD		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Commissioner Income (NHSE/CCG)	40,383	39,884	(499)	403,955	401,088	(2,867)	4,111	2,343	(1,768)	25,070	22,730	(2,339)	0	0	0	0	0	0	44,494	42,227	(2,267)	429,025	423,818	(5,207)
Other Patient Care Income	590	834	243	6,100	7,255	1,155	1,630	1,378	(252)	14,456	12,323	(2,133)	0	0	0	0	0	0	2,220	2,211	(9)	20,556	19,578	(978)
Other Operating Income	3,877	7,395	3,518	40,537	50,138	9,600	12	45	33	120	315	195	(201)	(204)	(3)	(1,973)	(1,976)	(3)	3,688	7,235	3,547	38,685	48,477	9,792
Unallocated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Income Total	44,851	48,112	3,262	450,592	458,480	7,888	5,753	3,765	(1,988)	39,646	35,369	(4,277)	(201)	(204)	(3)	(1,973)	(1,976)	(3)	50,402	51,674	1,271	488,266	491,874	3,608
Pay	(27,964)	(28,900)	(936)	(286,264)	(289,549)	(3,285)	(2,682)	(1,986)	696	(20,944)	(18,807)	2,137	0	0	0	0	0	0	(30,645)	(30,885)	(240)	(307,208)	(308,356)	(1,148)
Non Pay	(13,015)	(14,909)	(1,894)	(126,875)	(141,871)	(14,996)	(2,252)	(2,099)	153	(14,637)	(13,684)	953	0	0	0	0	0	0	(15,267)	(17,008)	(1,741)	(141,512)	(155,554)	(14,043)
Depreciation	(1,786)	(1,781)	4	(17,859)	(17,815)	44	(386)	(230)	156	(2,594)	(2,257)	337	145	148	3	1,450	1,453	3	(2,027)	(1,864)	163	(19,003)	(18,619)	384
Impairment	(578)	0	578	(5,784)	(9,218)	(3,434)	0	0	0	0	0	0	0	0	0	0	0	0	(578)	0	578	(5,784)	(9,218)	(3,434)
Expenditure Total	(43,343)	(45,590)	(2,247)	(436,782)	(458,453)	(21,670)	(5,320)	(4,315)	1,005	(38,174)	(34,748)	3,426	145	148	3	1,450	1,453	3	(48,518)	(49,758)	(1,240)	(473,506)	(491,748)	(18,241)
Operating Surplus/(Deficit)	1,508	2,523	1,015	13,810	28	(13,782)	433	(551)	(983)	1,472	621	(851)	(56)	(56)	(0)	(523)	(523)	(0)	1,884	1,916	32	14,759	126	(14,633)
Other Finance Charges	(938)	(743)	195	(9,380)	(7,486)	1,893	(144)	(35)	109	(627)	(432)	195	30	30	0	320	321	0	(1,053)	(748)	305	(9,686)	(7,597)	2,089
Other Gains/Losses	0	2	2	0	30	30	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	0	30	30
Finance Charges	(938)	(741)	197	(9,380)	(7,456)	1,924	(144)	(35)	109	(627)	(432)	195	30	30	0	320	321	0	(1,053)	(746)	307	(9,686)	(7,567)	2,119
Surplus/(Deficit)	570	1,782	1,212	4,430	(7,428)	(11,859)	288	(586)	(874)	845	189	(656)	(26)	(26)	0	(202)	(202)	0	832	1,170	338	5,073	(7,441)	(12,514)
Adjusted Financial Performance																								
Add back all I&E impairments/ (reversals)	578	0	(578)	5,784	9,218	3,434	0	0	0	0	0	0	0	0	0	0	0	0	578	0	(578)	5,784	9,218	3,434
Retain impact of DEL I&E (impairments)/ reversals	0	0	0	0	(333)	(333)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(333)	(333)
Remove capital donations/grants I&E impact	(1,410)	(3,407)	(1,996)	(10,860)	(10,407)	453	0	0	0	0	0	0	0	0	0	0	0	0	(1,410)	(3,407)	(1,996)	(10,860)	(10,407)	453
Adjusted financial performance surplus/(deficit)	**(262)**	**(1,625)**	**(1,363)**	**(646)**	**(8,950)**	**(8,304)**	**288**	**(586)**	**(874)**	**845**	**189**	**(656)**	**(26)**	**(26)**	**0**	**(202)**	**(202)**	**0**	**0**	**(2,236)**	**(2,237)**	**(3)**	**(8,963)**	**(8,960)**

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

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

5. Expenditure Trend Analysis

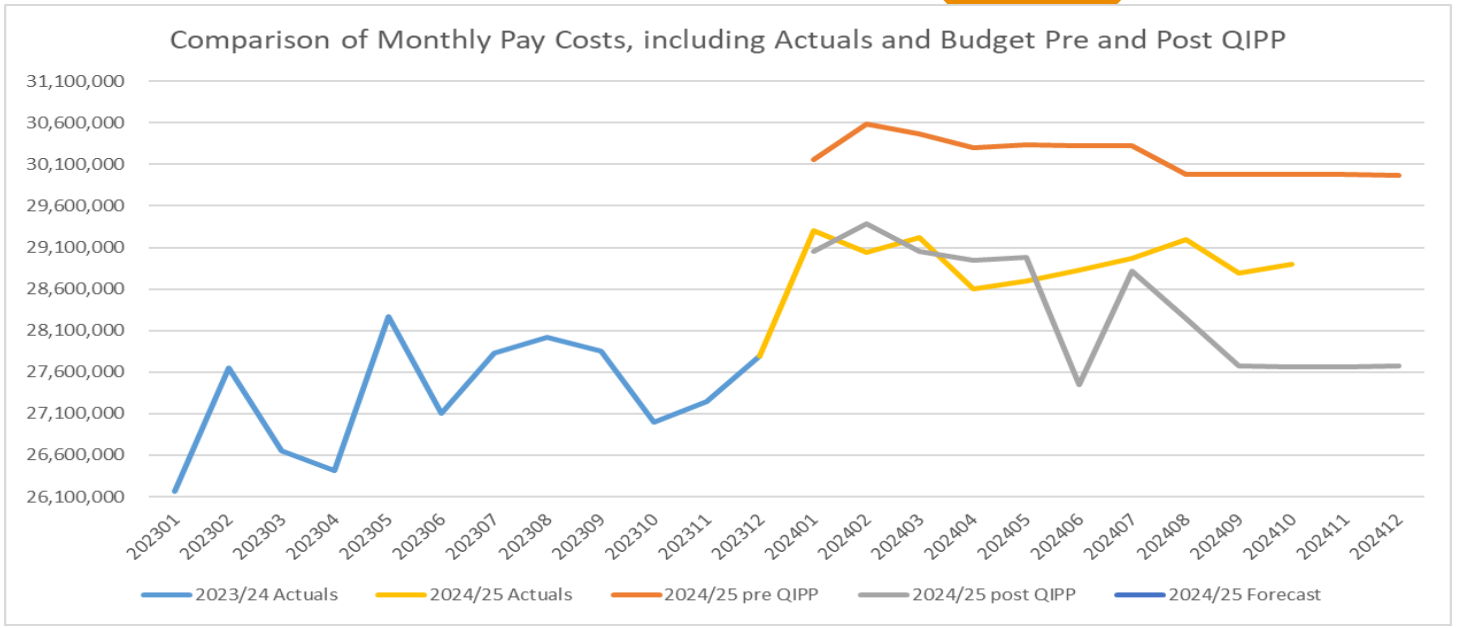
The graphs show the trend of Pay (top graph) and Non-Pay (bottom graph) by Month from April 2023 for the RUH Trust; and how these compare to operating plan assumptions before and after Savings delivery

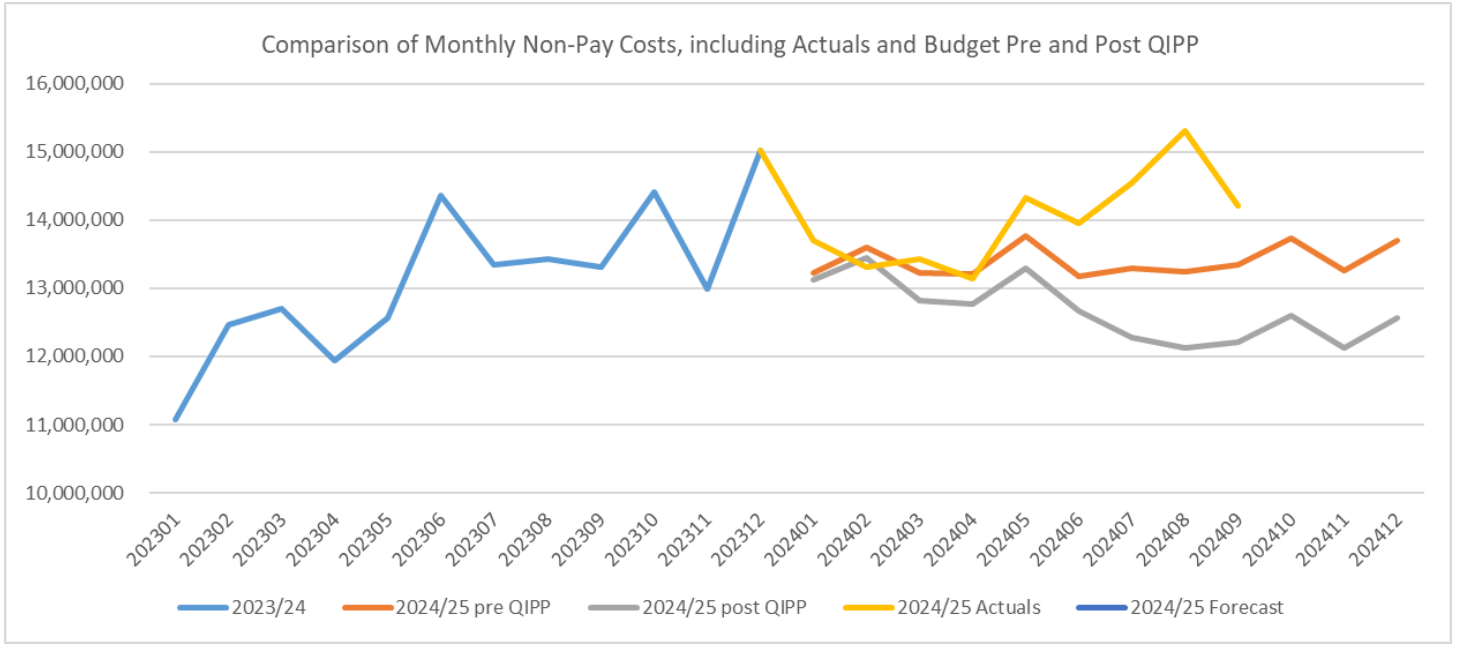
The actual Pay spend in 2023/24 has fluctuated due to backdated pay awards being funded, but there was an overall upward trend in pay costs in 2023/24.

Pay costs in M10 have increased slightly after reduced bank fill rates over the Christmas period.

Non-Pay costs do vary between month, partly related to clinical activity and seasonal variation for utility costs. The reduction in Month 9 related to one-off refunds against historic overcharging on gas.

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



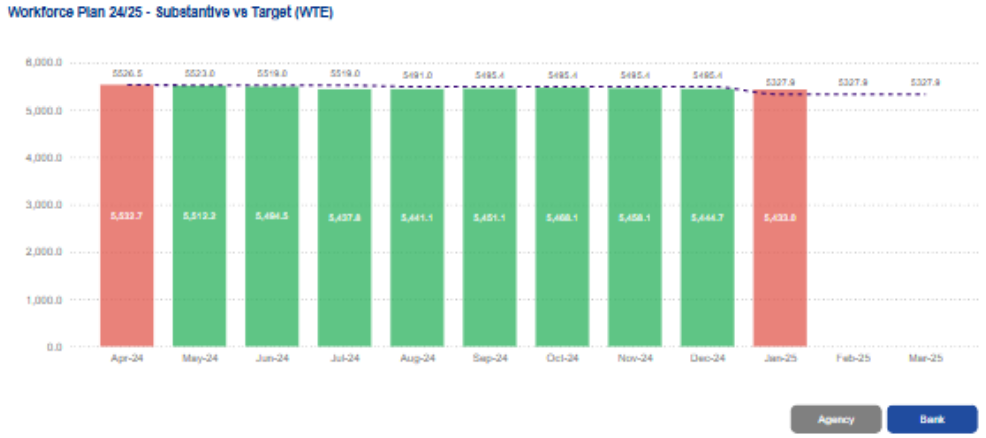


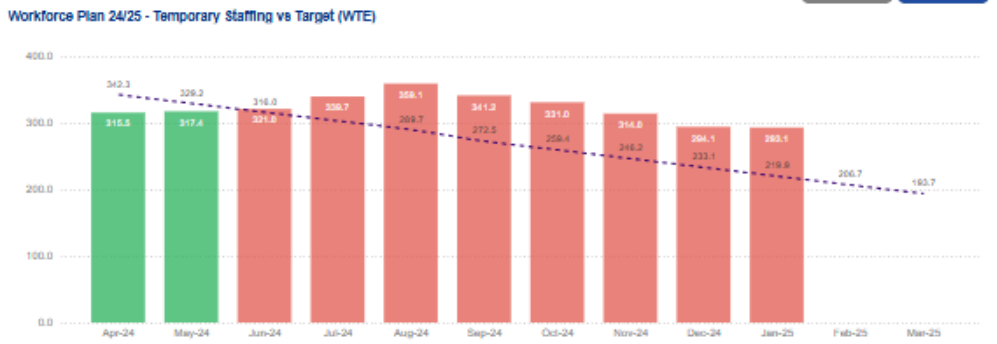
6. Driver Measure - Workforce Analysis

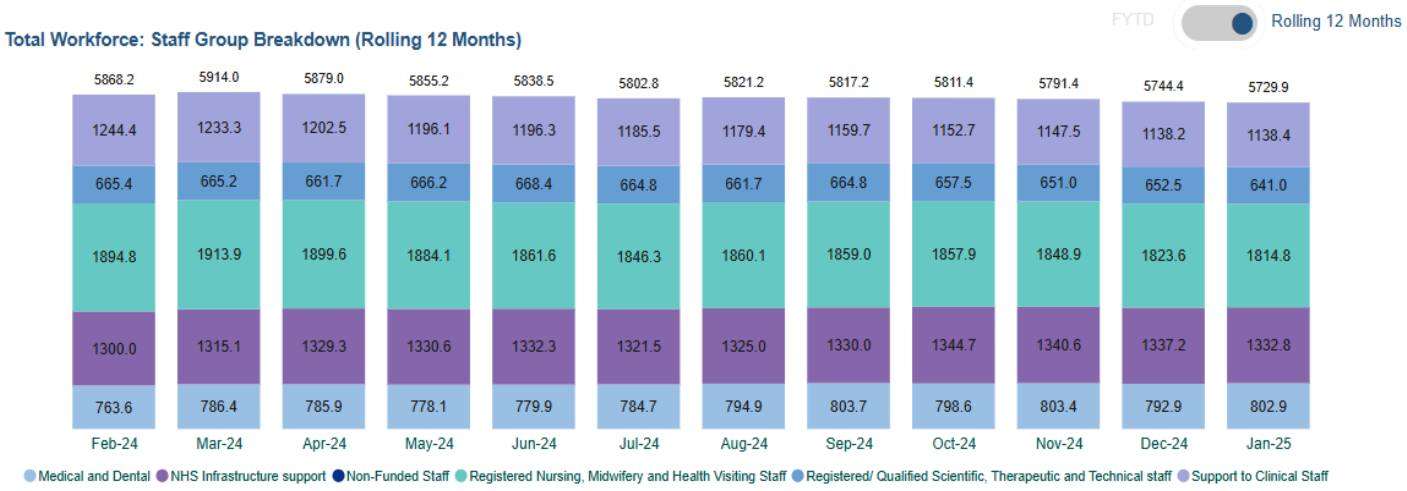
As well as tracking the overall value of Workforce Costs the Trust tracks the Whole Time Equivalent (WTE). The graphs show the Budgeted, Forecast and Actual WTE working per month.

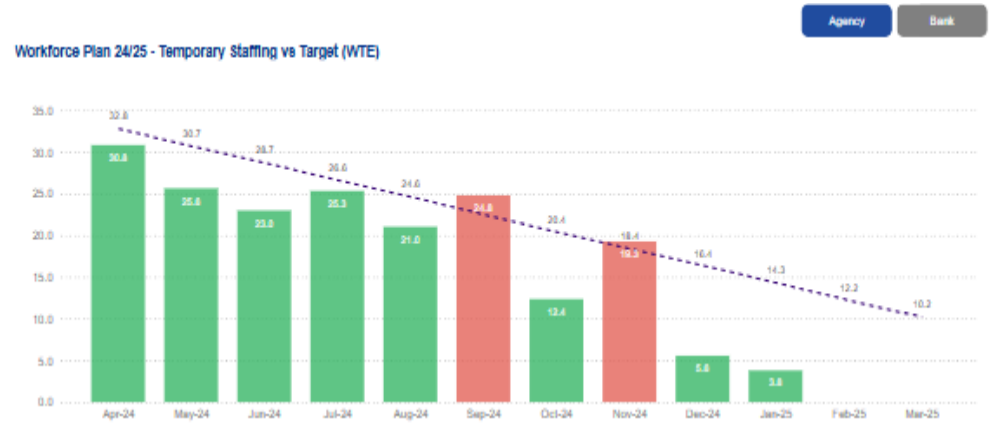
These reports show the actual worked in month. The calculation for Bank has been aligned between Workforce and Finance Reporting.

These graphs highlight the planned reduction of WTE during the year and will measure the performance against that plan. The total WTE has reduced by 171.5 (2.9%) from 5,914.0 in March to 5,729.9 in January. Bank usage reduced in December over Christmas but has stayed at similar levels in January.









7. QIPP | Financial Progress - overview

Delivery by Month 10 by Improvement Programme Theme

	Year to Date Plan	Year to date Actuals	Variance
	£'000	£'000	£'000
1_Clinical Operation Trans	£7,180	£6,938	-£243
2_Pay Bill reduction	£15,140	£14,362	-£778
3_Cost Control/Comm Income	£6,439	£5,131	-£1,308
Total	**£28,759**	**£26,430**	**-£2,328**

Delivery by Month 10 by Division

DIVISION	PAY	NON-PAY	INCOME	TOTAL
MEDICINE & ED	£3,570	£1,196	£138	£4,904
SURGERY	£3,032	£574	£285	£3,891
FASS	£1,554	£37	£75	£1,666
TOTAL Clinical Divisions	£8,157	£1,806	£498	£10,461
INCOME	£0	£0	£8,834	£8,834
TOTAL Clinical Divisions & Income	£8,157	£1,806	£9,332	£19,295
CORPORATE	£1,903	£204	£25	£2,132
ESTATES & FACILITIES	£2,221	£185	£122	£2,529
Annual Leave Accrual	£2,171	£0	£0	£2,171
Other Drugs		£304		£304
TOTAL Trust	£14,451	£2,500	£9,479	£26,430
SULIS	£0	£0	£0	£0
TOTAL Group	£14,451	£2,500	£9,479	£26,430

Summary

QIPP as at the end of month 10 delivered £26.24 million against a £28.8 million plan. This meant an under delivery of plan by £2.3 million.

This was achieved predominantly due to:

- Coding initiatives
- Vacancy Gap savings
- Ward 4 pay & non pay savings
- Paid break pay savings
- Reduction in bank/agency/overtime
- Procurement and medicine savings
- Theatres
- Release of annual leave accrual
- Pay efficiencies from paperless inpatient Project
- Increased elective productivity
- Corporate pay savings

The full in year forecast of the delivered savings is £30m million against the £36.6 million plan.

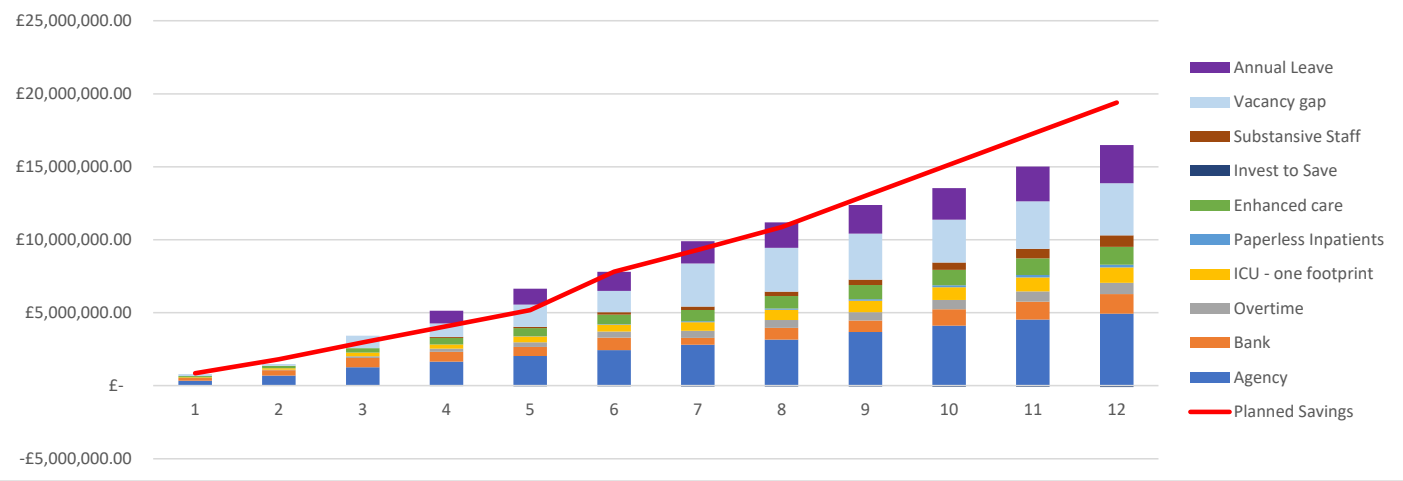
NB The plan assumes an acceleration of delivery of QIPP in the later part of the year and activities are focusing on the delivery of this, particularly in non pay and pay.

8. QIPP | Financial Progress – by Division & Programme–delivered M1-

Sum of ATD Actuals	Column Lab								
	MEDICINE & ED	SURGERY	FASS	INCOME	ESTATES & FACILITIES	CORPORATE	TRUST CENTRAL	SULIS	Grand Total
1_Clinical Operation Trans	**£258**	**£0**	**£0**	**£6,319**	**£360**	**£0**			**£6,938**
clinical service transformation		£0	£0	£2,450		£0			£2,450
Elective Income				£2,668					£2,668
Estates & Facilties					£360				£360
Outpatients (All Divisions)				£323					£323
Radiology	£161								£161
Theatres				£878					£878
Patient Flow	£98								£98
2_Pay Bill reduction	**£3,532**	**£3,032**	**£1,628**		**£2,150**	**£1,849**	**£2,171**		**£14,362**
Central HR Initiatives	£1,825	£1,897	£1,628		£2,150	£1,734	£2,171		£11,405
Patient Flow	£389	£878							£1,268
Nurse & Therapies Staffing	£1,318	£215	£0			£115			£1,647
Medical Staffing		£42							£42
3_Cost Control/Comm Income	**£1,113**	**£859**	**£38**	**£2,514**	**£19**	**£284**	**£304**	**-£0**	**£5,131**
Clinical Income (including coding)				£2,299					£2,299
IT improvement programme paperless inpatients						£0			£0
Commercial Opportunites	£85	£124	£75	£0		£16			£300
Pharmacy Services & Medicines Management	£33	£72	-£61	£215			£304		£564
Procurement & Inventory Management	£761	£552	£24		£19	£83			£1,438
FYE 23-24	£0	£0	£0	£0	£0		£0	£0	£0
Divisional Lead	£234	£111				£185			£530
Sulis								-£0	-£0
Grand Total	**£4,904**	**£3,891**	**£1,666**	**£8,834**	**£2,529**	**£2,132**	**£2,475**	**-£0**	**£26,430**

9. QIPP – Cumulative Pay savings delivered by month (including extra

Month	Agency	Bank	Overtime	ICU - one footprint	Paperless Inpatients	Enhanced care	Pay breaks	Ward 4	Invest to Save	Substansive Staff	Vacancy gap	Annual Leave	Total	Planned Savings	Variance
202401	£342,357	£187,185	-£9,977	£40,583	£0	£85,400	£0	£0	£0	£0	£147,385	£0	£792,933	£853,540	-£60,607
202402	£689,041	£379,006	£27,625	£95,583	£0	£170,400	£0	£0	£0	£0	£126,434	£0	£1,488,090	£1,805,956	-£317,866
202403	£1,271,486	£626,606	£113,661	£252,978	£0	£305,400	£0	£0	£0	£0	£857,025	£0	£3,427,156	£2,969,413	£457,744
202404	£1,652,380	£661,586	£220,231	£293,561	£0	£452,443	£0	£0	-£29,398	£71,147	£913,283	£868,232	£5,103,465	£4,077,667	£1,025,798
202405	£2,043,548	£618,848	£320,918	£389,477	£26,122	£546,008	£0	£0	-£36,748	£88,934	£1,521,928	£1,085,290	£6,604,326	£5,182,833	£1,421,493
202406	£2,441,257	£855,817	£414,641	£464,477	£45,929	£639,573	£26,163	£0	-£44,098	£170,920	£1,463,006	£1,302,349	£7,780,034	£7,810,983	-£30,949
202407	£2,810,278	£461,623	£489,753	£593,362	£65,736	£770,041	£168,673	£88,033	-£51,448	£234,853	£2,956,408	£1,519,407	£10,106,718	£9,297,304	£809,414
202408	£3,155,217	£801,809	£552,406	£688,362	£85,543	£863,606	£311,183	£167,756	-£58,798	£301,924	£3,000,344	£1,736,465	£11,605,816	£10,863,565	£742,251
202409	£3,686,246	£778,438	£575,293	£788,362	£105,350	£957,171	£453,693	£299,091	-£66,148	£368,995	£3,164,540	£1,953,523	£13,064,553	£13,001,738	£62,815
202410	£4,119,855	£1,116,526	£635,520	£878,362	£131,580	£1,050,736	£596,203	£389,400	-£73,498	£508,525	£2,930,973	£2,170,581	£14,454,763	£15,139,911	-£685,148
202411	£4,531,841	£1,228,179	£699,072	£966,198	£157,810	£1,144,301	£738,713	£464,967	-£80,848	£648,054	£3,250,714	£2,387,639	£16,136,641	£17,274,111	-£1,137,471
202412	£4,943,827	£1,339,831	£762,624	£1,054,034	£184,040	£1,237,866	£881,223	£554,246	-£88,198	£787,584	£3,570,455	£2,604,697	£17,832,230	£19,400,000	-£1,567,770
Total	£4,943,827	£1,339,831	£762,624	£1,054,034	£184,040	£1,237,866	£881,223	£554,246	-£88,198	£787,584	£3,570,455	£2,604,697	£17,832,230	£19,400,000	-£1,567,770



Year to date pay savings are on plan reflecting the uplift in the planned savings in the late part of the year.

The current forecast for Year end (based on average forecast) will deliver a £1.6 million shortfall against the plan.

10. QIPP | ERF – SLAM income performance

SLAM Income Performance

	April £	May £	June £	July £	August £	September £	October £	November £	December £	January £	Total YTD £	Total QIPP £
Productivity Performance												
Theatres/Elective Pathway	79,663	32,543	75,867	95,734	71,617	111,876	140,115	117,155	100,328	55,682	880,580	880,580
Outpatients DNA Reduction	57,018	85,859	70,083	36,548	58,181	48,536	23,643	54,591	14,429	30,908	479,796	479,796
Outpatients DNA Increases	(8,193)	(8,189)	(22,024)	(16,388)	(11,548)	(7,931)	(19,679)	(8,825)	(34,905)	(18,682)	(156,364)	(156,364)
Elective Other - balance	707,834	130,974					551,037	1,278,487	0	0	2,668,332	2,668,332
Productivity Over the Plan	(4,216)	519,128	179,062	(450,945)	(174,840)	(128,877)	(331,202)	179,960	(412,915)	122,895	(501,950)	
Total Productivity Income	832,106	760,315	302,988	(335,051)	(56,590)	23,604	363,914	1,621,368	(333,063)	190,803	3,370,394	3,872,344
PLICS Savings						927,960	154,667	154,667	154,667	154,667	1,546,628	1,546,628
AI Scheme										44,512	44,512	44,512
Clinical Coding	0	0	117,522	517,888	118,958	146,558	542,184	175,667	175,667	549,064	2,343,507	2,343,507
SLAM Income Performance	**832,106**	**760,315**	**420,510**	**182,837**	**62,368**	**1,098,122**	**1,060,765**	**1,951,702**	**(2,729)**	**939,046**	**7,305,041**	**7,806,991**

Performance at Month 10

Winter pressures and resulting outliers saw a reduction in elective activity, some of this was compensated by day case activity but overall activity, particularly in T&O was down against plan. This was off-set in other surgical areas resulting in a positive performance against plan.

Changes to coding Audiology procedures to be captured under national currencies has resulted in a significant increase in income for coding year to date.

Outpatient DNAs improved to give a small benefit in month, this is the level of savings expected over the rest of this year.

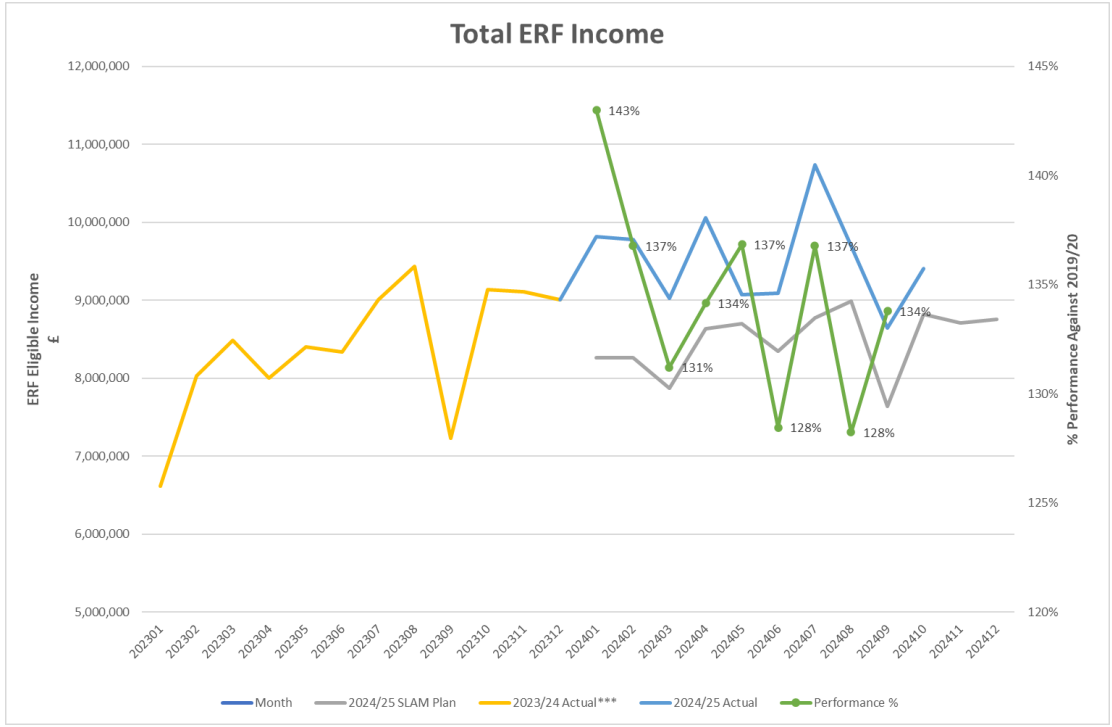
11. Driver Measure - RUH ESRF Performance

The total value of ERF eligible activity was £9.4m million in month, this is an increase from the M9 performance reported in November. Backdated coding contributed significantly to the income with underlying performance improved from M9 but still down against run rates. This was driven by the reduced elective activity in T&O.

	Investment Expenditure			Elective Recovery Performance			Metrics		
	Plan	Actual	Variance	Plan	Actual Performance Against 19/20	Variance	Performance Against 19/20	Performance Against Plan	Margin
Division	£'000	£'000	£'000	£'000	£'000	£'000	%	%	%
FASS	836	1,116	(280)	4,222	6,201	1,979	96%	111%	82%
Medicine	3,536	3,230	307	6,656	8,893	2,237	142%	108%	64%
Surgery	4,689	4,216	473	2,869	5,958	3,089	122%	107%	29%
Total	**9,061**	**8,561**	**500**	**13,746**	**21,051**	**7,305**	132%	108%	59%

Performance year to date:

- Actual investment costs are £8.6 million, over budget by £500k. This investment generated additional income of £21 million, £7.3 million above target.
- The margin is 59% compared to a planned margin of 35% and this has contributed £7.8 million to the Savings Programme



12. Tracker Measure - Productivity

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

Table 1 compares productivity to 19/20 up to Month 8.
On this metric RUH productivity has deteriorated by 9.1%,
Real terms costs have increased by 18.9%, cost-weighted activity has increased by 8.1%
This is better than Regional average of 12.3%
This is better than National average of 13.4%

	Explained change in spend				Explained activity				
System name	Inflation adj. expenditure	Service transfers	Non acute service change	Unexplained expenditure growth	Cost weighted activity	Service transfers	Unexplained Activity Change	Implied productivity growth	Variance to national
GLOUCS	13.4%	6.6%	0.0%	20.0%	3.0%	0.0%	3.0%	(14.1%)	(5.0%)
DEVON	29.3%	(6.1%)	0.0%	23.2%	14.6%	0.0%	14.6%	(7.0%)	4.4%
BNSSG	26.3%	(1.0%)	0.0%	25.3%	10.3%	0.0%	10.3%	(11.9%)	0.7%
DORSET	21.0%	0.0%	0.0%	21.0%	3.2%	1.1%	4.4%	(13.7%)	0.9%
SOMERSET	26.1%	0.0%	(2.0%)	24.1%	6.3%	0.0%	6.3%	(14.3%)	1.4%
BSW	28.2%	(5.5%)	(0.6%)	22.1%	7.3%	0.0%	7.3%	(12.1%)	4.2%
CORNWALL	22.6%	(0.4%)	0.0%	22.2%	1.8%	0.0%	1.8%	(16.7%)	0.3%
SW Region	25.4%	(2.1%)	(0.3%)	23.0%	7.7%	0.2%	7.9%	(12.3%)	1.8%
Salisbury	26.0%	0.0%	0.0%	26.0%	12.0%	0.0%	12.0%	(11.1%)	0.0%
GWH	24.4%	0.0%	(1.9%)	22.5%	3.4%	0.0%	3.4%	(15.6%)	1.3%
RUH	33.2%	(14.3%)	0.0%	18.9%	8.1%	0.0%	8.1%	(9.1%)	9.7%

Table 2 compare productivity to 23/24 up to Month 8
On this metric RUH productivity has increased by 3.4%,
Real terms costs have increased by 2.3%, cost-weighted activity has increased by 5.8%
This is worse than Regional average of 4.4%
This is better than National average of 2.4%

	Explained cost change			Explained activity change				
System name	Inflation adj. expenditure	Service transfers	Unexplained exp growth	Cost weighted activity	Changes to Activity	Unexplained activity change	Implied productivity growth	Variance to national output
DEVON	3.0%	0.0%	3.0%	11.3%	0.0%	11.3%	8.0%	0.0%
GLOUCS	2.2%	0.0%	2.2%	7.2%	0.0%	7.2%	4.8%	0.0%
BSW	2.9%	(0.2%)	2.8%	7.5%	0.0%	7.5%	4.6%	0.2%
CORNWALL	3.6%	0.0%	3.6%	8.1%	0.0%	8.1%	4.3%	0.0%
SOMERSET	3.3%	0.0%	3.3%	5.9%	0.0%	5.9%	2.5%	0.0%
BNSSG	3.9%	0.0%	3.9%	6.3%	0.0%	6.3%	2.3%	0.0%
DORSET	4.4%	0.0%	4.4%	6.7%	0.4%	7.1%	2.6%	0.4%
SW Region	3.4%	(0.0%)	3.3%	7.9%	0.1%	7.9%	4.4%	0.1%
Salisbury	2.1%	0.0%	2.1%	10.9%	0.0%	10.9%	8.6%	0.0%
GWH	3.7%	0.0%	3.7%	7.2%	0.0%	7.2%	3.3%	0.0%
RUH	2.9%	(0.5%)	2.3%	5.8%	0.0%	5.8%	3.4%	0.5%

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

13. System Position at M10

Alert, Assure, Advise	
Alert	• M10 YTD adverse variance of £16.3m • The key drivers are: continued UEC pressures, non pay and slippage against efficiency schemes • NCTR/Escalation continues to impact financial position. • The adverse variance at M10 represents a £0.4m divergence from the systems planned position after interventions.
Assure	• System FY forecast outturn agreed at £14.9m deficit. The forecast has been formally changed to this. • This position is after the previously agreed £30m support funding. • The forecast for ERF has also been adjusted to reflect the ceiling of £84.4m.
Advise	• National reporting regarding ERF for 24/25 validated achievement has not been confirmed. There is c. £20m (M9 £32m) of anticipated ERF income in the reported position.

14. ICS revised in year financial trajectories

	GWH				RUH				SFT				ICB				System			
	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG
Financial Position (£m)*	(1.7)	(1.8)	(0.1)		(8.9)	(9.0)	(0.1)		(12.4)	(12.6)	(0.2)		7.1	7.1	0.0		(15.9)	(16.3)	(0.4)	

Month 10 Financial position vs Plan:

- The system is reporting a £0.4m variance against the revised financial trajectory.
- This represents an adverse movement from Month 9 of £3.4m (M9 YTD £12.9m).
- The system has had detailed discussions with NHS England, and the full-year outturn position has been aligned to a £14.9m deficit.

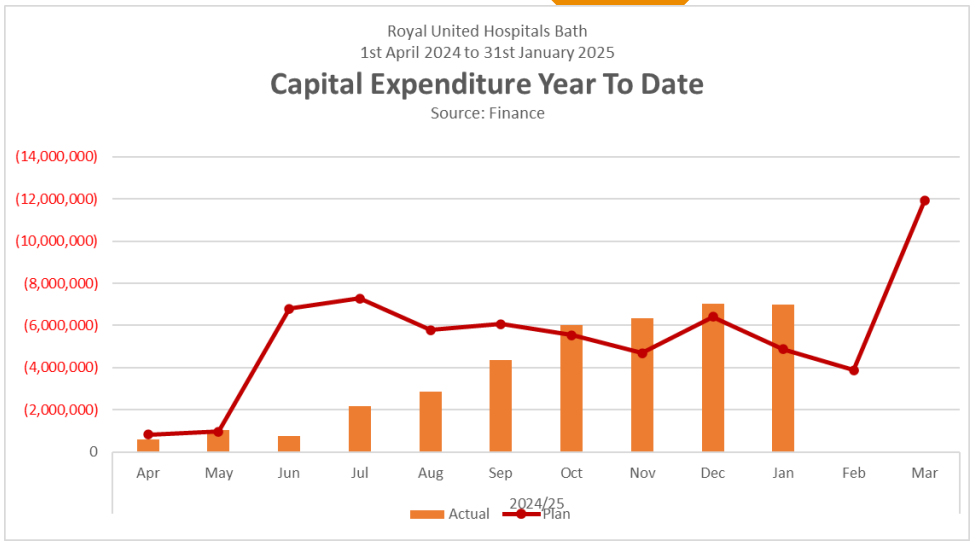
The anticipated financial trajectory and forecast outturn by organisation is:

	M10 £'m	M11 £'m	M12 £'m	Total £'m
GWH	(1.7)	1.5	1.6	1.4
RUH	(8.9)	0.2	(0.3)	(9.0)
SFT	(12.4)	0.4	(3.8)	(15.7)
ICB	7.1	0.5	0.8	8.4
	(15.9)	2.6	(1.7)	(14.9)

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

15. Tracker Measure | Sustainability – Capital (RUH and SULIS)

Capital Position as at 31st January 2025	Annual Plan	Forecast @ M10	Year to Date Plan	Year to Date Actuals	Year to Date Variance
	£000s	£000s	£000s	£000s	£000s
Internally Funded schemes	(13,559)	(13,564)	(11,085)	(8,554)	2,531
IFRS 16 Lease Schemes	(3,700)	(3,700)	(3,000)	(860)	2,140
Disposals - NBV write off - Internally Funded & Lease		5		5	5
External Funded (PDC & Donated):					
SEOC PDC	(20,010)	(18,138)	(20,010)	(15,124)	4,886
BSW EPR PDC	(2,793)	(2,794)	(2,686)	(851)	1,835
Digital Diagnostic PDC	(288)	(288)	(7)	0	7
Community Diagnostic Centre PDC	(3,193)	(2,165)	(2,198)	(735)	1,463
Cancer Centre PDC	(460)	(460)	(460)	(312)	148
UEC PDC	(1,400)	(1,400)	(875)	(161)	714
Digital Screening PDC	(1,045)	(1,045)	(250)	(157)	93
Critical Infrastructure Risk PDC	(741)	(741)	0	(38)	(38)
Trowbridge ICC PDC	(389)	(389)	0	0	0
Endoscopy Equipment PDC	(3,700)	(3,700)	0	0	0
Engergy Efficient Fund PDC	(123)	(123)	0	0	0
Salix Decarbonisation Grant	(10,819)	(10,819)	(7,961)	(9,403)	(1,442)
Donated	(2,580)	(2,962)	(377)	(1,958)	(1,581)
Total	**(64,800)**	**(62,283)**	**(48,909)**	**(38,148)**	**10,761**



Is standard being delivered? No
What is the top contributor for under/over-achievement?
The SEOC, CDC, BSW EPR and Pathology MES schemes are behind plan.

Trust funded programme. The largest underspends remain as the BSW EPR scheme (Trust funded element), the single ITU and fire risk reduction schemes. The profile of spend for the EPR scheme has been reviewed, and £2.0 million of the assigned funding will not be spent this year. Mitigations to offset this slippage by bringing forward priority schemes from next year have been agreed by CPMG. The single ITU scheme is behind plan and is due to complete soon. The fire risk reduction scheme is now under way and mitigations agreed at CPMG to offset known slippage due to delays in B12 being available as decant . Within the IFRS16 lease schemes Pathology Managed Equipment Service was expected to have been completed, however this has slipped to March. There is an underspend on IFRS16 leases with schemes being investigated to utilise this funding.

External funded schemes. The largest underspend is against the Sulis Elective Orthopaedic Centre (SEOC) scheme, The new theatre construction was not complete at the end of January, with the upgrade to laminar flow in existing theatres due to complete in March. There is a risk of a cost pressure on equipping which is currently being worked through and risk has reduced. The BSW EPR (PDC funded element) is behind plan, full PDC funding is expected to be spent this year. The community diagnostic scheme is also behind plan but is expected to complete on budget by year end. New PDC funding has been agreed for Endoscopy equipment, Energy Efficient schemes and Cyber.
The Heat Decarbonisation scheme construction is underway and planning in progress, grant funding for this year cannot be carried forward so any slippage will be a funding risk for the scheme.

Countermeasures completed last month

Countermeasure /Action	Owner

Countermeasures for the month ahead

Countermeasure /Action	Owner
CPMG to continue to monitor delivery of projects and schemes Capital leads agreeing further measures to offset known slippages and underspends	Head of Financial Services

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

	31/03/2024 Actual £'000	31/01/2025 Actual £'000	Movement from March 24 £'000
Non current assets			
Intangible assets	7,105	5,166	(1,939)
Property, Plant & Equipment	301,392	316,235	14,843
Right of use assets - leased assets for lesse	51,035	48,443	(2,592)
Trade and other receivables	1,861	2,123	262
Non current assets total	**361,393**	**371,968**	**10,575**
Current Assets			
Inventories	8,284	8,896	612
Trade and other receivables	29,887	44,496	14,609
Cash and cash equivalents	34,531	31,938	(2,593)
Current Assets total	**72,702**	**85,330**	**12,628**
Current Liabilities			
Trade and other payables	(54,354)	(61,311)	(6,956)
Other liabilities	(13,298)	(17,629)	(4,331)
Provisions	(475)	(712)	(237)
Borrowings	(3,070)	(2,961)	109
Current Liabilities total	**(71,197)**	**(82,612)**	**(11,415)**
Total assets less current liabilities	**362,897**	**374,685**	**11,788**
Non current liabilities			
Provisions	(1,370)	(1,311)	59
Borrowings	(54,128)	(52,574)	1,554
TOTAL ASSETS EMPLOYED	**307,399**	**320,800**	**13,400**
Financed by:			
Public Dividend Capital	253,535	274,379	20,844
Income and Expenditure Reserve	12,303	4,859	(7,443)
Revaluation reserve	41,562	41,562	0
Total Equity	**307,399**	**320,800**	**13,401**

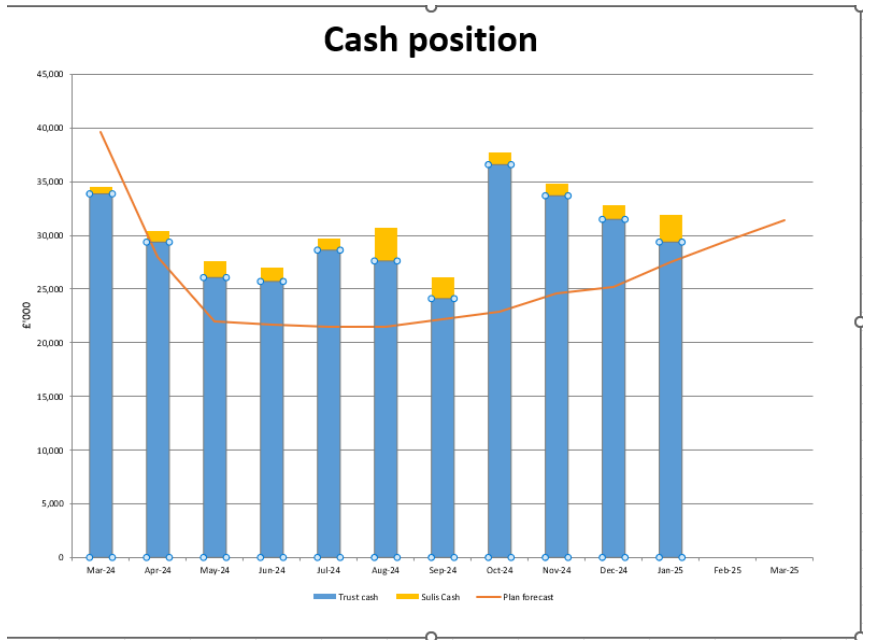
The Group Balance Sheet (RUH and Sulis)

Month 10 against 31/03/24:

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

17. Tracker Measure | Sustainability – Cash (RUH and SULIS)

Group Cashflow Statement Month 10



Is standard being delivered for cash? No

The Group cash balance is £4.4 million higher than planned.

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

The variance against plan is driven by capital expenditure being behind M10 plan, interest received, donated cash for capital, pay award funding and movements in working capital.

Sulis cash position has increased by £1.2 million against month 9.

Cashflow statement	Actual £'000
Operating Surplus/(deficit)	126
Depreciation & Amortisation	18,619
cash)	(11,361)
Impairments	9,218
Working Capital movement	(13,547)
Provisions	178
Net cash generated from / (used in) operating activities	**3,233**
Capital Expenditure	(30,906)
Cash receipts from asset sales	30
Donated cash for capital assets	9,644
Interest received	1,745
Proceeds from sales of intangible assets	0
Net cash generated from / (used in) investing activities	**(19,487)**
Public dividend capital received	20,844
Movement in loans from the DHSC	(312)
Capital element of finance lease rental payments	(1,841)
Interest on loans	(120)
Interest element of finance lease	(1,145)
PDC dividend (paid)/refunded	(3,765)
Net cash generated from/(used in) financing activities	**13,661**
Increase/(decrease) in cash and cash equivalents	**(2,593)**
Opening Cash balance	**34,531**
Closing cash balance	**31,938**

Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

February 2025 (January 2025 data)

The people in our community

The RUH, where you matter

Executive Summary I

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

	Performance Indicator	Performing	Outside Tolerance	Last 12 Months: Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Key Standard	Trust Vacancy WTE (Unit 4)			56.2	80.4	290.2	94.7	50.1	150.5	11.6	139.5	145.9	123.4	83.2	161.4
Contextual Information	Trust Establishment WTE (Unit 4)			5700.2	5699.4	5888.3	5693.9	5639.3	5699.8	5576.2	5728.4	5737.2	5696.9	5648.8	5709.2
Contextual Information	Substantive WTE (Unit 4)			5643.9	5619.0	5598.1	5598.6	5589.2	5549.3	5564.6	5588.9	5591.3	5573.5	5565.6	5547.9
Key Standard	Vacancy Rate	<=4.00%	>4.50%	0.99%	1.41%	4.93%	1.66%	0.89%	2.64%	0.21%	2.43%	2.54%	2.17%	1.47%	2.83%
Contextual Information	Total Pay Bill (exc R&D)					£27.5M	£27.2M	£27.3m	£26.7m	£28.1m	£25.7m	£36.1m	£28.6m	£28.2m	£28.3m
Key Standard	In Month Turnover	<=0.92%	>1.00%	0.51%	0.85%	0.66%	0.92%	0.69%	0.71%	0.66%	0.89%	0.73%	0.48%	0.73%	0.52%
Key Standard	Rolling 12 Month Turnover	<=11.00%	>12.00%	8.46%	8.47%	8.19%	8.52%	8.46%	8.62%	8.31%	8.20%	8.26%	8.19%	8.42%	8.36%
Contextual Information	Leavers Inside 1st Year WTE (Permanent Contract Held, All Reasons)			3.6	7.0	12.8	11.4	7.5	6.3	6.4	8.9	3.2	3.6	3.9	2.9
Contextual Information	Bank Use (Staffing Solutions Data)			193.6	183.3	189.2	199.1	197.3	207.5	222.7	198.0	204.8	182.3	176.7	181.1
Contextual Information	Agency Use (Staffing Solutions Data)			18.8	20.8	19.8	17.2	17.1	13.3	14.0	16.4	11.4	15.0	2.2	0.9
Key Standard	Agency Spend as Proportion of Total Pay Bill	<=2.50%	>3.50%	2.22%	1.05%	1.14%	1.13%	0.27%	1.02%	0.94%	1.03%	0.81%	1.11%	0.47%	0.81%
Contextual Information	Agency Spend			£600k	£446k	£315k	£310k	£73k	£277k	£267k	£268k	£297k	£321k	£135k	£233k
Contextual Information	% of agency usage that are off framework			0.54%	3.62%	1.26%	4.89%	9.15%	5.93%	7.07%	1.42%	5.27%	0.33%	12.45%	19.58%
Contextual Information	% agency shifts that are above price cap			81.4%	82.9%	95.6%	88.5%	76.8%	55,67%	34.7%	25.3%	24.7%	24.0%	46.1%	49.5%
Key Standard	Nurse Agency Spend as Proportion of Registered Nursing Pay Bill	<=3.00%	>4.00%	2.16%	1.57%	1.62%	1.71%	-1.71%	0.60%	0.69%	1.20%	1.22%	0.53%	0.09%	
Key Standard	In Month Sickness Rate (Actual) - Reported 1 month behind	<=4.62%	>5.12%	4.83%	4.57%	4.43%	4.39%	4.87%	4.64%	4.41%	4.64%	5.21%	4.60%	5.03%	
Contextual Information	In Month Sickness - Estimated Cost (£m)			£812k	£791k	£758k	£781k	£861k	£876k	£819k	£839k	£1m	£849k	£962k	
Key Standard	Rolling 12 Month Sickness Rate - Reported 1 month behind	<=4.30%	>4.80%	4.47%	4.47%	4.48%	4.49%	4.54%	4.54%	4.55%	4.61%	4.66%	4.68%	4.71%	
Tracker	Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.20%	1.22%	1.20%	1.17%	1.19%	1.21%	1.22%	1.24%	1.26%	1.27%	1.27%	
Contextual Information	In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.25%	1.17%	1.12%	1.14%	1.34%	1.25%	1.33%	1.24%	1.29%	1.16%	1.33%	

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

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Vacancy	The Trust vacancy rate has increased to 2.83%, following an increase in Budget WTE. Reserves continues to offset the Divisional Vacancy and gives the appearance of a lower vacancy than would otherwise be reported.	Trust led Vacancy Control and Agency Reduction Panel continues to support right-sizing our workforce against our workforce plans. The controls are supporting the Trust financial recovery plans and we anticipate vacancy rates to increase when it's safe to hold a post to support our financial position.
Sickness	12 month sickness rate continues to be on an upward trend and is now 4.71%. Anxiety, Stress and Depression sickness was again high in month, with seasonal sickness also up.	Long and short-term sickness management being supported with focus on countermeasures such as: increased pro-activity around case management (141 cases being supported), departmental stress risk assessments in hotspots, reasonable adjustment improvements, MSK campaign in cleaning and ED nursing and reviewing staff physiotherapy service.

Executive Summary II

	Performance Indicator	Performing	Outside Tolerance	Last 12 Months											
				Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
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	0.64	0.56	0.56	0.63	0.64	0.59	0.48	0.54	0.64	0.64	0.52	0.52
Contextual Information	% of Band 6/7 who are from Global Majority Background (WTE)			15.16%	15.41%	15.40%	15.39%	15.48%	15.49%	15.54%	15.66%	15.79%	15.84%	15.97%	15.76%
Contextual Information	% of Band8A+ who are from Global Majority Background (WTE)			6.14%	6.53%	6.54%	6.45%	6.39%	6.11%	6.44%	6.44%	6.43%	6.62%	6.61%	6.90%

	Performance Indicator	Latest Month Target	Outside Tolerance	Last 12 Months											
				Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Key Standard	Appraisal Compliance Rate	>=90.00%	<85.00%	77.04%	77.05%	77.66%	77.69%	78.91%	78.53%	82.75%	82.84%	80.19%	80.90%	80.86%	80.81%
Contextual Information	Global Majority Appraisal Compliance Rate	>=90.00%	<85.00%	75.64%	76.74%	76.89%	78.32%	81.24%	80.07%	85.91%	86.00%	83.23%	83.28%	82.00%	83.40%
Key Standard	Mandatory Training Compliance (exc Bank)	>=85.00%	<80.00%	90.84%	90.40%	90.32%	90.03%	90.04%	88.74%	89.01%	88.16%	88.38%	88.61%	88.57%	88.70%
Key Standard	IG Training Compliance (exc Bank)	<=95.00%	>100.00%	88.40%	87.72%	88.51%	86.61%	85.92%	85.24%	87.94%	86.34%	86.23%	88.69%	88.65%	86.47%
Key Standard	Safeguarding Adults Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	92.81%	92.43%	92.79%	92.84%	92.93%	92.56%	91.76%	91.60%	91.33%	91.63%	91.33%	92.11%
Key Standard	Safeguarding Adults Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	91.84%	91.34%	91.69%	91.84%	92.08%	91.96%	92.34%	91.09%	90.81%	90.45%	90.46%	90.51%
Key Standard	Safeguarding Adults Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	89.47%	93.21%	30.43%	36.01%	37.97%	42.16%	47.36%	52.25%	59.00%	67.62%	71.49%	72.13%
Key Standard	Safeguarding Children Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	92.88%	92.22%	92.55%	92.30%	92.11%	91.68%	91.43%	91.48%	91.05%	91.02%	90.91%	91.35%
Key Standard	Safeguarding Children Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	92.46%	91.57%	91.87%	91.51%	91.28%	91.19%	91.85%	90.44%	90.28%	90.57%	90.26%	90.33%
Key Standard	Safeguarding Children Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	90.95%	91.20%	91.32%	90.41%	88.14%	87.32%	89.34%	88.98%	87.90%	88.04%	88.75%	89.52%

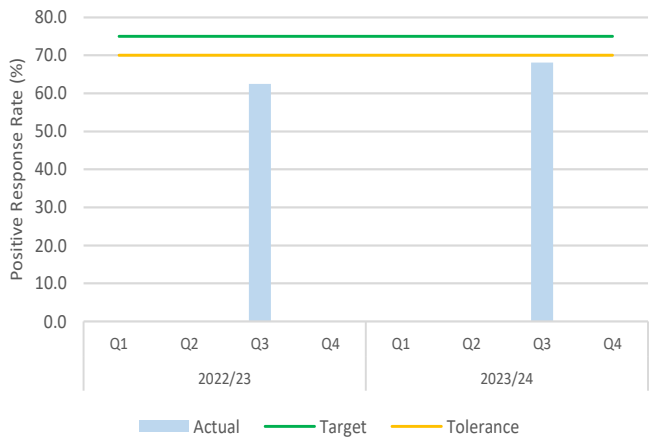
** Training data based on Learning Together from Jun-23; Appraisal and Training information re-stated due to new reporting methodology

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Appraisal Compliance	Appraisal compliance remains below the 90% target at 80.8%. This data does not inform us of the quality of the appraisal conversations or their outputs.	• Focussed work with specialities with low appraisal compliance led by DPP's. • Increase uptake of appraisal training and support to prioritise (Managers and DPPs) • Developing feasibility options for implementing an appraisal window to focus efforts on quality conversations • Revised Appraisal Policy due ratification • Forging alignment between health and wellbeing interventions and manager engagement with team colleagues • People Function skilling up for improving appraisal quality, which is likely to impact compliance positively

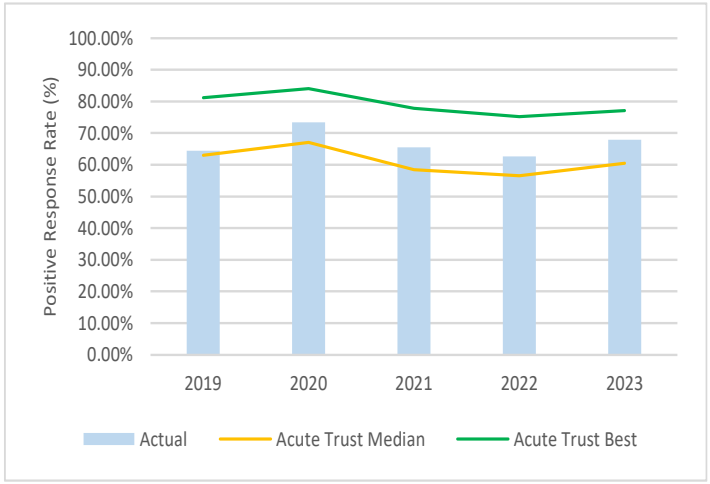
Trust Goal | Staff Recommend the Trust as a Place to Work

Making a Difference Survey Result



Latest Survey	68.1%

National Survey Results



Latest Survey	67.9%

Is standard being delivered?

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

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

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

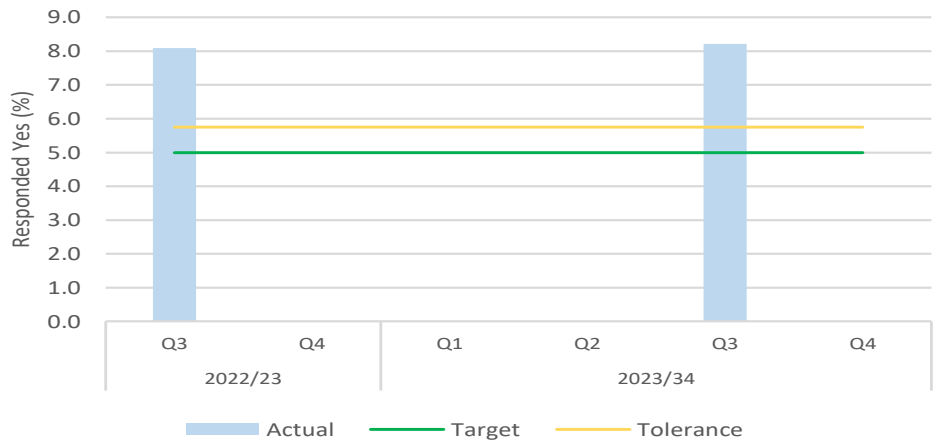
Countermeasure Summary

Countermeasure/Action	Owner
• Review of strategic recognition offer aligned to renewed culture communications and engagement plan. • Renewed, targeted wellbeing interventions for areas under most strain. • More focus on inclusion and belongingness throughout people projects and programmes (esp. Leadership Development) • Large-scale review of leadership and management development offer to enhance staff experience • Basics Matter programme identified priorities from staff survey to inform the content of the workstreams • Review Breakthrough Objective to focus on the organisational recognition and appreciation for roles undertaken	People Team for Culture Divisional People Partners/ Divisional Leadership Teams Basics Matter Team

Breakthrough Goal |

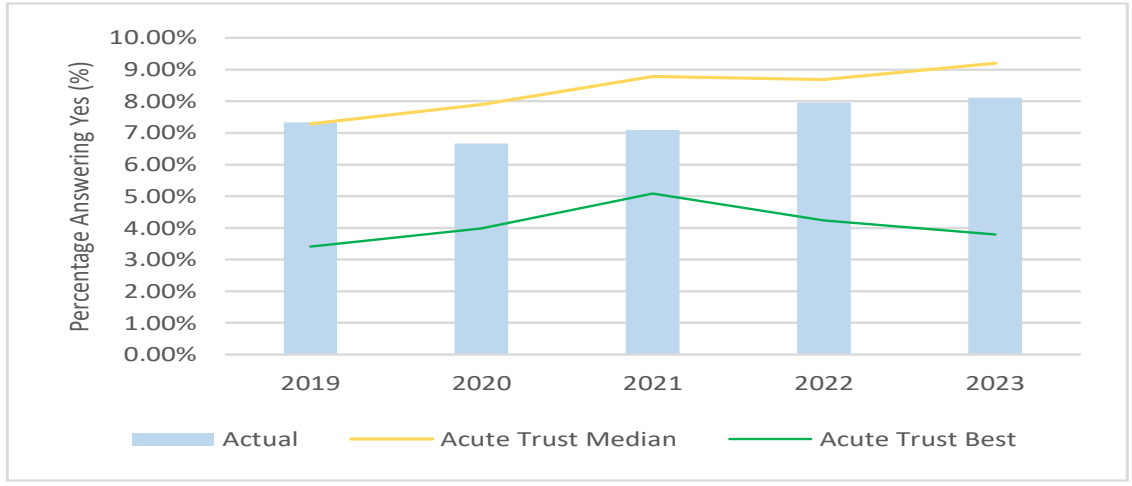
Reduce Proportion of Staff Reporting Experiencing Discrimination from Line Managers/ Colleagues

Making a Difference Survey Result



Latest Survey	8.22%

National Survey Results



Latest Survey	8.11%

Is standard being delivered?

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

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

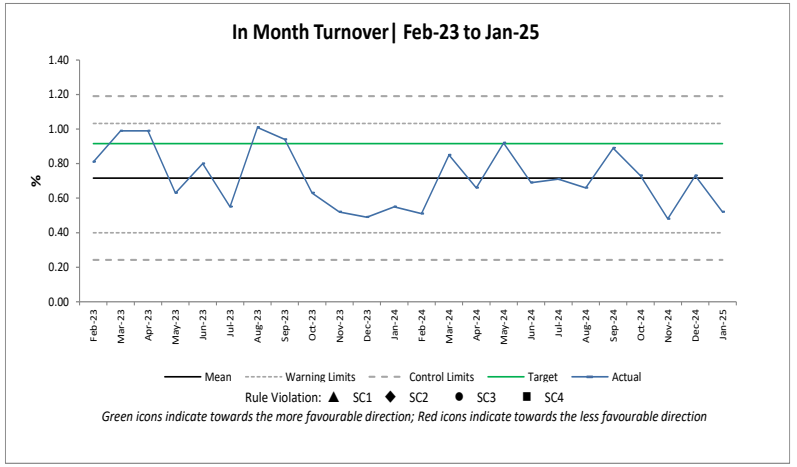
Emergency Medicine had the lowest proportion of staff reporting that they had not experienced discrimination from a manager or colleague at 85.9%.

Countermeasure Summary

Countermeasure/Action	Owner
• Targeted team development interventions (in collaboration with People Team) to address identified issues, including emergency medicine, theatres and cleaning – triangulated process to provide swifter action • Report and Support launched in August 2024, (renewed comms 2025 to support sexual safety work) therefore better, swifter support to areas most affected by discrimination. • Violence Management and Reduction Policy embedding programme ongoing (engagement and communications with Nursing and Midwifery colleagues) • Breakthrough foci from 2023 – 25 consolidation: i.e. race, disability and long-term conditions. • Real-time outliers will be identified using reports through Datix, DPPs and Report + Support – quarterly sample is small, and survey data requires additional balancing to identify specific areas of concern.	People Hub DPPs People Team AD for Culture

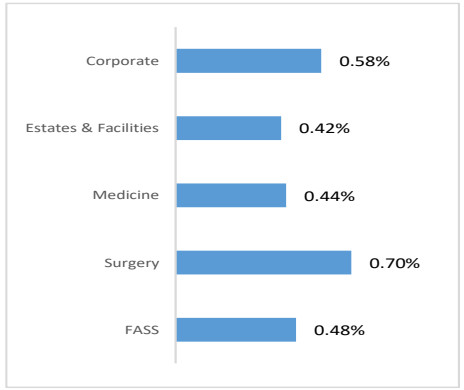
Key Standard| Turnover Rate

In Month Turnover - Trust

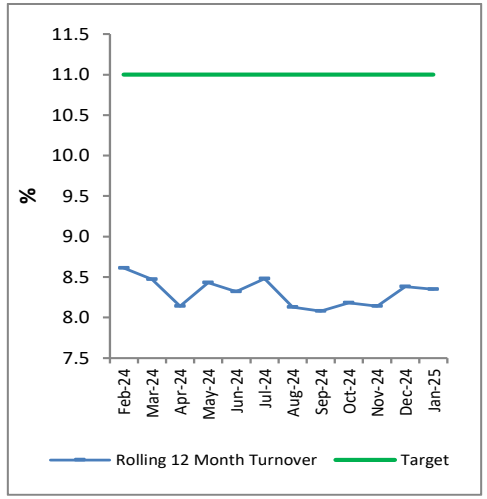


Turnover Rate	0.52%

In Month Divisional Turnover



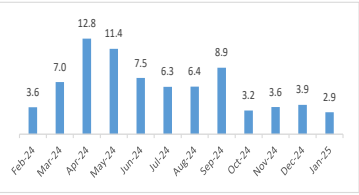
Rolling 12 Months Turnover - Trust



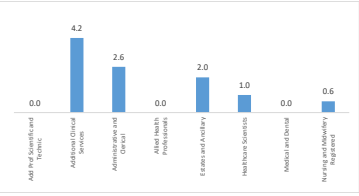
Turnover Rate	8.36%

Leavers Inside 1st Year (Permanent Contract)

Trust Trend



Staff Group - Last 3 Months



Is standard being delivered?

- In month turnover remains low at 0.52%.
- As a consequence, 12 month rolling turnover has slight reduced to 8.36%.

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

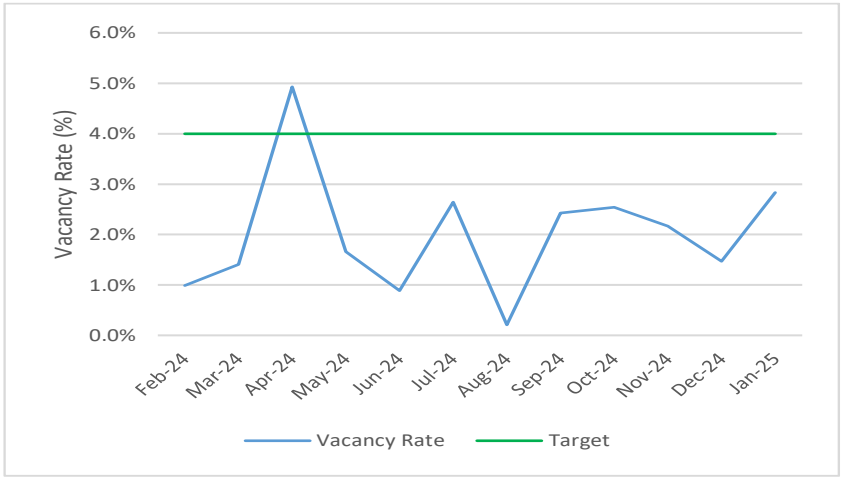
- Corporate Division is the only main division to have a 12 month turnover rate above target.at 11.1%
- Add Prof Scientific and Technical have the highest 12 month turnover rate at 14.9%. However, this does only equate to a leavers WTE of 20.2 across the year. Much of this has occurred though within the past 6 months.
- Allied Health Professionals (13.3%; 47.2 WTE) and Admin and Clerical (11.6%; 121.5 WTE) are the other staff groups above the 11% target.

Countermeasure Summary

Countermeasure/Action	Owner
Remains within target, therefore no specific countermeasure.	

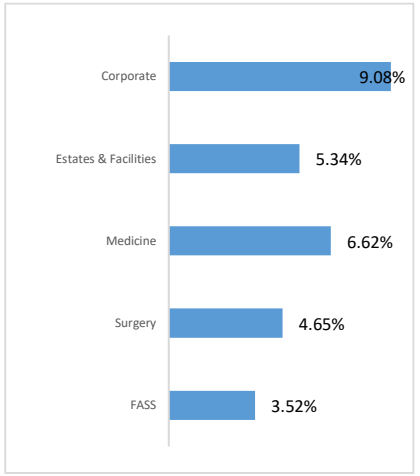
Key Standard| Vacancy Rate

Vacancy Rate - Trust

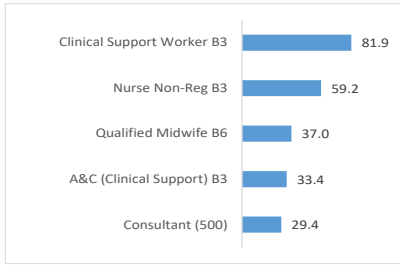


Vacancy Rate	2.83%

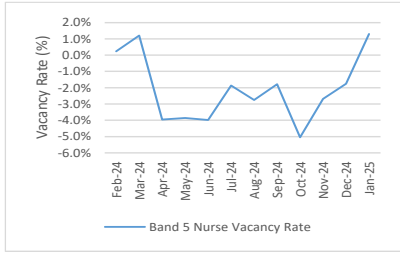
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

- The vacancy rate increased to 2.83% in M10 from 1.47% in M9 but remains within internal target of 4%
- Divisional vacancy rates may continue to increase as we take the necessary steps to secure a sustainable workforce and slow down the recruitment pipeline where feasibly safe to do so to support our financial position
- Leavers within the first year decreased slightly from 3.9WTE in M9 to 2.9WTE in M10 indicating the new joiner experience launched summer 2023 is having a positive impact on our new joiners onboarding experience and supporting retention

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

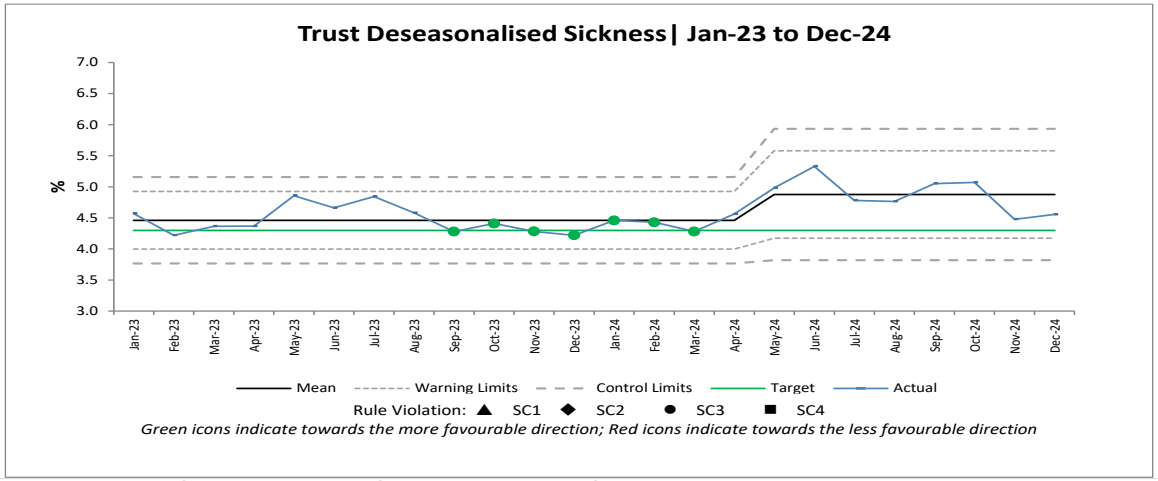
- M10 captures Corporate having the highest vacancy rate at 9% although Medicine has the highest vacancy WTE at 140.5 WTE
- At Staff group level the highest vacancy rate continues to be Band 3 unregistered nursing and we're proactively working to reduce this vacancy hotspot with events and career fairs.

Countermeasure Summary

Countermeasure/Action	Owner
Trust led Vacancy Control and Agency Reductional Panel continues to support the pay bill reduction and financial recovery plan.	Executive Team
International Recruitment cohorts eligible for Indefinite Leave to Remain will be supported to help the retention of this diverse workforce which includes the provision of legal workshops to assist with application process and hardship funds.	AD for People – Capacity and Talent
BSW group collaborative discussion with TRAC (applicant tracking system) taking place to explore how we can improve candidate experience and the sharing of group job opportunities.	AD for People – Capacity and Talent
As an anchor organisation we will be supporting our community by attending the local Bath Careers Fair in late February.	Recruitment Team
EVP work continues as we get ready to launch new pages on the internet to showcase all the RUH has to offer to support attraction and retention of staff/	AD for People – Capacity and Talent

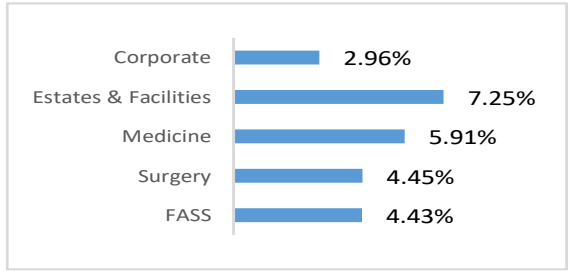
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

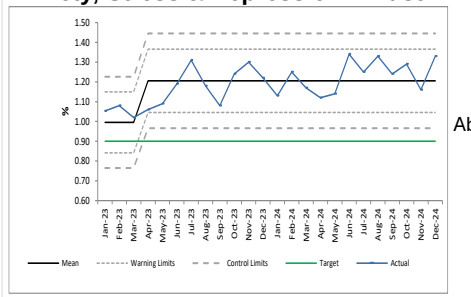


In Month Actual	5.03%	In Month Deseasonalised	4.56%	Rolling 12 Months	4.71%

In Month Divisional Sickness Rates



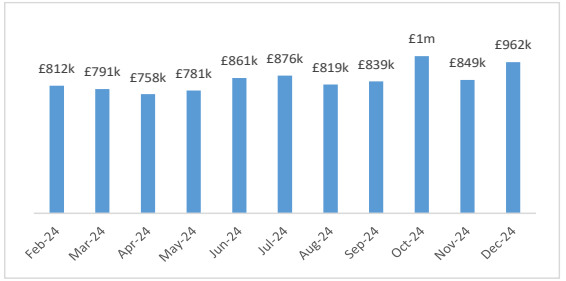
Anxiety, Stress & Depression - Trust



Absence Rate

1.33%

Estimated Absence Cost



RIDDOR Reporting - Employees

	2023/24				2024/25			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Dangerous Occurrence –release or escape of biological agents	-	-	-	-	-	-	-	
Exposed to harmful substance/ Work acquired Infection	-	-	-	-	-	-	-	
Lifting and handling injuries	-	1	3	-	1	4	3	
Physical assault	1	-	-	-	1	-	3	
Slip, trip, fall same level	-	1	3	1	1	2	1	
Struck against	-	-	-	-	1	-	-	
Struck by object	1	-	-	1	-	-	1	
Fell from height	2	-	1	-	-	-	1	
Another kind of accident	-	1	1	2	-	1	1	

Is standard being delivered?

- Sickness absence was 5.0% in December, which is above the seasonally adjusted target if 4.3% were to be achieved across the year.
- Rolling 12 month sickness absence continues to be on an upward trend, now standing at 4.7%.

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

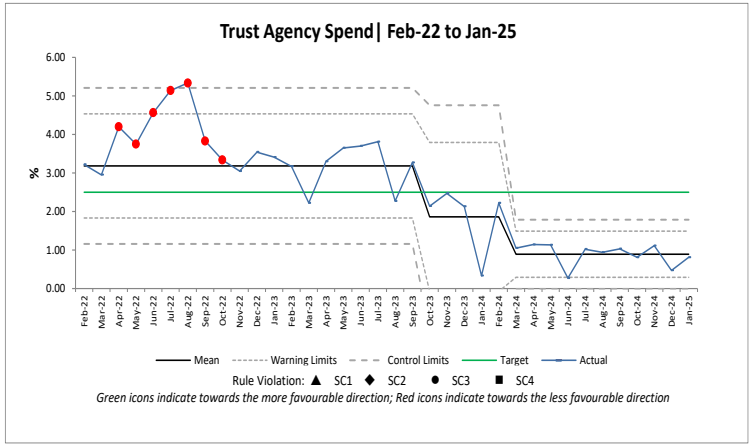
- Anxiety, Stress and Depression has again seen an upturn, with the in month absence rate 1.33%.
- Cold and Flu is also elevated, reflecting the season.

Countermeasure Summary

Countermeasure/Action	Owner
Short term absence • Allocate now being used to monitor and support short term absence. Work underway to build this into Halo. • Comm's campaign focussed on 'keeping yourself well this winter' **Long term absence** • People Hub currently supporting managers with 141 long term sickness cases. • Reviewing and developing the staff physiotherapy service • Reasonable adjustments working group developing ways to improve the support for staff with long term health conditions • Departmental stress risk assessments to be conducted in ED, Maternity and Radiology in line with the new Wellbeing at Work Policy	Divisional People Partners/ Nursing Improvement Group/People Hub Lead Wellbeing Service All – led by DPP for FASS

Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

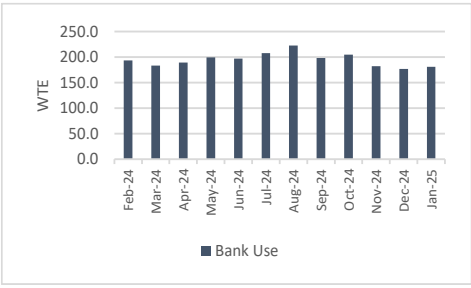


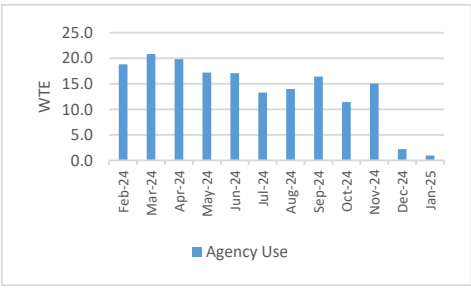
Proportion	0.81%

Agency Spend Breakdown

	In Month	FYTD
Consultants	£224,176	£1,601,409
Junior Medical Staff	£0	£0
Non Medical - Non-Clinical Staff	£1,515	£330,010
Registered Nurses & Midwives	£1,741	£549,393
ST&T - Allied Health Professionals	£2,902	£4,804
ST&T - Health Care Scientists	£0	£0
ST&T - Other	£2,183	£10,831

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

- Total agency spend recorded in January was £233k, which equates to 0.81% of the total pay bill supporting us to remain below the national target of 3.2%.
- Overall agency usage decreased from 2.2WTE in M9 to 0.9WTE in M10
- Price cap compliance decreased to 50.5% of all agency shifts secured at cap. The outlier is Medical and Dental as these shifts were outside of cap rate.

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

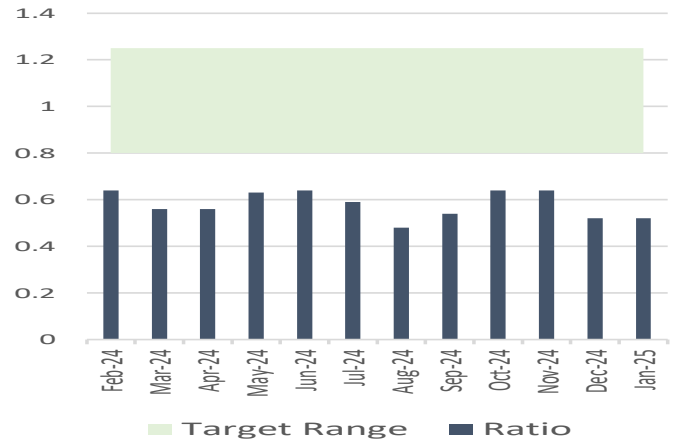
- Medical and Dental Consultants account for almost all agency spend this month.
- Medical and Dental remain the highest in month and FYTD spend on agency provision with Oncology, Clinical Haematology and Cellular Pathology Consultants being the top contributors.
- Nurse agency spend was negligible at only £1,741 (0.02%).
- Bank usage increased from 176.7WTE in M9 to 181.1WTE in M10

Countermeasure Summary

Countermeasure/Action	Owner
SW Agency rate card for Medical & Dental live from 1st September. A longer flight path in place for existing locums to reach rate card no later than March 2025 therefore work continues with suppliers to reach compliance and weekly tracker of progress shared with Deputy CMO	Associate Director for People – Capacity
AfC Bank rates align with system partners supporting collaborative work. Work continues on reviewing enhanced rates which sit outside of rate card to assess equity and impact. Workstream sits within NAMIP as a Driver 2	Associate Director for People – Capacity
Divisional workforce data tracked prospectively (and retrospectively) and shared with divisional teams to support management of spend	Workforce Lead

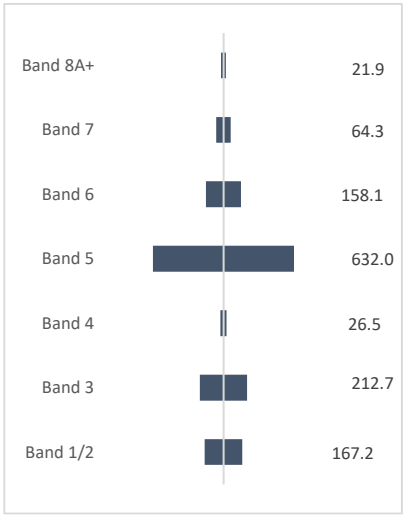
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

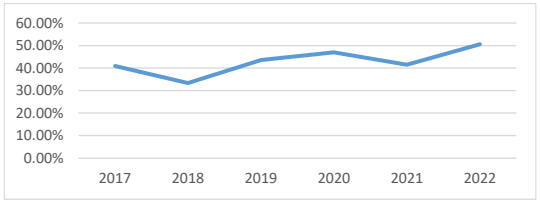


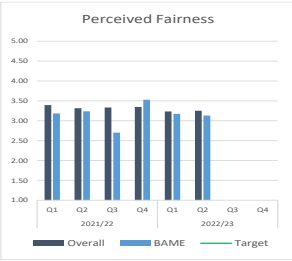
Proportion	0.52

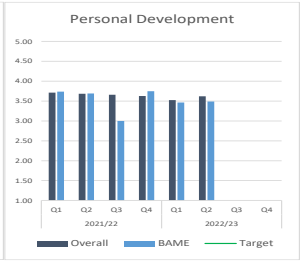
Agency Spend Breakdown



Bank & Agency Use – Staffing Solutions Data







Is standard being delivered?

Based on Trac data, the ratio of the likelihood of appointment from shortlisting comparing Global Majority to White candidates remains static at 0.52 - below the targeted two-fifths range(0.8-1.25).

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

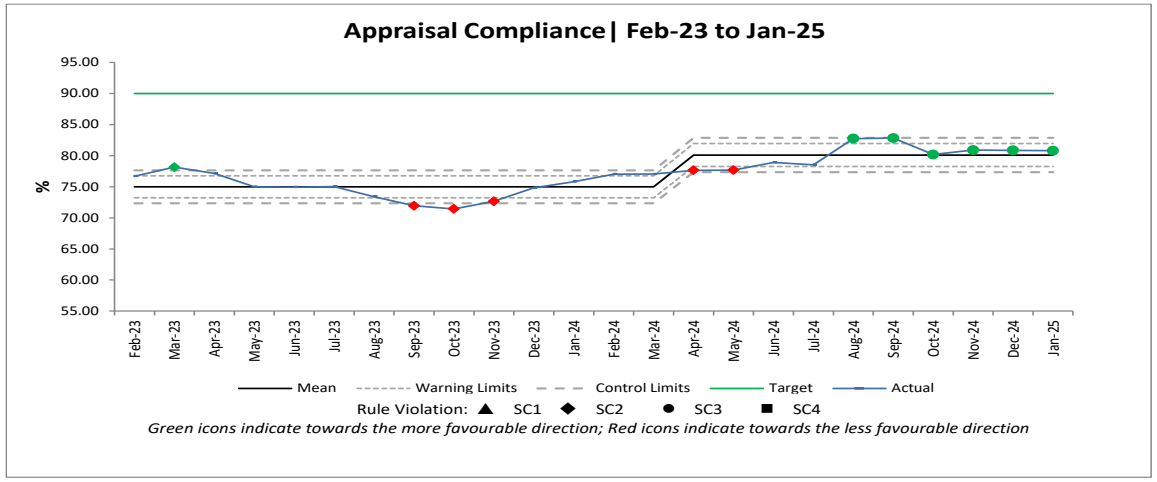
Candidate distribution across vacancies is masked by the aggregation and this has a significant impact in determining the overall figure.

Countermeasure Summary

Countermeasure/Action	Owner

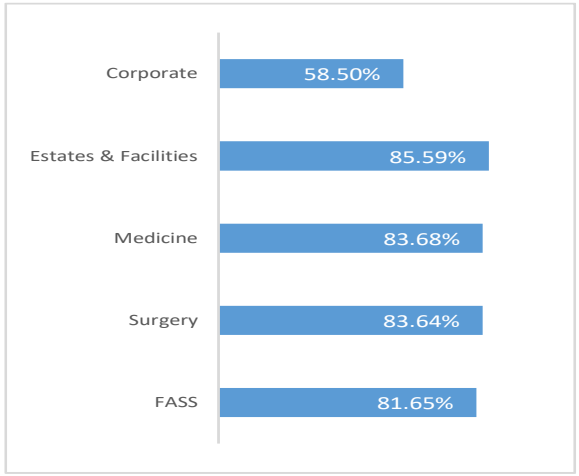
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	80.8%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff	81.3%
M&D Staff	75.7%
Consultants	81.8%
White	80.1%
BME	83.4%

Is standard being delivered?

Appraisal compliance is 80.81%. Whilst this is sufficient to trigger an SPC rule indicating the recent run of points suggest some improvement, the rate of improvement has slowed in recent months with there being little indication that the 90% target will be achieved imminently.

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

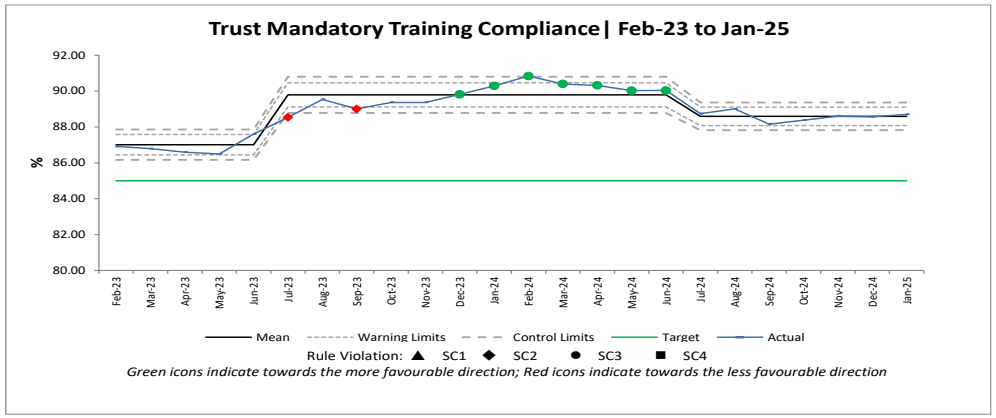
- Corporate Division is significantly underperforming in comparison to the other main divisions with a compliance of only 58.5%. FASS has the next lowest at 81.7%.
- None of the main divisions have achieved the 90% target however.

Countermeasure Summary

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

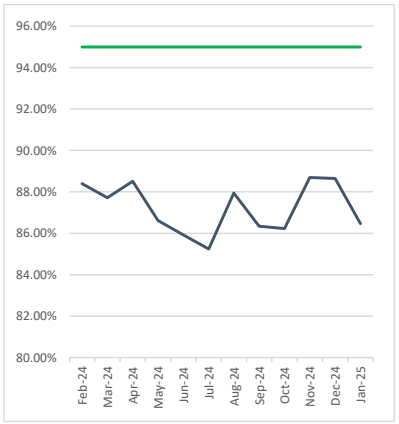
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



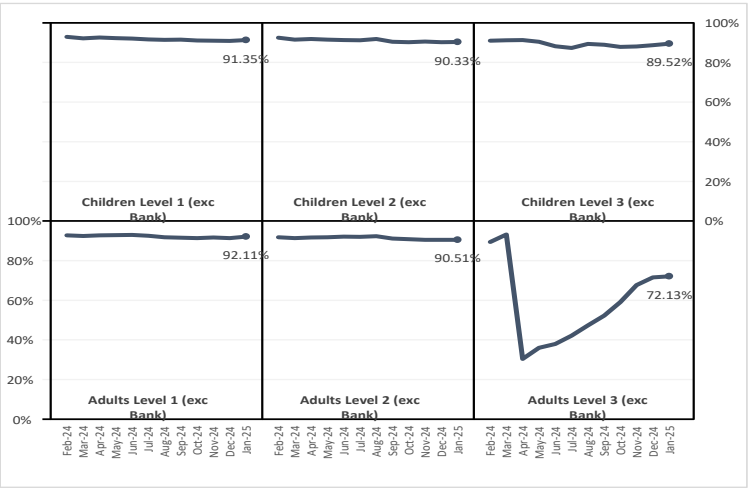
Compliance Rate	88.7%

Information Governance Training Compliance Rate - Trust



Compliance Rate	86.5%

Safeguarding Training Compliance Rates - Trust



Is standard being delivered?

Mandatory Training compliance remains above target at 88.7%. The minor change month on month may be attributed to natural variation rather than any significant indicator of change.

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

- All Divisions have a compliance that is above the 85% target, with Corporate actually exceeding the former 90% target and FASS fractionally below this.
- There has been no significant change in terms of which subjects are not rated green. These remain IG, Manual Handling L2, the Resuscitation subjects and the L3 Safeguarding subjects.

Countermeasure Summary

Countermeasure/Action	Owner
Continues to be pushed through Divisional PRM structure.	Deputy People Partners
Set up MT steering group as required by NHS E, move to measure impact not compliance	Head of corporate Education
Resus task and finish group in situ (people driver)	Head of corporate Education

Royal United Hospitals Bath
NHS Foundation Trust

Quality Report

February 2025 (December 2024 data)

The RUH, where you matter

Executive Summary | Quality

Trust Integrated Balanced Scorecard - December 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

Strategic Goal		Performance Indicator	Description	Target		2023/2024				2024/2025									Trend
				Performing	Under Performing	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Other Measures	People we care for	Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	2	4	6	6	4	3	3	3	6	5	7	5	7	
		Clostridium Difficile Hospital Onset, Healthcare Associated (counted)		<=3	>3	2	6	9	6	2	8	3	7	3	5	6	3	4	
		Clostridium Difficile Community Onset, Healthcare Associated				3	2	2	3	5	1	1	4	8	7	0	3	3	
		E.coli bacteraemia cases Hospital Onset, Healthcare Associated		<=6	>6	5	1	4	1	4	4	2	5	2	3	5	5	9	
		E.coli bacteraemia cases Community Onset, Healthcare Associated				2	5	4	4	5	6	2	4	3	0	1	2	7	
		MRSA Bacteraemias >= 48 hours post admission		0	>=1	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Klebsiella spp Hospital Onset, Healthcare Associated		<=2	>2	2	0	4	1	2	2	0	3	1	1	1	0	0	
		Klebsiella Spp Community Onset Healthcare Associated				0	1	0	2	2	2	1	1	1	1	0	1	0	
		Pseudomonas aeruginosa Hospital Onset, Healthcare Associated		<=1	>1	0	4	0	0	1	0	2	0	1	0	0	0	0	
		MSSA Post 48 Hours				1	3	6	5	2	0	1	1	2	2	3	1	0	
		Flu - Healthcare Onset (+3 days)				-	-	-	-	2	1	1	0	0	0	0	6	51	
		Norovirus Outbreaks				2	0	1	2	0	0	1	1	0	0	1	0	3	
		Number of Hospital Acquired Pressure Ulcers Category 2		<=5	>5	0	3	4	1	1	1	3	2	0	0	4	3	3	
		Number of Hospital Acquired Pressure Ulcers Category 3		<=4	>4	0	0	2	0	1	1	1	0	2	3	3	3	1	
		Hospital Acquired Category 4 Pressure Ulcer		<=0	>0	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Never events		0	>=1	0	0	0	0	0	0	0	2	1	0	0	0	1	
		Mixed Sex Accomodation Breaches				97	163	170	182	170	221	191	154	186	160	237	244	246	

Executive Summary | Patient Experience

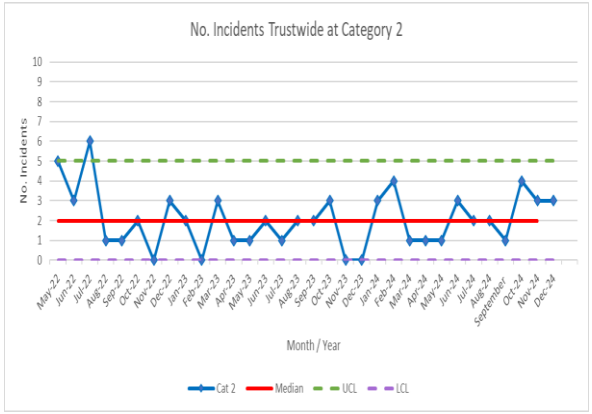
Trust Integrated Balanced Scorecard - December 2024

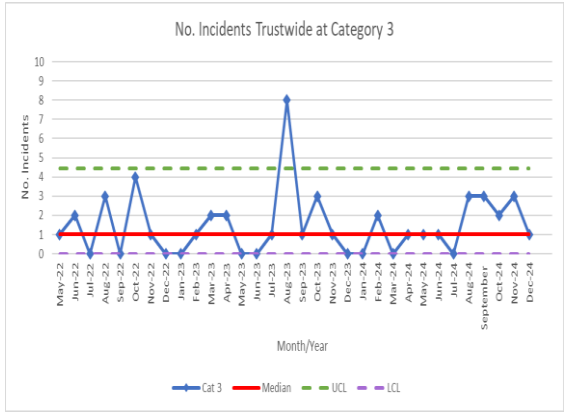
Royal United Hospitals Bath NHS
NHS Foundation Trust

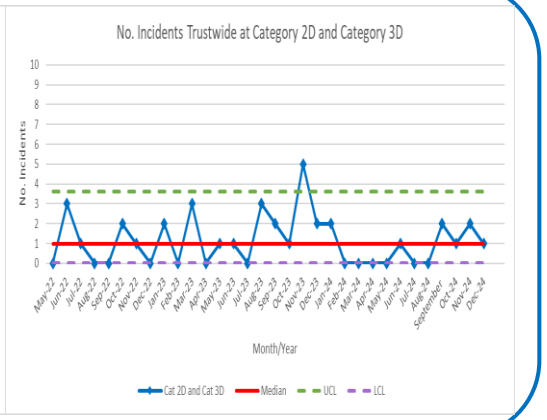
Strategic Goal		Performance Indicator	Description	Target		Baseline	2023/2024				2024/2025									Trend
				Performing	Under Performing		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Tracker Measures	People we care for	% of positive responses to friends and family test					93.9%	93.9%	93.9%	93.9%	93.9%	93.9%	93.9%	93.9%	93.9%	93.9%	93.9%	93.9%	93.9%	
		% of complaints responded to within agreed timescales with complainant		>=90%	<90%	-	93.3%	82.6%	90.9%	92.3%	86.7%	64.5%	73.1%	73.1%	87.5%	75.0%	69.0%	85.7%	61.3%	
		Number of complaints received		<30	>=30		30	22	39	33	25	25	26	38	29	32	41	30	26	
		Number of reopened complaints each month		<=3	>3	-	1	3	5	2	1	3	2	8	0	3	1	3	1	
		Concerns are acknowledged within 2 working days		>90%	<90%		-	-	-	-	100.0%	98.0%	99.0%	100.0%	99.0%	97.0%	98.0%	99.0%	98.0%	

Pressure Ulcers

Tracker measure







We are driving this measure because...

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

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

Understanding the performance

The RUH benchmarks performance against other Acute Trusts in the Integrated Care System (ICS) with both the number of pressure ulcers per 1,000 bed day and the overall number of pressure ulcers by category.

For December 2024, the RUH reported 0.3 pressure ulcers per 1,000 bed days (5 pressure ulcers). GWH reported 0.55 (11 pressure ulcers) and Salisbury data was not available.

The RUH investigated one category 3, three category 2 pressure ulcers and one medical device related pressure ulcers across four wards.

Actions (SMART)

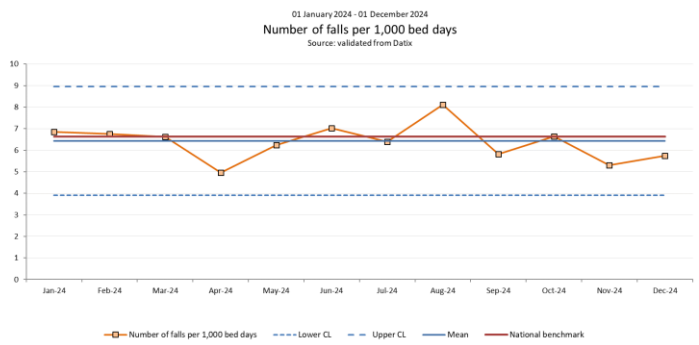
- Improvement plans have been commenced in clinical areas where pressure ulcers have developed. These are being monitored by the respective clinical Divisions.
- A clear target has been set for all skin assessment to be carried out daily and recorded on Millennium consistently by the end of December 2024. Divisions are monitoring compliance with skin assessment and will report to the Tissue Viability Improvement Group in January 2025.
- The Tissue Viability Improvement Group continues to monitor all acquired pressure ulcers category 2, 3 and medical device related to identify trends and opportunities for learning.

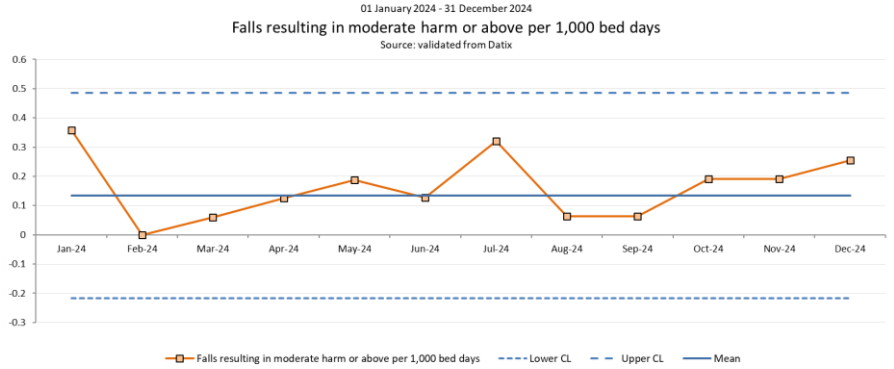
Risks and Mitigations

The Tissue Viability Team continue to work with the digital team to mitigate ongoing risks and following the transition to the full electronic patient record in 2024.

Falls

Tracker measure





We are driving this measure because...

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

Understanding the performance

Pareto analysis identifies the 4 top contributing inpatient areas are within 3 Older Persons wards and 1 Orthopaedic ward. The frailty and complexity of patients on these wards means they have an increased vulnerability to falling whilst they are in hospital. Data shows that consistently over the last 12 months 98.2 % of inpatients did not fall in our care.

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

Actions (SMART)

1. The Falls Prevention Improvement Group are driving a quality improvement project in 4 wards on improving lying and standing blood pressure compliance:

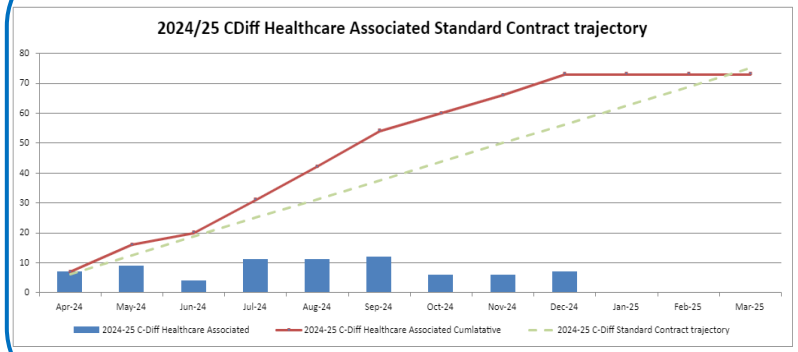
- Aim: 50% of patients in the 4 wards have a lying and standing blood pressure recorded on admission by February 2025.
- Next stage of project: Spread improvement project to 6 additional wards with the aim to increase compliance to 50% in these areas by July 2025.
- Outcome measure: to reduce the number of falls in the 10 wards by 10% by July 2025.

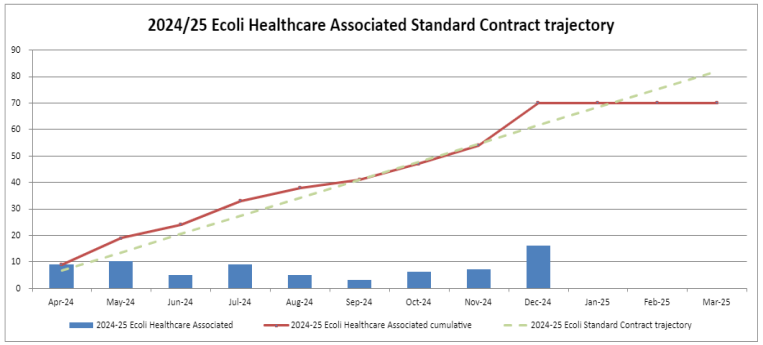
Risks and Mitigations

1. Staff are not always capturing when it is not appropriate for a patient to have a lying and standing blood pressure assessment (may not be medically stable or physically well enough to stand). This will affect the data as patients that are not appropriate will not be removed. Mitigations include how to document 'not appropriate' in training sessions.

Infection Prevention and Control

Tracker measure





We are driving this measure because...

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

Understanding the performance

There were 7 cases of Clostridioides Difficile infection (CDI) reported during December. 73 cases have been reported year to date against an annual threshold of 75.

There were 16 cases of E. coli infection reported during December 24. There have been 70 cases reported year to date against the annual threshold of 82. Benchmarking data shows our rate is in the middle of all Southwest Trusts.

The 3 IPC quality improvement projects listed (under actions) aim to improve the quality of care provided to patients and positively influence the health care associated infection rates longer term. The hydration committee is now meeting and workstreams have been identified with IPC focusing on accurate fluid charts.

Actions (SMART)

To reduce ingestion of environmental bacteria and virus' during a hospital stay, we will enhance hand hygiene opportunities.
Aim: To increase patient hand hygiene pre and post meals within a bay on an older person's unit by 30% within 3 months. Plan to start on pilot ward March 25.
Gloves off campaign: To ensure clinical gloves are worn appropriately. Aim: To reduce the inappropriate use of gloves by 30% within 3 months. Stand in the Atrium 11th February, to recruit new areas.
To develop and launch a RUH PPE App to improve the use of correct PPE for all non-high consequence infections/symptoms.
Aim: To empower clinical staff in a department to select the correct PPE plan to roll by April 2025

Risks and Mitigations

The numbers for COVID cases remain low across the region although numbers of acute respiratory infection and gastroenteritis continue to put pressure on clinical areas with 285 cases of confirmed Influenza.

UKHSA have been managing highly pathogenic avian influenza (HPAI) A(H5) which was identified in the East of England within poultry farm workers. There have been no cases identified across BSW. There has been no major ill health effects identified. HCID training is being completed by all staff in ED.

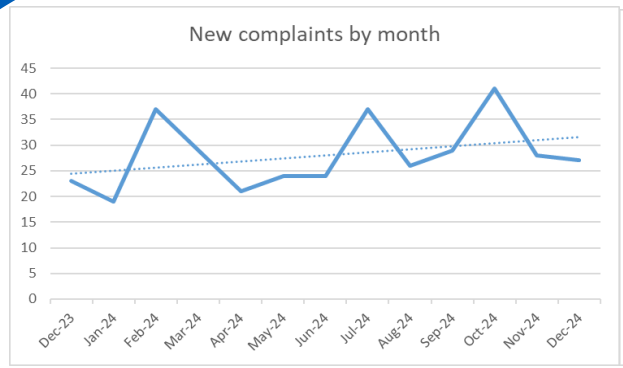
There has been one case of a new emerging ribotype of *C. difficile* that is highly transmissible within the Trust, careful management and strict standard infection control precautions including immediate isolation are needed, side room capacity is a notably restricted within the Trust.

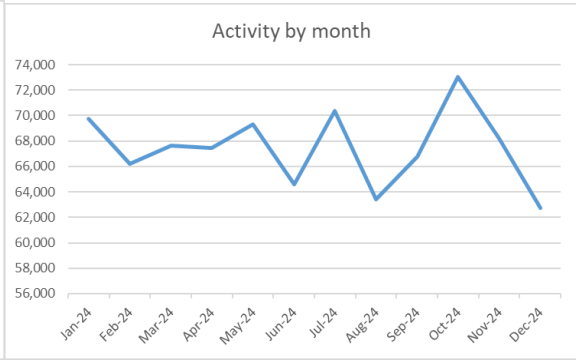
The RUH, where you matter

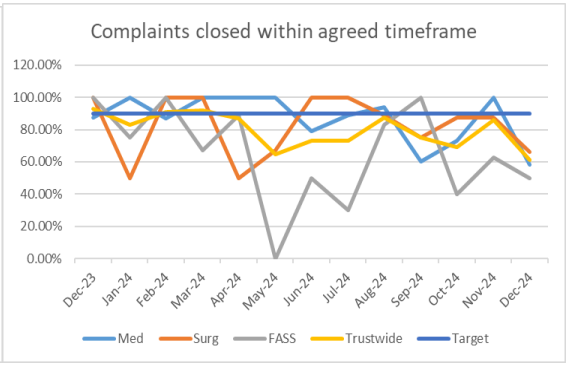
HOHA: Healthcare Onset Hospital Associated Community
COHA: Onset Healthcare Associated
PPE: Personal Protective Equipment

Patient Support & Complaints (PSCT)

Tracker measure







We are driving this measure because…

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

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

Month	December 2024
% complaints/concerns resolved with early resolution (14 days)	69% (target 75%
% of formal complaint responses closed within the timeframe agreed with the complainant	61% (target 90%)

Understanding the performance

In December, the Trust received 27 new complaints. (this compares to 26 in November. There are no specific themes that point to an area of concern, although a high number of cases relate to clinical care concerns (n=20), this is consistent with previous months.
The Medical Division received the highest number of new complaints (n=18).
The number of re-opened complaints remains low. In December one new complaint was reopened.
69% of all contacts with PSCT were resolved within 14 days in line with NHS Complaints standards. This is lower than previous months (target 75%) predominantly due to delays as a result of the Christmas period.

The RUH, where you matter

Actions (SMART)

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

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

The work plan is monitored by the Patient Experience Committee.

Risks and Mitigations

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

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

Royal United Hospitals Bath
NHS Foundation Trust

Perinatal Quality Surveillance

February 2025 (December 2024 data)

The RUH, where you matter

Safe – Maternity& Neonatal Workforce

	Target	Threshold G	Threshold A	Threshold R	Oct 24	Nov 24	Dec 24	Comment
Midwife to birth ratio	1:24	<1:24		>1:26	1:29	1:26	1:26	
Midwife to birth ratio (including bank)	1:24	<1:24		>1:26	1:26	1:24	1:24	
Consultant presence on BBC (hours/week)	98	>97			98	98	98	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0	
Percentage daily multidisciplinary team ward round	90%	>90%		<80%	94	97	97	
Band 5/6 Midwifery substantive vacancy rate WTEs	7.0 WTE	≤7.0		>10	0.9	0.9	0	
Percentage Neonatal Nurse QIS rate	70%	≥70%		≤60%	69	69	63	5 training places secured for 24/5 Funding for 4 further training places in 25/6 available Clarification from SWNNN re criteria for QIS calculation. Direct patient facing staff only.
Neonatal Nursing vacancy rate WTES					3.59	3.83	3.12	Over B4 1.32 due to uplift for SNA (actual -2.48 B6 and – 2.32 B5).
Percentage Neonatal shifts staffed to BAPM standards	100%	>90		<80%	79	85	95	
Percentage medical staffing to BAPM standards	100%	>97%			96.3	95.2	98.8	ANNP Vacancy out to advert.
Percentage Maternity 12-Month Turnover rate	≤5%	≤5%		≥7%	3.04	3.54	3.52	
Percentage Neonatal Unit 12-month Turnover rate	≤5%	≤5%		≤7%	6.51	6.51	6.28	
Percentage of TC shifts with staff dedicated to TC care only		>90%		<80%	97.2	97	100	3% of shifts TCP had more than 4 babies – staffing model is 1:4.

Is the standard of care being delivered?

- **Continue to achieve midwife to birth ration in line with BR+ report**
- **Improvement in BAPM standards**

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

- NNU shift fill inaccurate due to roster not aligning with staffing requirements therefore suspension of reporting. Safe staffing review signed off by CNO and roster alignment underway

Countermeasure /Action (completed last month)	Owner

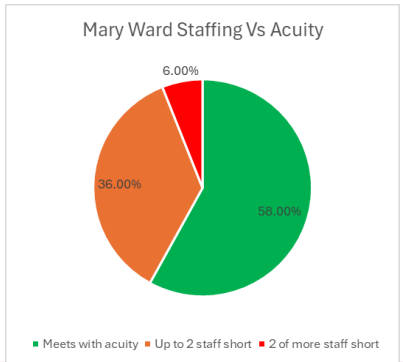
Countermeasure /Action (planned this month)	Owner
Work with health roster team to remove unused tiles and ensure roster requirement are validated for neonatal rosters continues. Final meeting 21/1/25 for workforce work	Inpatient matron

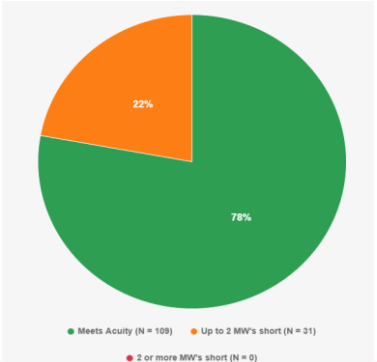
Average Shift Fill Rates- planned vs actual

			Oct 24	Nov 24	Dec 24
Maternity	Midwives	Day	94%	96%	88%
		Night	90%	93%	92%
	MCA/MSWs	Day	62%	59%	72%
		Night	78%	86%	84%
Neonates	Registered nurses	Day			Not available
		Night			See narrative
	Nursing support staffing	Day			
		Night			

Safe – Maternity& Neonatal Acuity Oct 24

	Target	Threshold G	Threshold A	Threshold R	Oct 24	Nov 24	Dec 24	Comment
Percentage of 'staff meets Acuity'	100%	>90%		<70%	74	80	78	Perceived increased short-term sickness in Dec – awaiting data. Increase in AN/PN 1:2 care requirements
Percentage of 'staff meets Acuity' Mary Ward (inpatient care)	100%	>90%		<70%	50	71	58	Redeployment to BBC to support 1:1 care in labour
Confidence factor in BirthRate+ recording BBC	60%	>60%		<50%	82.78	80	75.27	Percentage of possible episodes for which data recorded
Confidence factor in BirthRate+ recording Mary Ward	60%	>60%		<50%	83.87	89.17	85.48	Percentage of possible episodes for which data recorded
Maternity 12 month rolling absence rate %	4.5%	<4%		>5%	4.00	3.89	3.52	
Neonatal Unit 12 month rolling absence rate %	4.5%	<4 %		>5%	4.05	4.23	4.46	
1:1 care not provided in labour	0	0		>1	0	0	0	
Labour ward coordinator not supernumerary episodes	0	0		>1	0	0	0	
Number of red flags on Birth Rate + (NICE 2015 and RUH specific)	Total Red Flags				103	56	56	A midwifery 'red flag' event is a warning indicator that relates to staffing levels not meeting acuity. We record these as published by NICE & those set by locally at RUH
(NICE 2015 red flags)	NICE 2015				6	5	3	
Birth outside of BAPM L2 place of birth standards	0	0		1	0	0	0	
Number of days in LNU outside of BAPM guidance	0	0		>2	0	0	0	





Countermeasure /Action (completed)	Owner
BR+ meeting to review red flags and staffing baseline	SLT
BR+ training date booked for early 25	SLT

Countermeasure /Action (planned)	Owner
To complete the BirthRate+ guidance tool indicating the change requests required to ensure ability for national benchmarking (NICE 2015 'safe staffing red flags') and local proactive KPI measures work planned for quarter 4 24-25 to mitigate against risk of lost data during MIS reporting periods	Q&PS Lead / Acute Matron
To review missed or delayed care red flag in Nov and Dec	Acute matron
Staffing escalation guideline update continues inclusive of collaboration with Trust-Wide colleagues to support periods of high acuity to preserve safe staffing within Maternity Services	Acute Maternity Sister/Matron

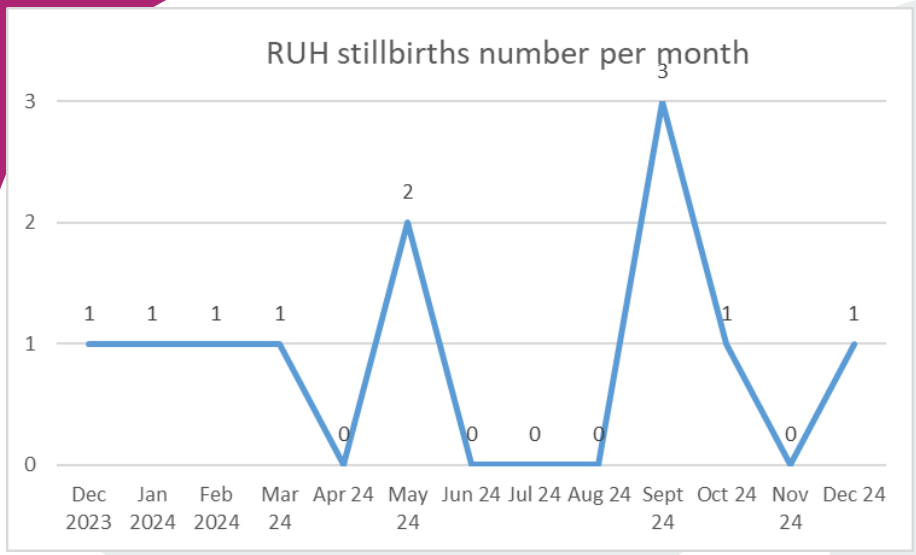
Is the standard of care being delivered?

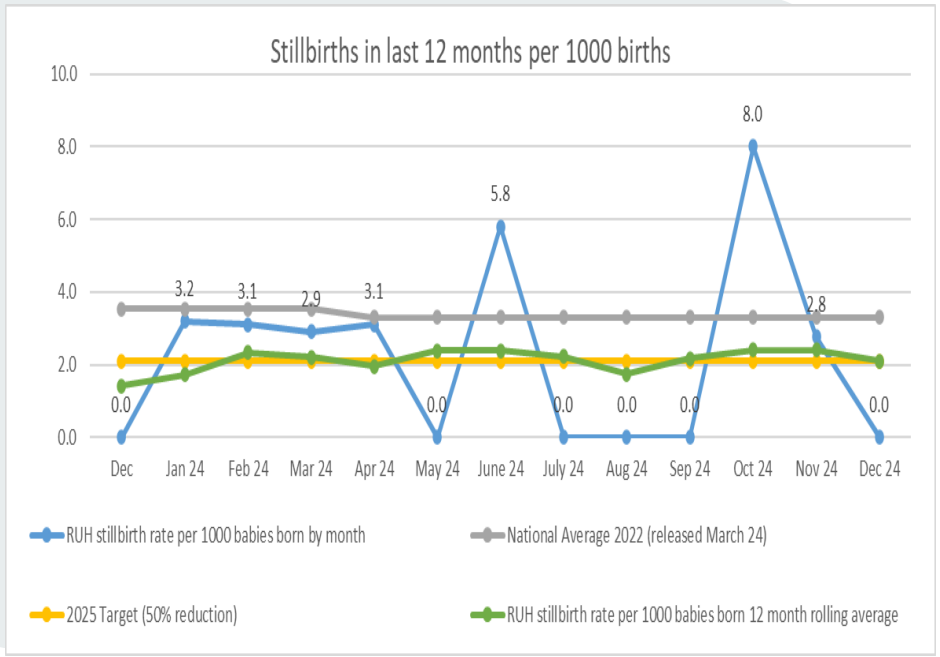
- No episodes of supernumerary Labour Ward coordinator status not maintained
- No episodes where 1-1 care in labour not provided
- RUH Red flags triggered due to delayed admission for IOL
- NICE red flags – Missed or delayed care (n1) and delay in continuing of IOL(n2)
- Mary ward staff meet acuity compliance to 56%. Increase in short by 2 or more short.

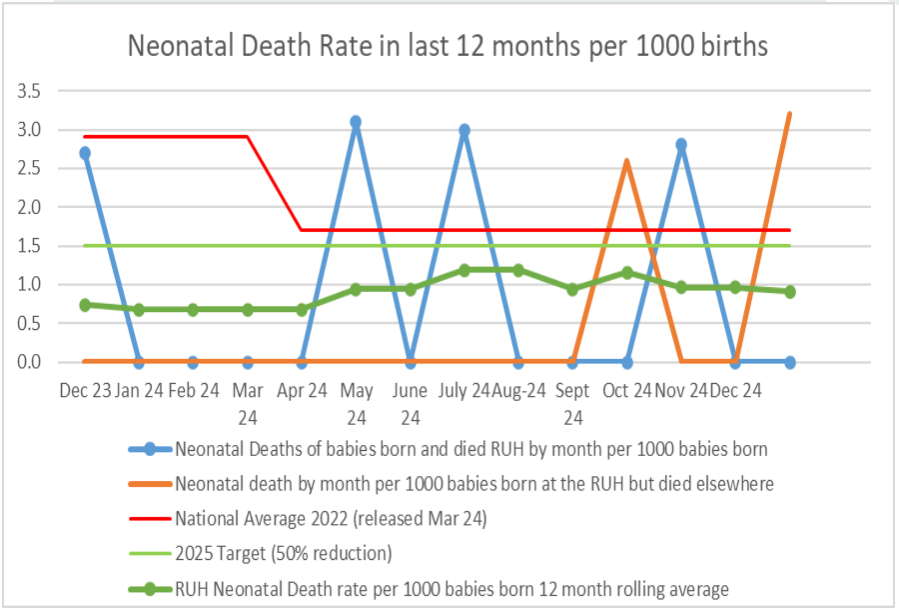
What are the top contributors for under/over-achievement?

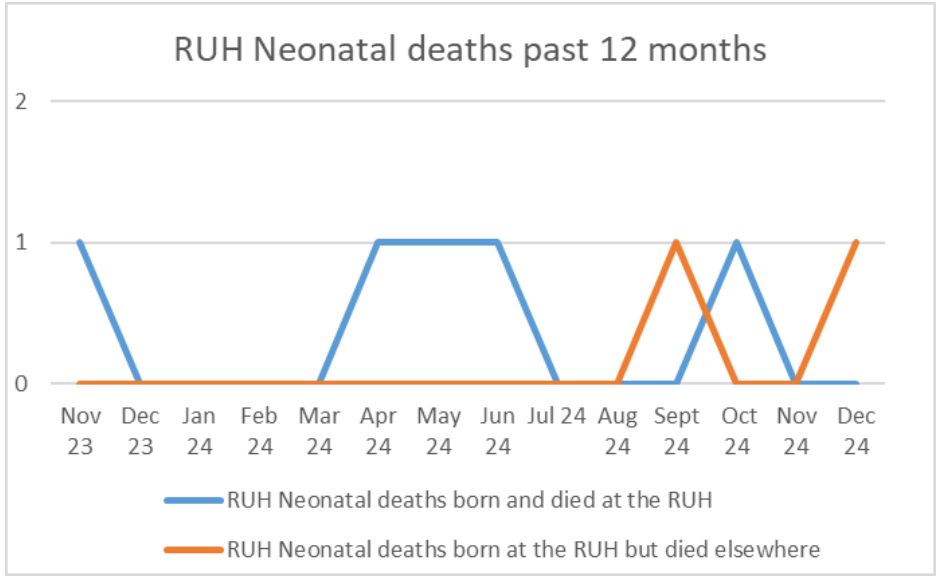
- Identification of disparity or red flag data for national 'NICE' red flags and locally set red flags.

Safe- Perinatal Mortality Review Tool (PMRT)









Background information

All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT) tool since 2018. PMRT reporting is Safety Standard 1 of the NHSR Maternity Incentive Scheme year 6. A quarterly update paper is shared with the Trust Board.

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

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

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

Monthly update

1 antenatal stillbirth at 24+0 weeks in the month of December.

1 neonatal death at 4 weeks of age in the month of December. Metabolic disorder.

Incidents

New Cases for Dec 24

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	PSII?
135481	05/12/24	Moderate harm	Fractured clavicle	Readmission on day 13. DOC commented. Rapid review undertaken. Missed opportunity to discuss with social care, action to align Trust guideline with BSW.		
135968	12/12/24	Moderate harm	Fractured humerus	Shoulder dystocia. DOC commenced. Rapid review undertaken; no immediate care concerns, actions identified.		
135801	12/12/24	Moderate harm	Readmission 6/52 with secondary PPH and DIC	Admitted to GWH. Rapid review date set.		
135844	12/12/23	Unavoidable death	23+5 IUD	Rapid review completed; no immediate care concerns identified. Will receive full PMRT.		
136290	30/12/24	Moderate harm	5L PPH and hysterectomy	DOC commenced. Known placenta accreta. Rapid review date set.		

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions/ Update of progress	MNSI Reference	PSII? Reference
134092	23/10/24	Unexpected death	36-week antenatal stillbirth, cord detached at birth of baby.	DOC commenced; Rapid review conducted no immediate care concerns identified will receive full PMRT review.		
133795	12/10/24	Unexpected death	Neonatal death of a 28-week gestation post placental abruption and Prolonged Pre-Labour Rupture Of Membranes from 22 weeks of pregnancy	DOC commenced; Rapid review conducted no care issues identified causal to the outcome for the baby- co-incidental learning identified regarding collaborative complex antenatal care pathways and counselling with neonatal colleagues. PMRT in Jan 25.		
134325	31/10/24	Moderate harm	Maternal Intensive Care Unit admission on day 16 post Elective Caesarean section birth with suspected bowel injury	DOC commenced by on call consultant. 2nd review completed, local review.		
133490	03/10/24	Moderate harm	Transfer of neonate to tertiary level NICU for active therapeutic cooling- MRI Normal – MNSI progressing at family request	DOC commenced by on call consultant, rapid review undertaken – period of 20 minutes of escalation/communication under review. MNSI progressing at family request. TOR received Dec 24.	MI-038594	
127900	04/04/2024	Unexpected Death	Neonatal death following elective caesarean birth	DOC commenced by on call consultant Referred to Maternity Independent Advocacy service PMRT review – report being finalised.	Discussed- did not meet criteria	
130511	29/6/2024	Moderate harm	Transfer of neonate to tertiary level NICU for active therapeutic cooling	DOC commenced. Referral to MNSI- MNSI review in progress at familial request. Ded 24 – draft report returned to MNSI following factual accuracy check.	MI-037619	
132682	10/09/2024	Unexpected Death	Intrauterine Death at 28 weeks of pregnancy	DOC commenced, PMRT review.		
133232	26/09/2024	Unexpected Death	Intrauterine Death at an unknown >37-week gestation in an undiagnosed/concealed pregnancy.	DOC commenced, discussed with MNSI, discussed with coroner, rapid review undertaken, plan for Systems Engineering In Patient Safety (SEIPS) Analysis to support full exploration of learning. PMRT report complete.	Discussed at MNSI regional meet 30/09/24 – does not meet criteria	
133329	28/09/2024	Catastrophic harm/ Unexpected Death	Death of 8-day old infant following call to Maternity Triage Line 12 hours prior to presentation	DOC commenced – PSII Terms of Reference looking at the systems and processes supporting the Maternity Triage line advice and referral pathways when contacted regarding a parental neonatal clinical concern. PSII report in draft.		Declared 07/10/24
133240	27/09/24	Unavoidable Death	38+4 antenatal stillbirth	DOC commenced. Rapid review undertaken. Will receive full PMRT		
134916	17/11/24	Unavoidable Death	Unexpected admission to NNU and transfer to tertiary unit	DOC commenced. Rapid review undertaken, no immediate care concerns. Metabolic disorder. Perinatal in Jan 25		
135577	20/11/24	Unavoidable death	22+5 neonatal death	Delay in obtaining notes from Bristol. Review Jan 25		
135330	29/11/24	Moderate harm	Entrapment of fetal head of 29/40 baby	DOC commenced. Rapid review undertaken, no immediate care concerns		
134753	21/22/23	Moderate Harm	LTFU. Cardiac referral not followed up. Presented 28+4 symptomatic, admitted to tertiary cardiac centre	DOC commenced. Rapid review undertaken; 2nd review required following collection of further information. Trust risk identified for lack of integration of EPR with Tomcat		

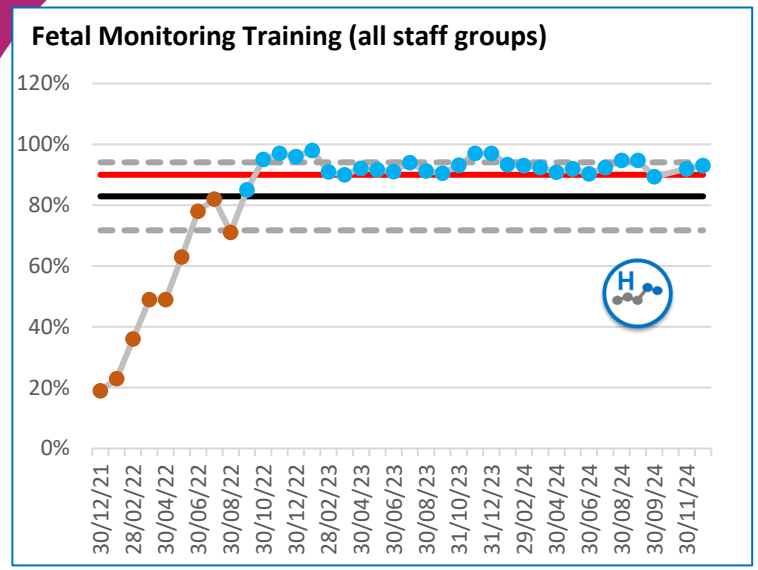
Incidents

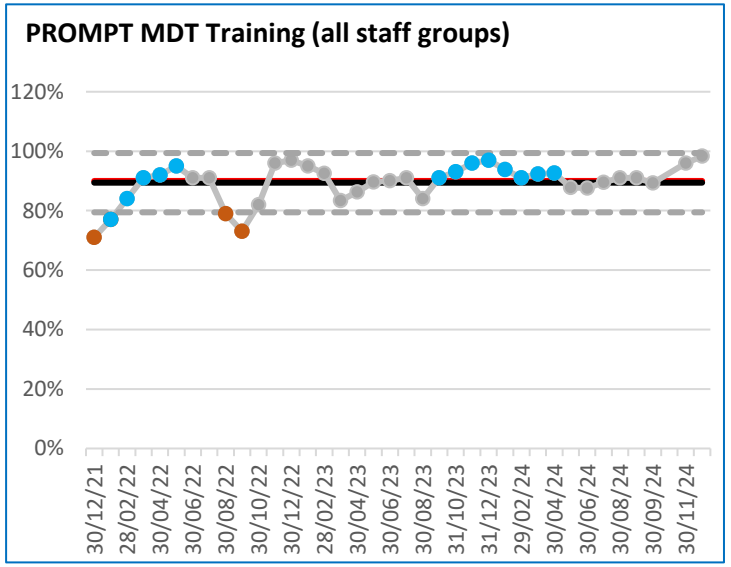
Closed Cases Nov 24

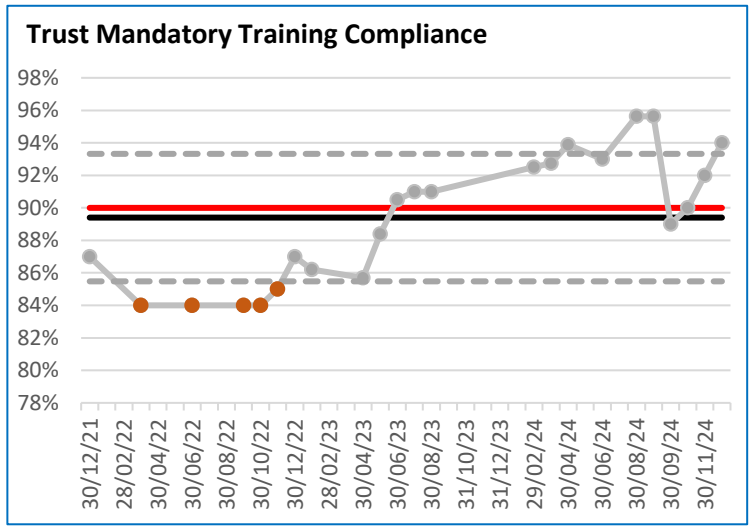
Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions - all monitored via action tracker	MNSI Reference	PSII Reference
134388	02/11/24	Moderate Harm	Admission to NNU	Bi-lateral pneumothorax. Unavoidable admission to NNU.		
134595	09/11/24	Moderate Harm	4th degree tear	DOC commenced, rapid review undertaken, no immediate care concerns. Buttonhole tear does not fit national reporting criteria for 4th degree tear. Action – new category to be created on Datix, case closed.		
134015	20/10/22	Moderate Harm	Avoidable admission to the neonatal unit following development of subgalea haemorrhage resulting in a 5 day stay in the neonatal unit	DOC commenced by on call consultant, rapid review undertaken, learning identified – actions identified and completed.		
134054	21/10/24	Moderate Harm	Brachial plexus injury following forceps birth	DOC commenced by on call consultant. rapid review, no care concerns identified causal to the injury. 2nd review undertaken. DOC closure letter sent.		

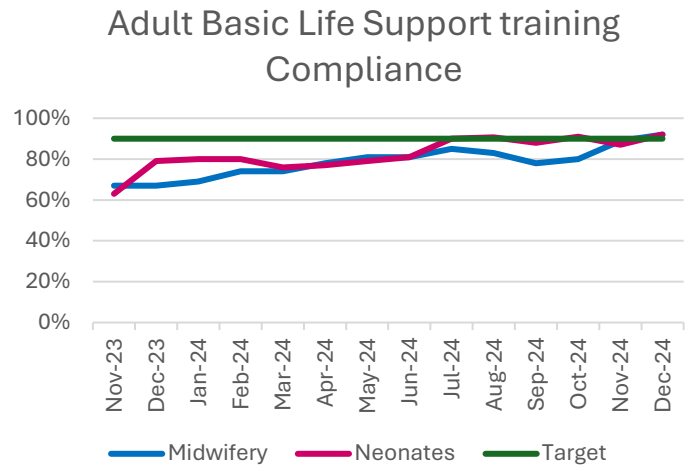
Maternity Safety Support Programme	N/A	**Coroner's regulation 28**	N/A

Well-led – Training









Training

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

Countermeasures/action:

- Bespoke refresher skills sessions available for community staff: skills drills and newborn life support with dates booked for the next year. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs).
- Additional skills sessions available to newly qualified staff and senior students facilitated by the Retention and Education team.

- PROMPT Faculty proposal completed decision to utilise Clinical Skills Framework to reduce using establishment hours
- Agreement for ABLS to become managed in specialty moving forwards as part of the PROMPT programme.
- ABLS compliant for maternity and neonatal.

Risks:

- The use of our own compliance tracker as opposed to using ESR data – ESR still reflects theatre teams which impacts on our compliance. Linking in with ESR and Theatres to find a resolution to this for transparency and information sharing.

Compliance to National Guidance

	Maternity Incentive Scheme Y6 - Safety Action Detail	Current position	Anticipated submission position March 25
1	Are you using the National PMRT to review perinatal deaths to the required standard?		
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?		
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?		
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?		

Maternity Incentive Scheme (CNST) Year 6

Key Achievements:

- Compliance with SBL achieved (SA6)
- KPMG draft report expected 18/01/25 – published, see below.

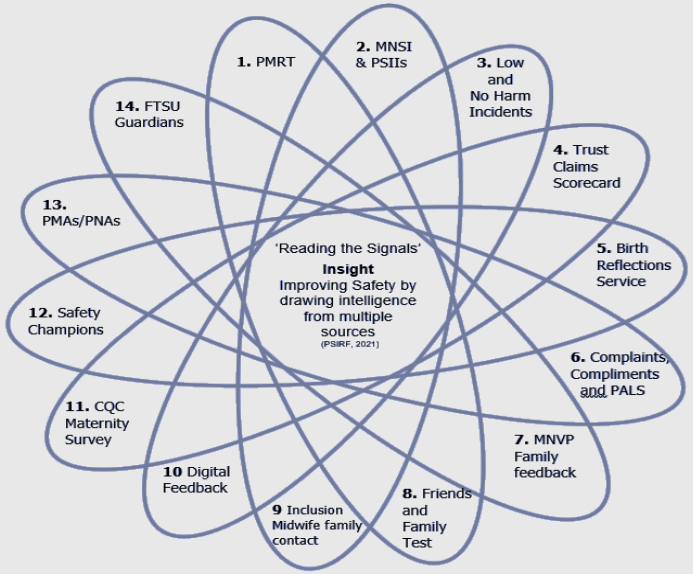
Next Steps for Progressions:

- Draft MIS compliance report underway – February 2025 – complete and compliance declared with 10 SA.
- Planning for year 7 underway

Responsive

Family Feedback 'Insights' Triangulation Group 24

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



December 24 Themes

Safety Champions Staff Feedback

Maternity:

- Chief Nursing Officer walk about December 2024

December – Triage (ground floor).

- Juggling space a little
- Families can hear other people's presentations through curtains which may impact privacy
- Was busy and not appropriate to have lengthy conversations with staff
- Staff did not want any further help on the day

Neonates:

- Visited 20 December 24

- Struggling to recruit ANNP, continuing to advertise
- The number of QIS trained staff remains below required, a plan is in place
- Staff looking forward to Christmas
- Staff Nurses we spoke to were happy and felt supported

- **Next steps:**

Captured in above slides re Neonates

Maternity and Neonatal Voices Partnership (MNVP)

feedback received across various sources including in person conversations and birth workers.

- **Key points raised** (NNU feedback from care in Spring 2023)
- Great expressing milk advice and good access to facilitates to aid this in NNU
- Access to psychologist to answer questions and help with PTSD
- Chairs old and uncomfortable
- Lack of drive to move babies forward, rather an approach of 'getting through my 12 hours shift'

Next Steps:

- Families have access to 3 sessions post discharge from NNU with psychologist/Consultant or Nurse Consultant to ensure families aware
- Family Integrated care SIG embedded within NNU

Compliments & Complaints

Formal Compliments	**1**	**PALS Contacts**	**3**
Online Compliments	**--**	**Formal Complaints**	**0**

- Compliments of care received across Mary Ward and BBC.

Friends & Family Survey

Key Achievements: 4 responses for Transitional care. All positive. Staff supportive . Supportive with feeding

Royal United Hospitals Bath
NHS Foundation Trust

Operational Performance Report

February 2025 (January 2025 data)

The people in our community

The RUH, where you matter

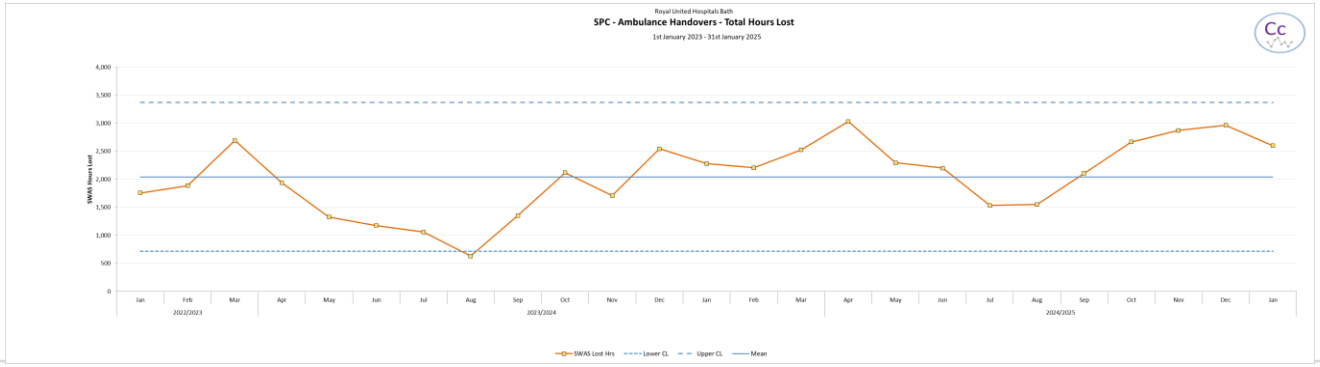
Executive Summary: Performance

Measure	Change	Executive Summary
Ambulance Handover		In January, the Trust lost a total of 2,597 hours in ambulance handovers, a decrease from the previous month (2,965). The percentage of ambulance handovers completed within 30 minutes decreased for January to 30% compared to previous month (33%) against the national standard of 95%. SWASFT have shared some data with RUH, and it does show an overall increase for ambulance handovers in 15-30mins, 30-60mins with a concurrent reduction in those ambulance handovers in 90-120mins, 2-3hrs, 3-4hrs and 4-8hrs, which is positive.
4 Hour Performance		RUH 4-hour performance in January 2025 was 68.9% and 60.5% on the RUH footprint (unmapped), an improvement on December 2024 (63.6% and 54.7% respectively). Non-admitted performance was 74.2% which is an increase against the performance for December (67.1%). Admitted performance was 31% which was also improved from December (28.2%). Improved senior staffing within CED has helped with this, along with more consistent senior staff in ED overnight.
Non-Criteria to Reside (NC2R)		During January , the Trust had an average of 102 patients waiting who had no criteria to reside, which is an increase of 15.7 than the previous month. Some localities saw a decrease in average numbers of NCTR. BaNES has seen a decrease to 20.4 which is positive, however still needs significant focus on system partner calls and support.
Referral to Treatment		In December 2024 the trust achieved an RTT performance of 60.2% which was a decrease of 1.2%. For waiters **> 65 weeks**, the Trust saw a decrease in January from 15 to 9 patients. There were 3 patients waiting **> 78 weeks** at the end of January (3x Ophthalmology)
Cancer 62 Days		Performance recovered in December, achieving 71.8% against the 70% target. Performance improved in Breast as planned in their recovery trajectory following the increased diagnoses and consultant sickness in late summer. Further improvement is seen in January and a locum is being appointed from February to maintain the position. Colorectal also improved, achieving performance above 50%. Waiting times for simple colonoscopy have improved through the use of capacity at Sulis. Lung performance deteriorated due to small delays for patients in OPA, PET and CT biopsies against the background of long term increasing demand through lung cancer screening. Upper GI also recorded worse performance with patients requiring multiple diagnostics as well as MDT discussions and treatments at UHBW. There is confidence performance will remain above target in Q4.
Diagnostics		In January 2025, 62.50% of patients received their diagnostic within the 6-week target against an in-month target of 77.97% and year-end target of 95% (revised trajectory October 2024). The number of patients waiting > 6 weeks decreased by 23 breaches when compared to previous month, despite delivering 2,061 additional diagnostics tests across all modalities. Increased demand for urgent and suspected cancer continues to impact on available capacity for routine diagnostics, despite increased activity levels in January.
Elective Recovery		M10 delivered 128% of 19/20 activity and 104% against the 24/25 plan, generating £322K of over delivery against plan

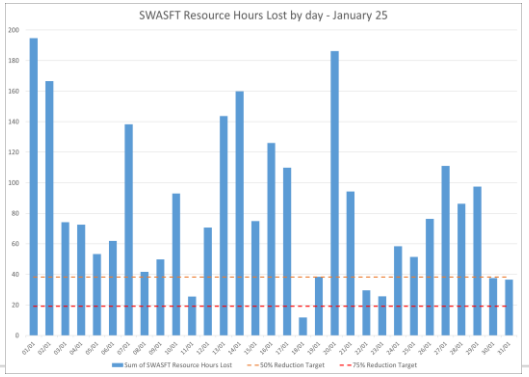
Key Standards | Ambulance Handover Delays:

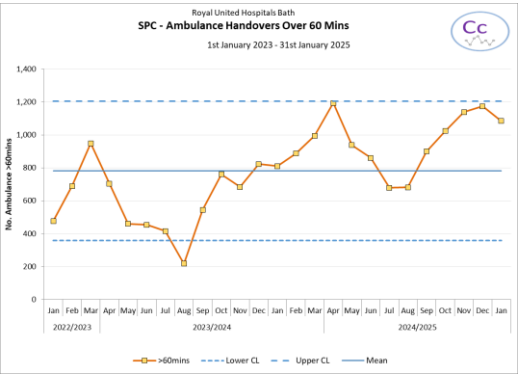
Performance Target:
Lose no more than 500 hours per month.

Historic Data: Hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

- In January, the Trust lost a total of 2,597 hours in ambulance handovers, a decrease from the previous month (2,965, -368).
- SWASFT have shared some data with RUH, and it does show an overall increase for ambulance handovers in 15-30mins, 30-60mins with a concurrent reduction in those ambulance handovers in 90-120mins, 2-3hrs, 3-4hrs and 4-8hrs, which is positive.

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

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

The overall performance was also contributed by:

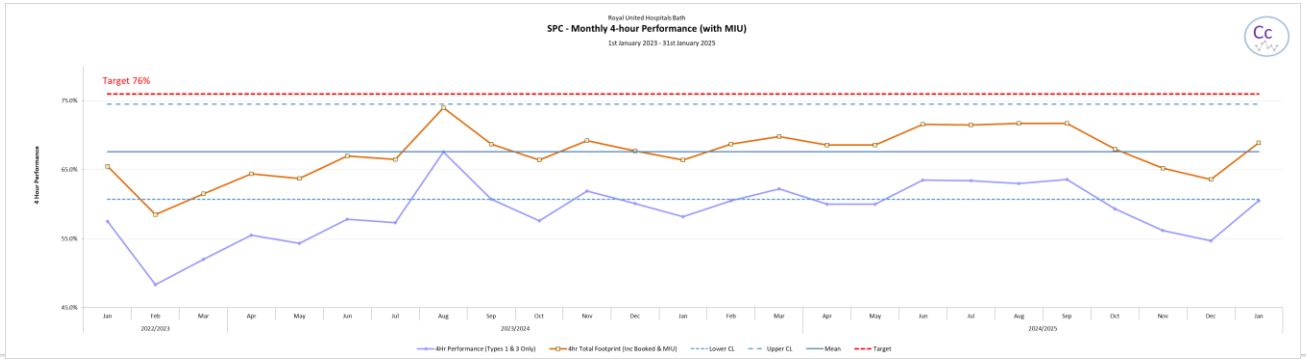
- X-CAD continues to only be utilised in ED, which is leading to data errors particularly when cohorting patients. This creates challenges with validating ambulance handover delays when a patient is placed into a Cohort Area. Daily validation is ongoing but manual validation will not override X-CAD recorded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

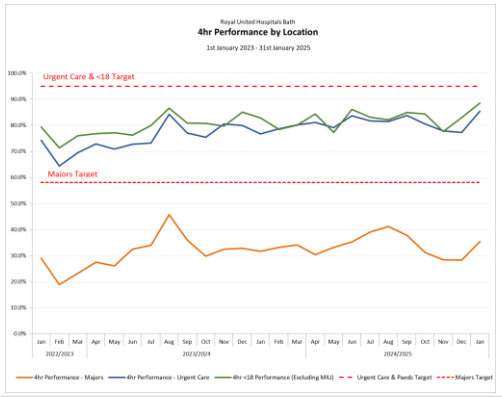
Countermeasures / Actions	Owner	Due Date
RAT working Group recommenced. SOP for Pitstop / RAT drafted, awaiting sign off by Deputy MD, then launch and embed monitoring impact.	M. Price / F. Maggs	28/02/2025
Recruit to Consultant posts and ensure that there are 3 Consultants on to allow RAT to occur consistently.	M. Price	28/02/2025
Open fit2sit 08:00 – 00:00 following PDSA.	T. Thorn/ C. Irwin-Porter	COMPLETE
Review Fit to Sit protocol and maximise with patients arriving by ambulance.	M. Price & C. Irwin-Porter	COMPLETE
Works to be done to increase size of SDEC waiting room Q4 2024/2025.	M.Rumble	WIP due Apr25
To have a discussion with BSW ICB / SWAST regarding role of HALO and impact on handover / XCAD issues.	C.Macgregor	31/10/2024
Trial of a second SpR overnight to be able to undertake overnight RAT.	M. Price	COMPLETE

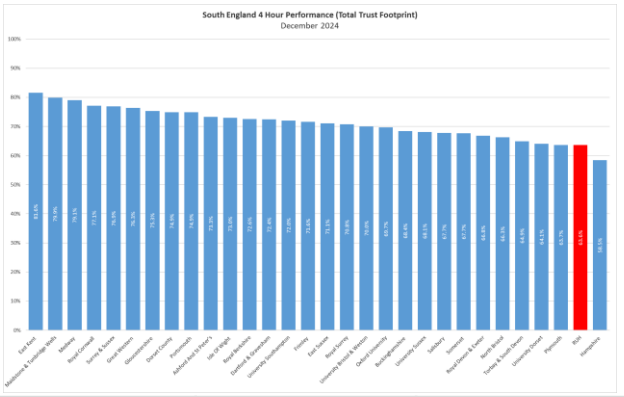
Key Standard | 4-hour Emergency Standard:

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

Historic Data:







Is the standard being delivered?

- RUH 4-hour performance in January was 68.9% and 60.5% on the RUH footprint (unmapped), an improvement on December.
- This is predominantly due to admitted Emergency Department performance…

Area	Admitted	Non-admitted	Total
Emergency Department	22.79%	48.43%	**34.98%**
Childrens Emergency Department	72.36%	92.00%	**88.54%**
Urgent Treatment Centre	85.74%	60.36%	**83.58%**
Urgent & Emergency Care	**30.96%**	**74.25%**	**60.48%**

Root causes	Jan25
Handovers from arrival <15mins	13.5%
Initial assessment from arrival <15mins	74.05%
Treatment from arrival <60mins	48.61%
DTA to admit <1hr	21.47%

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

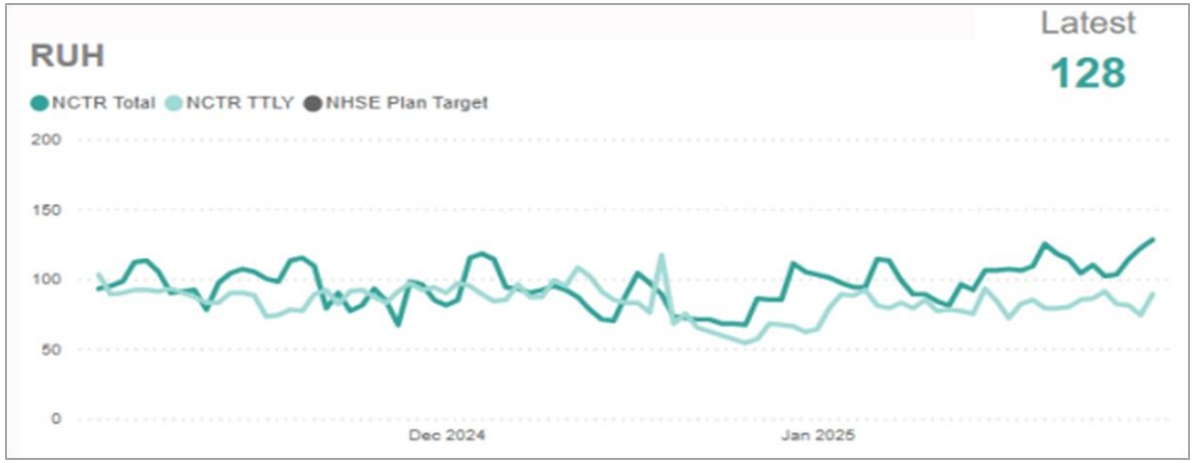
- Timely flow-out of the emergency department, delays with beds becoming available.
- IPC restrictions impacted on patient flow out of the ED.
- Identified patients breaching in Fit2Sit (delay to first clinician).
- Difficulty in flipping ACA to Fit2Sit at 08:00 due to the acuity of patients.
- Ongoing long waits for mental health patients to be seen by Mental Health Liaison / AWP, particularly overnight, and in addition long waits for MH beds.
- Vacancy within consultant workforce and urgent care staffing leading to gaps in rota and no consistent RAT cover.
- Overcrowding in ED leading to no assessment space, reducing time to assessment/treatment/referral.
- Inconsistent use of SAU and DAA waiting areas for Surgically and Medically expected patients.

Countermeasures / Actions	Owner	Due Date
(away day action) Plan PDSA of single front-door consultant to reduce wait to be seen/support early plans/streaming.	UEC Tri	28/02/2025
Update ED safety matrix and upload to intranet page.	C. Irwin-Porter/ T. Thorn	COMPLETE
Finalise draft escalation policy, ensure ratified and uploaded.	A. West/ S. Hudson/ D. Allison	31/01/2025
Link with the Urgent Care Directory of Services to ensure in line with GWH and the national specification.	T. Thorn / J. Rayner	COMPLETE
Complete ECIST staffing review for senior decision makers in ED.	C. MacGregor	ON HOLD
Open fit2sit 08:00 – 00:00 following PDSA.	T. Thorn/ C. Irwin-Porter	COMPLETE
Share learning from practitioner in charge PDSA and monitor impact on 4-hour performance.	J. Rayner / T. Thorn	COMPLETE

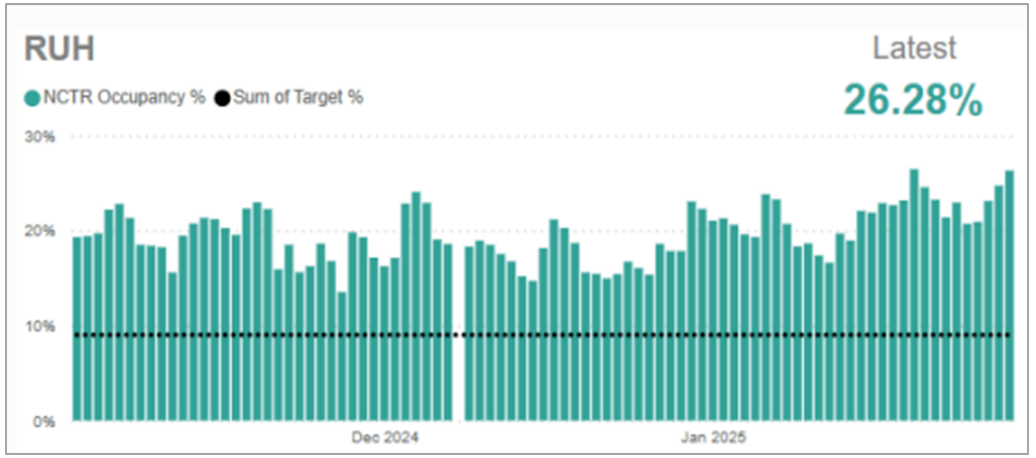
Is this a Key Standard?| Non-criteria To Reside:

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

Historic Data: as of 30/01/25



Supporting data



Is the standard being delivered?
The daily average target for NCTR patients at the RUH is 65.5 Patients per day across Community (pathways 1-3) & Hospital (majority of pathway 0 patients). During January , the Trust had an average of 102 patients waiting who had no criteria to reside, which is 15.7 higher than the previous month. This remains above the system refreshed target of 55.

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

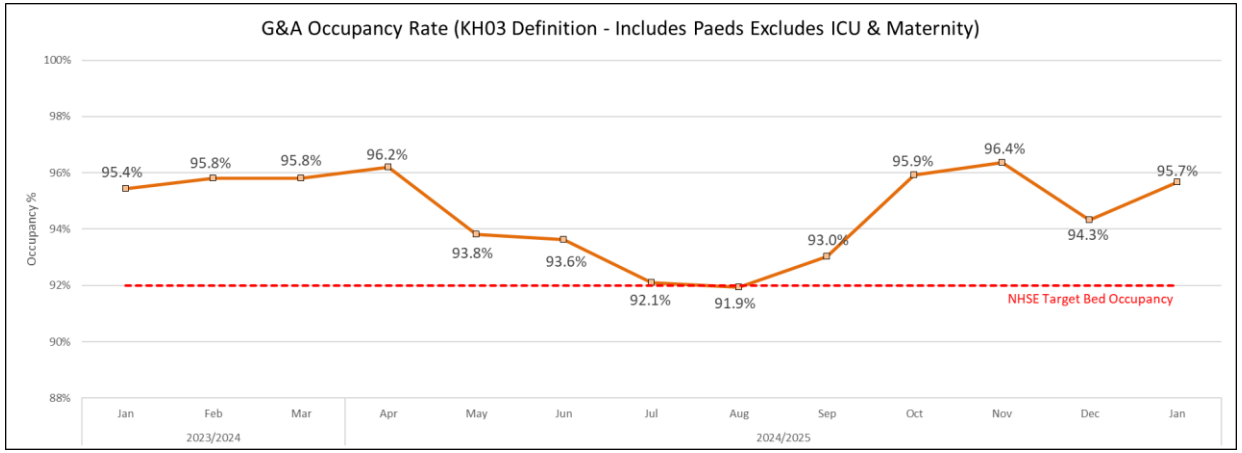
- In January 25, the daily average increased to 102 not achieving target and remains off course to achieving the trajectory of Decembers average rate at 60. or below (set in April 24) by the end of March 2025 as required.
- Key challenges remain
- P1 home based rehabilitation
- P2 bed-based rehabilitation
- Waiting for pathway confirmation.
- Lack of required funding at system level to sufficiently fund Pathway 1 leading to capacity gaps and subsequent discharge delays.
- Ongoing workforce challenges/gaps for pathway 1 providers reducing capacity.
- Lack of required LOS reduction in pathway 2 beds reducing capacity.

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

Key Standards | Bed Occupancy:

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

Historic Data:



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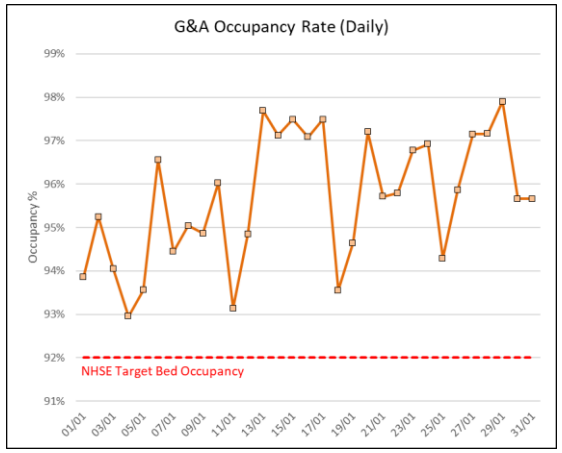
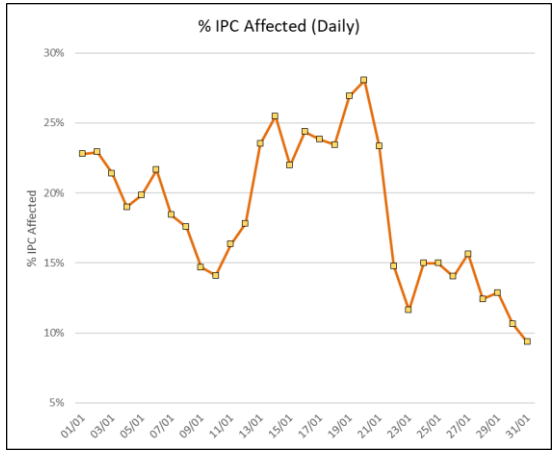




Is the standard being delivered?

NHS England target as described in the Urgent and Emergency Care Recovery Plan indicates that bed occupancy should be **92%**. For January 2025, the Trust's bed occupancy was **96.38.%**, an increase of 1.98% compared to December 2024.

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

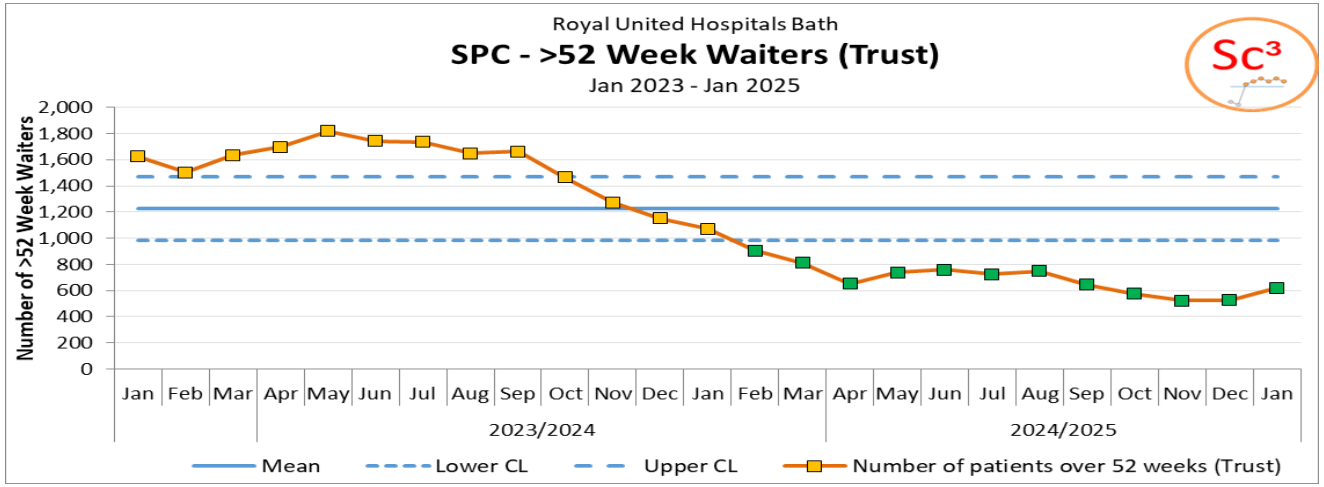
- In month up to 15% of the bed base affected with IPC restrictions.
- Discharge lounge underutilised which exacerbates the number of patients that can be discharged by midday.
    - The discharges before midday in December was 24.1% this increased from 22% in January .
    - A increase of patient leaving after 1700 from 67% in November to 69% in December
    - 10% average increase Discharge Lounge occupancy from August-December
- 33.8% of patients seen through an SDEC pathway in January 2025 .

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

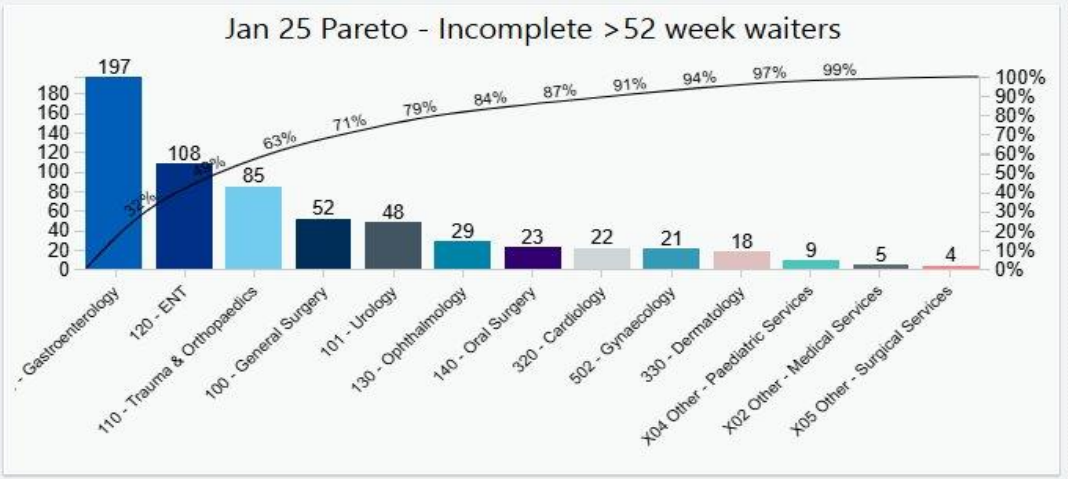
Trust Goal | Referral to Treatment:

Performance Target:
No patients waiting greater than 52 weeks by March 25.

Historic Data:



Supporting Data: - *Pareto 52+ by Specialty*



Is the standard being delivered?

- In Jan 2025, the Trust had 621 patients waiting **> 52 weeks**, an increase of 18% on December.
- For waiters **> 65 weeks**, the Trust saw a decrease in January from 15 to 9 patients.
- There were 3 patients waiting **> 78 weeks** at the end of January (3x Ophthalmology)
- RTT performance was 60.2% in January (-1.2%)
- For waiters over 52 weeks, the three largest specialties combined represent two thirds of the waiters. These are Gastroenterology, ENT and Trauma & Orthopaedics.
- Gastroenterology continued to increase in January, from 119 patients waiting up to 197
- ENT saw a decrease from 124 patients waiting >52 weeks in December to 108 patients waiting >52 weeks at the end of January
- T&O increased in January with 85 patients waiting >52 weeks, up from 69 in December

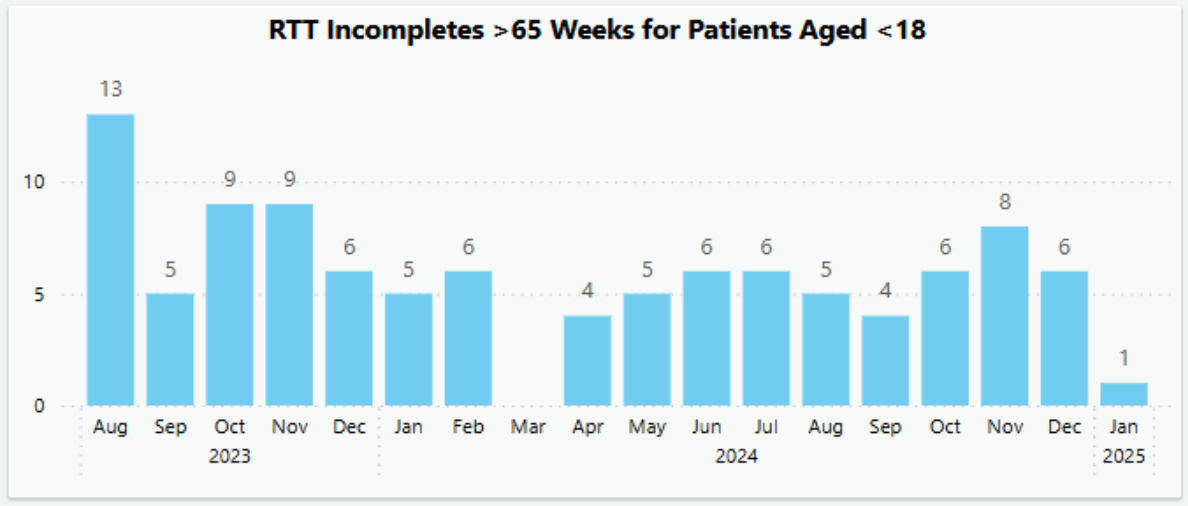
What's the top contributor for under/over achievement?

- Gastro – support from independent provider approved – 25 patients per week being transferred
- ENT – review of medical staff continues – locum approved but suitable candidate now not available
- Paediatric T&O waits reducing –locum started in January – wait to first appointment now c. 35 weeks

Countermeasures / Actions	Owner	Due Date
Review of medical staff with option for locum in ENT.	Schram	Jan 25
Continue 3 x weekly long waiter PTLs for "challenged" specialties to meet 65 weeks by end of Sept 24 – currently Gastro, T&O, Gen Surg, ENT.	Dando	End of Q3 24/25
Ensuring SEOC capacity is maximised for all suitable patients in Orthopaedics	Prosser	Feb 25
Validation "deep dive" into challenged specialties to obtain learning for specialties and drive process improvements.	Dando	Ongoing

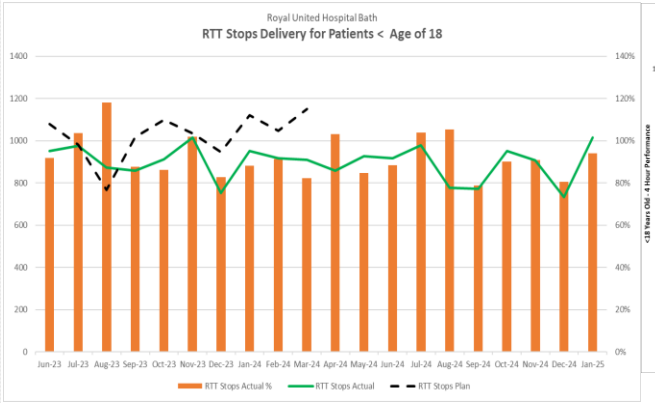
Trust Goal | Paediatrics:

Historic Data:

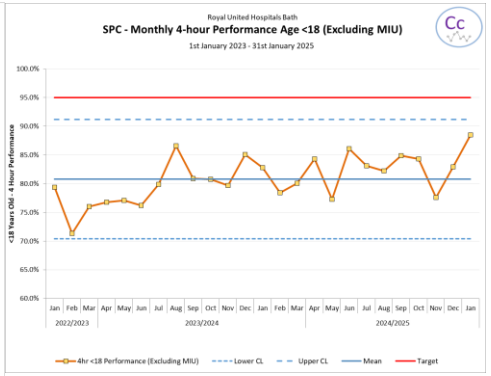


Supporting Data:

Stops v Plan



4 hr performance



Is the standard being delivered?

- RTT non-compliant – In January we reported 0 patients <age of 18 waiting **>78 weeks**. We reported 1 patient waiting over 65 weeks in Paediatrics

- Cancer 28 Day Diagnosis compliant – 85.7% (one breach). Patient was managed by the breast team, breaching due to the waiting time for imaging. They were diagnosed non-cancer.

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

Paediatric Orthopaedic Locum started in January and waits to first appointment are reducing.

Countermeasures / Actions	Owner	Due Date
Locum capacity to reduce waits to first appt in Paediatric T&O	Prosser	March 25
CED/PAU - working together to improve 4hrs - Ambulatory paediatrics pilot – launching end of October, (increase PAU capacity). - Plan to pilot surgical electives in PAU.	Gilby / Potter/ Goodwin	End of Jan 24
CAMHS pathway – new low risk pathway to expedite CAMHS discharge process. Awaiting sign-off by consultant psychiatrist.	Goodwin	In progress

Key Standards | Elective Recovery:

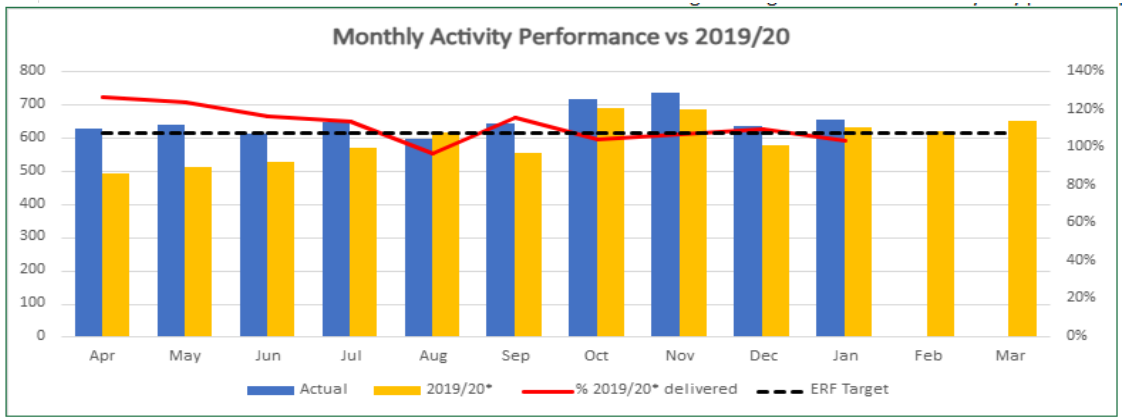
Performance Target:
Deliver 109% of elective activity compared to 2019/20.

ERF Performance:

	Vs 19-20										
Division	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	YTD
FASS	153%	161%	150%	153%	143%	144%	149%	137%	145%	127%	**146%**
Medicine	155%	151%	157%	148%	143%	142%	142%	141%	143%	127%	**145%**
Surgery	124%	114%	105%	114%	123%	109%	122%	112%	117%	107%	**115%**
Total	**137%**	**132%**	**127%**	**130%**	**133%**	**124%**	**132%**	**124%**	**130%**	**116%**	**128%**

	Vs 24-25										
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	YTD
FASS	111%	115%	113%	110%	99%	107%	116%	114%	116%	109%	**111%**
Medicine	109%	116%	117%	106%	106%	108%	110%	109%	101%	101%	**108%**
Surgery	116%	110%	103%	104%	106%	101%	114%	112%	102%	103%	**107%**
Total	**113%**	**113%**	**109%**	**106%**	**104%**	**105%**	**113%**	**112%**	**105%**	**104%**	**108%**

Supporting Data: - ERF Activity Delivery



Key areas of variance this month within each Division is as follows:
Month 10 ERF position for the trust was a decrease from Month 9 driven in part by cancellations due to increased urgent & emergency care demand. Performance in month generated £322k over delivery against plan but was £233k below forecast.
Key variances are as follows:
FASS
The Division delivered 127% of 19/20 and 109% of 24/25 plan
- EL income in **Breast Surgery** is under plan in month
- Income for **Gynae** was £67k than forecast across both DC and EL in part driven by the loss of bed capacity to non-elective pressures
- Income in **Oncology** has continued to increase
- Medicine

The Division delivered 127% of 19/20 and 101% of 24/25 plan
- **Dermatology** outpatient attendances and procedures benefited from a £38k increase in coding of OP procedures.
- **Gastro** income also saw a further big reduction of £131k from reduced Gastro DC due to a gap in insourcing following the planned scale of transfer of activity to Sulis not going ahead.
- **Gastro** news are below plan

Surgery
The Division delivered 107% of 19/20 and 103% 24/25 plan
ENT and **T&O** continued to under-deliver in January in part driven by increased emergency and urgent demand as well as theatre cancellations.
Ophthalmology continues to underperform against plan– locum starting March 25
OMFS and **Urology** saw increases in month across all settings contributing to Surgery's over performance in month
General Surgery were £76k below forecast due to underperformance in elective inpatient

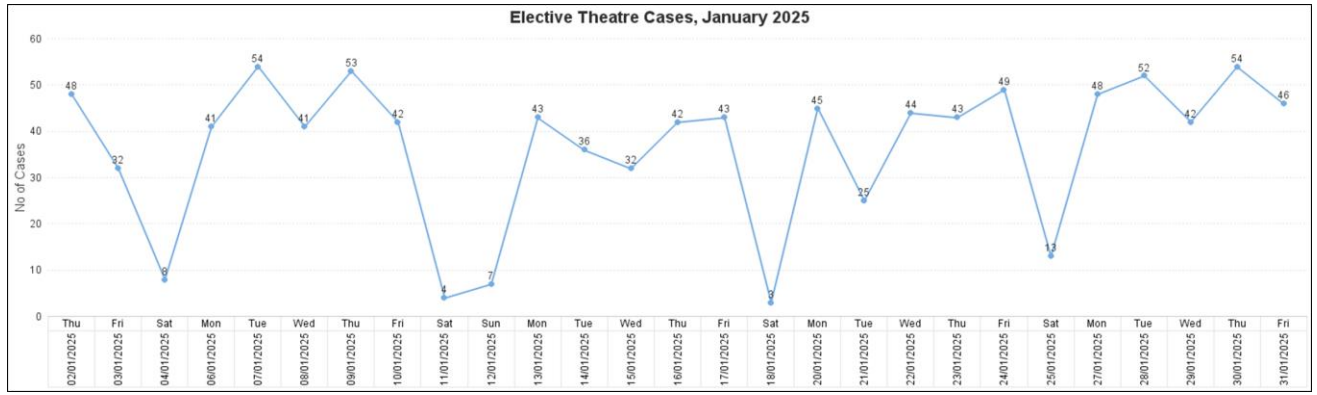
Is the standard being delivered?

M10 delivered 106 of 2019/20 ERF activity overall and 100% of the Trust of our planned activity volumes. Year to date we have delivered 112% against 2019/20 and 100% of plan. There have been opportunities identified to ensure we are securing the income for all the procedures completed in outpatient appointments, which generated £717k additional income across divisions. The Trust has delivered financial performance year-to-date of 128% of 19/20 and 108% of our 24/25 plan, in ERF.

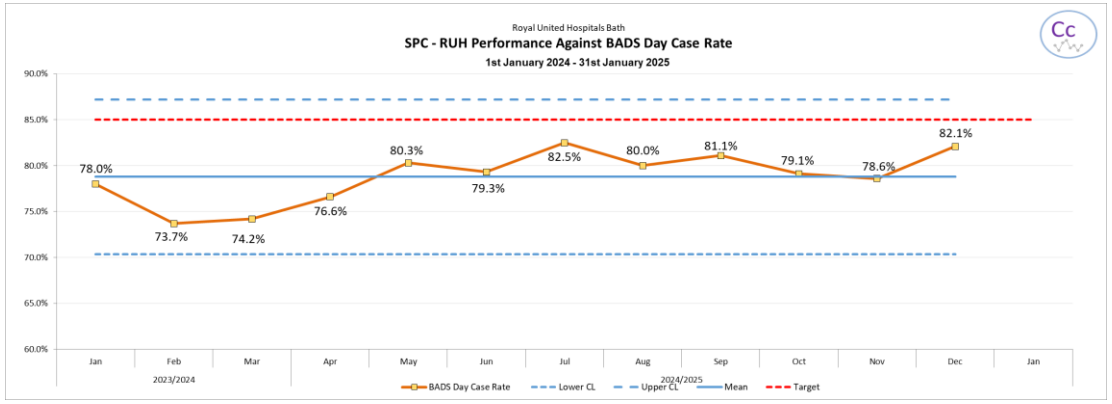
Countermeasures / Actions	Owner	Due Date
Transformation workstreams focused on supporting increased activity within Theatres and Outpatients. Extending to endoscopy/ Cath labs.	Divisions	Through Q1-Q3 24/25
Clinic Templates are being reviewed. In some specialities however there is an ongoing need to balance the NEW patient activity, for which we receive income, with any clinical risks in overdue follow-ups. Clinical Divisions are working to support clinical and administrative validation of follow/ups.	Divisions/ Improvement tea m	Q2-3 24/25
Meeting with Coding to form action plan to catch up on coding backlog. Update: Clinical Coding is improving though there are still some delays in clinical coding.	Wisher-Davies	Q4 24/25

Key Standards | Productivity:

Historic Data:



Supporting Data:



Is the standard being delivered?

- The RUH aims to book to 85% of lists available minutes (to allow for turnaround time), in January theatres were booked to 82.2% - this is continuing to improve and with reduced late changes and increased focus remains a key target
- The Capped utilisation in January was 75.9%, (target 85%).
- The British Association of Day case Rates (BADs) was 86.5% (unvalidated), against the 85% National Target. The RUH remains amongst top performer in region for day case rates

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

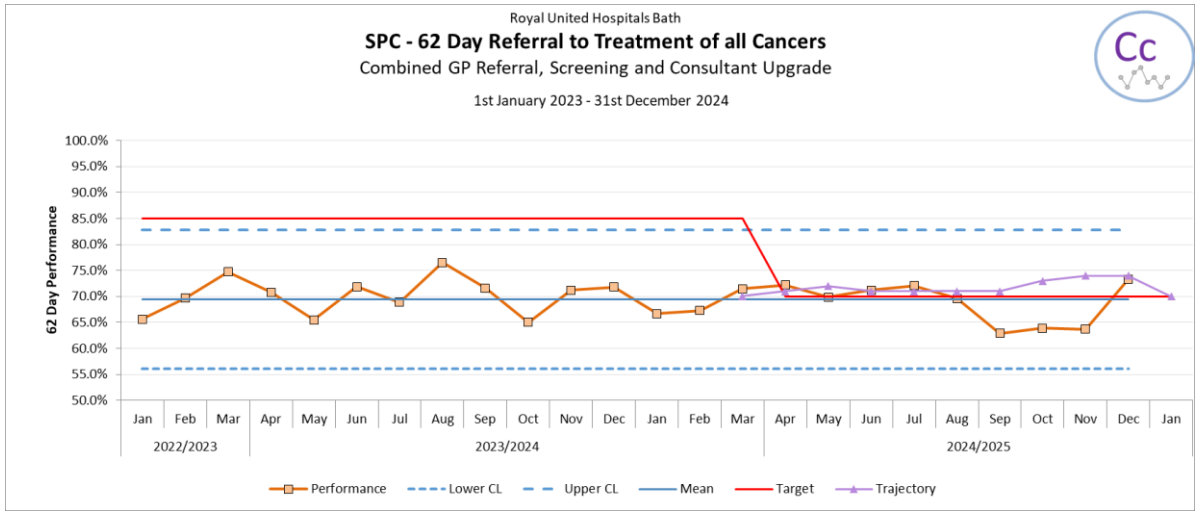
- In January, site pressures meant the Elective Orthopaedic ward was not available, resulting in significant lost activity .
- Elective cancellations on the day were 85, the biggest contributing factors being list overrun and staffing sickness.
- The Improvement Team continue to support theatre efficiency projects with focus on elective bookings and wider theatre efficiency measures, including late starts, turnaround time.
- The total number of additional High-Volume Low Complexity (HVLC) cases completed in January was 29 against a target of 37. YTD we have achieved 405 additional cases and £900k of additional income, £73k above YTD plan.

Countermeasures / Actions	Owner	Due Date
Theatre productivity is being incorporated into the "Improving Together" work across all theatre locations By reducing downtime and start delays - this will drive Capped utilisation improvements	B Baiju	Q1 25/26
BADs day case rates continue to be good and improvements will continue through 25/26 focusing on reaching 90%	R Edwards	Q1-Q4 25/26
Review/refresh of booking and procedure times to ensure lists booked more accurately. Additional cases being booked regularly to HVLC cataract lists now in place	J Price	Q4 24/25
Development of speciality specific productivity dashboard to become breakthrough objective for each speciality	S Williams	Q3 24/25
NHSE Theatre Improvement recommendations being incorporated into List Management and Booking. List booking being targeted to be at least 85% with this being achieved across all theatres	J Price/A Dougherty	Q3 24/25

Key Standards | Cancer 62 Days:

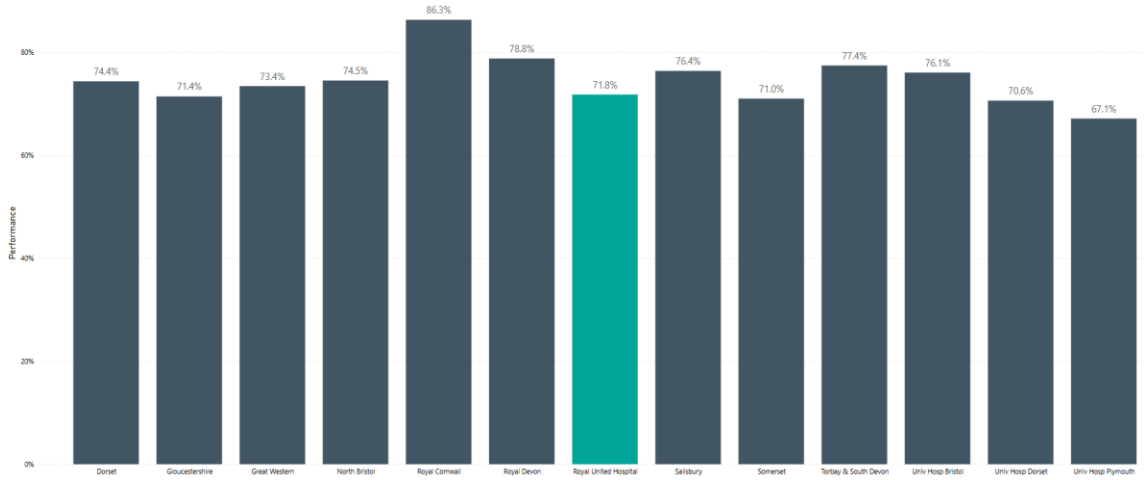
Performance Target: 70% of patients treated within 62 days of referral on a cancer pathway.

Historic Data



Supporting data

Regional 62 Day Combined RTT Comparison



Is the standard being delivered?

December recovered, achieving above national target and on trajectory at 71.8%.

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

62 Day Treated:

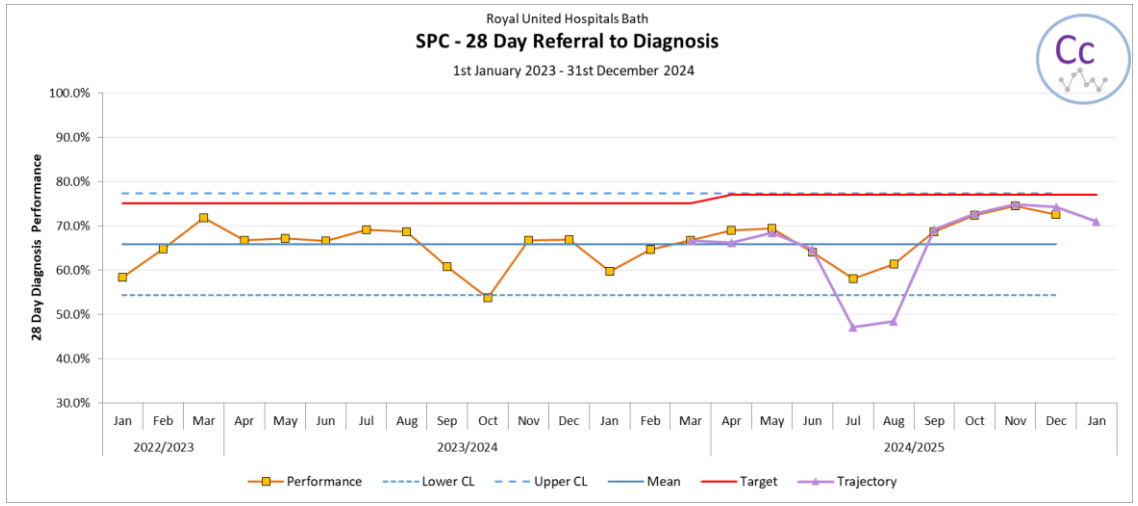
- Breast improvement in position as planned in specialty recovery trajectory following performance challenges over summer as a result of increased diagnoses and long term sickness of surgeon.
- Locum surgeon commencing in February to provide OPA and surgery capacity to further improve position.
- In Colorectal endoscopy waiting times in early autumn were a factor in breaches in December – now improved for simple colonoscopy through additional capacity provided at Sulis.
- Waiting times for surgical OPA and surgery also contributed to breaches. WLIs in place for OPA (2 clinics p/m) and theatre third sessions (6-7 operations p/m).
- Lung performance was challenged with breaches due to small delays for OPA, PET and CT biopsy.
- Diagnostic capacity required to deliver pathway being quantified and considered in 2025/26 business planning – to mitigate impact from lung cancer screening referrals and diagnoses.
- Upper GI breaches were due to complex patient pathways with all requiring MDT discussion and/or OPA and treatment at other Trusts.
- Urology recovered performance in December. This was delivered through a reduction in LATP waiting time three weeks through WLIs and insourcing in December and January. Above target performance expected from February once total LATP backlog cleared. Long term nursing staffing resource deficit remains.
- LATP insourcing also releasing theatre capacity for non-prostate patients in January.

Countermeasures / Actions	Owner	Due Date
Breast – Agency locum appointed, commencing beginning February – to cover long term consultant surgeon sickness	H Wheeler	Feb 2025
Colorectal – Gastro locum appointed, commencing beginning February – to cover 2x vacancies	R Wilson	Feb 2025
Colorectal – Surgical OPA and third session theatre lists in place every month to maintain waiting times	N Lepak	Feb 2025
Lung - Radiology reviewing consultant workload allocation to help create additional CT biopsy capacity	N Aguiar	Mar 2025
Urology – Long term nursing plan to support LATP service. Being raised through business planning	K Rye	Mar 2025
Trust-wide – Demand, capacity resource required to deliver timed pathways and performance	Specialty Managers	Feb 2025

Key Standards | Cancer 28 Days:

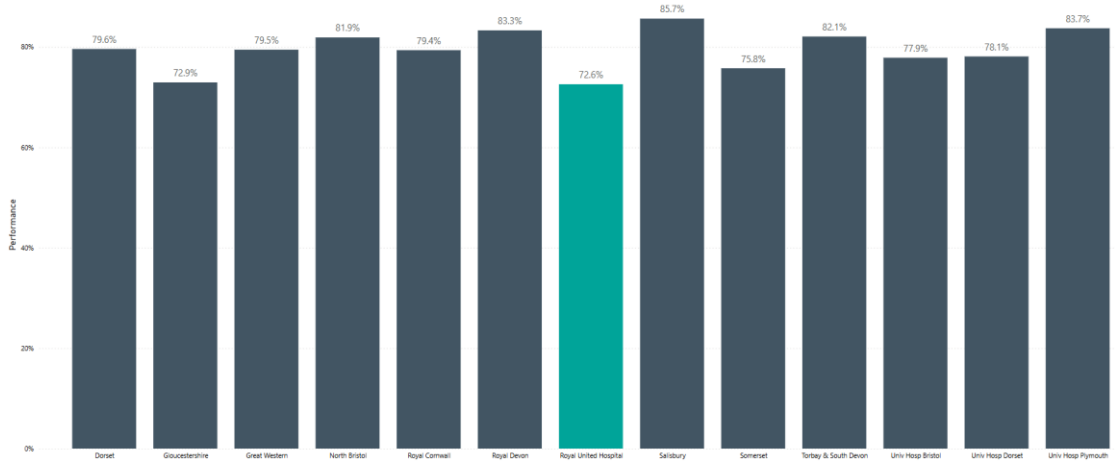
Performance Target: 77% of patients given their diagnosis within 28 days of referral.

Historic Data



Supporting data

28 Day FDS Regional Comparison



Is the standard being delivered?

- December performance improved further achieving 72.6%, above the 70% tiering threshold for third consecutive month. RUH remains in NHSE tier 2.

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

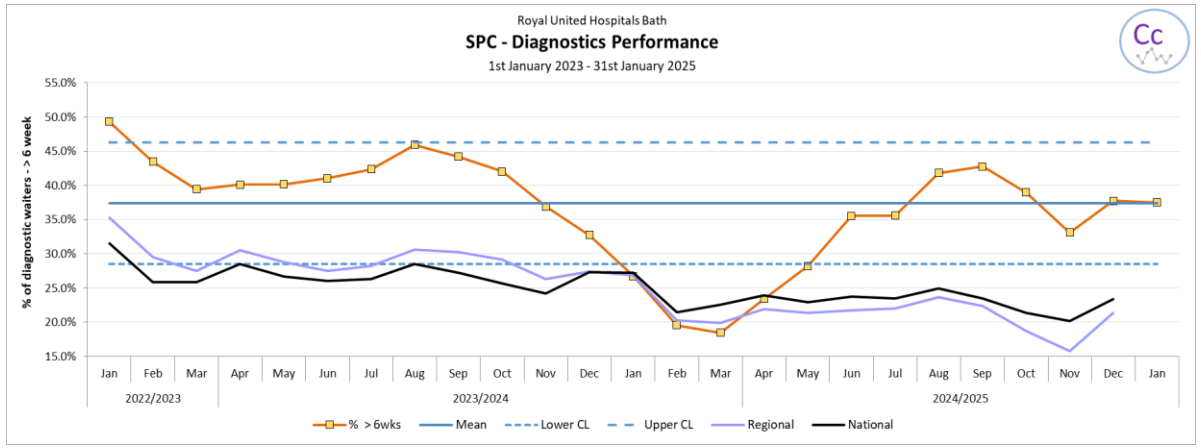
- Breast performance improved slightly with imaging WLIs in place in December but remained under target due to staffing sickness in the surgeon and radiology workforce. The service was supported by NBT releasing two sessions of RUH radiologist time from the screening service.
- Locum outpatient consultant contract ended by specialty, replacement recruited commencing February.
- One-stop clinic to go live in March with further pilot clinics run in January and February.
- In Colorectal breaches were recorded due to the outpatient waiting time in Gastro for IDA patients which remains approx. 4 weeks. A locum consultant has been appointed, commencing in February.
- Medilogic went live which will improve performance from mid-January onwards with greater clarity on clock stops.
- Some impact on performance expected in January/February due to colonoscopy service provision issues at Sulis which increased the waiting time. This was mitigated with increased weekend insourcing at RUH.
- Gynaecology performance was impacted by the histology waiting time. This is improving with increased outsourcing, reducing from a high of 8-10 weeks to 3 weeks by February.
- In Urology the LATP waiting time contributed to breaches. This has been improved from late December through WLIs and insourcing with performance improvement from January. Long term nursing resource requirement is being identified through business planning.
- Breaches were also recorded due to haematuria patients undergoing CT IVU. Recent GIRFT guidance on use of CT IVU being reviewed which may significantly reduce demand and reduce breaches from late Q4.

Countermeasures / Actions	Owner	Due Date
Breast – One-stop pilot days Q3/4. Go live delayed until March due to staff sickness/training of HCAs	H Wheeler M Jarvis	Mar 2025
Breast – Locum consultant surgeon appointed starting in February	H Wheeler	Feb 2025
Colorectal – IDA pathway – reviewing capacity required for Colorectal nurse team to manage pathway and how resource can be provided	R Wilson N Lepak	Mar 2025
Colorectal – Locum consultant gastroenterologist appointed, starting in February	R Wilson	Feb 2025
Pathology – SWAG funding bid submitted to extend locum consultant until end of March	L Edwards	Mar 2025
Urology – Review/implement GIRFT CTIVU guidance	J McFarlane	Mar 2025

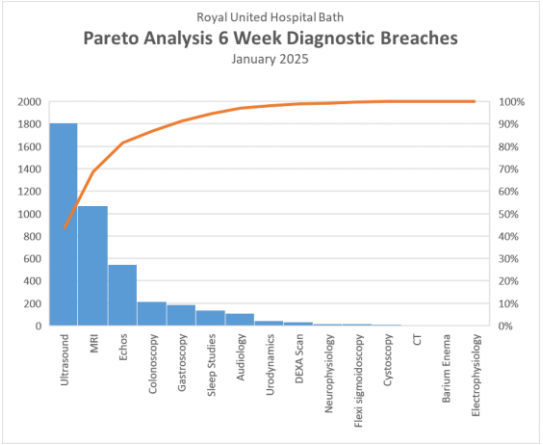
Key Standards | Diagnostics 6 Weeks:

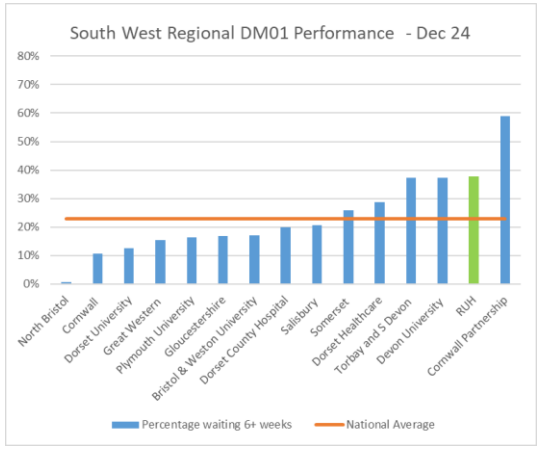
Performance target: No more than 5% of patients waiting over 6 weeks for their diagnostic test.

Historic Data



Supporting data





Is the standard being delivered?

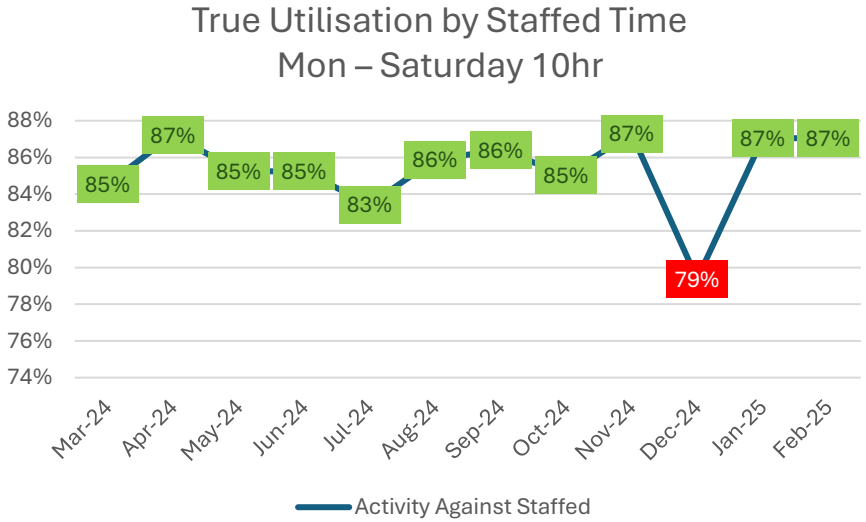
In January 2025, **62.50%** of patients received their diagnostic within the 6-week target against an in-month target of 77.97% and year-end target of 95% (revised trajectory October 2024). The number of patients waiting > 6 weeks decreased by **23 breaches** when compared to previous month, despite delivering 2,061 additional diagnostics tests across all modalities. Increased demand for urgent and suspected cancer continues to impact on available capacity for routine diagnostics, despite increased activity levels in January.

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

- Top contributors for breaches: MRI, USS and Echo.
  - Ongoing staffing issues for USS, being mitigated with weekend insourcing and additional WLI's.
  - Capacity challenges with mobile Endoscopy Unit at CDC.
  - Echo additional activity delayed due to staff engagement (positive impact already being seen in February's position).
  - Delay in transferring Sleep Studies referrals to Sulis CDC due to clinical reasons – discussions ongoing re: remaining >6 weeks backlog.
- Mitigation against current underperformance for the rest of Q4:
  - 13 additional USS WLI lists, above plan (+260 scans).
  - 2 additional weekend USS lists (insourcing), above plan (+70 scans).
  - 9 additional MRI WLI lists, above plan (+ 126 scans).

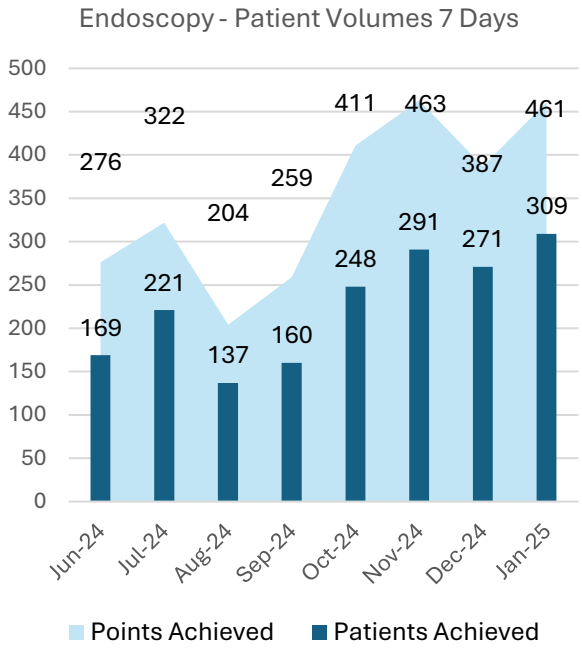
Countermeasures / Actions	Owner	Due Date
Sustain and increase radiology activity at Sulis CDC (additional 150 CT/MRI diagnostics) - monitored weekly. Review of plans for direct access to CDC for GP's and CDC reporting DM01 for activity delivered.	NA / PN / MC	Ongoing
WLI rates approved – to support increased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

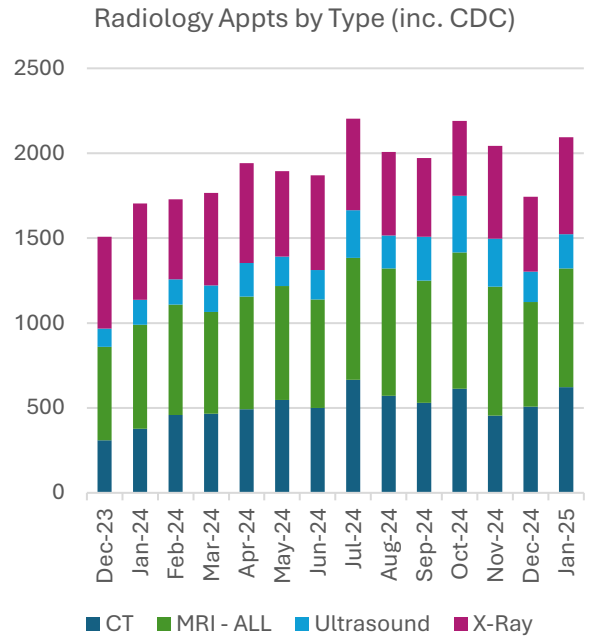
Key Standards | Sulis Hospital



RTT: **74%**

Weeks	PT QTY
78+	3
65+	9
42-65	67
19-42	682
0-18	2202





Is the standard being delivered?

- **Theatre** – Session up-take still performing lower than standard at 81%. The team are reviewing options to increase up-take. Staffed utilisation is consistent at 87%, performing above our 85% target.
- **Radiology** volumes were up MoM 20%. The decline in Private activity continues to impact but CDC and NHS work is performing well against plan.
- **Endoscopy** volumes over performing against plan for suite. Activity against staffed time is at 89%. **Endoscopy Van** Ongoing risks with the mobile van capacity limit capacity. Volumes down against squeezed capacity. Operational plan in place to ensure squeezed capacity is met.
- **RTT position** at 74%. Number of longer waiters are down to supporting. Majority have plans in place for end of March. 12 of 15 patients are results of IPT support programmes.

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

- Consultant availability was limited with theatre activity. Work required to improve up-take is underway.
- Endoscopy triage and booking process limiting throughput of activity, but a plan has been established to mitigate.

Countermeasures / Actions	Owner	Due Date
Review performance and operational model of van to increase activity	Milner	Ongoing
Ensure 65+ week breach position is achieved to maintain patient care in line with national standard.	Milner / Harrison	March
Review SLA agreement for Medicine division to improve staffing provision and understanding of capacity and demand between partners.	Milner/ MacGregor	March
Complete planning profile for 2025/26 for Sulis, SEOC and CDC	Milner/ Partners	February

Trust Integrated Balanced Scorecard - January 2025

Royal United Hospitals Bath NHS
NHS Foundation Trust

Strategic Goal		Goal Description	Performance Indicator	Measure description	Target		Baseline	2023/2024			2024/2025									
					Performing	Under Performing		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
People Group Goals (5yr ambition, annual measure)	People we care for	Together we will support you, as when you need us most	To achieve 'much better than expected' score and best in class for our region	Annual CQC IP survey	8.5	7.8	8.2	-	-	-	-	-	-	-	-	-	-	-	-	-
	People we work with	Together we will create the conditions to perform at our best	% Recommend RUH as a place to work		>=70%	<62%	62%	-	59.0%	-	-	53.0%	-	50.1%	-	-	-	-	-	-
	People in our community	Together we will create one of the healthiest places to live	RUH Social Impact Score?					-	-	-	-	-	-	-	-	-	-	-	-	-
Trust Goals (monthly or quarterly measure)	People we care for	Consistently delivering the highest quality healthcare and outcomes	Number of patients over 65 weeks	Ensure no patient waits over 65 weeks for treatment by December 2023	Target is 0 by March - trajectory being agreed during business planning			256	193	39	33	41	56	36	42	26	22	18	15	9
		Communicating well, listening and active on what matters to you	% of positive responses to friends and family test					93.9%	94.0%	93.6%	93.9%	93.7%	93.2%	94.7%	93.9%	93.8%	93.6%	92.9%	95.1%	94.4%
	People we work with	Demonstrating our shared values with kindness, civility and respect	% Recommend RUH as a place to work		>=70%	<62%	62%	-	59.0%	-	-	53.0%	-	50.1%	-	-	-	-	-	-
		Taking care of and investing in teams, training and facilities	% staff say the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age					-	57.1%	-	-	57.0%	-	50.1%	-	-	-	-	-	-
	People in our community	Working with partners to make the most of our shared resources and plan wisely for future needs	Delivery of Breakeven Position	Variance from Plan YTD (£'000)	>=0	<0		-5545	-6130	1665	527	192	-1086	-817	976	1744	1380	-6901	-5521	-2993
		Taking positive action to reduce health inequalities	Equity of access to the RUH for all					-	-	-	-	-	-	-	-	-	-	-	-	-
		Creating a community that promotes the wellbeing of our people and enviornment	Carbon emission reduction	Monthly proxy measure - % carbon footprint reduction of electricity & gas, against 20/21 carbon footprint	<=0%	>0%		-	-	-	-	-	-	-	-	-	-	-	-	-
Breakthrough Goals	People we work with		% staff reporting they have personally experienced discrimination at work from manager, team leader or other colleagues					-	13.7%	-	-	14.0%	-	16.7%	-	-	-	-	-	-
			We improve together	Number of teams that are regularly holding improvement huddles (out of 128 frontline teams)	>=115 (90%)	<115 (90%)		69	-	-	57	-	-	72	-	-	84	-	-	112
	People we care for		Why not home, why not today	Average Length of Stay for Emergency Admissions (days)	<=8.4	>8.4		8.7	9.1	8.6	9.5	9.1	9.2	8.9	9.2	8.8	9.1	9.0	9.0	9.3
	People in our community		Delivery of financial plan'	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	(£5.03m)	(£6.70m)	£0.01m	£0m	(£0.08m)	(£1.50m)	(£0.61m)	(£0.63m)	(£1.88m)	(£2.11m)	(£4.24m)	(£6.27m)	(£8.96m)

Key Standards

Strategic Goal			Description	Performance Indicator		Target		Baseline	2023/2024			2024/2025									
						Performing	Under Performing		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Key Standards	People in our community			Deliver 109% of 19/20 Elective Activity		>=109%	<109%		112.0%	114.0%	115.0%	130.0%	125.0%	122.0%	122.0%	123.0%	124.0%	128.0%	130.0%	129.0%	128.0%
	People we care for		Improve safety of patients needing unplanned care across the RUH from arrival at ED to discharge	% treated and admitted or discharged within four hours	To ensure 76% of patients can be treated within 4 hours of arrival at ED	>=76%	<76%		66.4%	68.7%	69.8%	68.6%	68.6%	71.6%	71.5%	71.7%	71.7%	68.0%	65.2%	63.6%	68.9%
		L	C Diff Total Healthcare Associated (Hospital & Community) tolerance = 59	Clostridium Difficile Hospital Onset, Healthcare Associated				-	6	9	6	2	8	3	7	3	5	6	3	4	9
		SOF	RTT - Incomplete Pathways in 18 weeks	RTT - Incomplete Pathways in 18 weeks		>=92%	<92%	87.1%	60.4%	62.3%	63.6%	65.4%	66.4%	66.2%	65.5%	64.3%	63.7%	62.8%	62.7%	61.3%	60.2%
		NT	28 day referral to informed of diagnosis of all cancers	28 day referral to informed of diagnosis of all cancers		>=70%	<70%	-	59.7%	64.6%	66.7%	69.0%	69.4%	64.0%	58.0%	61.4%	68.5%	72.6%	72.0%	72.6%	(LAG 1)
		NT	Combined 31 Day Cancer Targets	Combined 31 day cancer targets for first treatment, subsequent surgery, subsequent drug, subsequent radiotherapy and subsequent other treatments; excludes subsequent active monitoring and subsequent palliative care)		>=96%	<96%		90.8%	94.4%	95.8%	91.6%	95.0%	90.6%	94.5%	95.2%	94.2%	92.9%	89.2%	94.7%	(LAG 1)
		SOF	Combined 62 Day Cancer Targets	Combined 62 day cancer targets for GP referral, screening and consultant upgrade		>=75%	<75%		66.5%	67.3%	71.5%	72.2%	70.1%	71.2%	72.1%	69.6%	62.9%	62.6%	63.7%	73.3%	(LAG 1)
		SOF	Diagnostic tests maximum wait of 6 weeks	Diagnostic tests maximum wait of 6 weeks		<=1%	>1%		26.8%	19.6%	18.5%	23.4%	28.2%	35.5%	35.6%	41.8%	42.8%	39.0%	33.1%	37.7%	37.5%

Trust Integrated Balanced Scorecard - January 2025

Royal United Hospitals Bath NHS
NHS Foundation Trust

Strategic Goal			Performance Indicator	Description	Target		Baseline	2023/2024			2024/2025										Trend
					Performing	Under Performing		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Tracker Measures	People we care for	IT	% of complaints responded to within agreed timescales with complainant		>=90%	<90%	-	82.6%	90.9%	92.3%	86.7%	64.5%	73.1%	73.1%	87.5%	75.0%	69.0%	85.7%	61.3%	81.1%	
			Number of complaints received		<30	>=30		22	39	33	25	25	26	38	29	32	43	29	27	31	
		IT	Number of reopened complaints each month		<=3	>3	-	3	5	2	1	3	2	8	0	3	1	3	1	1	
			Concerns are acknowledged within 2 working days		>90%	<90%	-	-	-	-	100.0%	98.0%	99.0%	100.0%	99.0%	97.0%	98.0%	99.0%	98.0%	99.0%	
			Complaints acknowledged within 2 working days (target 90%)					-	-	-	-	-	-	-	-	-	-	-	-	-	
			Number of cases referred to the PHSO					-	-	-	-	-	-	-	-	-	-	-	-	-	
		IT	Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	-	3	5	5	3	2	2	2	5	4	7	6	8	6	
		IT	ED time to triage	Percentage of ED attendances triaged within 15 minutes			-	53.1%	48.8%	49.2%	47.1%	44.7%	55.0%	56.3%	62.1%	61.4%	57.4%	55.2%	59.4%	64.8%	
		IT	Medication Incidents per 1000 bed days	All Incidents			-	7.4	7.3	7.2	8.4	6.0	6.5	6.8	5.7	6.1	7.5	8.7	7.7	8.9	
		IT	Number of Patients given medication by scanning device					39.5%	40.6%	41.2%	42.1%	46.3%	46.6%	45.9%	47.0%	46.0%	47.1%	49.1%	49.8%	49.5%	
			Early Identification of Deteriorating Patient					24.5%	25.3%	23.5%	22.4%	26.2%	24.6%	23.8%	24.7%	24.4%	20.6%	21.4%	20.5%	19.5%	
			COVID 8+ Days					45	22	12	37	9	13	34	11	31	32	9	10	9	
		IT	Same Day Emergency Care (SDEC)	Non-elective adult admissions with 0 day LOS, Medicine only.	>=30%	<30%	-	32.4%	32.7%	32.9%	35.3%	33.9%	33.1%	34.1%	30.2%	33.4%	34.7%	32.6%	30.2%	33.3%	
			Ambulance Handover Delays	minutes (below 39 is upper quartile)				810	887	995	1194	938	860	679	681	899	1023	1138	1174	1084	
		IT	Time from arrival in ED to decision to admit	Percentage of majors attendances with DTA within 3 hours of arrival. Excludes non-admitted patients with DTA.	>=80%	<80%	-	52.7%	52.8%	48.0%	51.6%	49.9%	53.4%	52.0%	50.5%	49.4%	50.6%	47.9%	53.1%	58.8%	
		IT	Time from decision to admit in ED to admission	Percentage of majors patients admitted via ED that are admitted within 1 hour of DTA. Excludes non-admitted patients with DTA.	>=50%	<50%	-	24.8%	26.0%	25.8%	22.8%	24.5%	23.7%	29.2%	29.2%	25.6%	21.7%	21.2%	22.5%	21.7%	
			% with Discharge Summaries Completed within 24 Hours					84.3%	84.2%	84.6%	84.3%	83.7%	84.0%	83.2%	84.0%	84.7%	82.2%	84.3%	84.4%	83.7%	
			Non Criteria to Reside (Average per day)					81.9	80.7	86.2	88.0	92.8	93.3	86.9	90.2	85.6	94.6	96.3	87.8	106.5	
			HSMR - Total					99.8	100.4	99.5	97.6	99.0	101.9	100.4	101.6	98.6	96.3	(LAG 3)	(LAG 3)	(LAG 3)	
			HSMR -Weekday					100.4	101.5	99.7	97.4	98.5	102.0	99.3	101.4	98.3	95.7	(LAG 3)	(LAG 3)	(LAG 3)	
			HSMR -Weekend					97.7	96.9	99.0	98.4	100.7	101.6	104.3	102.5	99.5	98.2	(LAG 3)	(LAG 3)	(LAG 3)	
	People we work with	IT	Turnover - Rolling 12 months	Voluntary turnover only	<=11%	>12%		8.7%	8.5%	8.5%	8.2%	8.5%	8.5%	8.6%	8.3%	8.2%	8.3%	8.2%	8.4%	8.4%	
		IT	Vacancy Rate		<=4%	>5%		1.6%	1.0%	1.4%	5.6%	5.2%	2.9%	6.1%	4.1%	5.0%	2.9%	3.8%	4.4%	5.6%	
		IT	Sickness Rate	Rolling 12 months	<=3.5%	>4.5%		4.9%	4.8%	4.6%	4.4%	4.4%	4.9%	4.6%	4.4%	4.6%	5.2%	4.6%	5.0%	(LAG 1)	
		IT	Mandatory Training Compliance		>=90%	<80%		90.3%	90.8%	90.4%	90.3%	90.1%	90.0%	88.7%	89.0%	88.2%	88.4%	88.6%	88.6%	88.7%	
			% Staff with annual appraisal		>=80%	<80%		75.8	77.0	77.1	77.7	77.7	78.9	78.5	82.8	82.8	80.2	80.9	80.9	80.8	
	People in our community		Health Inequalities 1	% Difference in DNA rates between IMD1-2 and IMD 9-10				3.9%	5.4%	4.1%	4.4%	3.7%	3.0%	3.5%	3.9%	3.6%	3.6%	3.9%	4.1%	4.4%	
			Health Inequalities 2	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD9-10				8.1%	0.5%	12.0%	5.7%	4.2%	12.5%	0.2%	5.2%	2.3%	6.8%	9.6%	8.9%	4.3%	
		IT	Sustainable Development Assessment Tool (SDAT) Score	Overarching measurement across all sustainability areas	>=44%	<44%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
		IT	Delivery of Financial Control Total - Variance from Revised Plan (£'000)	Under/Overspent, YTD	<=0	>0	-	-6438	-6807	3986	308	526	-537	-185	1086	579	835	-7565	-11704	-10569	
		IT	Forecast Delivery of Financial Control Total at end of financial year		<=0	>0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
		IT	Delivery of Recurrent Finance Improvement Programme (£'000)	Variance from year to date planned recurrent QIPP	>=0	<0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
		IT	Forecast Delivery of Recurrent Finance Improvement Programme at end of financial year	Forecast variance from annual planned recurrent QIPP			-	-	-	-	-	-	-	-	-	-	-	-	-	-	
		IT	Reduction in Agency Expenditure	Agency costs as a % of total pay costs	< 19/20 %	> 19/20 %	-	2.7%	2.7%	2.5%	1.2%	1.2%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	
			% activity delivered off site (virtual and community)					22.8%	21.8%	22.1%	22.1%	22.3%	22.0%	21.6%	21.4%	21.4%	21.4%	21.6%	21.2%	21.8%	

Strategic Goal			Performance Indicator	Description	Target		Baseline	2023/2024			2024/2025									Trend
					Performing	Under Performing		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Other Measures	People We Work With		Total monthly fill rate, day hours, RN	Average per ward	>=90%	<90%		79.9%	75.0%	82.3%	84.4%	86.3%	85.9%	87.7%	88.0%	87.1%	88.1%	90.6%	91.3%	91.6%	
			Total monthly fill rate, day hours, HCA	Average per ward	>=90%	<90%		75.1%	78.4%	77.3%	77.3%	84.2%	84.7%	84.1%	83.2%	82.8%	86.3%	85.3%	85.1%	90.4%	
			Total monthly fill rate, night hours, RN	Average per ward	>=90%	<90%		92.7%	92.0%	93.5%	93.4%	93.1%	94.7%	95.9%	94.5%	93.9%	95.4%	94.5%	96.4%	98.3%	
			Total monthly fill rate, night hours, HCA	Average per ward	>=90%	<90%		83.8%	85.6%	85.4%	87.9%	88.8%	92.5%	92.5%	92.0%	103.6%	96.4%	97.6%	91.1%	104.4%	
			Information Governance Training Compliance		>=80%	<80%		87.6%	88.4%	87.7%	88.5%	86.8%	86.0%	85.2%	87.9%	86.3%	86.2%	86.7%	86.6%	86.5%	
	People we care for	NR	Hip fractures operated on within 36 hours		>=80%	<=70%		67%	53.2%	46.9%	66.0%	39.6%	69.2%	51.4%	66.7%	72.7%	81.0%	74.5%	80.4%	85.7%	
		NR	Time to Initial Assessment - 95th Percentile					104	102	106	154	120	79	42	34	28	29	33	32	30	
		NR	% of mothers booked within 12 completed weeks		>=90%	<=85%		85.0%	88.8%	87.4%	87.0%	86.3%	85.6%	84.3%	81.2%	84.6%	81.9%	82.8%	83.2%	83.5%	
		NR	% Women identified as smokers referred to specialist stop smoking service		>=90%	<=80%		100.0%	100.0%	93.1%	89.3%	94.7%	95.0%	100.0%	100.0%	85.7%	95.2%	100.0%	100.0%	100.0%	
		NR	Midwife to Birth Ratio		<=1:27	>1:32		1:27	1:29	1:27	1:27	1:29	1:28	1:28	1:28	1:31	1:30	1:27	1:26	1:28	
		NT	TIA Treated within 24 hours		>=60%	<=55%		44.2%	41.7%	21.2%	19.0%	20.8%	49.0%	28.3%	42.9%	37.0%	41.0%	41.9%	19.6%	12.5%	
		NT	12 Hour Breaches		0	>0		21	24	16	39	4	19	5	15	54	123	131	142	204	
		LC	Number of medical outliers - median		<=25	>=30		9	16	11	10.5	6	3	4	9	9	13	14	10	16	
		L	Readmissions - Total		<=10.5%	>12.5%		7.4%	7.6%	7.9%	7.9%	8.0%	7.8%	8.7%	7.7%	7.6%	7.8%	7.7%	8.3%	8.6%	
		L	Discharges by Midday (excluding Maternity)	Includes transfers to the Discharge Hub	>=45%	<45%		22.6%	21.9%	22.6%	23.3%	22.5%	22.5%	23.6%	21.6%	22.5%	25.6%	26.7%	21.7%	23.9%	
		NT	Number of 52 Week Waiters Incomplete Pathways					1072	905	813	650	737	760	725	748	645	576	524	527	621	
		L	GP Direct Admits to SAU		>=168	<168		237	243	249	218	259	211	256	228	205	233	264	302	360	
		L	GP Direct Admits to MAU (including DAA)		>=84	<84		328	269	353	289	305	286	329	323	277	281	293	258	227	
		NR	Bed occupancy (Adult)		<=93%	>97%		96.6%	96.9%	96.7%	97.5%	95.0%	95.0%	93.8%	94.1%	94.6%	96.9%	97.2%	95.6%	97.2%	
		NR	% Cancelled Operations non-clinical (number of cancelled patients) Surgical		<=1%	>1%		1.2% (43)	1.3% (46)	0.6% (24)	0.9% (33)	1.2% (44)	1.1% (37)	0.9% (33)	1.6% (53)	1.1% (36)	0.9% (33)	1.2% (43)	1.1% (35)	1.3% (45)	
		NT	Urgent Operations cancelled for the second time		0	>0		1	1	2	0	0	0	1	1	0	0	0	1	1	
		NT	Cancelled operations not rebooked within 28 days - Surgical		0	>0		0	0	0	0	0	1	0	0	0	0	2	1	0	
		SOF	Clostridium Difficile Community Onset, Healthcare Associated					2	2	3	5	1	1	4	8	7	0	3	3	1	
		SOF	E.coli bacteraemia cases Hospital Onset, Healthcare Associated		<=6	>6		1	4	1	4	4	2	5	2	3	5	5	9	11	
		SOF	E.coli bacteraemia cases Community Onset, Healthcare Associated					5	4	4	5	6	2	4	3	0	1	2	7	3	
		SOF	MRSA Bacteraemias >= 48 hours post admission		0	>=1		0	0	0	0	0	0	0	0	0	0	0	0	0	
		L	Klebsiella spp Hospital Onset, Healthcare Associated		<=2	>2		0	4	1	2	2	0	3	1	1	1	0	0	0	
			Klebsiella Spp Community Onset Healthcare Associated					1	0	2	2	2	1	1	1	1	0	1	0	0	
		L	Pseudomonas aeruginosa Hospital Onset, Healthcare Associated		<=1	>1		4	0	0	1	0	2	0	1	0	0	0	0	1	
			Pseudomonas aeruginosa, Community Onset Healthcare Associated					-	-	-	0	1	2	1	0	0	0	2	0	1	
			MSSA Post 48 Hours					3	6	5	2	0	1	1	2	2	3	1	0	0	
			Flu - Healthcare Onset (+3 days)					-	-	-	2	1	1	0	0	0	0	6	51	8	
			Norovirus Outbreaks					0	1	2	0	0	1	1	0	0	1	0	3	9	
			Number of Hospital Acquired Pressure Ulcers Category 2	Includes Medical Device Related	<=5	>5		3	4	1	1	1	3	2	0	0	4	3	3	2	
			Hospital Acquired Category 3 Pressure Ulcer	Includes Medical Device Related	<=4	>4		0	2	0	1	1	1	0	2	3	3	3	1	2	
			Hospital Acquired Category 4 Pressure Ulcer					0	0	0	0	0	0	0	0	0	0	0	0	0	
		SOF	Never events		0	>=1		0	0	0	0	0	0	2	1	0	0	0	1	0	
		SOF	SHMI		<=Expected	> Expected		0.9506	0.94	0.93	0.93	0.93	0.94	0.95	0.94	0.95	(LAG 4)	(LAG 4)	(LAG 4)	(LAG 4)	
			Mixed Sex Accomodation Breaches					163	170	182	170	221	191	154	186	160	237	244	246	263	
	People In Our Community	L	Delivery of Group financial plan	Variance from year to date plan	<=0	>0		(£5.03m)	(£6.70m)	£0.01m	£0m	(£0.08m)	(£1.50m)	(£0.61m)	(£0.63m)	(£1.88m)	(£2.11m)	(£4.24m)	(£6.27m)	(£8.96m)	
		L	Delivery of capital programme	Variance from year to date planned capital expenditure (Internally Funded Schemes)	-5%	<5%		-57.9%	-33.1%	-0.5%	67.3%	51.9%	69.7%	65.7%	61.8%	51.8%	63.7%	66.2%	63.2%	76.9%	
		L	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+/-5%	><5%		0.0%	0.0%	-0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
		L	Delivery of planned cash balance	Variance from year to date planned cash balance	+/-10%	><10%		-5.1%	-8.6%	-12.8%	8.8%	25.6%	24.5%	38.7%	40.0%	17.4%	64.9%	41.6%	30.2%	16.0%	

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

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**11**
Date of Meeting:	**5 March 2025**		
Title of Report:	**Alert, advise and assure report – Quality Assurance Committee**		
Status	**For Information**		
Author	**Simon Harrod, Non-Executive Director**		

Key discussion points and matters to be escalated from the meeting on 10 February 2025

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

- Flow through the hospital: ambulance handover, Emergency Department overcrowding and non-criteria to reside numbers worsening.

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

- Infection control issue secondary to lack of side rooms. Impacts on flow and risk to patients from hospital acquired infection.
- Hospital cleanliness.
- Adult safeguarding – Q2 2024 – 24 allegations received for investigation. Themes are premature/early discharge, communication and info sharing with partners.

ASSURE: Inform the Board where positive assurance has been achieved

- Antibiotic stewardship: assurance around appropriate AB use and duration of therapy.
- Two changes to manage the structured judgement review (SJR) backlog (275 cases): removing cases where another review process had occurred and removing Coroner's inquest as a reason for a SJR for 2021-23.
- Radiopharmacy - continuous improvement against all quality domains highlighted by 2024 audit. No overdue actions. Accountable pharmacist appointed 06/01/25.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- Safety agenda in Patient Safety Incident Response Framework (PSIRF) - potential capacity issue to facilitate roll out and risk of emerging themes as PSIRF is implemented.
- Recent rise in C. diff (not detailed in the infection, prevention, and control report as report for Q2.
- Rise in clinical letter typing backlog across specialities.

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

- Pressure ulcer rates.

• Management of falls
APPROVALS: Decisions and Approvals made by the Committee
The Committee approved the Patient Experience Group Terms of Reference.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**5 March 2025**		
Title of Report:	**Alert, Advise and Assure Report – People Committee**		
Status:	**For discussion**		
Author:	**Paul Fairhurst, Chair of the People Committee**		

Key Discussion Points and Matters to be escalated from the meeting held on 30 January 2025

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

- **Pay cost reduction:** the Committee continues to scrutinise plans, programmes and risks related to the target to deliver £19.4m pay cost savings/ a reduction of 388 whole time equivalents (WTE).

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

- **Staff well-being (ongoing monitoring) – staff story:** Grace Jones, Specialist Paediatric Physio therapist shared work within the children's therapies team which models our approach to helping managers take more action on stress (the leading cause of sickness absence). The Committee reflected on success factors for this initiative including protected time and safe spaces for colleagues to take time out and share their experiences; having robust platforms to escalate concerns; and the development of leaders to listen, support, lead through change and role model resilience (which will be part of our leadership development offer). In March Grace joins the Employee Assistance Programme Team on a 6-month secondment as a Wellbeing Project Support Worker, supporting the team with stress risk assessments.
- **Breakthrough objective – reducing discrimination (ongoing monitoring)**: The Committee noted progress: the Working with Cancer Policy will be completed in February; the Workplace Adjustments Policy is on track to be launched in March (and will be evaluated in August); by April we aim to commission Direct Access to identify opportunities to improve accessibility; the Chief People Officer will set up regular meetings with Staff Network Chairs to help ensure the voice of the Networks is heard and acted upon.
- **2024 Staff Survey**: the committee received the initial staff survey results which are embargoed until later in March 2025. The results will be presented at a future Board meeting.

ASSURE: Inform the board where positive assurance has been achieved

- **People Directorate Fit for Purpose (ongoing monitoring):** The Committee reviewed an upward report from the People Performance Review Meeting, which aims to continuously improve service quality, efficiency, and the overall experience for service users and staff. Non-Executive Directors will review Staff Survey results for the three People workstreams and visit teams within the Function.
- **Sexual safety in the workplace:** In 2023 NHS England launched the Sexual Safety in Healthcare Organisational Charter. The Worker Protection (Amendment of Equality Act 2010) Act 2023 creates a duty on employers to take reasonable steps to stop sexual harassment from colleagues and third parties in the workplace. The Trust's Sexual Safety Charter and Policy is ready for ratification. Implementing the policy will

require cultural change and training for all staff. BSW discussions will address access to fit for purpose sexual safety investigators. Measures of success will include reporting levels and quality of data. The Committee will receive regular updates.
RISK: Advise the board which risks where discussed and if any new risks were identified.
• Restrictions on staffing due to financial performance is impacting the percentage of people who would recommend the RUH as a place to work. • The collective grievances resulting from the removal of paid breaks present a risk of localised industrial action.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• No items to report.
APPROVALS: Decisions and Approvals made by the Committee
None

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	13
Date of Meeting:	5 March 2025		

Title of Report:	Health and Safety Annual Report
Status:	For Information
Board Sponsor:	Toni Lynch, Chief Nursing Officer
Author:	Corrina Sheridan, Health and Safety Manager
Appendices	Appendix 1: Annual Health and Safety Report 2023/2024

1. Executive Summary of the Report

This annual report has been prepared to inform the Board of Directors of the health and safety management activities from 1 April 2023 to 31 March 2024. These activities are based on the Trust's management responsibilities and governance defined herein. These are aligned with the Health and Safety Executive (HSE) key health and safety issues relating to healthcare provision. The Trust approach and framework are intended to give visibility and assurance that the Trust has measures in place to limit the impact of health and safety issues on patients, employees, and members of the public.

The Health and Safety Committee and its subcommittees are in place and well attended. They review the risk areas and actions, develop mitigation plans, and monitor progress.

The health and safety audits are in year 2 of a 3-year rolling programme; the health and safety (H&S) team has audited 48 of the 133 known departments within the last 12 months. The audits have identified a need to embed the risk assessment process, which requires capacity and an assessment of knowledge and skills in undertaking the assessments.

During the reporting period, 438 reported incidents were recorded compared to 437 in 2022/23. The number of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents decreased from 26 in 2022/23 to 18 in 2023/24.

All subject areas relating to health and safety training illustrate increased compliance for Trust staff completing.

2. Recommendations (Note, Approve, Discuss)

The report does not make any recommendations.

3. Legal / Regulatory Implications

Health and Safety at Work Act 1974
Health and Social Care Act 2008
Workplace (Health, Safety and Welfare Regulations) 1992
CQC regulations 2009
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework, etc.)
The Health and Safety Committee oversees various risks captured on the RUH risk register (Datix) and managed by the most appropriate subgroups. Each risk has a named lead and an associated action plan with timeframes.	

5.	Resources Implications (Financial/staffing)
As outlined in risk 2159, there is no budget to staff the Fit-Testing service. The Health and Safety team budget has been used to pay for Bank staff and buy masks and filters so that the fit-testing service can continue to provide appointments.	

6.	Equality and Diversity
No issue identified	

7.	References to previous reports/Next steps
Annual Health & Safety Report 2022/23 - NCGC Health & Safety Committee Upward Report Q1 2022/23 - NCGC Health & Safety Committee Upward Report Q2 2022/23 - NCGC Health & Safety Committee Upward Report Q3 2022/23 - NCGC	

8.	Freedom of Information
Private	

9.	Sustainability
N/A	

10.	Digital
N/A	

Annual Health and Safety Report 2023-24

Contents

1. Executive Summary

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During the reporting period, 438 reported incidents were recorded compared to 437 in the previous year. The number of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents decreased from 26 in 2022/23 to 18 in 2023/24.

All subject areas relating to health and safety training illustrate increased compliance for Trust staff completing training in the year.

2. Introduction and Background

2.1 Introduction

The Health and Safety Manager has compiled this annual report; the data and content have been prepared with input from the Interim Head of Estates, the Health and Safety Manager, and the Health and Safety team.

This annual report covers the period from 1 April 2023 to 31 March 2024. It aims to provide essential information regarding the Trust's health and safety arrangements to protect its employees, patients, contractors, and members of the public.

The Trust's health and safety management system framework is based on the 1997 Health and Safety Executive publication, Successful Health and Safety Management (HSG 65), which follows the plan, do, check, act approach.

The Trust also creates, monitors, and develops an annual Health & Safety Action Plan. This plan is the main operational driver for the Trust to enable continuous improvement within its safety management system by regularly reviewing performance against key objectives. The key objectives are determined and progressed annually, and a regular focus is provided on the Trust H&S improvement priorities for the year.

During 2023-24, the key themes for the H&S Action Plan were:

- Developing robust health & safety leadership, essential for creating a progressive health & safety culture within the organisation.
- Implementing a proactive health & safety audit programme across the Trust.
- Formalising the moving & handling training programme within the wards & departments across the Trust.
- Enabling processes to help ensure safe control of hazardous substances (COSHH) across the Trust.
- Horizon scan for new regulations/legislation and guidance affecting Health and Safety law and arrangements.
- To provide a fit-for-purpose fit-testing service.

Progress regarding these principal Health & Safety Action Plan objectives are outlined within Section 4.

The Health and Safety Executive (HSE) set out key health and safety issues relating to healthcare provision. The Trust has measures in place to limit these impacts on patients, employees, and members of the public.

2.2 Management Responsibilities

Responsibility for health & safety in the Trust rests with the Board of Directors, specifically with the Executive Lead responsible for Health and Safety.

Trust responsibilities are managed through the Health & Safety Committee (HSC) and the Trust Health and Safety Policy.

Staff at all levels throughout the Trust have devolved responsibilities for health and safety, and the Trust has a risk management framework to measure and manage these responsibilities.

3. Governance and Assurance from Subgroups

3.1 Governance Structure

The Executive Lead responsible for Health and Safety chairs the organisation's Health and Safety Committee (HSC), which includes representatives from staff and management across various departments. The committee meets quarterly.

The HSC upwardly reports to the Non-Clinical Governance Committee (NCGC), which reviews the minutes of the quarterly meetings.

Two key subgroups (Safer Staff Group and Safer Environment Group) collect and review quarterly reports from all specialist subgroup meetings. As demonstrated in Figure 1, the HSC subgroups are assigned the operational assurance of specific areas or aspects. A relevant expert chairs each subgroup, represented by Staff and Trust leaders and meets quarterly.

Health & Safety Committee Structure

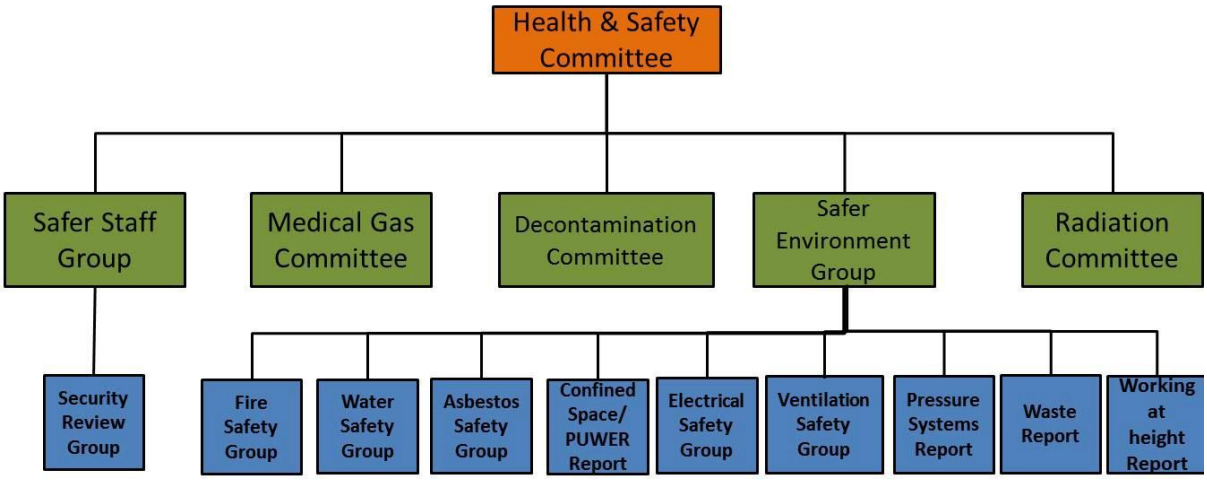


Figure 1: The Trust Health and Safety structure

The Health and Safety team comprises a Health and Safety Manager (Band 7), a Health and Safety Advisor (Band 5 part-time, two days a week), a Manual Handling Lead (Band 5) and two Health and Safety Support officers (Band 4).

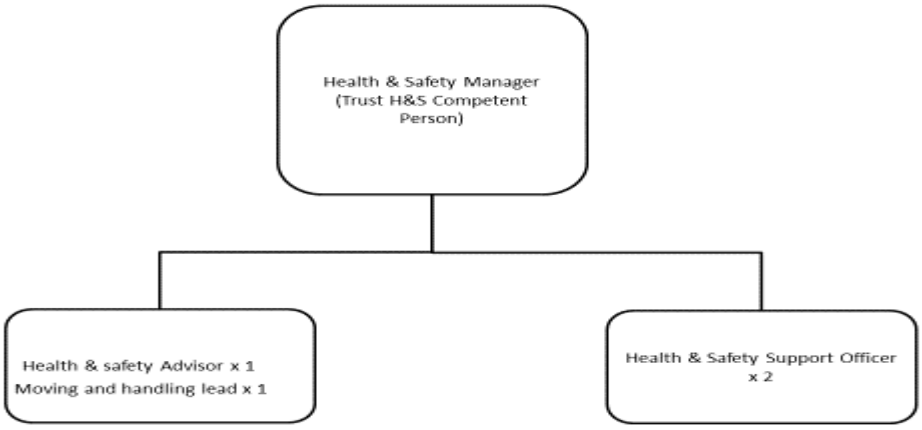


Figure 2: The Health and Safety team structure

3.2 Safer Staff Group

Chaired by: Health and Safety Manager

Item	Status	Comments
Policy		Within date.
Terms of Reference		Within date. Undergone significant review.
Attendance		Well represented.

The Safer Staff Group (SSG) meets quarterly and reports to the Health and Safety Committee. The statistics presented in the SSG report are taken from the Datix reporting system.

The information within the quarterly report enables SSG to agree or recommend actions necessary to achieve current and future legal, regulatory, and internal standards in the Health & Safety of staff, project manage those actions and monitor performance in this area. The SSG identifies key risks to the Trust and reports these to the Health and Safety Committee as part of the Trust's Risk Assurance Framework. The report contains details of the total number of accidents/incidents reported to the Health and Safety Team during the relevant quarter and the incidents that were reported to the Health and Safety Executive (HSE) in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

3.3 Medical Gas Committee

Chaired by: Head of Estates

Item	Status	Comments
Policy		Within date.
Terms of Reference		Within date. Undergone significant review.
Attendance		Well represented.

Key Updates

- **Designated Nursing Officer Training (DNOs):** Considerable progress has been made with identifying and training DNOs. A working group have undertaken a training needs analysis, developed a training plan, and identified individuals requiring training, including the 'training burden' on the organisation. Changes have been made to the mandatory training requirement, which will take twelve months to embed. The recently appointed Fire Safety Trainer will deliver face-to-face 'top-up' training for DNOs during local fire safety training sessions.

- **Nitrous oxide decommissioning:** The manifolds have been fully decommissioned within the past twelve months to reduce the harm of any pipeline leaks. As required, anaesthetic gas continues to be provided locally.

- **Cylinder and Stock Management**: The Deputy Head of Facilities provided an assurance report. There are no concerns to note, although recognition that the report's contents will change with the proposed Terms of Reference.

Key Risks

Insufficient Designated Nursing Officers (DNO) training for the nursing team (Datix 1898 – Score rating 9)

- **Description:** Insufficient nursing staff trained in medical gases to function as the designated nursing officer and sign permits. As a result, there is a risk that untrained staff sign permits to interrupt the provision of piped medical gases to patients or that staff are unaware of how to respond in an emergency.

- **Control Measures:** Authorised Persons (Medical Gas) provide additional support to nurses in charge upon issuance of permits to work, explaining their responsibilities and ensuring no patients are adversely impacted by the potential disruption to the supply of medical gases.

- **Progress Notes:** The mandatory training content for 'Medical Gas Safety' was updated in August 2024 to include the responsibilities of DNOs and the importance of a permit to work. The Fire Safety Trainer will provide targeted face-to-face training to nurses in high-risk areas during mandatory training embeds during the 12 months ending in August 2025. Progress and effectiveness are monitored through the Medical Gas Committee.

3.4 Decontamination Committee

Chaired by: Head of Estates

Item	Status	Comments
Policy		Within date.
Terms of Reference		Within date. Undergone significant review.
Attendance		Infrequent representation from Theatres and Urology. Escalated to Divisional leadership.

Key Updates

The Decontamination Committee have made the following progress during the past twelve months:

- **Accreditation and Standards:** The Sterile Services Department retained ISO 13485:2016 accreditation for quality management. An unannounced audit by BSI passed with only one minor non-conformance related to standard operating procedure (SOP) training recording. The audit was successfully passed, with only one minor non-conformance being identified. This non-conformance is associated with the recording of staff members' SOP training. A corrective action plan has been submitted, and actions are being progressed.

- **Quality:** Product non-conformance averaged below 0.20% for the year, where the service level agreements (SLA) permit up to 1% non-conformance. Note that some non-conformances are due to damaged instrumentation. Environmental monitoring has taken place as required. The differential pressure regime to maintain cleanliness has been satisfactory. Temperatures within the inspection, assembly and packing (IAP) clean room have been within best practice limits. Inspection, assembly and packing microbiological contact plates have been within permissible limits

- **Local Decontamination Audits:** These have taken place as planned. However, there are some gaps in assurance regarding the actions taken in response to non-conformances, and strengthening this assurance is a priority for the Committee during the following year.

Key Risks

Obsolete porous load autoclaves (Risk 2329 – Score 12)

- **Description:** The autoclaves and clean steam generators serving the sterile services department are beyond the end of life, and consequently, there is a business continuity risk that they will eventually fail beyond repair. One of the six autoclaves has failed beyond economical repair. The department needs a minimum of three autoclaves to maintain current production levels. A business continuity incident would likely result in the cancellation of theatre waiting lists, impacting patient care or the costly reprovision of sterile services from the private sector.

- **Control Measures:** Planned Maintenance has been increased where possible to prolong the life of the assets. Critical spares are retained from decommissioned units, but this is unsustainable.

- **Progress Notes:** A business case presenting options for their replacement has been developed and is due to be presented to the Clinical Refurbishment Group (CRG), a Capital Prioritisation and Management Group (CPMG) subgroup. Please note that these assets are included in the overall £66 million backlog maintenance we report annually via Model Hospital and ERIC.

3.5 Safer Environment Group

Chaired by: Head of Estates

Item	Status	Comments
Policy		N/A
Terms of Reference		It requires review to reflect the consolidation of new reporting arrangements. E.g. RAAC, Backlog Maintenance, PLACE. Planned for November 24
Attendance		Well represented.

The Safer Environment Group (SEG) oversees several safety groups and disciplines and assures the Health & Safety Committee.

The scope of the SEG has increased during the previous 12 months to strengthen its governance over safety domains that previously had no explicit routes to the Board. This includes RAAC, Radon, Pest Control, PLACE, and Waste. The Terms of Reference are under review to reflect these changes and will be submitted to the Health & Safety Committee for approval in November 2024.

Key Updates

- **Backlog Maintenance:** There continue to be challenges with backlog maintenance across the Combe Park estate. The value of backlog maintenance increased to £66M from £61M, with critical infrastructure risk now at £23m. As a result, the number of safety incidents reported via Datix due to the environment is increasing.

- **External Environment:** Creation of new blue badge spaces in Lansdown Car Park and between Apley House and Bernard Ireland House. Refreshed double yellow lines in multiple areas, including the main staff car park. Re-introduction of penalty charge notices (PCN) to address unsafe and obstructive parking.

- **Radon Testing & Management:** Comprehensive radon testing completed across the site. Two areas were identified above the action threshold (300 Bq/m3): a room in William Budd (this ward has now moved to the Dyson Cancer Centre) (452 Bq/m3) and a room in Diabetes (315 Bq/m3). HSE notified as per Ionising Radiations Regulations. Staff informed and site-wide update planned via Staff News. Remedial works carried out in Diabetes.

- **Capital Projects (safety related):** Significant refurbishment and installation works completed. Enhanced fire safety measures, utility improvements, accessibility upgrades, and security enhancements implemented. Emergency lighting system upgrades were carried out. Successful completion of Path Labs flooring replacement project

- **RAAC (Reinforced Autoclaved Aerated Concrete):** Identified above Waterhouse and Parry Ward on site. Immediately made safe during the Christmas Period. The £155k business case was approved by NHSE for RAAC removal by 31 March 2025.

Key Risks

ID2110 - Business interruption due to backlog maintenance or critical infrastructure risks. Score 16.

- There is an escalating risk of service disruption due to growing backlog maintenance (£66m) and critical infrastructure issues (£23m). Contributing factors

include inadequate ventilation, fire safety deficiencies, and faulty systems. The backlog is increasing by £5m annually, outpacing the £1m average investment, potentially impacting patient care and the environment for extended periods. In 24/25, £2m has been allocated to fire infrastructure improvements, with a further £0.5m for Rolling Replacement, including a lift upgrade.

ID1882 - Damaged Fire Doors. Score 15.

- There is a risk that numerous fire doors across our site, identified as requiring repair, upgrading, or replacement, may not effectively contain fire or smoke due to their current condition. During 24/25, the intention is to replace several fire doors through the fire infrastructure upgrade project, carry out a full fire door survey underway, due completion Oct 2024, and identify remedial doors via a risk-based approach.

ID1886 - Fire compartmentation deficiencies. Score 15.

- There is a risk that the breaches in fire compartmentation across the site could not contain the fire and, therefore, reduce the effectiveness of progressive horizontal evacuation. Progress has been made to ensure that fire training now identifies the requirement to move two compartment lines from any risk; a “Permit to breach” has been implemented as part of the wider investment for 2024-25, complete a detailed site-wide fire compartmentation survey, Implementation of compartmentation remediation during 2024-25.

ID1881 - Emergency Lighting. Score 12.

- There is a risk that, due to non-compliant emergency lighting in certain outpatient and non-clinical areas, insufficient lighting levels may impede the safe evacuation of people or the execution of department business continuity plans during an emergency. The focus for 24/25 is to update the programme of emergency lighting replacement, install lighting in remaining inpatient areas as identified in the programme, install emergency lighting in the Emergency Department by 31 March 2025, and complete the assetting and full discharge testing of all conventional lighting systems.

ID2684 - Fire Risk Assessments (FRA). Score 12.

- FRA Surveys have been completed throughout 2023 across the site. The assessor highlighted a number of generic risks that would compromise or hinder patient safety during a fire or evacuation event. The focus for 24/25 is to ensure that all responsible persons are issued improvement plans. Notably, an additional fire trainer will be appointed to commence on 6 May 2024, demonstrating our commitment to increased fire awareness training and support the closure of items highlighted via the action plans and identification of fire wardens throughout the Trust.

ID2723 - Risk to Health from Radon Gas. Score 12.

- Elevated cancer risk due to Radon gas exposure, particularly for staff working in areas with Radon levels above the action threshold for extended periods. Controls: Trust policy for Radon management, co-authored by Estates and the Radiation Protection Advisor/Subject Matter Expert Monitoring in high-risk areas (Residences, Children Ward, Neonatal Unit) and areas with noted high Radon levels; Yearly monitoring and fan maintenance in Medical Equipment Management/Medical Equipment Library area to keep levels below action threshold; Radon control barriers included in new building foundations; Expanded monitoring to wider areas of the Trust as advised by external contractor

ID1881 - Departments have insufficient emergency lighting. Score 12.

- A phased action plan has been developed to address this work. Phases 1-3 to install emergency lighting in thirty-eight departments have been completed. Phase 4, which involves another twenty-eight departments, has commenced but is subject to capital funding being made available.

ID1205 - The Trust cannot demonstrate sufficient compliance with the Control of Asbestos Regulations (CAR) 2012. Score 9.

- This Datix is historic (2015), and significant improvement has been made in the last three years. The Trust now has yearly asbestos audits, a suite of revised SOPs, and a revised Asbestos Management Plan (AMP). The Asbestos Management Plan and corresponding SOPs has been reviewed, re-issued, and staff trained. The score will be reduced to 6 and further reduced pending a satisfactory audit by the Authorising Engineer in October 2024.

ID2676 - Residual Asbestos Risk in South Duct. Score 9.

- The area has been locked down, and an SOP (No 36) covers access into the South and permissible Planned Preventative Maintenance (PPMs) that can be completed in the area. Outstanding action to produce an action plan to reduce the score to 6.

ID1891 - Periodic Testing and Inspection is out of date—score 9.

- A five-year action plan has been developed, and the Trust is in the second year of its implementation. A tender has been evaluated to complete years 3 and 4, and it is underway.

ID2493 - Obsolete Nurse Call Haygarth and Forrester Brown Wards. Score 9.

- The ageing Haygarth and Forrester Brown nurse call systems are now obsolete and no longer supported by the manufacturer. If the main control panel fails, the ward will have no call bell system until a new call bell system is purchased and installed. A project is underway 24/25 to replace the nurse call in Cheselden Ward and retain any working spares.

3.6 Radiation Protection Committee (RPC)

The RPC reviews the management of radiation safety within the Trust, including compliance with the Ionising Radiations Regulations 2017 (IRR17) and aspects of the Environmental Permitting Regulations 2016 (EPR16) related to radioactive materials. The RPC reports to the Trust Health and Safety Committee.

It also reviews compliance with the patient-focused Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17). These aspects of the RPC's work are reported to the Trust Quality and Safety Group and are not included in this report.

The RPC met in April and November 2023.

Regulatory Compliance and Inspections

The Trust reported a breach of its EA permit in August 2023. This breach related to removing radioactive materials from the site, where they had entered the wrong waste stream. A subsequent near miss happened due to a very similar cause.

An EA inspection took place in November 2023. The inspector assessed that the waste permit breach was a category three non-compliance (a non-compliance with the potential for a minor impact on human health or the environment). Although the Inspector was content with the actions taken to correct the problem and stated that there would not be any enforcement action, the Inspector judged the Trust to be in full compliance with the Environmental Permitting Regulations.

Until this year, the Trust still held an EA permit for using Y-90 on the old RNHRD site. An application for surrender was successful, and a surrender notice was issued in March 2024. The RUH no longer holds an EA permit to use radioactive substances on the RNHRD site.

The Trust has re-registered its work with X-ray generators under IRR17 regulation 6 (as required by HSE; this is a one-off to comply with HSEs new requirements regarding reporting of our inventory of generators). The Trust has also registered its work with radioactive materials; the trust already holds the more stringent consent for practices related to this work. However, the consensus of the UK radiation protection community is that registration is required for associated practices not directly covered by the consent.

HSE has introduced a new process for granting consent for high-risk practices. In the coming years, we will be required to re-apply for the consents we hold (for nuclear medicine, radiopharmacy and radiotherapy). This will involve a significant cost, and we are actively engaged in discussions about how this will be covered.

Significant Changes to Practices

Radiopharmacy re-opened in January 2024. This required significant work, including from the Trust's lead RPA. Some training remains outstanding; this is being addressed. All risk assessments are in place, but some procedures require review in

light of experience and results on monitoring in the first few months of work. This includes purchasing a syringe shield, as finger doses for the worker performing QC were at levels which would exceed the dose limit if maintained for the rest of the year.

Management of Radiation Protection

The RPCs business included:

- Review and ratification of appointments of qualified experts (Radiation Protection Advisers (RPA), Radioactive Waste Adviser (RWA), Laser Protection Adviser (LPA)), Radiation Protection Supervisors (RPS) and Laser Protection Supervisors (LPS).
- Monitor the compliance audit schedule and review radiation risk assessments, local rules, and contingency plan rehearsals. Some of these are overdue for review, with an agreed plan to tackle the backlog.
- Receiving reports on compliance with legislation and good practice from managers and RPSs. There are no significant issues to escalate.
- Review of the management of radiation protection, including staff dosimetry and the results of investigations of doses above investigation thresholds, communication between employers where individuals have more than one employment and arrangements for classified workers, environmental radiation monitoring, and review of incidents involving radiation exposure.

Exceptions and Challenges

Training is an identified area of regulatory non-compliance.

- Issue with staff who work in radiation areas but whose role doesn't directly involve radiation (e.g. cleaners, porters, estates staff). There have been incidents involving radioactive waste, one resulting in a permit breach and one near miss.
- HSE/EA expectation is that any training requirements identified in radiation risk assessment are met and that they are evidenced.
- The Trust's RPAs and RWAs have worked with the Health and Safety and Learn Together teams to implement radiation awareness training as part of all staff's mandatory health and safety training.
- Once this is in place, work will begin on creating a robust system for providing additional training (and evidence of training) for staff working in radiation areas whose role does not directly involve radiation.

4. Progress against the Health and Safety Action Plan

4.1 Leadership

The health and safety annual plan set out key actions that focus the Trust's attention on encouraging strong leadership through active management and collective ownership, creating healthier, safer workplaces by targeting risk priorities and implementing effective measuring and monitoring systems.

The Health and Safety team supports departments as requested by supporting risk assessments. Generic risk assessment templates are available on the health and safety page on the intranet for Departments to amend and use. The Health and Safety team is also responsible for providing the Face Fit Testing service to the Trust, health and safety audit, and it also provides face-to-face moving and handling training across the Trust; this includes induction, training the trainer for the Department trainers and as required the team investigates incidents, advises on health and safety issues and endeavours where possible to promote a good health and safety culture. Other functions are described within the report.

Key themes from the annual health and safety action plan:

- Developing robust health and safety leadership is essential in driving and improving the Trust safety culture.

Health & Safety training for the Trust Executive and Non-Executive Board members was initially carried out in February 2024.

During 2023-24, a Health & Safety for Managers Training course was developed. It was held monthly via Microsoft Teams and recorded on the Trusts' “Learn Together” education and learning platform. From its launch in September 2023 to March 2024, 23 additional Managers were trained via this medium. This low number is due to staff not having the time to attend the one-hour session, held on Microsoft teams, due to conflicting priorities.

- Health and safety audits are a fundamental requirement of any safety management system and understanding and proactive planning for improvements when areas of safety concern are identified is essential.

The Health & Safety Audit program completed its first year of a 3-year cycle during 2023-24, and the details of this significant achievement are highlighted in the audit section [4.2].

- Ensure that moving and handling training is delivered to all staff in line with organisational requirements.

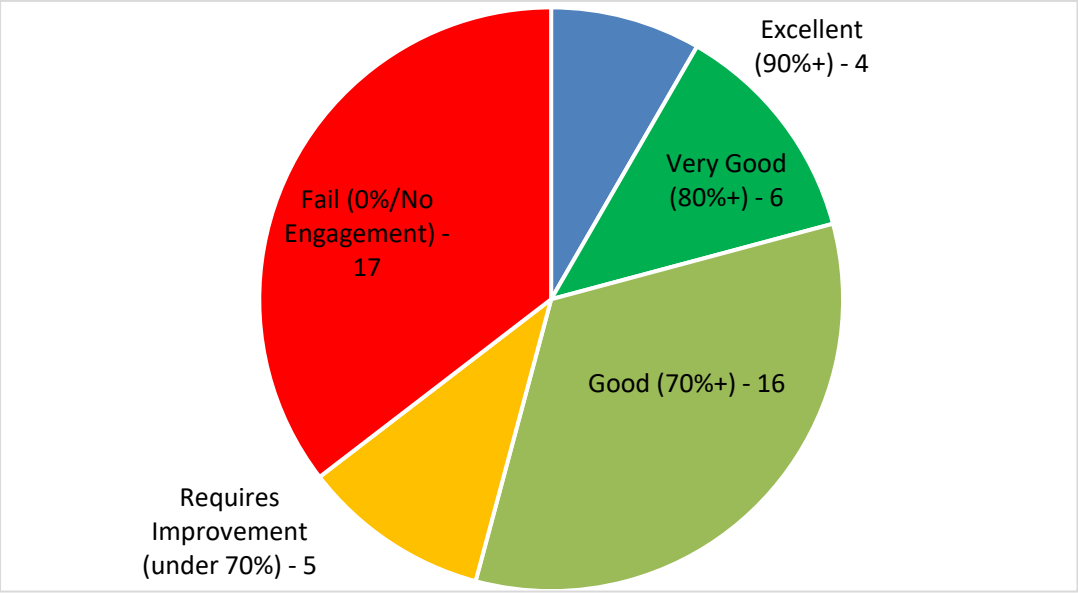
The Trust Moving and Handling Leads deliver moving and handling training to the Departmental trainers. The Departmental trainers provide ongoing handling training, monitoring, and mentoring for staff at the ward level, which achieved significant improvements during 2023-24. Five courses were provided, and 22 Departmental manual handling trainers were trained. Eight refresher sessions for Department Trainers have been completed, and 35 trainers have been trained.

- Safe control of substances hazardous to health and routine checking of safe systems of work are key requirements of a robust safety management system.

4.2 Audit

Under the Trust Health and Safety policy, section 6.1, and in line with HSE best practices, formal safety auditing is part of our management control system. This process identifies whether the Trust meets its legal responsibilities under the Health and Safety at Work, etc. Act 1974 and ensures effective action is being taken to safeguard our staff and patients.

The Health and Safety team conducted a comprehensive audit of all RUH departments, planned over three years. By the end of 2023-2024 (Year One), the team audited **48 out of 133 departments**. The audit timetable for 2024-2025 (Year Two) is available on the RUH intranet within the Health & Safety pages.



Audit Score	Number of Departments	Percentage
90+	4	8.33
80+	6	12.5
70+	16	33.3
Below 70	5	10.4
Not Complete	17	35.42
Total	48	100

Figure 3: Results from the 48 completed audits

Figure 4 illustrates the scores for 31 respondents across 15 areas reviewed in the audit. Seventeen areas did not complete the audit, as indicated in Figure 3; thus, their

data wasn't captured. Figure 4 consolidates information from all verified audits conducted throughout Quarters 1 to 4 of 2023-2024 (year 1).

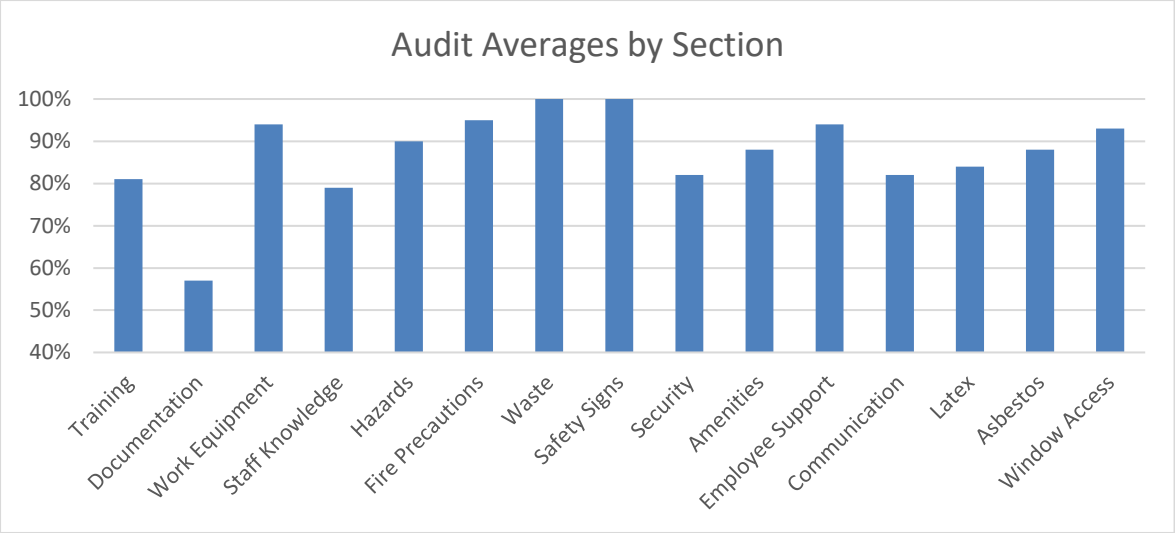


Figure 4: Verified audits undertaken throughout Q1, Q2, Q3 and Q4 of 2023-2024 (year 1)

Areas of Focus

Documentation (57%)

Documentation is crucial for protecting the Trust to evidence its compliance with legal obligations and demonstrates a proactive approach to managing health and safety risks.

Risk assessments are essential documentation items that help protect our staff and patients and ensure compliance with the law. They focus on significant workplace risks—the ones with the potential to cause actual harm.

The Health & Safety team initiated online training sessions focused on risk assessments, health and safety for managers, and understanding Control of Substances Hazardous to Health (COSHH) to enhance documentation practices. Participation has been encouraging, with 83 staff completing risk assessment training and 23 managers completing health and safety training.

Departments are asked to author their own risk assessments. Staff knowledge and understanding of the work involved are best positioned to identify hazards and risks and ensure accurate and relevant documentation.

The Health and Safety Committee will continue to oversee the documentation audit results, which measure documentation practices. The Committee will highlight ongoing documentation compliance in reports to the Non-Clinical Governance Committee.

The Health and Safety team will support departments needing help with documentation.

Staff Knowledge (79%)

According to the Management of Health and Safety at Work Regulations 1999, employers must make suitable and sufficient assessments of risks and consult with employees. Staff should be aware of safety documentation and emergency procedures to mitigate risks effectively.

The audit aims to ensure that all employees are familiar with the contents and locations of safety documents. Departments are encouraged to involve staff in creating and reviewing safety documentation to foster a deeper understanding. The health and safety team reinforces this through various training courses, including risk assessment, manual handling, and COSHH.

The Health and Safety Committee will monitor and report on audit results, as well as review and promote participation in various training programs.

Training (81%)

Training is vital in preventing incidents and ensuring legal compliance. Under the Health and Safety (Training for Employment) Regulations 1990, appropriate training must be provided, with refresher sessions for high-risk, complex, or infrequent tasks.

Mandatory training in both essential and core subjects showed improvement over the reporting year, with core subjects above target (89.49% as of March 2024) and essential subjects slightly under target (84.49% as of March 2024).

The Health and Safety Committee and its subcommittees will closely monitor and report on training compliance levels and follow up with departments that are not meeting targets.

In cases of ongoing non-compliance, divisional or departmental representatives are responsible for addressing the issue during divisional or departmental meetings to increase awareness and compliance levels. The People Directorate also monitors mandatory training and reports through the People Committee.

Departments Not Completing Annual Audits (35.42% Non-Participation)

Formal safety auditing is integral to the Health and Safety Management system and follows the HSE's Plan, Do, Check, Act cycle. Non-participation undermines the Trust's ability to assess health and safety performance fully.

In Year One, 35.42% of wards/departments did not participate in the audit process. This gap reduces the overall effectiveness of health and safety governance and reporting.

Heads of Departments not yet audited have been emailed to schedule dates, and future reports will include detailed audit exceptions for quick response to non-compliance.

The Health and Safety Committee regularly reviews audit participation and seeks to address non-compliance with departmental representation. This will be strengthened through detailed reporting and escalation to ensure transparency and escalate concerns when necessary.

The Committee cross-references audit participation with incident rates, training compliance, and other metrics to identify trends and prioritise interventions.

4.3 Horizon Scanning

The Health and Safety Manager and Advisor are members of the Institute of Occupational Health and Safety (IOSH) Southwest Health Care group. This group allows the sharing of best practices and the identification of changes in health and safety legislation. The Health and Safety Manager has also developed working relationships with health and safety team members within Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust to share examples of best practices.

4.4 Manual Handling

Ergonomics and Working Environment, Including DSE

The Trust is required to undertake risk assessments for ergonomics and the working environment, and this is achieved via the Trust template assessment for display screen equipment (DSE). Individual employees are responsible for preparing a DSE assessment, and line managers are responsible for ensuring these are produced and mitigations implemented that may arise from the assessments. DSE assessments need to be undertaken by staff and reviewed/updated where any ergonomics or working environment changes (i.e., staff member moves, new desks, or equipment, etc.).

The Health and Safety team has supported 70 DSE assessments this year, an increase of 8 compared with last year. Some of these have been due to staff moving to new locations within the Trust requiring support setting up workstations to ensure the best setup within the workplace.

Moving and Handling Training

The Health and Safety team has a resource of a competent Moving and Handling lead to provide moving and handling training across the Trust. This includes induction training for all new starters who will be assisting patients, fall kit training, and department trainers training the trainer courses. To mitigate the single point of failure of having only one competent person to provide the moving and handling training, a second team member is undertaking an external manual handling train-the-trainer course in July 2024.

4.5 Face Fit Testing (FFT)

The Health and Safety team continue to run the Fit Testing service in addition to providing the health and safety service provision. This requires review and planning to deliver this in the long term. There will be added pressure to provide appointments to ensure the Trust meets the criteria set out by NHSE* FFP3 resilience principles in acute settings; this requires the Trust to test each staff member for two different masks to enable them to wear the masks they are fit tested on interchangeably. The Infection, Prevention and Control team is leading the paper in considering the options available to the Trust to ensure we comply with these principles.

*FFP3 face masks protect from viruses, bacteria, and solid or liquid toxic aerosols. These masks are commonly used by those working in the healthcare industry as personal protective equipment (PPE).

4.6 Control of Substances Hazardous to Health (COSHH)

Information about managing COSHH is available on the Trust Intranet. The Health and Safety team provides COSHH awareness sessions on Teams, which is booked via the Learn Together platform. The team also supports departments as requested by conducting risk assessments, including COSHH assessments. Safe control of substances hazardous to health and routine checking of safe systems of work are key requirements of a robust safety management system. The Health & Safety Audits completed during 2023-24 include a section of questions regarding the ‘Control of Substances Hazardous to Health’ [COSHH] and ensured that essential feedback on any improvement requirements identified was provided to the appropriate Departmental management.

During 2023-24, a COSHH Training course was also developed. From April 2024, it will be launched monthly via Microsoft Teams and recorded on the Trusts Learn Together education and learning platform.

5. Progress against other Key Objectives

5.1 Incidents

Table 1 demonstrates the breakdown of reported incidents from 2018-19 to 2023-24,

using the risk categories and data drawn from Datix.

Category	2019-20	2020-21	2021-22	2022-23	2023-24	Trend
Environment/H&S non-clinical	113	57	85	52	55	↑
Fire	86	72	70	59	40	↓
Ill Health	11	260	118	76	93	↑
Personal Accident/accidental injury	364	315	258	249	294	↑
Vehicle	18	2	0	1	1	↔
Total	**590**	**706**	**531**	**437**	**483**	↑

Table 1: Breakdown of incidents

The top three categories within personal accidents/accidental injury are as follows:

Collision/contact with an object - staff has been affected by several incidents involving broken or malfunctioning equipment or structural items. All offending items have been repaired or replaced.

Contact with sharps/needlestick - no trend was noted; departments affected are spread across the Trust. Reported issues include no harm and incorrect disposal of sharps within the reported incidents.

Slip, trip or fall - there continues to be a trend of wet floors throughout this year, as reported incidents related to slips, trips, and falls continue to occur. This includes wet floors caused by the influences of weather. It is also acknowledged that the cleaning department is short-staffed, which can impact how floors are managed while being cleaned, as insufficient cleaners are available to dry wet floors when wet weather causes water and leaves to be brought into corridors by footfall.

5.2 Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR) Incidents

Eighteen RIDDORS were reported from 1 April 2023 to 31 March 2024, as highlighted in Table 2.

The patient incident below was detailed as a patient falling from a height from a bed with bed rails. This was managed as a clinical incident.

	Employee	Patient	Total

Another kind of accident	3	0	3
Fell from height	2	1	3
Lifting and handling injuries	4	0	4
Physical assault	1	0	1
Slip, trip, fall same level	5	0	5
Struck by object	2	0	2
Total	17	1	18

Table 2: Incidents by RIDDOR Accident Types and Type

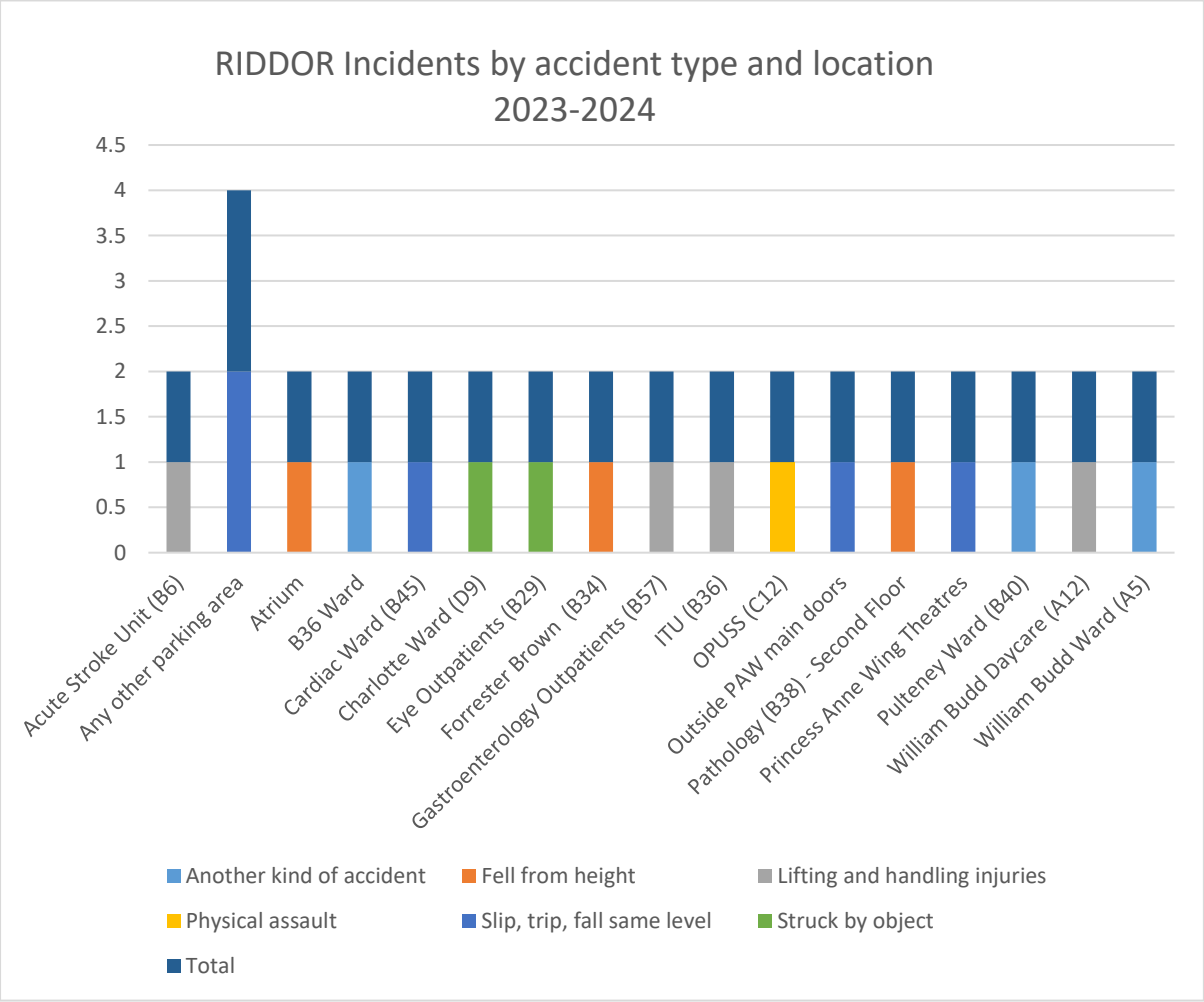


Table 3: RIDDOR incidents by accident type and location

There have been 438 incidents, n=437, for the previous year. RIDDOR reportable incidents have decreased from 26 to 18. The Health and Safety team oversees all reported incidents and checks which incidents should be reported as a RIDDOR.

Table 4 identifies the types of reported RIDDOR incidents over the last five years; the increase in 2020-21 relates to COVID-19 and staff exposure, which is classed as an occupational disease under RIDDOR criteria.

Type of RIDDOR	2019-20	2020-21	2021-22	2022-23	2023-24	Trend
Over 7 days	30	19	18	17	14	↓
Dangerous occurrence	3	2	0	2	0	↓
Specified Injury	5	2	6	6	4	↓
Occupational disease	0	150	2	1	0	↓
Member of public	0	1	0	0		↓
Total	**38**	**174**	**26**	**26**	**18**	↓

Table 4: Five-year overview of reported RIDDOR incidents

5.3 Health and Safety Mandatory Training

Health and safety training relates to the areas shown in Table 5. The training compliance figures and annual trajectory for the reporting year are shown.

Subject	2019-20	2020-21	2021-22	2022-23	2023-24	Trend	Target
Conflict Resolution Training	86.7%	**89.1%**	87.4%	88.1%	96.7%	↑	85%
H & S	90.0%	**87.8%**	84.7%	83.1%	92.6%	↑	85%
Moving and Handling (Level 1)-Loads	91.3%	**88.8%**	85.6%	84.5%	92.7 %	↑	85%
Moving and Handling (Level 2)-Patients	93.9%	**76.4**	71.1%	76.2 %	83.6%	↑	85%

Table 5: Health and Safety Mandatory Training Compliance

All modules have achieved increased compliance from the previous year; work is underway to provide more Induction sessions for Moving and Handling Level 2 to improve compliance. These figures do not take into account Bank or Agency staff.

Safety training

All line managers must manage health and safety as part of their responsibilities, and all staff are responsible for working safely and following health and safety arrangements. The Health and Safety team has provided H&S training for managers, risk assessment training, and COSHH training via the Teams one-hour session for each subject, which can be booked via the Learn Together platform.

5.4 Culture

The Trust acknowledges that establishing and growing a strong health and safety culture is a fundamental cornerstone of ensuring our safety management systems remain safe, efficient, and effective for all stakeholders and forms an integral part of the Trust Transformation planning for health and safety and the re-invigoration and continued growth of its safety culture. The annual health and safety plan is also derived from the understanding as to how all Trust staff need to help in continual H&S improvement, whether that is a simple promotion and reinforcement of positive action such as consistently reporting something unsafe that you have observed or following a safe system of work to keep yourself and your colleagues safe at work.

All the health and safety annual action plan objectives and targets have been reviewed and approved by the Health and Safety Committee and chosen as this year's health and safety improvement actions based on identified safety concerns at a national or local level or would provide potential areas of improvement.

The results of the health and safety audit demonstrate that improvements are required.

5.5 Fire Safety

2023/24 builds on the advances made in the previous year. The Fire Safety Strategic Action Plan continues to form the basis of the Fire Team's work and progress against this.

During the previous twelve months, the Fire Safety Committee has made considerable progress in the following areas:

- **Fire Safety Policy.** This has been ratified, and its next review is due on 12 June 2025. Minor amendments regarding the updated responsible Director will be completed.

- **Fire Safety Protocols**. These are being reviewed and, where necessary, rewritten to support the management arrangements and actions regarding fire safety. The progress of these is part of the Project and Driver fortnightly review.

- **Recruitment and induction of an Additional Fire Safety Trainer**. This role was identified as an output of the 2023 Authorised Engineer Audit. The trainer started working with the Trust on 6 May and targets staff groups that have historically always had lower-than-average compliance rates. They will also expand the training to RUH staff based at external sites, in-house evacuation chairs, and non-clinical areas.

- **Fire Risk Assessments**. Fire Risk Assessments have now been completed for the Combe Park estate. Any findings that impact safety or compliance have been collated, and a Datix incident has been completed and assigned to the relevant person in charge where actions have been found. Further FRAs have been completed, and reviews of 3rd party documents have been undertaken where the RUH has patients or staff in external locations. During the next 12

months, the Combe Park FRAs will be reviewed against the recently re-published Health Technical Memorandum 05-03: Operational provisions Part K – Guidance on fire risk assessments in complex healthcare premises.

- **Planned Maintenance**. Outputs from the review of the required planned maintenance activities are currently being implemented. During the previous 12 months, an external third party completed a full site survey and service on all dampers. A third-party inspection of the fire doors will also be completed within the next quarter. Despite significant investment during 2024/25, these surveys will highlight the need for prolonged investment in maintaining and replacing continually damaged or worn-out items. No concerns remain concerning the other maintenance areas, such as extinguishers or device testing.

Mandatory Training

Table 6 provides a summary of mandatory compliance as of April 2024.

End of Month Subject Compliance Heatmap

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Bank [Division]	53.54%	52.27%	53.83%	54.83%	56.46%	55.95%	54.11%	54.32%	54.02%	58.19%	57.40%	56.82%
Capital Summary [Division]	92.31%	91.67%	90.91%	90.00%	90.00%	80.00%	77.78%	80.00%	80.00%	77.78%	72.73%	72.73%
Charity Summary [Division]	92.31%	100.00%	100.00%	100.00%	100.00%	100.00%	75.00%	75.00%	100.00%	100.00%	100.00%	100.00%
Corporate Division	78.60%	82.11%	84.22%	83.07%	83.51%	83.56%	86.60%	86.41%	87.67%	87.87%	87.79%	88.68%
Emergency Medicine Division	71.62%	75.34%	77.82%	78.17%	79.17%	82.17%	80.48%	82.37%	80.33%	82.77%	79.47%	83.16%
Estates and Facilities Division	46.12%	68.89%	79.00%	81.34%	82.96%	81.93%	80.24%	81.17%	83.88%	84.73%	82.66%	82.24%
Family and Specialist Service Division	83.93%	86.49%	88.06%	89.88%	90.45%	90.48%	89.18%	89.63%	90.70%	91.07%	91.29%	90.81%
Medical Division	85.91%	88.43%	88.86%	91.46%	91.07%	91.15%	92.43%	92.79%	91.00%	92.15%	91.70%	91.68%
Research & Development [Division]	85.14%	95.83%	98.57%	98.57%	98.53%	97.18%	88.89%	91.89%	94.81%	94.67%	97.26%	95.71%
Surgical Division	84.59%	86.32%	86.74%	88.43%	88.99%	89.48%	89.10%	90.18%	90.06%	91.28%	89.61%	89.75%
Total	**76.38%**	**79.53%**	**81.14%**	**82.43%**	**83.24%**	**83.25%**	**83.17%**	**83.93%**	**83.91%**	**85.73%**	**85.05%**	**85.17%**

Table 6: Mandatory Training Compliance

The figures for most areas have remained the same or improved over the last year. The new Fire Safety Trainer is working on areas such as the Bank staff, cleaning and non-clinical areas. They also deliver out-of-hours training to staff on night shifts.

Significant improvements are in the areas of highest risk, notably the three clinical Divisions (Medical, Surgery, and FASS). Actions are underway to address areas of low compliance within the bank staff, Cleaning Department, and Emergency Medicine and are due to be completed on December 24.

Key Fire Infrastructure Risks

The Trust Board has been made aware of several critical risks related to the Trust fire safety infrastructure. These risks, previously identified, require ongoing attention and significant investment to ensure the safety of patients, staff and visitors. Key points include:

- **Extensive Fire Safety Issues:** As reported to the Trust Board in February 2024, an estimated £15 million is required to address known high-risk fire safety

issues at the RUH Combe Park site. This estimation is based on identified deficiencies in fire systems and compartmentation and previous cost benchmarks for their repair.

- **Limited Current Budget:** For the 2024/25 financial year, £2 million has been allocated to address high-priority fire safety infrastructure risks. This significant budget leaves a substantial funding gap for addressing all identified issues.
- **Emergency Lighting Deficiencies:** Some areas require upgrades to emergency lighting to ensure safe evacuation routes. Within this year's scope, Cheselden Ward will receive emergency lighting upgrades to achieve compliance and ensure all areas have a visible and safe escape route.
- **Compromised Compartmentation:** Several areas, particularly in the Princess Anne Wing (PAW), have been identified with compromised fire compartmentation, increasing the risk of fire spread. For the 2024/25 scope, the focus will be improving 60-minute compartment boundaries between Charlotte, Mary, Urology and Cheselden wards on PAW's first floor. Work is currently being undertaken to rectify this.
- **Potential Service Disruptions:** Addressing these infrastructure issues will lead to temporary bed closures and ward relocations, potentially impacting patient care. The project team is working on mitigation strategies, including the potential relocation of Charlotte Ward to B12 (old ITU) during work, resulting in a net loss of 7 beds.
- **Future Capital Requirements:** The estimated capital required to address all critical infrastructure risks of fire remains at £13 million. To continue addressing high-priority areas, incremental, year on year funding is required from the Capital plan to address the work required.

While actions are being taken to improve fire detection, alarms, and emergency lighting in priority areas, it is important to emphasise that some risks will persist due to budget limitations. Ongoing vigilance, staff training, and regular risk assessments will be crucial to maintaining safety standards in areas awaiting future improvements.

5.6 Risk Management and Mitigation

The Health and Safety Committee oversees various risks captured on the risk register (Datix) and managed by the most appropriate subgroups. Each identified risk is assigned a named lead and an associated action plan with specific timeframes.

The Committee ensures that all risks are systematically reviewed, and appropriate mitigation strategies are implemented. This includes regularly monitoring and updating the risk register to reflect any changes in the risk landscape. The Committee also ensures that all staff are adequately trained and informed about the risks and mitigation measures.

Furthermore, the Committee collaborates with other departments and external agencies to ensure a comprehensive approach to risk management. This includes

sharing best practices, conducting joint risk assessments, and participating in external audits and inspections.

6 Conclusion/Summary

In conclusion, the Health & Safety Annual Report 2023/2024 provides a comprehensive overview of the Trust's health and safety management activities over the past year. The report highlights significant achievements, including the successful implementation of health and safety audits, increased compliance in training, and effective incident reporting mechanisms. Despite facing challenges such as resource constraints and needing improved risk assessments, the Trust has demonstrated a commitment to maintaining a safe environment for patients, employees, and the public.

The Health and Safety Committee and its subcommittees have played a crucial role in identifying and mitigating risks, ensuring that all necessary measures are in place to address potential hazards. The progress made in key areas, such as the training of Designated Nursing Officers and the management of obsolete equipment, underscores the Trust's dedication to continuous improvement.

The Trust aims to build on these achievements by addressing documentation gaps, enhancing training compliance, and fostering a robust health and safety culture. The ongoing efforts to monitor and update the risk register, collaborate with external agencies, and implement best practices will be instrumental in achieving these goals.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**14**
Date of Meeting:	**Wednesday 5 March 2025**		
Title of Report:	**Alert, Advise and Assure Report – FPC Committee**		
Status:	**For information**		
Author:	**Antony Durbacz, Non-Executive Director and Chair of FPC**		

Key Discussion Points and Matters to be escalated from the meeting held on 30 January 2025

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 business plan process is running late due to delays in the publishing of instructions from NHS England. The timing is now very tight, with higher expectation on performance and the extent of additional review by the board
- The underlying performance indicates that previous forecasts are now considered unachievable. At the time of the meeting a new forecast was still working its way through the management team and was unavailable for committee review

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

- The winter plan for 2024/25 was reviewed identifying learnings for next winter. It is recognised that the trust is failing to reach its contractual standards. There are several reasons for this, but two significant factors are identified as NC2R and the rising acuity of patients
- Cancer performance was reviewed with the challenge in 28 days acknowledged but overall, 62 days was expected to be on trajectory. Of note is the outperformance of the trust in early-stage diagnosis compared to SW peers
- Diagnostics DM01 performance remains challenged, even though overall diagnostic output is high. This improvement is offset by higher demand and allocation of capacity to high need areas such as cancer
- The improvement plans continue to target £36m but there remains some doubt on achieving that target

ASSURE: Inform the board where positive assurance has been achieved

- The IA reports for purchasing and payroll controls were reviewed both gave partial assurance with improvements required

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

- A draft business case is in circulation for £44m of diagnostic equipment across the AHA. There are difficulties in the case associated with Sulis footprint, available capital spend and the ongoing economics of the equipment

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• No items this month.
APPROVALS: Decisions and Approvals made by the Committee
• The Terms of Reference were approved and are attached at appendix 1 for ratification.

The Board is asked to NOTE the content of the report and to ratify the updated Committee Terms of Reference.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**14.1**
Date of Meeting:	**Wednesday 5 March 2025**		
Title of Report:	**Alert, Advise and Assure Report – Joint Board Committees (Finance & Performance/Quality/People)**		
Status:	**For information**		
Author:	**Antony Durbacz, Non-Executive Director and Chair of FPC**		

Key Discussion Points and Matters to be escalated from the meeting held on 25 February 2025

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

- A joint meeting of Board subcommittees was held to begin a process of assurance in relation to this years business plan. It received draft documents relating to a headline plan to be included as part of a BSW Integrated Care Board combined submission to NHS England on 27th February.
- The material reviewed was work in progress following on from the issuance of national planning guidance at the end of January, with several elements that still needed completing before final plan submission in March.
- The focus of the meeting was around the very significant scale of challenge required to balance the planning asks for 25/26, a review of benchmarking opportunities and also review against a series of checklists (Elective, Non Elective, Productivity). The level of risk being faced both locally and nationally around cost, demand and transformation requirements on the NHS was also discussed.
- Across coming weeks work will continue to develop further detail around delivery plans and risk which will help the Board to build its position of assurance around a final plan submission.

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

- Development of delivery plans and risk assessment to enable validation of our aspired year end position.

ASSURE: Inform the board where positive assurance has been achieved

- The team have worked expeditiously to identify productivity and efficiencies identified using the national productivity pack.

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

- The level of challenge and transformation requirement in the national planning guidance for 25/26 is significant and delivery will carry a range of risks which will be further detailed prior to final plan submission.

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

- No items this month.

APPROVALS: Decisions and Approvals made by the Committee
• The committee approved for submission to the ICB the required headline submission templates and narrative on the basis that they had been systematically produced using available data and had been constructed in line with the modelling assumptions demanded by the ICB/NHS.

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

Royal United Hospitals Bath
NHS Foundation Trust

Finance and Performance Committee
Terms of Reference

1. Constitution of the Committee

The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Finance and Performance Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Purpose and objectives

The Finance and Performance Committee's purpose is to provide assurance to the Board on the Trust's Improvement Programme, financial and operational performance, and in particular:

- the effectiveness of the Trust's business planning process and principles for internal budget setting
- the effectiveness of the Trust's financial management systems
- the effectiveness and robustness of financial planning
- the effectiveness and robustness of capital investment management
- the robustness of the Trust's cash investment strategy
- the extent to which the Trust is operating in line with its annual business plan objectives in terms of financial and operational performance
- the extent to which forecast performance matches operational targets and improvement trajectories, ensuring that issues of non-delivery are escalated to the Board
- the identification, forecast and delivery against Quality, Innovation, and performance improvement schemes
- the Trust's relationship with its partners within the BaNES, Swindon and Wiltshire Integrated Care System (BSW), and the changing approaches to commissioning, contracting, joint working and the allocation of resources.

The Committee will incorporate the principles of Improving Together into their work.

3. Roles and Responsibilities

3.1 Reporting

- To oversee the ongoing development of the Integrated Performance Report.
- Monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is fully sighted on areas of compliance and non-compliance.
- To review the Trust's annual financial plan, monitoring and challenging any changes to forecast outcomes.
- To review in detail any major performance variations in order to obtain assurance on behalf of the Board as to the effectiveness of corrective actions and associated governance arrangements.
- To consider changes to Trust reporting requirements in response to any new regulatory arrangements.
- To review the trust's performance against its improvement plan considering both the improvement in operational performance and the financial implications.

3.2 Financial performance management

To monitor the Trust's performance against its financial control total.

- To undertake high level, exception-based monitoring of the delivery of financial performance to ensure that the Trust is operating in accordance with its annual business plan objectives and where it is not, assure itself that appropriate action is being taken by the Executive Team.
- To assess the factors, across BSW, that contribute to the risk of financial deficits and monitor the effectiveness of action plans to address these.
- To oversee the creation and achievement of divisional and corporate financial recovery plans.

3.3 Operational performance management

- Assessment of the Trust's delivery against NHS constitutional standards.
- Review forecast performance against operational targets and improvement trajectories, escalating issues of non-delivery to the Board, and monitoring against achievement of any incentive funding arrangements.
- To particularly oversee improvement in key areas of operational performance, including in elective, diagnostic and cancer care, emergency care, and working with community and local authority partners to reduce the number of length of stay for patients who are medically fit to be discharged.
- To assess Trust performance against established benchmarking indices and that of neighbouring and similar organisations.

- To maintain scrutiny of operational performance and the extent to which this continues to be affected, and to review the impact that this has on other aspects of care across the Trust.

3.4 Income management

- Review the Trust's evolving relationship with its key commissioners and BSW partner organisations, taking account of new and emerging funding models.
- Review arrangements for non-activity related income streams, particularly CQUIN, to understand alignment with Trust clinical priorities and levels of income risk.

3.5 Annual Trust planning cycle

- To consider the Trust's medium- and long-term financial strategy, in relation to both revenue and capital.
- To oversee the Trust's business planning process and agree the principles and approach to internal budget setting and the development of divisional business plans linked to the Trust's True North and Breakthrough Objectives.
- Review the annual QIPP and Cost Improvement Programmes to provide assurance that delivery risk is minimised, and productivity and efficiency opportunities maximised, in particular that savings programmes and forecasts are realistic and deliverable.

3.6 BSW

- To contribute to the development of a system-wide approach to resource allocation and management across BSW, and to support efforts aimed at ensuring that the ICS achieves and maintains break even.

3.7 Other matters

- To review and, where delegated from the Board of Directors, approve Trust wide and BSW wide projects, including advising the Board of Directors on business cases and procurement and contract recommendations over £1m.
- Review the Trust's procurement strategy, systems and arrangements with a view to ensuring that best value is derived. To monitor progress against NHS standards for procurement using, for example, the Model Hospital.
- To receive updates on any changes to relevant areas of national policy or guidance, and how these will be implemented within the Trust.

4. Membership

The Committee shall be appointed by the Board to ensure representation by Non-Executive and Executive Directors.

The membership of the Committee shall consist of:

- Non-Executive Director (Chair)
- Two other Non-Executive Directors
- Chief Finance Officer
- Chief Operating Officer
- Chief Medical Officer

The following staff are required to attend meetings of the Finance and Performance Committee:

- Deputy Chief Finance Officer
- Deputy Chief Operating Officer
- Head of Corporate Governance

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

5. Quorum and attendance

Business will only be conducted if the meeting is quorate. The Committee will be quorate with four members present, two of whom must be Non-Executive Directors.

Members will be required to attend a minimum of 8 meetings per year.

6. Reporting

The Chair of the Finance and Performance Committee will provide an upward report on key items for escalation to the Board which will be issued at the next Public Board meeting.

The Chair of the Finance and Performance Committee shall make whatever recommendations to the Board deemed by the Committee to be appropriate (on any area within the Committee's remit where disclosure, action or improvement are needed).

The Chair of the Finance and Performance Committee shall liaise with the Chairs of other Board Committees where necessary to ensure that cross-committee issues receive adequate oversight (by, for example, arranging to attend other Committee meetings).

7. Frequency

The Committee will meet at least ten times a year. Additional meetings may be arranged as required.

8. Other Matters

The Head of Corporate Governance will be responsible for providing administrative and governance support to the Committee, including:

- Agreement of the agenda with the Chair, the Chief Financial Officer and the Chief Operating Officer.
- Collation of the papers which will be disseminated five working days in advance of the meeting.
- Arranging for minutes and actions which will be disseminated five working days after the meeting.
- Accessing advice to the Committee as required.

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 objectives. The outcome of this review will be reported to the Board.

These Terms of Reference will be reviewed at least every year as part of the process of monitoring the Committee's effectiveness.

Terms of Reference approved by the Finance and Performance Committee on 29 January 2025

Ratified by the Board of Directors on: 5 March 2025

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**Wednesday 5 March 2025**		
Title of Report:	**Charities Committee Upward Report**		
Status	**For information / discussion**		
Author	**Sumita Hutchison, Non-Executive Director**		

Key discussion points and matters to be escalated from the Charities Committee meeting on 13 February 2025

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 RUH Bath have a planning obligation to develop the green heart and have also received donations on this basis. RUH Bath are only able to contribute to a proportion of what they had originally hoped due to capital constraints. This challenge/risk was discussed alongside the potential impact from both a planning obligation perspective and a charities donation perspective. The Committee questioned whether the costed plan, currently at £2.5m, should be revised given that the Council obligations arise from diversity net gain.
- The general fund monies are constrained, and the Committee has recommended that no further monies are spent unless there is a very good reason for this expenditure. A discussion took place regarding expenditure for the staff awards and some proposals were put forward.

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

- No items to report.

ASSURE: Inform the Board where positive assurance has been achieved

- No items to report.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- No items to report.

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

- The funds from RUHX have contributed to some important projects. A summary of these is as follows:
  - Stacking chairs for the Children's Ward.
  - Travel for staff to attend the Royal College of Emergency Medicine 2025 Advanced Clinical Practitioner Conference.
  - Head mounted binocular indirect ophthalmoscope for Ophthalmology.
  - Cardiac monitor for the Pain Clinic.
  - Improvements to the Mortuary Viewing Room and relatives' area.
  - Oncology clinical trials rotor and adaptors for centrifuge.

    - Patient Experience project to support patient dignity through clothing donations.
    - Research project around serological markers in systemic autoimmune disease.
- The RUH are hugely grateful to the League of Friends for the significant impact they have on the hospital. This financial year, they made a sum of £400,000 available to the Trust which wards and departments have the opportunity to submit bids. They also have a good cohort of volunteer, a total of 207.
- NHS Charities Together funded community partnerships and some of the outcomes of these were highlighted to the Committee. This work supports the Trust to make progress as part of its You Matter Strategy, for its communities, and to fulfil its function as an anchor organisation.

APPROVALS: Decisions and Approvals made by the Committee

- The Committee approved:
    - funding applications for a number of projects.
    - The RUHX spending plan for 2025/26.
    - The service level agreement for admin services between the Trust and charity.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	16
Date of Meeting:	5 March 2025		

Title of Report:	Non-Clinical Governance Committee Terms of Reference
Status:	For Approval
Board Sponsor:	Sumita Hutchison, Non-Executive Director
Author:	Roxy Milbourne, Interim Head of Corporate Governance

1. Executive Summary of the Report

The Terms of Reference (ToR) for the Non-Clinical Governance Committee defines the structure and purpose of the Committee. The Committee reviewed its ToR at its meeting in January and they are presented for approval and endorsement by the Board of Directors.

The ToR have been refreshed to reflect the format of the other sub-Committees of the Board and to update the membership and frequency of the Committee. The Committee agreed to make one further amendment to the membership to reflect that the Chief Nursing Officer was part of the membership in her role as Interim Director of Estates and Facilities.

The Interim Head of Corporate Governance also informed the Committee of the statutory reporting requirements around Emergency Preparedness, Resilience, and Response (EPRR) and the following line has been added to the Committee's objectives to incorporate this:

- Receive the Emergency Preparedness, Resilience, and Response (EPRR) Annual Report, including the overall assurance rating, to ensure that the Trust is compliant with the NHS EPRR Framework.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to approve the Terms of Reference.

3. Legal / Regulatory Implications

Updating the Committee's Terms of Reference is part of governance best practice, and in line with processes undertaken by other Board Committees.

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

Not applicable

5.	Resources Implications (Financial / staffing)
Not applicable	

6.	Equality and Diversity
Not applicable	

7.	References to previous reports
This review is conducted annually.	

8.	Freedom of Information
Public	

9.	Sustainability
Not applicable	

10.	Digital
Not applicable	

Non-Clinical Governance Committee
Terms of Reference

1. Constitution

The Board of Directors ("Board") hereby resolves to establish a Committee to the Board to be known as the Non-Clinical Governance Committee ("the Committee"). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Terms of Reference

2.1 Purpose

To provide assurance to the Board that the Trust has a robust framework in place for the management of risks arising from or associated with estates and facilities, environment and equipment, environmental sustainability, health and safety, digital development, cyber-security, information governance, business continuity and other non-clinical areas as may be identified.

The Committee will provide assurance to the Board around the processes for the delivery of non-clinical services and systems and maintain oversight of the effectiveness and value of those services.

To provide assurance to the Board that robust controls are in place to ensure compliance with external and internal regulatory guidance for the delivery of non-clinical services and systems.

2.2 Objectives

The primary objectives of the Committee are to provide assurance to the Board that the key critical non-clinical systems and processes are effective and robust, and to provide effective scrutiny in these areas under delegated responsibility from the Board. The Committee will ensure a sustained focus on reputational management and how any potential risks could impact the Trust, in addition to maintaining oversight of business continuity across the Trust.

The Committee will oversee and monitor performance in the following non-clinical systems and processes:

- Digital;
- Cyber Security;
- Information Governance;
- Health & Safety;

- Estates and Facilities;
- Environmental Sustainability;

In addition the Committee will:

- Review the controls and assurances against relevant risks on the Board Assurance Framework, in order to assure the Board that priority risks to the organisation are being managed and to facilitate the completion of the Annual Governance Statement at year end.
- Undertake a programme of deep-dives or site visits into the key critical non-clinical areas to provide greater understanding and assurance.
- Consider external and internal assurance reports and monitor action plans, in relation to non-clinical risk, resulting from improvement reviews/notices from the Health and Safety Executive and other external assessors.
- On occasion seek assurance from a Lead Director from another Committee.
- Receive the Emergency Preparedness, Resilience, and Response (EPRR) Annual Report, including the overall assurance rating, to ensure that the Trust is compliant with the NHS EPRR Framework.

3. Membership

Membership of the Committee will comprise of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors
- Chief Nursing Officer in capacity as Interim Director of Estates and Facilities (Lead Executive)
- Chief Strategic Officer
- Chief Financial Officer

The following staff are required to attend meetings of the Non-Clinical Governance Committee:

- Chief Digital Information Officer
- Head of Information Governance
- Deputy Director of Estates and Facilities
- Head of Corporate Governance

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

4. Quorum and Attendance

Business will only be conducted if the meeting is quorate. The Committee will be quorate with three members present, including at least one Non-Executive Director and one Executive Director.

Members will be required to attend a minimum of 4 meetings per year.

5. Frequency

The Committee will meet a minimum of four times a year. Additional meetings may be arranged as required.

6. Accountability and Reporting Arrangements

The Committee will be accountable to the Board. The Chair of the Committee will complete an upward report to the Board of Directors on the activity of the Committee at its last meeting. The report shall draw to the attention of the Board issues that require disclosure to the full Board, or require executive action.

The Committee shall refer to the other Board Assurance Committees (the Audit and Risk, People, Finance and Performance and the Quality Assurance Committees) matters considered by the Committee to be relevant to their work. The Committee will consider matters referred to it by those other Assurance Committees.

The Committee will develop a work plan which will describe the key reports it will consider during the year. This work plan will be agreed by the Committee.

7. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Board will retain responsibility for all aspects of internal control, supported by the work of the Committee, satisfying itself that appropriate processes are in place are in place to provide the required assurance.

The Committee has decision making powers with regard to the ratification of non-clinical policies and approval of non-clinical procedural documents. It is established to provide recommendations to the Board on risk management, governance and patient, staff and public safety issues.

The Committee is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

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.

9. Other Matters

The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:

- Agreement of the agenda with the Chair and Executive Leads;
- Collation of the papers which will be disseminated five working days in advance of the meeting.
- Arranging for minutes and actions which will be disseminated five working days after the meeting.
- Advising the Committee on pertinent areas.

10. Review

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

Terms of Reference approved by the Non-Clinical Governance Committee on 14th January 2025

Ratified by the Board of Directors: 5th March 2025

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**5 March 2025**		

Title of Report:	**Mineral Hospital Assets**
Status:	**To note**
Board Sponsor:	**Joss Foster, Chief Strategic Officer**
Author:	**Roxy Milbourne, Interim Head of Corporate Governance**
Appendices	**None**

1. Executive Summary of the Report

The Royal United Hospitals Bath NHS Foundation Trust (RUH) acquired the Royal National Hospital for Rheumatic Disease (RNHRD) on 1st February 2015. This transaction was a statutory acquisition under the NHS Act 2006 (Section 56A). A Grant of Acquisition was issued by Monitor at the time (now NHS England), stating that the RUH is the statutory successor to the RNHRD. As a result of the acquisition, the Trust inherited a number of heritage assets from the RNHRD building, these assets included equipment, paintings, books and documents.

In 2018, a Loan and Joint Working Agreement was drawn up between the Trust and the Bath Medical Museum (BMM) to enable the Trust to provide a long-term loan of historic medical artefacts to the BMM for safe keeping and appropriate public exhibition within the context of establishing a medical museum. A number of other items went to Pulteney Practice GP Surgery as well as the Victoria Art Gallery.

In November 2024, the Trust was notified that renovation works had begun at Great Pulteney Street GP Surgery and the future use of the site as a GP surgery may change in the near future. As a result, the loan of the items that went to Pulteney Practice was terminated on 31st January 2025 and options for relocation are outlined within the report.

In particular, the Board is asked to note the Chair's action to gift (with conditions) five paintings and the Bust of Dr William Falconer to the Guildhall, Bath in January 2025.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to:

1. Note that Chair's action was taken in January 2025 to gift the following items with conditions to the Victoria Art Gallery/Guildhall; five paintings and the Bust of Dr William Falconer to The Guildhall, Bath.
2. Note that work is being undertaken to create a comprehensive inventory of RNHRD assets on loan to BMM. Once complete an appendix will be added to the Deed of Variation of Loan and Joint Working Agreement between the Trust and BMM.
3. Note that this work will be progressed and RNHRD assets will be discussed at the Trust's Finance and Performance Committee meeting on behalf of the Board and a further update will be provided to the Board in due course.

3.	Legal / Regulatory Implications
The transaction to acquire the RNHRD was a statutory acquisition under the NHS Act 2006 (Section 56A). A Grant of Acquisition was issued by Monitor at the time (now NHS England), stating that the RUH is the statutory successor to the RNHRD. The Grant of Acquisition confirms that all of the assets, property and contracts including but not limited to those specified in the Transaction Agreement, transferred from RNHRD to RUH on 1 February 2015, and by virtue of Paragraphs 3.1.4/5, those transfers are binding on third parties.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
All RNHRD assets with BMM have not been fully documented and have not been recognised in the Trust's statement of financial position to date. Work is ongoing to understand what items there are and is they have any monetary value.	

5.	Resources Implications (Financial / staffing)
The Trust has not obtained any up-to-date valuations since 2015, as it could be argued that the cost would not be commensurate with the benefits to users of the Trust. The Finance and Performance Committee will need to consider this and any associated risks.	

6.	Equality and Diversity
No equality, diversity, and inclusion impacts have been identified.	

7.	References to previous reports/Next steps
N/A	

8.	Freedom of Information
Public	

9.	Sustainability
N/A	

10.	Digital
N/A	

Introduction
The Royal United Hospitals Bath NHS Foundation Trust (RUH) acquired the Royal National Hospital for Rheumatic Disease (RNHRD) on 1st February 2015. This transaction was a statutory acquisition under the NHS Act 2006 (Section 56A). A Grant of Acquisition was issued by Monitor at the time (now NHS England), stating that the RUH is the statutory successor to the RNHRD.

The Grant of Acquisition confirms that all of the assets, property and contracts including but not limited to those specified in the Transaction Agreement, transferred from RNHRD to RUH on 1 February 2015, and by virtue of Paragraphs 3.1.4/5, those transfers are binding on third parties.

As a result of the acquisition, the Trust inherited a number of heritage assets from the RNHRD building, these assets included equipment, paintings, books and documents.

In 2018, a Loan and Joint Working Agreement was drawn up between the Trust and the Bath Medical Museum (BMM) to enable the Trust to provide a long-term loan of historic medical artefacts to the BMM for safe keeping and appropriate public exhibition within the context of establishing a medical museum.

A number of other items went to Pulteney Practice GP Surgery as well as the Victoria Art Gallery.

Great Pulteney Street GP Surgery
In November 2024, the Trust was notified that renovation works had begun at Great Pulteney Street GP Surgery and the future use of the site as a GP surgery may change in the near future. As a result, they would need to terminate the loan of the following items by 31st January 2025:

1. **Paintings, includes valuations:**

Paintings on Loan	Artist	Age/ Size / Paint	Value
Portrait of Mrs Morris Mother of the 1st Apothecary	Benjamin Morris	Est. C18th / 75x62 / Oil on Canvas	**£6,000.00**
D Richard Frenwin	English School	Est. C18th / 75x63 / Oil on Canvas	**£2,000.00**
Portrait of Unknown Gentleman	Joseph Beschey	Est. C18th / 73x61 / Oil on Canvas	**£7,000.00**
Major William Brereton	English School	C1760 / 74x62 / Oil on Canvas	**£4,000.00**
John Donne	English School	Est. C18th / approx. 75x63 / Oil on Canvas	**£2,000.00**

2. **Bust of William Falconer – value unknown**
3. **The Bath Sedan Chair – value unknown**
4. **Strong Box – value unknown**
5. **Xray Box – value unknown**

Assets
Whilst there is a record of some heritage assets on loan to BMM and Pulteney Practice, not all items with BMM are fully documented. In collaboration with BMM, the Trust's Art Manager is undertaking a piece of work to clearly document and photograph all items.

As the assets are not operational and are not held to deliver front line services or back-office functions, to date, the assets have not been recognised in the Trust's statement of financial position. In addition to this, the Trust has not obtained any up-to-date valuations since 2015, as it could be argued that the cost would not be commensurate with the benefits to users of the Trust.

BMM have suggested that valuing the whole collection would be difficult as the assets were mostly of historical rather than monetary value.

The Board of Directors via the Finance and Performance Committee will be asked to consider whether or not to value the RNHRD assets and discuss the risks associated.

Once this work is complete, an inventory will be added to the Deed of Variation of Loan and Joint Working Agreement between the Trust and BMM.

Relocation options
The items from Pultney Practice have been collected and the Trust is currently storing them. BMM and the Trust's Art Manager are working to relocate the following items:

- Strong Box
- X-ray Box

Victoria Art Gallery / Guildhall, Bath: B&NES Council
The Victoria Art Gallery / Guildhall, Bath: B&NES Council have agreed to take the following items:

- Five paintings as described on page 3 of this report.
- The Bust of Dr William Falconer

As these items needed to be removed from Great Pulteney Street Practice by 31st January 2025, The Chair of the Trust agreed to the gift these items with conditions of the artefacts referred to as the "Bust of William Faulkner" as well as five paintings to the Victoria Art Gallery/ Guildhall. The key conditions of this gift being that they remain on public display and should Victoria Art Gallery/ Guildhall wish to dispose of these in the future, that the Trust have first refusal to have these returned as a gift.

The Board of Directors is asked to note this update.

The Jane Austen Museum, Bath
On the 3rd February, The Jane Austen Museum, Bath, have taken receipt of the Bath Sedan Chair for display in their museum.

Recommendations

The Board of Directors is asked to:

1. Note that Chair's action was taken in January 2025 to gift the following items with conditions to the Victoria Art Gallery/Guildhall; five paintings and the Bust of Dr William Falconer to The Guildhall, Bath.

2. Note that work is being undertaken to create a comprehensive inventory of RNHRD assets on loan to BMM. Once complete an appendix will be added to the Deed of Variation of Loan and Joint Working Agreement between the Trust and BMM.

3. Note that the Finance and Performance Committee will review whether or not to value the RNHRD assets and discuss the risks associated, a further update to the Board would be provided in due course.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	18
Date of Meeting:	5 March 2025		

Title of Report:	Board Sub Committee, Terms of Reference Update
Status:	For approval
Board Sponsor:	Toni Lynch, Chief Nursing Officer
Author:	Roxy Milbourne, Interim Head of Corporate Governance
Appendices	None

1. Executive Summary of the Report

The Trust's Internal Audit provider, KPMG undertook a review of the Trust's Corporate Risk Management system in 2023/24. The subsequent review identified that the risk management responsibilities at Board Sub Committee level required an update.

It was agreed that the Terms of Reference for each sub-committee would be updated to ensure that the roles and responsibilities of risk domains were explicit. At the time the report was published, the Trust was assigning newly agreed risk domains to relevant Board Sub-Committees.

The risk domains have now been agreed, and the Board is asked to approve the suggested text for each Sub-Committees' Terms of Reference.

Once approved, the Head of Corporate Governance will insert the text as an objective within each Committees Terms of Reference.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to approve the updated draft risk objective for each Committee's Terms of Reference.

3. Legal / Regulatory Implications

Updating the Committee's Terms of Reference are part of governance best practice, and in line with processes undertaken by other Board Committees.

4. Risk

There is a risk that risk management at board sub-committee level is incomplete and some major risks may not receive sufficient discussion.

5. Resources Implications

Not applicable.

6. Equality and Diversity

Not applicable.

7. References to previous reports

This review is conducted annually or by exception.

8.	Freedom of Information
Public	

9.	Sustainability
Not applicable	

10.	Digital
Not applicable	

Board Sub-Committees Terms of Reference update

Introduction

In 2023/24, the Trust's Internal Audit provider, KPMG, undertook a review of the Trust's Corporate Risk Management system and the subsequent report identified that the risk management responsibilities at Board Sub-Committee level required an update.

It was agreed that the Terms of Reference for each Sub-Committee would be updated to ensure that the roles and responsibilities of risk domains were explicit. At the time the report was published, the Trust was assigning newly agreed risk domains to relevant Board Sub-Committees.

The risk domains have now been agreed, and rather than wait for the Board Sub-Committees annual review in September 2026, the Board of Directors is asked to approve the suggested text to add to each of the Sub-Committees' Terms of Reference.

It is proposed that the Trust Management Executive (TME) TOR are also updated to ensure roles and responsibilities are explicit.

Terms of Reference

The Board of Directors is asked to approve the following text for each sub-committees Terms of Reference:

Finance and Performance Committee	• The Committee shall ensure the Trust has robust risk management systems and processes in place for financial, service delivery and performance risks, statutory duty/compliance and reputational (financial and performance related) risks. In particular, the Committee will: o Act as the forum for these risks to be discussed, and assure itself that where concerns are raised, action is taken, and that action plans are completed. o Act in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.
People Committee	• The Committee shall ensure the Trust has robust risk management systems and processes in place for workforce risks, statutory duty/compliance and reputational (workforce related) risks. In particular, the Committee will: o Act as the forum for these risks to be discussed, and assure itself that where concerns are raised, action is taken, and that action plans are completed.

	○ Act in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.
Non-Clinical Governance Committee	• The Committee shall ensure the Trust has robust risk management systems and processes in place for Estates and Facilities, Digital, Information Governance, Health & Safety and Environmental risks, statutory duty/compliance and reputational (non-clinical related) risks. In particular, the Committee will: ○ Act as the forum for these risks to be discussed, and assure itself that where concerns are raised, action is taken, and that action plans are completed. ○ Act in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.
Trust Management Executive	The Trust Management Executive (TME) is responsible for the corporate oversight of the risks facing the organisation, which will include: • Monitoring the structures, processes, and responsibilities for identifying and managing key risks facing the organisation. • The final approval of all risks added to the Risk Register with a score of ≥ 16, to assess whether the scoring and proposed action plans are appropriate. • The monthly review of all current risks on the Risk Register with a current score of ≥ 16, monitoring progress against the action plan agreed to mitigate the risk or identifying actions necessary to achieve completion of the action plan.

The Trust's Audit and Risk Committee reviews the process by which the Trust's significant risks are identified and ensures that the Board is fully appraised of these risks.

The risk domains are already included within the Quality Assurance Committee's terms of reference.

Once approved, the Head of Corporate Governance will insert the text as an objective within each Committees Terms of Reference.

A comprehensive review is underway of the Trust's risk management policy and processes. A revised framework and policy is due to be completed in Q2.

Recommendations

The Board of Directors is asked to:

- Approve the text outlined in this report for use in each Sub-Committees Terms of Reference.
- Approve the additional text on risk management for inclusion in the TME Terms of Reference.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**5 March 2025**		

Title of Report:	**Group Joint Chair Role**
Status:	**Approval**
Board Sponsor:	**Nigel Stevens, Senior Independent Director**
Author:	**Roxy Milbourne, Interim Head of Corporate Governance**
Appendices	**Appendix 1: Guide to the appointment of Group Chair** **Appendix 2: Joint Chair and Local Lead NED tasks and assumptions**

1. Executive Summary of the Report

At the Board meetings of the Great Western Hospitals NHS FT, Royal United Hospitals Bath NHS FT on 22 July 2024 and Salisbury NHS FT on 5 September 2024 each Board of Directors approved the Case for Change to move to a Group model, which included the approval of shared leadership and to identify a BSW Hospitals Group Chief Executive and a Joint Chair for the Trusts.

On 1 November 2024 Cara Charles-Barks was appointed as BSW Hospitals Group Chief Executive. The proposed next step is to appoint a Joint Chair to support Group development leadership.

The post would be a single role across three separate statutory organisations, each responsible for delivering their own services, but ensuring a strengthened delivery of joint commitments for improving quality of care, effectiveness and efficiency for the BSW population we serve.

The focus and test of effectiveness must be about the benefit to patients, and whether these are being delivered.

A Joint Chair is expected to create a number of benefits whilst recognising the potential of a discreet number of associated disbenefits.

There is no legal restriction that would impede an individual simultaneously being the Chair of more than one Trust.

There are Statutory requirements and National guidance to consider in respect of the appointment process.

The BSW ICB Chair has indicated support for the recruitment of a Joint Chair, considering the role will enable a strong response to the significant system challenges BSW faces. NHS England's Regional team also supports recruitment of a Joint Chair and establishment of Joint Committee arrangements.

To facilitate the appointment of the Joint Chair as early as is practical, it is recommended that each Council of Governors agree a clear process for nominating a

Joint Chair, working with the Senior Independent Directors (SIDs) and with support of People Services.

It is recommended that the Councils of Governors establish a Joint Nominations Committee with responsibility for undertaking the selection process of the Joint Chair and making a recommendation to each Council of Governors of a preferred candidate. Options are presented for consideration and further development by the Joint Nominations Committee.

A job description and person specification will be initiated for consideration and further development by the joint Nomination Committee [in March] incorporating the already agreed current roles and responsibilities of a Trust Chair plus the additional responsibilities of the new group role.

The time commitment for the Joint Chair role is proposed as between three to four days per week.

2.	Recommendations (Note, Approve, Discuss)

The Board is requested to:

- Support the development of a Job Description and Person Specification for a Joint Chair in support of the Nominations Committee of the Council of Governors recommendation to the Council of Governors (CoGs); and,
- Consider and recommend to respective CoGs the options to appoint a Joint Chair as outlined in section 4.

3.	Legal / Regulatory Implications

There is no legal restriction that would impede an individual simultaneously being the Chair of more than one Trust.

There are Statutory requirements and National guidance to consider in respect of the appointment process as outlined in the paper.

4.	Risk

A Joint Chair is expected to create a number of benefits whilst recognising the potential of a discreet number of associated disbenefits.

5.	Resources Implications (Financial / staffing)

Not applicable

6.	Equality and Diversity

Not applicable

7.	References to previous reports/Next steps

None

8.	Freedom of Information
Public	

9.	Sustainability
Not applicable	

10.	Digital
Not applicable	

1. Background

1.1 At the Board meetings of the Great Western Hospitals NHS FT, Royal United Hospitals Bath NHS FT on 22 July 2024 and Salisbury NHS FT on 5 September 2024 each Board of Directors approved the Case for Change to move to a Group model, which included the approval of shared leadership and to identify a BSW Hospitals Group Chief Executive and a Joint Chair for the Trusts.

1.2 On 1 November 2024 Cara Charles-Barks was appointed as BSW Hospitals Group Chief Executive following a robust recruitment process and approval from each of the Council of Governors.

1.3 The proposed next step is to appoint a Joint Chair to support Group development leadership.

2. Introduction

2.1 The proposed Joint Chair appointment follows similar approaches being adopted by hospital providers across England and reflects wider NHS provider collaboration policy.

2.2 The post would be a single role across three separate statutory organisations, each responsible for delivering their own services, but ensuring a strengthened delivery of joint commitments for improving quality of care, effectiveness and efficiency for the BSW population we serve.

2.3 The creation of a joint post does not indicate any desire for or proposals for merger between the Trusts. There is no system pressure for a merger between the Trusts and all three Trusts remain distinct organisations with their own Board of Directors.

2.4 The focus and test of effectiveness must be about the benefit to patients, and whether these are being delivered.

2.5 A Joint Chair is expected to create the following benefits:-

- Enables a cross fertilisation of cultures, learning and practice between the Trusts.
- Assists building relationships across trusts, helping stabilise leadership teams.
- Facilitates more joined-up care and increased alignment of the Trusts, reduction in unwarranted variation, encouragement of collaboration in service provision, including specialised services.
- Aids system working and the creation of an integrated healthcare system – working with partners and sharing services.
- Supports BSW Hospitals to address significant operational and financial system challenges ahead.
- Creates a unified governance structure for measuring delivery of Group ambitions.

- Supports taking of difficult decisions by the Trusts, in the current and future interests of wider BSW population.
- Helps to facilitate mutual support.
- Supports the BSW Hospitals Group Chief Executive to create environment to deliver the benefits of working as a Group, including the BSW Hospitals Case for Collaboration, set out in May 2024.

2.6 Some potential disbenefits to be managed have also been identified:-

- Potential loss of local leadership and visibility.
- Potential impact on individual relationship development between Chair and Governors.
- In response, it is envisaged that the Chair will put governance arrangements in place to support them in their role, with emphasis on the role of the Vice Chairs in each Trust - whilst being clear that the responsibility to provide visible leadership remains that of the Chair. **Appendix 2** sets out potential division of roles between Joint Chair and Vice Chairs.

3. Governance, legal or regulatory considerations

3.1 There is no legal restriction that would impede an individual simultaneously being the Chair of more than one Trust.

3.2 **Statutory Requirement**: The National Health Service Act 2006 (NHSA) requires NHS foundation trusts to have a chair.

The Council of Governors is responsible at a general meeting for the appointment, re-appointment and removal of the Chair and other non-executive directors (paragraph 17(1) of Schedule 7 to the NHSA).

The Council of Governors must also decide the remuneration and allowances, and the other terms and conditions of office of the Chair and other non-executive directors (paragraph 18(1) of Schedule 7 to the NHSA)

3.3 **National Guidance**: The Code of Governance for NHS Provider Trusts (April 2023) sets out the following points in respect of the appointment of the Chair:

A Nomination Committee, with external advice as appropriate, is responsible for the identification and nomination of non-executive directors (paragraph 2.1).

The Nominations Committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them (paragraph 2.1).

The governors should agree with the Nominations Committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the Nominations Committee should make recommendations to the Council of Governors (paragraph 2.4).

When considering the appointment of non-executive directors, the council of governors should take into account the views of the Board of Directors and the Nominations Committee.

3.4 **System and Regional support**: The BSW ICB Chair has indicated support for the recruitment of a Joint Chair, considering the role will enable a strong response to the significant system challenges BSW faces. NHS England's Regional team also supports recruitment of a Joint Chair and establishment of Joint Committee arrangements.

3 Process to recruit a Joint Chair

4.1 To facilitate the appointment of the Joint Chair as early as is practical, it is recommended that each Council of Governors agree a clear process for nominating a Joint Chair, working with the Senior Independent Directors (SIDs) and with support of People Services.

4.2 It is recommended that the Councils of Governors establish a Joint Nominations Committee with responsibility for undertaking the selection process of the Joint Chair and making a recommendation to each Council of Governors of a preferred candidate.

4.3 Options for consideration and further development by Joint Nominations Committee

Options	**Timeline Assumptions, Risks and Benefits**
Option 1 • Open external recruitment process, assume internal candidates short-listed.	• Executive Search firm confirmation: end March • Recruitment process April - July • If new post holder, settling-in period Sept – March 26 • Risks/ benefit. Impact on benefits delivery during challenging period for Group – including during recruitment exercise and settling period.

	Benefit of external process – perceptions among stakeholders regarding process strength/ wider pool of candidates. • Assume 3-year role, with standard additional term potential.
Option 2 • Interim appointment, pending completion of external open recruitment process. • Role ringfenced to current Chairs of Trusts. Applications and interview process. Propose 6-8 months role.	• Interim appointment potentially in Q1 • Risk/ benefit. Supports stabilisation and benefits delivery during challenging period for Group. • 6-8 month term to allow time for an open recruitment process supporting stabilisation. • To be followed Q1-Q3 by external recruitment exercise.

4.4 A guidance document has been developed outlining the recruitment process to support the governors and SIDs in this process, attached as **appendix 1**.

5. Job Description

5.1 A job description and person specification will be initiated for consideration and further development by the joint Nomination Committee [in March] incorporating the already agreed current roles and responsibilities of a Trust Chair plus the additional responsibilities of the new group role.

5.2 The time commitment for the Joint Chair role is proposed as between three to four days per week for the following reasons:-

- The limit allows focus on the strategic role of the Chair without encroaching on the role of the CEO and the Executives.
- As described in s. 2.6 above, it is anticipated that the Chair will put governance arrangements in place which support them in their role, with a particular emphasis on the role of the Vice Chairs. **Appendix 2** *[NOTE: Document to be developed further]* outlines a summary of the suggested disposition of Chair tasks between a Chair and a Vice-Chair for consideration and further development by the Nominations Committee. It is suggested that the Vice-Chair role time commitment would increase to accommodate this support to six days per month, with no committee responsibilities.
- Formation of joint committees and committees in common in due course, where appropriate, will mitigate some time pressures.

6. Recommendations

6.1 The Board is requested to:

- Support the development of a Job Description and Person Specification for a Joint Chair in support of the Nominations Committee of the Council of Governors recommendation to the Council of Governors; and,
- Consider and recommend to respective CoGs the options to appoint a Joint Chair as outlined in section 4.

APPENDIX 1

Guide to the appointment of Joint Chair

Table of Contents

Table of Contents (continued)

1. Purpose of Document

1.1 The aim of this document is to:

- Support Governors of the three BSW Hospital Group Trusts in relation to the process for the appointment of a Joint Chair including their role and the role of the Boards of Directors (Board), Senior Independent Directors (SID) and other stakeholders.
- Ensure that the appointment is made as smoothly and effectively as possible in a fair, open and transparent way.
- Ensure that the successful candidate has the skills and experience to lead three Trusts over the coming years.

2. Context

2.1. A Joint Chair is defined as '*an individual who is appointed to chair more than one Trust to maximise the potential for synergy*'; in particular to:

- Lead and enable the three organisations to harness the strengths of each other
- Share resources, innovation and leadership for the benefits of the populations we serve
- Provide leadership to the acute and community health collaborative arrangements in the system of which the Trusts are part.

2.2 The Joint Chair will be a single post across the three separate organisations, each responsible for delivering their own services but ensuring a strengthened delivery of joint commitments for improving the quality of care and efficiency for the populations we serve.

2.3 The Joint Chair will chair the three separate Trust Boards and three Councils of Governors.

2.4 The aim of the recruitment process is to ensure the Trusts appoint the best person to lead the organisations within the context they are currently operating in, particularly in respect of a move towards greater collaboration within a Group model and beyond.

3. Responsibilities

3.1 **Role of Governors**

Under the National Health Service Act 2006, the Council of Governors appoints the Chair and decides their remuneration, allowances and other terms and

conditions of office. **It is proposed that the Councils of Governors agree to form a Joint Nominations Committee to undertake the selection process of the Joint Chair and to make a recommendation of a single preferred candidate to each Council of Governors**. The Joint Nominations Committee does not have any formal powers delegated by the individual Trusts or Councils of Governors; all responsibilities are undertaken in support of the Councils of Governors who each hold the responsibility for decisions relating to the appointment of the Joint Chair.

Following the start of the selection process, all three Councils of Governors will be offered separate informal drop-in sessions to enable them to raise questions and keep governors informed during the selection process. It is anticipated one of the sessions for each Council of Governors will be led by the Chief Executive (CEO) and respective SID.

The Joint Nominations Committee will be responsible for identifying a single preferred candidate on behalf of each Council of Governors. A recommendation for appointment will then be presented to each Council of Governors.

3.2. **Role of the Boards**

It is important that the views of the Board and the CEO in particular are taken into account with regards to the skills and experience required for the Joint Chair role particularly in respect of Board balance and succession planning as well as both the local and national NHS context in respect of the Chair.

3.3. **Role of the Joint Nominations Committee**

The membership of the Joint Nominations Committee (Joint NomCo) comprises of the following from each Trust:

- [Two] nominated Governors from each Trust.
- Senior Independent Directors (SIDs) – one to be chair of the Joint NomCo
- CEO.

The SIDs and CEOs are non-voting members of the Joint NomCo. As detailed in its terms of reference, the Joint NomCo will have delegated responsibility to select candidates to fill the Joint Chair role and recommend a candidate to each Council of Governors for appointment. This includes:

- Establishing an open and transparent process in line with the Nolan Principles and other good practice guidance.
- Carrying out the selection process on behalf of the Councils of Governors for the selection of a suitable candidate from the current Trust Chairs who fits

the criteria for the appointment of the Joint Chair set out in the job description developed by the Boards.

- Appointing an external recruitment agency to facilitate the search and support the overall recruitment process.
- Preparing a description of the role, capabilities, skills, knowledge and experience and expected time commitment required taking account of the recommendations of the Boards. In particular, account shall be taken of the focus on improving population health, changing external landscape and the Trusts' role as an integrated care system leader. The views of NHS England and the ICB will also be sought and reflected.
- Recommending to each Council of Governors the Joint Chair's remuneration and terms and conditions of office including time commitment.
- Ensuring compliance with any mandatory guidance and relevant statutory requirements.
- Agreeing the members of the interview panel. The recruitment process and in particular the interview process demands a certain level of experience and understanding by Joint NomCo members and this will be borne in mind when agreeing the members of the interview panel. The interview panel shall include a representative of NHSE / the ICB. All Governors involved on the interview panel will be required to attend refresher training which also covers the relevant equality and diversity requirements prior to interviews taking place.
- Providing assurance to the Councils of Governors that it has followed due process and highlight the proposed candidate's significant attributes.

3.4 **Role of the Recruitment Agency**

A recruitment agency will be appointed by the Joint NomCo to lead the search. Working in partnership with the Joint NomCo the agency will use their expertise to help identify the best candidates for the vacancy. The agency will support with the preparation, generate the candidate pool, and support with the selection process:

- Preparation: this will include understanding the demands of the role, criteria, the timetable and advertising opportunities
- Generating the candidate pool: this will include developing a pool of candidates for the role using their relevant networks and contacts, and ensuring diversity through a fair, balanced and inclusive process, as well as undertaking relevant Fit and Proper Persons checks
- Selection: this will cover support throughout the recruitment process including with sifting, longlisting, shortlisting, stakeholder panels and interviews.

4. Joint Chair Role Description and Person Specification

As mentioned above, the development of the Joint Chair role description and person specification will be undertaken by the Joint Nominations Committee, and the views of Boards, NHSE and the ICB will also be sought and reflected.

The role description and person specification will be included within the Candidate Information Pack. This will include specific responsibilities and the essential and desirable skills, knowledge, experience and attributes required to undertake the Joint Chair duties including ensuring the Boards can function efficiently and effectively given the existing composition of the Boards, the Trusts' vision and strategic priorities, as well as the external NHS environment.

5. Terms and Conditions

The terms and conditions, including appropriate remuneration and required working days, are also considered by the Joint NomCo. Remuneration will be considered using benchmarking information and ensuring that it reflects the time commitment and responsibilities of the role. In addition, consideration will be taken of the NHSE guidance on Chair remuneration and other benchmarking information.

The Joint NomCo will provide recommendations to the Councils of Governors for approval.

6. Recruitment Campaign

The vacancy will be advertised as agreed with the recruitment agency and will include both local and national advertising as well as through social media, and the use of the Trusts' own internal communications function. An advert will be included in the Candidate Information Pack. During the advertising phase, potential candidates will have the opportunity of having information conversations with the CEOs and/or Chairs/SIDs or other colleagues including other Board members and Governors if requested.

7. Internal Candidates

It is proposed that internal candidates be asked to submit an expression of interest and those that submit an expression of interest would be guaranteed a place on the final shortlist of candidates. Final decisions about invitation to interview will be on merit alongside external candidates.

Internal candidates are those operating as a Trust Chair at any of the three Trusts.

8. Selection Process

This section covers arrangements from the applications closing date to completion of interviews.

This section covers arrangements from the applications closing date to completion of interviews.

8.1. Sifting

The sifting process will be undertaken to reduce the number of applications to a manageable list for review. This would usually take the form of grading each applicant for consideration for the next stage, e.g. recommended, marginal, not recommended. This process will be undertaken by the **recruitment agency** to ensure that candidates to be considered for longlisting have met the application requirements and agreed competencies of the post as included in the person specification.

8.2. Longlisting

Information on all applicants will be circulated to the members of the **interview panel and SIDs** for consideration prior to the longlisting meeting. This will include the 'sift' summary, the application letters and CVs and also an equal opportunity monitoring report. The aim of the longlisting meeting is to identify those applicants who meet the application requirements and agreed person specification, and to invite them to a preliminary interview with the recruitment agency. Those not longlisted will be advised accordingly by the agency.

8.3. Preliminary Interviews

The **recruitment agency** will undertake preliminary competency and values-based interviews with those applicants confirmed as longlisted. The interviews will explore the applicant's background and achievements, their style and overall suitability for the role. The interview will also cover other considerations such as time commitment, conflicts of interest and remuneration. A report on the preliminary interviews will be produced by the recruitment agency. This will highlight the strengths and areas of concern/development for each candidate interviewed, and include recommendations for shortlisting, the grading of each applicant based on the interview, and an equal opportunity monitoring report.

8.4. Shortlisting

The shortlisting process is conducted by the **interview panel** with the aim of identifying suitable candidates for interview, supported by **SIDs** as well as the recruitment agency. The agency will provide a report following the preliminary interviews which details the suitability, eligibility and credibility of applicants; the recommendations are based on the person specification.

Only those applicants who have been shortlisted will then be invited to interview; those applicants who are not shortlisted will be advised by the recruitment agency.

8.5. **Interview Panel**

The Joint NomCo agrees the composition of the interview panel which would comprise:

- Governors: [Two] from each Trust who will be voting members
- Chair of panel who will be an independent NHS provider Chair (ie ideally an experienced Chair in Common/Joint Chair role)
- NHSE: one representative
- ICS representative

All SIDs will attend the interviews as observers.

In line with the Trusts' practice, the interview panel will include diverse representation.

8.6. Role of the Interview Panel

The role of the interview panel is to make objective and reasoned decisions concerning the relative merit of competing candidates against the criteria included in the person specification, and thereby identify the appointable candidate for recommendation to the Joint NomCo and subsequently to the Councils of Governors.

The key elements of the interview panel's role are to:

- Determine which applicants should be longlisted on the basis of the available information about them, ensuring equal consideration of all candidates
- Determine which applicants should be shortlisted on the basis of the feedback from the preliminary discussions led by the recruitment agency
- Interview each candidate against the established selection criteria
- Assess which candidates are appointable in the light of all the relevant evidence including the interview and taking account of feedback from stakeholder panels, etc
- Identify appointable candidates, describing how and the extent to which they met the key criteria
- Preserve the confidentiality of candidates throughout the selection process
- Ensure any personal or family relationships with particular candidates are declared within the panel and dealt with appropriately and consistent with the principles of fairness and merit.

8.7. Role of the Governors on the Interview Panel

In addition to the roles described in 8.6 above and following due consideration, the Governor representatives on the interview panel will vote on a suitable

candidate for appointment to the Joint Chair role for recommendation to the Joint NomCo and subsequently to the Councils of Governors. The candidate must be considered appointable by NHSE.

8.8 Role of the Independent Chair and other Independent Assessors

The independent assessors:

- Ensure that selection is made on merit after a fair, open and transparent process
- Are independent of the appointing organisation
- Provide guidance to the interview panel on the calibre, ability and attributes of the candidates at interview
- Contribute to the discussion among interview panel members when discussing the candidates' performance in the post interview discussions
- Play a full part in the interview process, i.e. will ask questions
- Do not vote.

8.9 **Recruitment Refresher Training**

Governors on the interview panel will be required to attend a refresher recruitment training session to ensure there is a common understanding and consistent approach and which also covers the relevant equality and diversity requirements. In addition, a briefing session with the CEO will be held for all Governors on the importance of the relationship between the Joint Chair and CEO.

8.10. **Informal Meetings/Discussions**

Applicants will be provided with the opportunity of having an informal conversation with the SIDs/CEO (and others as requested, such as Governors) during the application period.

8.11. **Stakeholders Survey**

The Joint NomCo may decide to carry out a stakeholder survey. The aim is to provide staff, Governors, service users and carers, and external stakeholders with the opportunity of sharing their views as to the key qualities they would like to see in the new Chair. Key themes identified can be used to help inform the questions asked at or presentations required at the stakeholder sessions.

8.12. **Governor Engagement and Communications**

Following the start of the recruitment process, Councils will be offered regular, separate informal drop-in sessions to enable them to raise questions and keep them informed during the lengthy identification and selection process. It is anticipated one of the sessions each will be joined by the CEO and SIDs.

8.13. Checks and References

The Trusts will:

- Take up references for the candidates shortlisted for interview in advance of the interview
- Carry out relevant checks including Fit and Proper Persons checks, disqualification checks with Companies House and other government agencies, and due diligence checks including various media searches.

8.14. **Stakeholder Sessions**

In addition to the formal interviews, there will be an opportunity for key stakeholders to meet with the candidates on an informal structured basis. The questions and focus at these sessions may be based on the feedback from the stakeholder survey. The key stakeholders panels usually included are:

- Directors from the three Boards, Governors, service users, staff and carers
- System stakeholders (representatives of the ICSs, usually the Chairs and CEOs)
- External stakeholders (e.g. representatives from local authorities, MPs, voluntary and partner organisations, other Trusts within the ICSs, etc).

Although the focus and questions and/or presentations will differ for the different stakeholder groups, the sessions will be structured so that the same format and the same questions/requirements are asked of each candidate and will be supported by an independent representative. The stakeholder groups' views will be shared with both the interview panel and Joint NomCo either by the independent representative or a member of the stakeholder group during the post-interview discussion to aid deliberations.

8.15 **The Interview**

The aim of the interview is to identify the most suitable candidate for the role.

(a) Interview Preparation

Prior to the interviews, the interview panel will decide on a set of questions to ask each candidate taking account of the essential criteria in the person specification and the Trusts' values. The interview panel will be chaired by the independent Trust Chair who will manage the welcome and closing remarks at the interview, as well as post interview discussions. All interview panellists should ensure that they have reviewed the applications in preparation for the interview and remind themselves of the key requirements and role description of the Joint Chair.

(b) Interview

Interview packs will be provided consisting of the interview programme and questions sheet as well as the role description, person specification, and CVs and application forms.

All interview panellists will have the opportunity of asking a question(s) and, where appropriate, asking follow-up or probing question(s).

The following best practice principles should be noted and applied throughout the interview process:

- The same questions should be posed to each applicant: these should be investigative and open ended with probing questions asked where needed
- The interview should start by easing the candidate into the interview – asking them to talk through their application form – ensuring any gaps in their employment history are explored
- Questions should be based on the criteria detailed in the person specification and the Trusts' values
- Personal questions/yes or no questions/leading questions/multiple questions in one/discriminatory questions should be avoided
- Notes should be taken during the interview to support with identifying whether the candidate is appointable or not and to allow the ranking of those identified as appointable. This will also form part of the audit trail to confirm that the process is fair.
- Each candidate should be scored; the interview panel will agree the final scores for each applicant
- All candidates should be asked as part of the interview process whether there are any reasons known to them that would create a conflict of interest or, in the event of their appointment, bring the Trust into disrepute (alternatively this will be taken up by the recruitment agency)
- Any gaps in employment, questions relating to referees or convictions disclosed should be addressed and a note kept on the applicant's interview notes of the discussion (alternatively this will be taken up by the recruitment agency)
- Candidates will be advised of the next steps including when a decision will be made, how they will be communicated with and how they can access feedback. The interview timetable will provide sufficient time for the interviews plus the opportunity to finish writing notes. For interviews that are held in person, copies of the interview panel interview notes will be collected by the Trusts for filing in line with Trusts' records retention policy. For interviews that are held virtually, interview panellists will be asked to either scan their interview notes and email to a designated Trust Secretary or asked to post the hard copies to the designated Trust Secretary.

SIDs will attend all interviews as observers.

8.16. **Recommendation to Appoint**

Following completion of all interviews, the interview panel, chaired by the Independent Chair, will review the evidence collected as part of the recruitment process including the responses and scores to interview questions to support with identifying the preferred candidate. At this meeting, which will include the full Joint NomCo as observers, the interview panel will:

- Hear the advice and opinion of the non-voting interview panel members
- Hear from interview panel members regarding their opinion of each candidate
- Hear the views from the stakeholder sessions.

Once agreement has been reached, references for the preferred candidate which will have been obtained in advance, will be provided to the interview panel for review or the Trusts will confirm that the relevant references and checks have been undertaken and are satisfactory. [***Note: process to be confirmed with CPOs & Trust Secretaries***] With these being considered satisfactory and the interview panel in agreement, the Joint NomCo will formally receive the outcomes of the interviews and appointment recommendation.

Members of the Joint NomCo will have the opportunity to ask questions for clarification and assurance.

Unsuccessful candidates should be offered feedback.

8.17. **Decision to Appoint: Council of Governors**

A report from the Joint NomCo will be presented to each Council of Governors at separate meetings in private with the appointment recommendation. This report should also provide a detailed overview of the various stages of the selection process and the reasoning behind the selection proposal, including the attributes of the preferred candidate. Due to representation from each constituent Nominations Committees, it is anticipated that decisions reached by the Joint NomCo will be endorsed when presented to each Council of Governors. Any decision by a Council of Governors not to appoint must be reasonable and full reasons for the decision provided.

9. Post Selection Actions

Following approval by the Councils of Governors of the appointment to the Joint Chair role, the Chief People Officer will formally inform the successful candidate of their appointment. The appointment letter will include the terms and conditions of office and a Memorandum of Understanding [***MOU to be developed, will confirm Joint Chair hosting, remuneration, division of costs between Trusts, allocation of time arrangements, and so forth***]; the individual will be required to sign and return both documents.

10. New Starter Requirements and Induction

10.1. **New Starter Requirements**

The following will also need to be actioned (but not limited to):

- Relevant HR processes including DBS checks and OH referral
- Completion of FPPTF checks
- Preparation of a joint Press/Media Release and communications to staff
- Update Trusts' websites
- Complete New Staff Starter Form
- Arrange access to IT systems
- Order ID badge(s)

10.2. **Induction**

The successful candidate will be required to undertake the Trusts' induction programme, complete mandatory online training, and attend NHS Providers relevant development programmes.

11. Background/Reference

11.1. **Relevant Statutory Requirements (National Health Service Act 2006):**

The Council of Governors are responsible at a general meeting for the appointment, reappointment and removal of the Chair and other NEDs.

11.2. **NHS England Code of Governance for NHS Provider Trusts**

[Note: Correct Numbering]

2. Appointments to the Board of Directors:

2.1 The Nominations Committee, with external advice as appropriate, is responsible for the identification and nomination of NEDs. The Nominations Committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.

2.3 The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.

2.4 The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chair and NEDs. Once suitable

candidates have been identified the Nominations Committee should make recommendations to the Council of Governors.

2.6 the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority… and also a majority of Governor representation on the Interview Panel.

2.14 Commitment:
The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.

5. Development, information & support

5.2 Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.

11.3. **Fit & Proper Persons Test Framework (FPPTF)**

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) introduced a “fit and proper person requirement” (Regulation 5) for all Board Directors of NHS bodies. Compliance with the Regulations will be monitored and enforced by the CQC as part of their inspection regime
- Under the regulations all provider organisations must ensure that Director-level appointments meet the FPPTF and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director (or equivalent) or a Non-Executive Director under given circumstances.
- The Trust must demonstrate that it has appropriate systems and processes in place to ensure that all new appointees and current Directors are, and continue to be, fit and proper persons
- The purpose of the FPPTF is not only to hold Board Directors to account in relation to their conduct and performance but also to instil confidence in the public that the individuals leading NHS organisations are suitable to hold their positions. There is an expectation of senior leaders to set the tone and culture of the organisation that leads to staff adopting a caring and compassionate attitude.

Annex 1 – Joint Chair Recruitment Roadmap

Trust Council of Governors (3 separate meetings)	**Key Decisions**: To establish a Joint Nominations Committee between GWH, RUH & SFT and to approve responsibility for the selection process of the Joint Chair
Meeting 1 - Joint Nominations Committee	**Key Decisions**: Review first draft of Joint Nomination Committee terms of reference, candidate information pack, role description and person specification
Meeting 2 - Joint Nominations Committee	**Key Decisions**: Approve final versions of above documents ready for recommendation to full COGs
Trust Council of Governors (3 separate meetings)	**Key Decisions:** Ratify Joint Nominations Committee recommendations
Meeting 3 - Joint Nominations Committee	**Key Decisions:** Chair terms and conditions including remuneration, stakeholder and interview panel membership, survey questions (if required)
Post advert - survey to staff, governors and stakeholders (if required	***N.B.*** *Candidates will have the opportunity to speak to Chairs/CEO/Lead Governors*
Longlist Meeting	*Conducted by Interview Panel & SIDS*
Agency preliminary interviews	*Conducted by Recruitment Agency*
Shortlist Meetings	*Conducted by Interview Panel & SIDS* ***N.B.*** *Candidates will have the opportunity to speak to key stakeholders to gather key insights about the organisations*
Stakeholder sessions and formal interviews	
Decision Meeting -Interview Panel	**Key Decision:** Joint Nominations Committee to observe interview panel discussion, and agree appointment recommendation to formal Council of Governors
Trust Council of Governors (3 separate meetings)	**Key Decision:** COGs to receive and approve the Joint Chair appointment recommendation

Appendix 2

Introduction & Summary:

This appendix 2 contains the following:

1. Proposed division of tasks/ responsibilities between the BSW Hospitals Group Joint Chair and the proposed Local lead or Vice Chair NED [*name of role to be confirmed*].

2. Proposed Assumptions in Relation to Joint Chair and Vice Chair/ Local Lead NED for BSW Hospitals Group.

3. Summary role description for Vice/Deputy/Lead NED for BSW Hospitals Group.

1. Proposed Role/ Task Division between Joint Chair and Vice Chair

Task/responsibility	Local 'Lead/ Vice or Deputy NEDs'	Single Chair	Notes
4. Board Agendas and meetings		Y	Agreed
5. Appraising and performance managing CEO		Y	Agreed
6. Appraising NEDs	TBC	Y	Responsibility of Single Chair but activity for collating and presenting feedback needs to be spread through a single system facilitated by A N Other
7. Interface with Region /ICB		Y	Agreed
8. Interface with and Chairing CoG		Y	Agreed
9. Induction of new Governors	Y	Y	Both need to be involved from time to time
10. Interface with Lead Governor	Y	Y	Both need to be involved from time to time
11. Interface with MD/other Execs	Y	(Y)	Single Chair only occasionally
12. Chair for local appeals	TBC		Delegate to a NED
13. Consultant interviews and pre-interviews	TBC		Delegate to a NED
14. Anchor organisation representative	TBC		Delegate to a NED
15. Other ambassadorial/ceremonial roles - external	TBC		Decide *ad hoc*
16. Ceremonial roles – internal	TBC	(Y)	Decide *ad hoc* but Single Chair should be prepared to participate in some
17. Interface with subsidiaries	TBC		
18. Local Go and See visits/Birthday Break chats with staff/ward accreditations	Y		Decide *ad hoc* but principally Deputy Chair
19. Chair Rem Coms	(Y)	Y	Work towards Group Rem Com Chaired by Single Chair. Soley local issues to Deputy Chair
20. Meetings with other local providers/stakeholders	Y		
21. Meetings with MPs			Decide *ad hoc*
22. Attending HWBs			Decide *ad hoc*

2. Proposed Assumptions in Relation to Joint Chair and Vice Chair/ Local Lead NED

It is proposed that:

1. ***Senior NED roles***. It would be appropriate to divide the formal SID roles from a Vice Chair position

2. ***Role description***. The JD for the Vice Chair for the Foundation Group in the Midlands has been used as a base for a draft BSW Hospitals Group Vice/ Deputy Chair role [refer section 3 below].

3. ***Time commitment***. The requirement would be 1.5 days pw; one of these days being on site.

    a. *To do: further develop BSWHG Vice Chair JD in parallel to Joint Chair JD.*

4. ***Coordination of NED recruitment***. Subject to approval by respective CoGs new NEDs would be recruited through a single Group campaign (first one late Spring early Summer 2025) with aspirations to recruit Shared NEDs and cover skills gaps across all three hospitals.

    a. *To do: Establish NED succession, development, and recruitment system.*

    b. ***BSW Hospitals Group NED Development Roles***. All three Trusts would work together to create a system of development post "Associate NEDs" and "Specialist NEDs" *To do: Establish system. [CC, AR, CPO?]*

5. ***Succession Planning***. Chairs would arrange with current NEDS on the verge of departure to facilitate this timetable.

6. ***NED Capacity/ Workload and Associated Board Paper Content and Quality***. It is difficult to see how shared NEDs could cope with the current load of attending Board meetings. The majority of the work will need to be done at Committee so the quality of "Reports Up" will need to be enhanced.

    a. *To do: Develop plan with committee leads to enhance quality of 'reports up'. Include in 'Ideal Board' workstream plan.*

7. ***NED Capacity/ Workload Alignment of Board Committees and Agendas***. Bringing Board committee meeting agendas into alignment at an early date will help to reduce loads on NEDs.

    a. *To do: 'Ideal Board' workstream to prioritise*.

8. ***Joint Committee Scope and NED Membership Considerations***. If Joint Committee covers the majority of the responsibilities for the Group including delivery, then voting members of each Board need to be in attendance so they can discharge their fiduciary duties. However, if the JC is only doing a selection of the work, then we can choose which NEDs should attend.

    a. To do: To help us confirm and communicate our approach, Browne Jacobson are advising our Joint Committee working Group, how other NHS Groups are approaching NED membership.

3. BSW Hospitals Group [Based on South Warwickshire Trust – Foundation Group]

VICE CHAIR ROLE DESCRIPTION

Reports to: Chair
Time Commitment: minimum commitment of 1.5 days per week (one day on site)
Remuneration: TBC per annum (Non-Executive + responsibility allowance)

As part of our evolution as the **BSW Hospitals Group**, and in support of the appointment of a shared chair (the "Chair") for those organisations, each of the individual Trusts will have a Vice Chair to assist the Chair in delivering the key responsibilities of that role.

The role of the Vice Chair is predominantly internally focussed; the main external partner relationships being conducted by the Chair on behalf of the all the Boards. The Vice Chair shall be a non-executive director and shall have the additional responsibilities in addition to their duties as a non-executive director.

The Vice Chair will support the work of the chair in ensuring collaboration not only between the three Trusts and unitary boards, but also just as importantly, with the places throughout the BSW system, through working with fellow ICS and Place leads.

The Vice Chair, in common with all Non-Executive Directors, has the same general responsibilities to the Trust as any other director. The Board as a whole is collectively responsible for promoting the success of the Trust to help drive the delivery of sustainable healthcare services for the local population

There is an expectation to support working across the three different organisations and on site as required to ensure the Trust delivers safe, effective and efficient services.

Duties and Responsibilities

- To work with the Chair to ensure that the board is able to carry out its responsibilities effectively
- Helping to ensure that the individual Trust board is fit for purpose to support the organisation's activities and contribute to the achievement of its statutory objectives, by ensuring that clear corporate and business plans are set
- To maintain and improve the credibility and governance standards of the Trust within the Group Model, ensuring the board understands its accountability for governing the organisation
- To support the chair in ensuring all board directors participate fully in developing and determining the trust's vision, values, strategy and overall objectives to deliver organisational purpose and sustainability (and for the trust, have regard to the council of governors' views)

- Ensuring organisational design supports the attainment of strategic objectives providing visible leadership in championing the health needs of the local population and developing a healthy, open, and transparent patient-centred culture for the organisation, where all staff have equality of opportunity to progress, the freedom to speak up is encouraged, and ensuring that this culture is reflected and modelled in their own and in the board's behaviour and decision-making
- To provide visible leadership with at least one day per week on site that may comprise walk around activity, to support developing a healthy, open and transparent patient-centred culture for the organisation, where all staff have equal opportunity to progress, the freedom to speak up is encouraged, and ensuring that this culture is reflected and modelled in their own and in the board's behaviour and decision-making
- To support the chair in ongoing horizon scanning utilising the collective skills of the board to support and challenge assumptions and long-term strategy.
- To ensure that constructive relationships based on candour, trust and mutual respect exist between executive and non-executive directors and between elected and appointed members of the council of governors and between the board and the council
- To be the critical link between the chair and boards ensuring effective and timely communications, messages, actions and feedback.
- To help ensure the board sees itself as a team, has the right balance and diversity of skills, knowledge and perspectives, and the confidence to challenge on all aspects of clinical and organisational planning
- To lead on continual non-executive director and, governor development of skills, knowledge and familiarity with the organisation and health and social care system, to enable them to conduct their role on the board/council effectively, including non-executive director induction and annual appraisal
- To demonstrate visible, ethical, compassionate and inclusive personal leadership by modelling the highest standards of personal behaviour and ensuring the board follows this example
- Ensure that governors have the dialogue with directors they need to hold the non-executive directors (which includes the trust chair), individually and collectively to account for the board's performance.

Board of Directors

To work with the chair on planning of the annual board cycle and agenda setting. The Vice chair shall normally preside at meetings of the Board of Directors in the following circumstances:

a) when the Chair is unavailable to chair.
b) on occasions when the Chair declares a pecuniary interest that prevents them from taking part in the consideration or discussion of a matter before the Board of Directors.

Council of Governors
The Vice Chair shall normally preside at meetings of the Council in the following circumstances:

a) when there is a need for someone to have the authority to chair any meeting of the Council when the Chair is not present

b) when the remuneration, allowance and other terms and conditions of the Chair are being considered

c) when the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment

d) on occasions when the Chair declares a pecuniary interest that prevents them from taking part in the consideration or discussion of a matter before the Council

Condition of office

- The vice chair shall be appointed (and, where necessary, re-appointed or removed) by the Council
- The term of office for the vice chair shall be the same as the term of office for which the non-executive director (holding office as vice chair) has been appointed to the Board of Directors
- In addition to this Role Description, the vice chair shall comply with the Role Description for non-executive directors and any Code of Conduct or other relevant policies approved by the Council

Report to:	**Public Board of Directors**	**Agenda item:**	**20**
Date of Meeting:	**5 March 2025**		

Title of Report:	**Maternity Incentive Scheme Declaration Year 6**
Status:	**For Noting**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer and Board Safety Champion**
Author:	**Zita Martinez, Director of Midwifery and Neonates** **Jodie da Rosa, Head of Midwifery and Neonates** **Claire Park, Clinical Director**
Appendices	**Appendix 1: Maternity (and perinatal) Incentive Scheme Year 6** **Appendix 2: MIS Year 6 Board Notification Form** **Appendix 3: MIS Year 6 KPMG Audit January 2025**

1. Executive Summary of the Report

The Maternity and Neonatal Service within the Family and Specialist Services (FASS) Division have submitted a full compliance position for each of the 10 Safety Actions and their associated sub-requirements within the Maternity Incentive Scheme (MIS) Year 6 (Appendix 1). To support this self-assessment, KPMG conducted an internal audit on the evidence supporting 6 of the 10 maternity Safety Actions (Appendix 2). The remaining 4 Safety Actions will undergo external validation, as outlined in Table 1.

MIS Year 6 evidence, check and challenge, meeting was held on 22 January 2025 with Antonia Lynch (Chief Nursing Officer & Board Level Maternity and Neonatal Safety Champion), Simon Harrod (Non-Executive Director & Board Level Maternity and Neonatal Safety Champion), Gill May (Integrated Care System Accountable Officer) and Sandy Richards (Local Maternity and Neonatal System Lead Midwife). Zita Martinez, (Director of Midwifery and Neonates), presented the data and information.

Next Steps:

The Trust Board to give permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. The CEO must sign to confirm that:

1) The Trust Board are satisfied that the evidence provided to demonstrate achievement of the 10 Safety Actions meets the required Safety Actions' sub-requirements as set out in the 10 maternity Safety Actions.
2) There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to the declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/MNSI investigation reports etc.)
3) There are no reports covering an earlier time-period that may prompt a review of previous MIS submissions.

In addition, the CEO will ensure that the Accountable Officer (AO) for the Bath and

North East Somerset, Swindon and Wiltshire Integrated Care System (ICS) is appraised of the MIS Safety Actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Board declaration must then be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.

The Trust Board gave permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution at their meeting in private on 5 February 2025.

2.	**Recommendations (Note, Approve, Discuss)**
Trust Board are asked to note the Maternity Incentive Scheme (MIS) self-declaration form (Appendix 1) which confirms full compliance with the Maternity Incentive Scheme Year 6 following review of the supporting evidence (Appendix 2).	

3.	**Legal / Regulatory Implications**
N/A	

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)**
Risk ID 2950 Non-compliance with BAPM nursing standards (QiS) Patient Safety and Quality Risk Score 12 (High Risk)	

5.	**Resources Implications (Financial / staffing)**
N/A no financial implication within this paper.	

6.	**Equality and Diversity**
N/A, Equality, Diversity and Inclusion assessment not required as no significant changes to services or policy.	

7.	**References to previous reports/Next steps**

8.	**Freedom of Information**
Public.	

9.	**Sustainability**
N/A	

10.	**Digital**
N/A	

1. Purpose

1.1 The purpose of this paper is to demonstrate to the Trust Board that the Service has achieved all 10 Safety Actions for the Maternity Incentive Scheme (MIS) Year 6.

1.2 The purpose of this paper is to ensure the Trust Board are satisfied that the evidence provided demonstrates achievement of the 10 maternity Safety Actions and sub-requirements as set out in MIS Year 6 (Appendix 1) and evidenced within the MIS declaration form (Appendix 3).

1.3 This paper accompanies the declaration form (Appendix 3) and should be used to detail the Services' position and progress with MIS Year 6.

1.4 To confirm there are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to the declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/MNSI investigation reports etc.). To also confirm there are no reports covering an earlier time-period that may prompt a review of previous MIS submissions.

2. Background

2.1 The Maternity Incentive Scheme is part of the Clinical Negligence Scheme for Trusts (CNST) that is now in Year 6. The scheme incentivises 10 maternity Safety Actions, Trusts that can demonstrate they have achieved all 10 of the Safety Actions will recover the element of their contribution to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

2.2 Trusts that do not meet the ten out of ten thresholds will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help make progress against actions they have not achieved.

2.3 The scheme uses a self-assessment declaration form that must be signed off by the Trusts Chief Executive Officer to confirm the Trust Board are satisfied with the evidence provided to demonstrate achievement of meeting each Safety Action.

2.4 The Trust has engaged KPMG to conduct an audit to validate the evidence supporting compliance with MIS Year 6. KPMG assessed the minimum evidence requirements for Safety Actions 3, 4, 5, 7, 8, and 9. Safety Actions 1, 2, 6, and 10 were excluded from the KPMG audit scope, as assurance for these actions will be obtained through external validation processes.

2.5 The KPMG audit report identified 4 maternity Safety Actions which required further evidence which fell outside of the KPMG audit timeframe. The service has subsequently collated this evidence and is assured of all minimum evidential requirements are now met and this is reflected in the deceleration form (Appendix 3).

2.6 The Trust is also responsible for ensuring the Accountable Officer for the ICB is appraised of the MIS Safety Action' evidence.

2.7 The relevant reporting period for MIS Year 6 is 8 December 2023 to 30 November 2024. The Board declaration form must be sent to NHSR before 12 noon on 3 March 2025.

3. Declaration of Compliance

3.1 The Maternity and Neonatal Service within the Family and Specialist Services (FASS) Division is declaring compliance with each of the 10 maternity Safety Actions and their sub requirements. This position is supported following an in-depth internal audit by KPMG (Appendix 2).

SA no.	Safety Action Title	Compliance self certified	Validation Process
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Compliant	External/MBRRACE-further data extract for verification on 1 February 2025.
2	Are you submitting data to the Maternity Services Data Set to the required standard.	Compliant	External/NHS Digital
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme.	Compliant	Internal Audit/KPMG
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliant	Internal Audit/ KPMG
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Compliant	Internal Audit/KPMG
6	Can you demonstrate that you are on track to compliance with all elements of the saving babies lives v3?	Compliant	External/LMNS ICB
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Compliant	Internal Audit/ KPMG
8	Can you evidence the following 3 elements of local training plans and in house one day multi professional training?	Compliant	Internal Audit/KPMG
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?	Compliant	Internal Audit/KPMG

10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and NHSR EN Scheme	Compliant	External/ NHS Resolution – MNSI, National research database and NHSR will cross reference record of qualifying incidents

Tabe 1: Overview of compliance status and method of validation

4. Safety Action Updates

4.1 Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

4.1.1 The Service is compliant and there is sufficient data to evidence the position against the required timeframes and standards. This is demonstrated within the Quarterly Perinatal Mortality Review Tool (PMRT) reports. The Quarterly PMRT reports are shared with the Safety Champions, Trust Board (via the Quarterly Quality Reports) and the LMNS.

4.1.2 NHS Resolution will use data from MBRRACE-UK/PMRT, to cross reference against the Trusts' self-certification. MBRRACE-UK/PMRT will take the data extract for verification on 1 February 2025.

4.2 Safety Action 2: Are you submitting data to the Maternity Services Data set to the required standard?

4.2.1 The service has received confirmation of compliance from NHS Digital with data quality on the scorecard.

4.3 Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and babies?

4.3.1 The Service is compliant, there is sufficient supporting evidence to demonstrate there are pathways of care into transitional care (TC) in place which aligns with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice.

4.3.2 Avoiding Term Admission into Neonatal Units (ATAIN) requirements are met. The Service can evidence it has drawn on insights from themes identified from any term admissions to the neonatal unit. The service has undertaken at least one quality improvement initiative to decrease admissions and/or length of stay. The progress on the QI initiative has been shared with the Safety Champions and LMNS.

4.4 Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

4.4.1 The Service is compliant and there is sufficient evidence to support the position of compliance.

4.4.2 Neonatal nursing workforce is not in line with the British Association of Perinatal Medicine (BAPM) Standards however an action plan is in place to continue to work towards a position of compliance.

4.5 Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

4.5.1 The Service is compliant with Safety Action 5, the funded establishment is in line with the most recent Birthrate+ recommended funded establishment and one to one care and supernumerary status compliance has remained at 100% for the MIS relevant reporting period.

4.6 Safety Action 6: Can you demonstrate you are on track to compliance with all elements of the Saving Babies Lives Care Bundle Version Three (SBLCB V3)?

4.6.1 The Service is compliant using the Saving Babies Lives Care Bundle Version 3 NHSE Implementation Tool and at least quarterly required improvement discussions with the ICB have been held.

4.6.2 The Service received confirmation from the LMNS ICB on 12 December 2024, that compliance with Safety Action 6 has been met. Whilst full implementation of SBLCB V3 is not in place yet, compliance is still achieved as the ICB have confirmed it is assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory.

4.6.3 Table 2 outlines SBLCB V3 element progress and the % of interventions fully implemented.

Intervention Elements	Description	Element Progress	% of Interventions Fully Implemented
Element 1	Smoking in Pregnancy	Partially Implemented	90%
Element 2	Fetal Growth Restriction	Partially Implemented	80%
Element 3	Reduced Fetal Movement	Fully Implemented	100%
Element 4	Fetal Monitoring in Labour	Fully Implemented	100%
Element 5	Preterm Birth	Partially Implemented	93%
Element 6	Diabetes	Fully Implemented	100%
All Elements	TOTAL	Partially Implemented	90%

Table 2: SBLCB V3 Implementation progress

4.7 Safety Action 7: Listen to women, parents, and families using maternity and neonatal services and coproduce with service users.

4.7.7 The Service is compliant with Safety Action 7. The Maternity and Neonatal Voices Partnership (MNVP) for Bath and North East Somerset, Swindon and Wiltshire (BSW) is in place and established in line with MIS requirements with the workplan aligned to the Three Year Delivery Plan for Maternity and Neonatal services.

4.8 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

4.8.1 The Service is compliant with Safety Action 8 and can confirm all staff working in maternity services have attended annual training.

4.8.2 Training compliance for all requirements (PROMPT, Fetal Wellbeing and Neonatal Life Support) is above 90% overall and for each staff group. A 90% minimum compliance is required for MIS.

4.9 Safety Action 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?

4.9.1 The Service is compliant with Safety Action 9, the Perinatal Quality Surveillance Model (PQSM) is embedded. The Service has evidenced collaboration with the LMNS/ICB lead, demonstrating shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

4.9.2 The Maternity and Neonatal Board Safety Champions (BSC) work closely with and support the perinatal quadrumvirate to understand, communicate and champion learning, challenges, and best practice. There is sufficient evidence of ongoing BSC engagement sessions with staff and service users. There is also evidence the Service and BSC monitor progress and actions relating to local improvement projects such the Perinatal Culture and Leadership Programme which utilise the Patient Safety Incident Response Framework (PSIRF) methodology.

4.10 Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution Early Notification Scheme?

4.10.1 The Service is compliant with Safety Action 10, all qualifying cases have been reported to HSIB/MNSI. There were no qualifying Early Notification (EN) cases to NHS Resolution's EN Scheme within the relevant time frame.

4.10.2 For all qualifying cases statutory duty of candour letters have been sent to families covering the required information. The Trust Board have oversight of HSIB/MNSI and

EN incidents and sight of compliance with the statutory duty of candour as part of the PQSM.

5. Summary

5.1 The Service is proposing that a position of compliance is declared against each of the 10 Maternity Safety Actions for the Maternity Incentive Scheme Year 6.

5.2 The proposed position of compliance follows an in-depth review of the evidence by KPMG and external validation processes as outlined in MIS Year 6.

6. Recommendations and Next Steps

6.1 Trust Board are asked to note the Maternity Incentive Scheme (MIS) declaration form (Appendix 1) which confirms full compliance with the Maternity Incentive Scheme Year 6 following review of the supporting evidence (Appendix 2).

6.2 The Trust Board gave permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution at their meeting in private on 5 February 2025. The CEO has signed to confirm that:

1) The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity Safety Actions meets the required Safety Actions' sub-requirements as set out in the ten Safety Actions.

2) There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to the declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.).

3) There are no reports covering an earlier time-period that may prompt a review of previous MIS submissions.

4) The Board declaration must then be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.

In addition, the CEO will ensure that the Accountable Officer for Bath and North East Somerset, Swindon and Wiltshire Integrated Care System is appraised of the MIS Safety Action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

NHS Resolution

Maternity Incentive Scheme - Year 6 Board declaration form

Trust name	**Royal United Hospitals Bath NHS Foundation Trust**
Trust code	**T318**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2024/25) or the previous financial year (2023/24)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Royal United Hospitals Bath NHS Foundation Trust
Name:	Mrs Cara Charles Barks
Position:	Chief Executive Officer, BSW Hospitals
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Royal United Hospitals Bath NHS Foundation Trust
Name:	Mrs Gill May
Position:	Executive Nurse
Date:	

NHS Resolution

Maternity (and perinatal) Incentive Scheme

Year Six

Conditions of the scheme

Ten maternity safety actions

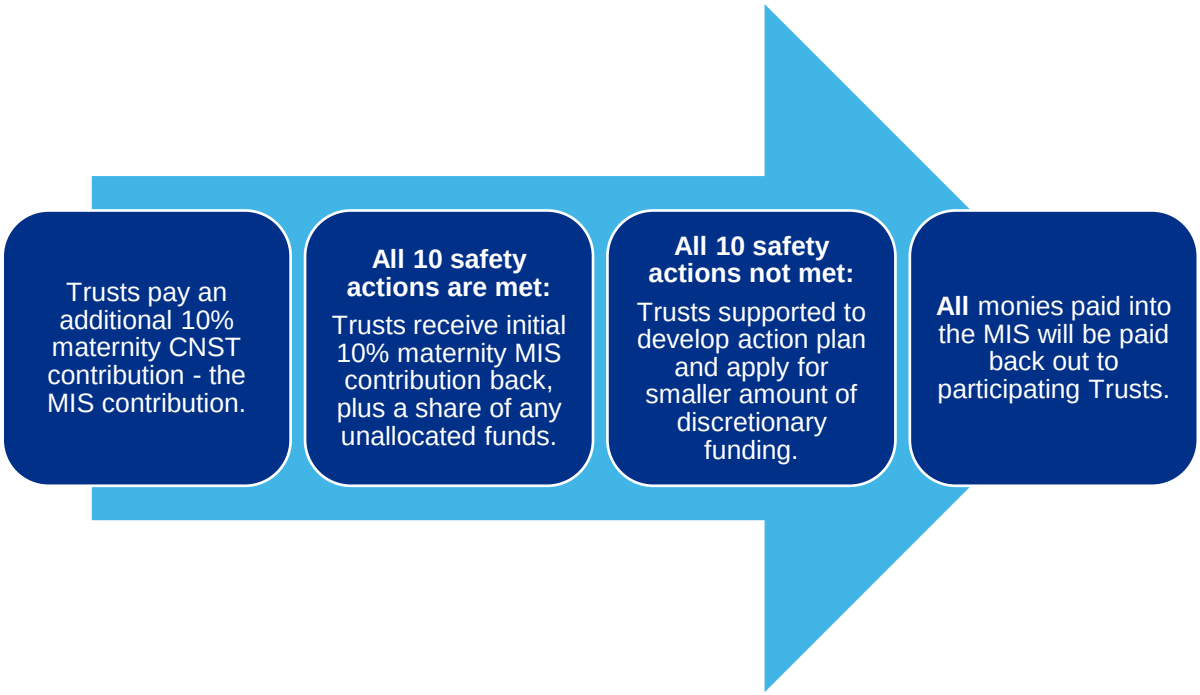
Additional guidance

Contents

Introduction

Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund:



The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigation Programme (MNSI).

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution.

MIS year six: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon** on **3 March 2025** and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the director of midwifery/head of midwifery and clinical director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that:

  ☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

  ☑ There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2025.

  ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates from Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the MIS results. See 'Reverification'.

NHS Resolution will publish the outcomes of the MIS verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

External verification

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c).

NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

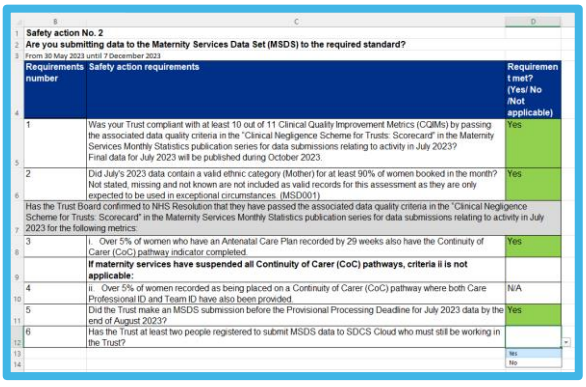
National Neonatal Research Database (NNRD), MNSI and **NHS Resolution** for the number of qualifying incidents reportable (safety action 10, standard a).

Trust submissions will also be sense checked with the **CQC**, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year.

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided internally in the Trust to support the Trust Board decision only. This will not be reviewed by NHS Resolution unless requested. See 'Reverification'.
- On the Board Declaration form Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.



Safety action No. 2		
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
From 30 May 2023 until 7 December 2023		
Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	N/A
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	
		Yes No

- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **12 noon 3 March 2025** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.

- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by AO of Clinical Commissioning Group/Integrated Care System.
- The Board declaration form will be made available on the MIS webpage during the MIS reporting period.

'What Good Looks Like'

Trusts are reminded to retain all evidence used to support their compliance position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described below) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net prior to the 3 March 2025.
- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.
- Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
    - Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation.
    - Technical errors outside the Trust's control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- The NHS Resolution MIS clinical team will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results. Information on how to do this

will also be communicated to all Trusts when the confirmed MIS results are sent out.

Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a smaller amount of funding to support progress. To apply for funding, such Trusts must submit a completed action plan together with their completed Board declaration form by 12 noon on 3 March 2025 to NHS Resolution nhsr.mis@nhs.net.

Action plans submitted must be:

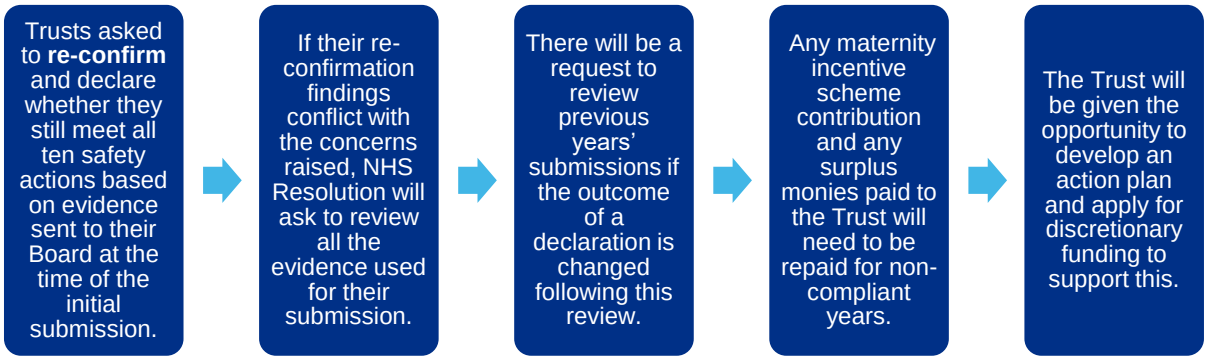
- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and will enable the financial calculation of the funding requested.
- Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE).
- Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Action plans should not be submitted for achieved safety actions.

Ruth May, NHS England Chief Nursing Officer wrote to NHS Trusts on 8th April 2021 confirming that commissioners must ensure that any funding awarded to implement the agreed action plan for improvement is ringfenced for the maternity service to support the delivery of the action plan.

Reverification

Reverification is initiated if a concern is raised that a Trust Board may have incorrectly declared compliance with one or more of the ten safety actions' sub-requirements within the MIS. This may be identified through whistleblowing or following a CQC report that may call into question the original declaration. This concern may relate to any completed year of the MIS.

In the first instance, Trusts are asked to complete their own internal review of the evidence that was used to support their compliance for the relevant year at the time of submission. This must be the same evidence that was used to inform the Trust Board at the point of declaration. Trusts will be given the opportunity to downgrade their position at this point.



If following their own internal review, the Trust remains confident that their compliance declaration was correct, the Trust will be asked to provide all of their supporting evidence to NHS Resolution. A full review of the relevant evidence will then be undertaken by two members of the MIS clinical team.

Following this review, any Trusts found to have mis-declared compliance will be notified and will be required to repay the funds originally awarded to them for that MIS year. They will be asked to develop an action plan to introduce safety improvements and work towards full compliance, and they will be advised to bid for discretionary funding to support this action plan. Any discretionary funds agreed must be spent on the improvements in the agreed plan. Any amount of discretionary funding agreed will be deducted from the total MIS rebate amount repayable to NHS Resolution.

If a mis-declaration has been identified (as above), reverification of the previous MIS year will automatically be initiated. When a further mis-declaration is identified, this process will then be repeated for the previous year. This process will be limited to impact the current MIS year, and the two preceding historical MIS years only.

Any funds retrieved from non-compliant Trusts will be redistributed to all Trusts that achieved compliance for the applicable MIS year. This redistribution must take place within the same financial year that NHS Resolution receives the funds.

Need Help?

If you have any queries or concerns regarding any aspect of the MIS, please contact the MIS clinical team on nhsr.mis@nhs.net. There is a new FutureNHS MIS workspace where queries can be submitted and additional information and resources will be provided.

To ensure you receive all correspondence relating to the MIS, please add your name to the MIS contacts list.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Required Standard
a) **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards. c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months. d) **Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.
Minimum Evidence Requirement for Trust Board
Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical guidance regarding the introduction of the NHS Submit a Perinatal Event Notification system - SPEN). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process
Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 1 February 2025.
Relevant Time period
From 8 December 2023 to 30 November 2024

Link to technical guidance

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required Standard
This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 MSDS-only (see technical guidance) Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. Final data for July 2024 will be published during October 2024. 2. July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).
Minimum Evidence Requirement for Trust Board
The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Required Standard
a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice Or Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards. b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.
Minimum Evidence Requirement for Trust Board
Evidence for standard a) to include: **For units with TC pathways** • Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04. **For units working towards TC pathways** • An action plan signed off by Trust and LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.
Evidence for standard b) to include: 1. By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team. 2. By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required Standard

a) Obstetric medical workforce

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

   a. currently work in their unit on the tier 2 or 3 rota
      or
   b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
      or
   c. hold a certificate of eligibility (CEL) to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.
   rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**
   rcog-guidance-on-compensatory-rest.pdf

4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service
   roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing.

or

the standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

or

The standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal ODN.

Minimum Evidence Requirement for Trust Board

Obstetric medical workforce

1) Trusts/organisations should audit their compliance via Medical Human Resources.

   Information on the CEL for short term locums is available here: www.rcog.org.uk/cel

   This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk)

   A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk

2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance.

3) Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS

doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations.
NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG

4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.

Anaesthetic medical workforce

The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota.

Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce.

If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Neonatal nursing workforce

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020).
For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.
A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.

Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Standard

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

d) All women in active labour receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

Minimum Evidence Requirement for Trust Board

The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement.

It should include:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- 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 BirthRate+ or equivalent calculations.
- Where Trusts are not compliant with a funded establishment based on BirthRate+ 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.

- The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.

    - The midwife to birth ratio.

    - The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required Standard
Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.
Minimum Evidence Requirement for Trust Board
Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. *The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Required Standard

1. Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:

   a) Engagement and listening to families.

   b) Strategic influence and decision-making.

   c) Infrastructure.

2. Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

Minimum Evidence Requirement for Trust Board

1.

a) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

b) Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member, (Trusts should work towards the MNVP Lead being a quorate member), such **as:**

- Safety champion meetings
- Maternity business and governance
- Neonatal business and governance
- PMRT review meeting
- Patient safety meeting
- Guideline committee

c) Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as:

- Job description for MNVP Lead
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare costs

- If evidence of funding support at expected level is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.

2. Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as an action plan.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required Standard
90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.
Minimum Evidence Requirement for Trust Board
*See technical guidance for details of training requirements and evidence.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 1 December 2023 to 30 November 2024

Link to technical guidance

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Required Standard

a) All Trust requirements of the PQSM must be fully embedded.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

Minimum Evidence Requirement for Trust Board

Evidence for point a) and b)

- Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice.

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the **perinatal** leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.

- Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

- Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action

and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.

- Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

Evidence for point c):

Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.

- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Required Standard
a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024. b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024. c) For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum Evidence Requirement for Trust Board
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. Trusts' reporting will be cross-referenced against the MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard A) and B) have been met in the relevant reporting period. In addition, for standard B and C(i) there is a requirement to complete field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
Relevant Time period
From 8 December 2023 to 30 November 2024

Link to technical guidance

Technical Guidance

Technical Guidance for Safety Action 1	
Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.	
SA 1(a) – Notify all eligible deaths	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal deaths must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that the Submit a Perinatal Event Notification system (SPEN) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through SPEN and this information will be passed to MBRRACE-UK. It will still then be necessary for reporters to log into the MBRRACE-UK/PMRT system to provide the surveillance information and to use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route

	of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in 2024.
SA 1(b) – Seek parents' view of care	
We have informed parents that a local review will take place and they have been asked if they have any feedback or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' feedback, perspectives, and any questions can be considered during the review, this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' feedback and perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died, and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their feedback and raise any questions and/or concerns they may subsequently have about their care.

	Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.
Parents have not responded to our messages and therefore we are unable to discuss their feedback at the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
SA 1(c) – Review the death and complete the review	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: d) Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) e) Stillbirths (from 24+0 weeks' gestation) f) Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) up to 28 days after birth While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session

	(which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: 
What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the Trust who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
What should we do if our post-mortem service has a long turn-around time?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than six months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death, complete and publish the report using the information you have available. When the PM results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than six months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.

What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.
How does 'assigning a review' impact on safety action 1, especially on starting a review?	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the PMRT verification process.
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between 2 April 2024 and 30 November 2024 you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
What deaths should we review outside the relevant time period for the safety action verification process?	Trusts should review all eligible deaths using the PMRT as a routine on-going process, irrespective of the MIS timeframe and verification process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 6 MIS requirements.
What happens when an MNSI (formerly HSIB) investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by MNSI (formerly HSIB). Your local review using the PMRT should be started (to identify any early and immediate learning which needs to be actioned) but not completed until the MNSI report is complete. You should consider inviting the MNSI reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the MNSI review to be incorporated into the PMRT review. Depending upon the timing of the MNSI report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an MNSI investigation is taking place, and this will be accounted for in the external verification process.

SA 1(d) – Report to the Trust Executive Board	
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period of time defined by the user. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.
Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from completed reviews over a period time which can be generated within the PMRT by authorised PMRT users for a user-defined period of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. Please note that these reports will only show summaries, issues and action plans for reviews that have been completed and published, therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on the PMRT for the maternity incentive scheme, where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1, will be communicated via NHS Resolution email and will also be included in the PMRT 'message of the day'.

Technical Guidance for Safety Action 2	
What are the 11 "MSDS-only" CQIMs in scope for this assessment?	These include: • Babies who were born pre-term • Babies with a first feed of breastmilk • Proportion of babies born at term with an Apgar score <7 at 5 minutes • Women who had a postpartum haemorrhage of 1,500ml or more • Women who were current smokers at booking • Women who were current smokers at delivery • Women delivering vaginally who had a 3rd or 4th degree tear • Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section • Caesarean section delivery rate in Robson group 1 women • Caesarean section delivery rate in Robson group 2 women • Caesarean section delivery rate in Robson group 5 women These do not include the following as they rely on linkages between MSDS and other datasets: • Babies breastfed at 6-8 weeks • Babies readmitted to hospital <30 days after birth
Some CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on those for three months?	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2024 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "CNST: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics

The monthly publications and Maternity Services Dashboard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the: Maternity Services Monthly Statistics publication series
The monthly publications and national Maternity Services Dashboard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.
Where can I find out more about MSDSv2?	maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Technical Guidance for Safety Action 3	
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
How can we evidence progress towards a transitional care service?	A current action plan with specified timescales and progress against these should be reviewed by the Trust and LMNS Boards before the submission deadline
How do we identify our themes of unplanned term admissions?	All term admissions will be reported through DATIX/LFPSE (as per local implementation of PSIRF) and themes identified through this intelligence. ATAIN proforma reviews are no longer mandated.
Who should be involved in the quality improvement initiatives?	The team should include members of maternity and neonatal multidisciplinary team including liaising with service user representative (MNVP) and support sourced from Trust quality improvement and service improvement teams if required.
How do we register our quality improvement initiative?	This will vary depending on local Trust policy. In the absence of any Trust policy, evidence of registering the quality improvement initiative, could be documented in the safety champion minutes.
What is considered as evidence of an update on the quality improvement initiative?	Evidence should include: 1) a presentation to the LMNS which includes an aim statement, measures, change actions and outcomes. 2) Discussion with safety champions and noted in the minutes at least once before the end of the reporting period.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)

	Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk) The Handbook of Quality and Service Improvement Tools: the_handbook_of_quality_and_service_improvement_tools_2010-2.pdf (england.nhs.uk)

Technical Guidance for Safety Action 4	
a) Obstetric medical workforce guidance	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2024. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	No.
Where can I find the documents relating to short term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2024 and prior to submission to the Trust Board.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	No.
Where can I find the documents relating to long term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG

How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors taking compensatory rest after non-resident on call?	Trusts should have documentary evidence of standard operating procedures and their implementation. Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should have a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and have this as evidence that they are working towards compliance.
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Yes. However while this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans

element of safety action 4 if consultants have not attended clinical situations on the mandated list?	implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net (MIS Team) or workforce@rcog.org.uk (RCOG).	
b) Anaesthetic medical workforce guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.
c) Neonatal medical workforce guidance	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.
BAPM BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)	
NICU **Neonatal Intensive Care Unit**	All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics. Trusts that have more than one NNU providing IC or HD care should have separate cover at all levels of medical staffing appropriate for each level of unit. **Tier 1**

	Rotas should be European Working Time Directive (EWTD) compliant and have a minimum of 8 WTE staff Units with more than 7000 deliveries should have more than one Tier 1 medical support **Tier 2** EWTD compliant rota with a minimum of 8 WTE staff NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift) **Tier 3** Minimum of 7 WTE consultants on the on-call rota with 24/7 availability of a consultant neonatologist NICUs undertaking more than 2500 IC days per annum should provide two consultant led teams during normal working hours. Neonatal consultant staff should be available on site in all NICUs for at least 12 hours a day, generally expected to include two ward rounds/handovers For units undertaking more than 4000 IC days per annum, consideration should be given to 24-hour consultant presence All NICU consultants appointed from 2010 should have CCT in Neonatal Medicine.
LNU **Local Neonatal Unit**	Where LNUs have a very busy paediatric/neonatal service and/or have neonatal and paediatric services that are a significant distance apart, the above staffing levels should be enhanced. The threshold should be judged and monitored on clinical governance grounds such as the ability consistently to attend paediatric or neonatal emergencies immediately when summoned. Units with more than 7000 deliveries should have more than one Tier 1 medical support.

	Tier 1 Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition. **Tier 2** Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff. **Tier 3** Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN. At least one LNU Tier 3 consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training). All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).
SCU **Special Care Unit**	**Tier 1** Rotas should be EWTD compliant (58) and have a minimum of 8 WTE staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery. There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7. **Tier 2** Shared rota with paediatrics comprising a minimum of 8 WTE staff. Tiers 1 and/or 2 may be able to be covered by appropriately skilled nursing staff

	Tier 3 A minimum of 7 WTE consultants on the on-call rota with a minimum of 1 consultant with a designated lead interest in neonatology. Tier 3 consultants should have a Certificate of CCT in paediatrics or Certificate of Eligibility for Specialist Registration (CESR) in paediatrics or an equivalent overseas neonatal or paediatric qualification. They must demonstrate knowledge, skills and CPD appropriate for the level of neonatal care through annual appraisal. Minimum of 1 consultant with a designated lead interest in neonatology, who should have completed a special interest (SPIN) module in Neonatology*. (if this was available during training)
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declared compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 6 reporting period.
Please access the followings for further information on Standards	BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)
d) Neonatal nursing workforce guidance	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here:

	Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

Technical Guidance for Safety Action 5	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six-monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice.**	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for further details and definitions: safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward. As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this is not a recurrent daily event, Trusts may declare compliance with this standard.

	If the co-ordinator is regularly required to cover for breaks (more than 2-3 times a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Technical Guidance for Safety Action 6	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: saving-babies-lives-version-three/ An implementation tool is available for trusts to use if they wish at future.nhs.uk/SavingBabiesLives and includes a technical glossary for all metrics and measures. For any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to MSDS issues for this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net. Some data items are or will become available on the National Maternity Dashboard (Element 1); from NNAP Online (Element 5); and from NPID (Element 6). For any other queries, please email nhsr.mis@nhs.net
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. Where MSDS does not capture all process and outcome indicators given in the care bundle, this is indicated in the Implementation Tool.
What percentage performance is required to be compliant for a given intervention?	Where element process and outcome measures are listed in the evidence requirement of the SBLCB V3 a performance threshold is recommended. However, LMNS/ICBs are able to agree local performance thresholds with a provider in view of local circumstances, and the agreed local improvement trajectory.
How do we provide evidence for the interventions that have been implemented?	Trusts will need to verify with their LMNS/ICB that they have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBL e-learning for health modules have all been updated to reflect the changes in version 3. A new module for element 6 has also now been developed and published on the e-learning for health site.

Technical Guidance for Safety Action 7	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the LMNS. MNVPs ensure service user voice influences improvements in the safety, quality and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What advice is there for Maternity and Neonatal Voices Partnership (MNVP) leads when engaging and prioritising hearing the voices of neonatal and bereaved service users, and what support or training is in place to support MNVP's?	MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback. Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families. It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided. MNVPs can also work in collaboration with their Trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the Trust training could be beneficial.
What does evidence of MNVP engagement look like?	Engagement can include lots of different methods as detailed in the MNVP Guidance under the section *Engagement and listening to families*. Evidence for this includes: • 15 Steps for Maternity report. • MNVP Annual Report. • Engagement reports. • Expenses paid to service users. • List of organisations engaged. • Online surveys and feedback mechanisms. • Analysis of surveys by demographics of respondents.

Technical Guidance for Safety Action 8	
How will the 90% attendance compliance be calculated?	The training requires 90% attendance of relevant staff groups by the end of the 12-month period at: 1. Fetal monitoring training 2. Multi-professional maternity Emergencies training 3. Neonatal Life Support Training
Which maternity staff should be included for Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants and SAS doctors. • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor). • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees
Which maternity staff should be included for Maternity emergencies and multi-professional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants and SAS doctors. • All other obstetric doctors including obstetric trainees (ST1-7), sub speciality trainees, Locally Employed Doctors (LED), foundation year doctors and GP trainees contributing to the obstetric rota. • Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum). • Obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors. • All other anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) **who contribute to the**

	obstetric anaesthetic on-call rota <u>in any capacity</u>. This updated requirement is supported by the RCoA and OAA. • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 6 compliance assessment. • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 6 compliance. At least one emergency scenario/drill should be conducted in a clinical area during the whole MIS reporting period, ensuring attendance from the relevant wider professional team, including theatre staff and neonatal staff. The clinical area can be any area where clinical activity takes place e.g. Delivery Suite, Clinic, A&E, theatre, a ward. This should not be a simulation suite.
Do non-obstetric anaesthetists that contribute to the obstetric rota need to attend obstetric emergency training?	Yes. However, it is recognised that the inclusion of anaesthetic staff who provide only intermittent or on-call coverage to the maternity unit may significantly extend the standards. Therefore, for the inaugural year of this standard, a threshold of 70% achievement is required as the minimum standard for this specific group.
Do non-obstetric anaesthetists need to attend the full day of obstetric emergency training?	It is the gold standard that all staff including non-obstetric anaesthetists that may find themselves responding to an obstetric emergency when on-call attend the full training day together, so that they can benefit from local learning and train alongside their multi-disciplinary colleagues, however it is appreciated that this may be a challenge for this group of staff. Therefore a minimum standard of attendance at half of the full day including obstetric skills drills will be accepted.
Training attendance for rotational clinical staff	It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary colleagues, however it is appreciated that this may be especially challenging for rotational staff. In the following circumstances, evidence from rotating medical trainees having completed their training in another maternity unit will be accepted: • Staff must be on rotation.

	• The training must have taken place in the previous Trust on their rotation during the MIS training reporting 12-month period. • Rotations must be more frequent than every 12 months. This evidence may be a training certificate or correspondence from the previous maternity unit.
Does the multidisciplinary emergency training have to be conducted in the clinical area?	Ideally at least one emergency scenario should be conducted in any clinical area as part of each emergency training day. You should aim to ensure that all staff attending emergency training participate in an emergency scenario that is held in a clinical area, but this will not be measured in year 6 of MIS.
Which staff should be included for Neonatal basic life support?	Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants/SAS doctors or Paediatric consultants/SAS Doctors covering neonatal units. • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training: • All obstetric anaesthetic doctors (consultants, SAS, LE Doctors and anaesthetic trainees) contributing to the obstetric rota. • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training dependant on their role within the service. • If nursery nurses work within the service, this should also be recognised in your local training needs analysis.
I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 6 you do **not** need to attend neonatal basic life support training

I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 6 you do **not** need to attend neonatal basic life support training as well.
Which members of the team can teach basic neonatal life support training and NLS training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates.
What do we do if we do not have enough instructors who are trained as an NLS instructor and hold the GIC qualification?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your LMNS to explore sharing of resources. It is recognised that for smaller hospitals, such as Level 1 units, there may be difficulty in resourcing qualified trainers. These units must provide evidence to their Trust Board that they are seeking mitigation across their LMNS and an action plan to work towards NLS and GIC qualified status. As a minimum, training should be delivered by someone who is up to date with their NLS training. Please see the RCUK website for the latest guidance regarding NLS GIC training
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined, however a minimum of 90% of paediatric/neonatal medical staff who attend neonatal resuscitations should have a valid resuscitation council NLS certification. Trusts that cannot demonstrate this for MIS year 6 should develop a formal plan demonstrating how they will achieve this for a minimum of 90% of their neonatal and paediatric medical staff who attend neonatal resuscitations by year 7 of MIS and ongoing.
The Core Competencies TNA suggests periods of time for each element of training, e.g. 9 hours for fetal monitoring. Is this a mandated amount of time?	We envisage that the fetal monitoring and obstetric emergencies training will require 1 whole day each. The hours for each element of training can be flexed by the individual Trust in response to their own local learning needs.

Technical Guidance for Safety Action 9	
Where can I find additional resources?	NHS England, Perinatal Quality Surveillance Model PSIRF (Patient Safety Incident Response Framework) Measuring culture in maternity services: Safety Culture Programme for Maternal and neonatal services Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board safety champions to access the culture and leadership programme, view wider resources and engage with a community of practice to support them in their roles. The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work.
Perinatal Quality Surveillance Model	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local governance for sharing intelligence checked, and when needed, updated. • Describe the local governance processes in place to demonstrate how intelligence is shared from the ward to Board. • Formalise how Trust-level intelligence will be shared and escalated with the LMNS/ICB quality group and from there with regional quality groups which will include the Regional Chief Midwife and Lead Obstetrician.
Reporting to Trust Board	
What do we need to include in the dashboard presented to Board each month?	The dashboard should be locally produced, based on a minimum data set. It should include themes identified in line with PSIRF, and actions being taken to support; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. Themes and progress with culture

	improvement plans following local cultural surveys or equivalent should also be included. This may include the SCORE culture survey, NHS staff survey, NHS pulse survey, focus groups or suitable alternative. The dashboard can also include additional measures as agreed by the Trust.
Our Trust Board and / or sub-committee only meet 10 times a year. Is this acceptable?	If the Board or appropriate sub-committee do not meet monthly, it is the expectation that maternity and neonatal quality and safety will be discussed every time the Board or sub-committee meet.
Clarification as to what constitutes a Trust Board, can sub committees be categorised as a Board?	In year 6 the standard has been updated to reflect that an appropriate Trust Board sub-committee, chaired by a Trust Board member, can be delegated to undertake the monthly review of perinatal safety intelligence. If a sub-committee of the Board undertakes this work, an exception report or highlight report must still be provided to the Board and discussion evidence in the Board minutes.
Culture Surveys	
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will have participated in the Perinatal Culture and Leadership Programme. As part of this programme every service completed work to meaningfully understand the culture of their services. This diagnostic was either a SCORE culture survey or an alternative as agreed with the national NHSE team. Diagnostic insights and plans for improvement were to be shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings. The expectation is that all maternity and neonatal services will understand how it feels to work in their services, either from the SCORE culture survey, or suitable alternative.
What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture survey was a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work.
Perinatal Culture and Leadership Programme	
Who is expected to have	Senior perinatal leadership teams from all Trusts that have a maternity and neonatal service in England have undertaken

undertaken the Perinatal Culture and Leadership Quad programme?	the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the DoM/HoM, clinical lead / CD for obstetrics, clinical lead for neonates and the operational manager.
Is there an expectation that the Board safety champions have undertaken the programme?	The Board Safety Champions should be supporting the perinatal leadership team 'Quad' and their work as part of the PCLP, but there is no expectation for them to attend the programme.
Safety Champions	
What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Do both the NED and Executive BSC and all four members of the 'Quad' have to be present at each meeting?	Ideally the meeting would have both Board Safety Champion (BSC's) and at least two members of the Quad present. If this is not always possible, it would be appropriate for either the Executive or NED BSC and at least one member of the quad to be present. However, the expectation is that each professional group is represented throughout the year, and that the nominated member attending brings all four voices to the conversation.
What are the expectations of the NED and Exec Board safety champion in relation to their support for the Perinatal Culture and Leadership Programme (PCLP), culture	As detailed in last year's MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provides an opportunity to share safety intelligence, examples of best practice, identified areas of challenge and need for support. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive. As a minimum the content should cover:

surveys and ongoing support for the Perinatal Leadership teams? **What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal Leadership teams?**	- Learning from the Perinatal Culture and Leadership Development Programme and how they are using this locally. - How they plan to continue being curious about their local culture. This may be in the form of pulse surveys, or team check ins. - Updates on recent local insight into their team's health, as gathered in the above bullet points. Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, this plan will be fluid and iterative, based on continued conversations with perinatal teams. It is not a plan that can be completed and filed as culture is ever changing and something leaders continually need to be curious about. - Progress with interventions relating to culture improvement work, and any further support required from the Board.
Do the non-executive and executive maternity and neonatal Board safety champion not have to register to the dedicated FutureNHS workspace to access the resources available this year?	We encourage all NED and Exec Board Safety Champions to register on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace. New content and resources are added throughout the year, and we would encourage all BSC's to continue to access the page to benefit from these. You can also reach out to other Board Safety Champions and develop your own community of peer support. However, this will not be a formal requirement in year 6 of the MIS.
We had not continued to undertake feedback sessions with the Board safety champion, what should we do?	Parts a) and b) of the required standard builds on the year four and five requirements of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board level safety champions to raise concerns relating to safety and identify any support required from the Board. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions with staff as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three and four of the maternity

	incentive scheme and the expectation is that this should have been continued.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.
What are the expectations of the Board safety champions in relation to quality improvement work undertaken by the maternity and neonatal quality improvement programme?	The Board safety Champions will be expected to continue their support for continuous quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
Scorecards	
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here.
Why do we need to review the scorecard quarterly alongside current complaint and incident data?	The scorecard is a quality improvement tool that provides insight into claims in support of clinical governance and quality assurance in your organisation. It provides details of all CNST claims, combined with data from the EN scheme and can provide a full picture of maternity related claims in your organisation. The scorecard provides 10 years of claims experience allowing the impact of clinical effectiveness and safety interventions to be assess over time. It can be reviewed alongside other data sets to provide a fuller picture of safety. It highlights themes occurring in claims which can be addressed through staff education and training. The scorecard provides a number of speciality filtered views allowing quick access to the relevant data for your division/speciality. Where data sharing agreements exist, members may share scorecard data to support learning across partnerships, networks and regions.

	The safety and learning team at NHS Resolution can support you in accessing and using your scorecard, nhsr.safety@nhs.net . A short video on using your scorecard can be found here Videos (resolution.nhs.uk) (Extranet login required). The GIRFT/NHS Resolution Learning from Litigation Claims can be found here Best-practice-in-claims-learning-FINAL.pdf (gettingitrightfirsttime.co.uk) and includes advice on engaging with NHS Resolution Safety and Learning resources, including the scorecard.
Examples have been requested for the scorecards.	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historical claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historical themes re-emerged. NHS Resolution have developed an example template to share, and this can be accessed via the FutureNHS platform Maternity Incentive Team workspace, or the MIS Team can send a copy out on request. NHS Resolution staff are always happy to talk through this process if it is helpful.

Technical Guidance for Safety Action 10	
Where can I find information on MNSI (previously HSIB)?	Information about MNSI and maternity investigations can be found on the MNSI/ website https://mnsi.org.uk
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website: • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: (i) when the baby was therapeutically cooled (active cooling only), or (ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following: (aa) hypotonia; (bb) abnormal reflexes including oculomotor or pupillary abnormalities; (cc) absent or weak suck; (dd) clinical seizures Trusts are required to report their qualifying cases to MNSI via the electronic portal. Once MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury. * This definition was updated from 1 October 2023. Please see our website for further information, this does not change the cases referred to MNSI.
What is the definition of labour used by MNSI and EN?	The definition of labour used by MNSI and EN includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to)

	abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Changes in the EN reporting requirements for Trust <u>from 1 April 2022 going forward</u>	As in year 4 of MIS, in addition to reporting their qualifying cases to MNSI, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once MNSI have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must input the MNSI reference number to confirm the investigation is being undertaken by MNSI (otherwise it is rejected). The Trust must share the MNSI report, along with the MRI report, with the EN team within 30 days of receipt of the final report by uploading the MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where MNSI are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury and have a confirmed reference number. • Where a family have declined a MNSI investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution and advised of this reason for reporting. There is more information here: ENS Reporting Guide - December 2023 (for Member Trusts) - NHS Resolution
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a MNSI investigation where the baby has a normal MRI. • Cases that MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to	If a baby has a clinical or MRI evidence of neurological injury and the case is being investigated by MNSI because of this, then the case should also be reported to NHS Resolution via the Claims Reporting Wizard along with the MNSI reference number (document the MNSI reference in the "any other comments box").

MNSI or NHS Resolution?	Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or MNSI maternity team maternityadmins@mnsi.org.uk
How should we report cases to NHS Resolution?	Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by MNSI as under investigation. They must also complete the EN Report form and attach this to the Claims Reporting Wizard: EN-Report-Form.pdf
What happens once we have reported a case to NHS Resolution?	On completion of the MNSI investigation, and on receipt of the MNSI report and MRI report, following triage, NHS Resolution will overlay an investigation into legal liability. Where families have declined an MNSI investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. Regulation 20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by MNSI and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all qualifying cases to MNSI as soon as they occur and to NHS Resolution as soon as MNSI have confirmed that they are taking forward an investigation.

	Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to MNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.
How can we confirm our cases have been reported to NHS Resolution?	We strongly advise making a note of the Claims Management System (CMS) reference number received once the matter is reported, as this will be confirmation that the case has been successfully reported to NHS Resolution.

MIS FAQ	
What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly recognised, and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision-making processes within a Trust and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of sub-committee meetings should demonstrate that the required discussion around MIS standards have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee, and how does it differ from a Trust Board?	A Quality Governance Committee (QGC) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a QGC will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The QGC should also have the opportunity to discuss the Trust's quality improvement plans and provide feedback and recommendations. A QGC is appropriate to review evidence around safety actions, provide additional scrutiny **and then report to the**

	Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern. **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	NHS Providers Board Assurance Toolkit Quality Governance in the NHS
Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice for the Board notification form?	Trust Boards must self-certify the Trust's final MIS declaration following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the CQC for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the AO for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution. The declaration form must be signed by both CEO and the AO of Clinical Commissioning Group/Integrated Care System before submission.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and

	AO (ICB). Where relevant, an action plan is completed for each action the Trust has not met. **Please send only the Board notification form to NHS Resolution. Do not send your evidence or any narrative related to your submission to NHS Resolution unless requested to do so for the purpose of reverification.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2024 and all Trusts will be notified. It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 3 March 2025, NHS Resolution will treat that as a nil response.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 3 March 2025**. If not returned to NHS Resolution by 12 noon on 3 March 2025, NHS Resolution will treat that as a nil response.
Our Trust has queries, who should we contact?	Any queries prior to the 3 March 2025 must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated MIS link contacts via the link on the NHS Resolution website.
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results.

appeals this year?	The AAC will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal: • alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation. • technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated when final results are confirmed and sent to Trusts.
Merging Trusts	Trusts that will be merging during the year six reporting period (April 2024 – January 2025) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2024/25 and the reporting of claims and management of claims going forward.

Maternity Incentive Scheme

Royal United Hospitals Bath NHS Foundation Trust

KPMG Internal Audit and Enterprise Risk Management

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January 2025

Contents

Auditee feedback:

We welcome feedback via the below:

https://forms.office.com/e/J9Qrs7Dm3S

Distribution list

For action:

Zita Martinez, Director of Midwifery;

Jodie da Rosa, Head of Midwifery and Neonates; and

Kerry Perkins, Maternity Neonatal Matron

For information:

Toni Lynch, Chief Nurse

Report Status

Closing meeting: 8 January 2025

Draft report issued: 20 January 2025

Final Report issued: 22 January 2025

Presented to Audit & Risk Committee: 13 March 2025

01 - Executive Summary

Conclusion

We reviewed evidence available to support the Trust's upcoming self-assessment on compliance to the Maternity (and perinatal) Incentive Scheme (MIS) for Year 6. The Trust Board (Board) declaration form is required to be signed by the Trust CEO and ICS Accountable Officer, before being sent to NHS Resolution between 17th February and 3rd March 2025. Within the form there are specific requirements across each of the ten Safety Actions (SA's), each requiring a compliance response of Yes, No, or Not appliable. In Year 5, the Trust self-assessed full compliance to all ten safety actions. The qualifying time period for the Year 6 declaration was 2nd April to 30th November 2024.

For Year 6, the NHS supplied a template audit tool to support Trusts in monitoring compliance or establishing actions to address shortfalls where it was not yet. The Trust utilised the tracker, establishing leads to each requirement and noting the supporting evidence available for each requirement.

Our review only considered 6/10 SA's, excluding 1,2,6, and 10. We found the minimum evidence recorded in the MIS Year 6 additional guidance was available for 2/6 SA's, SA3 and SA8. These corresponded to transitional care services and training completion rates. For the remaining 4/6, although partial evidence was available in accordance with the guidance, we found instances where governance oversight and/or sign off from the Board and Maternity and Neonatal Safety Champions (MNSC) had not yet been completed at the time of the audit. The remaining evidence for the Board included documenting the level of compliance to British Association of Perinatal Medicine national standards of nursing, whether the Trust is compliant to the outcomes of the BirthRate+ calculations, demonstrating MNSC are meeting with Perinatal Leadership, and receiving updates on the drafted Perinatal Culture and Leadership Improvement Plan. The remaining evidence for the MNSC related to oversight and progress updates on the National Maternity Patient Experience Survey action plan developed.

We recognise these requirements may need to be addressed after the period ending on 30th November 2024 to ensure the entire period is considered. However, as our review only considered the evidence available within the relevant time period, the Trust should ensure the remaining requirements are addressed ahead of declaration form submission.

Our Year 5 review identified three low-priority findings, each with a corresponding management action. One action was no longer relevant for Year 6, and another closed upon finalisation of prior year's review. The remaining action related to SA10 and reportable cases to the NHS Resolution's Early Notification Scheme. We did not consider SA10 within the scope of this year's review, but we noted its relevance to the Year 6 requirements. As there had been no reportable cases within the 24/25 period we were unable to test the implementation of the action, but we did confirm a revised feedback process had been established.

Summary			
Actions	Control design	Operating effectiveness	Total
High	0	0	0
Medium	0	0	0
Low	0	3	0
Total	0	0	0

Acknowledgements

We would like to thank the following individuals for their contribution during this internal audit:

- Toni Lynch, Chief Nurse (Executive Sponsor);
- Jodie da Rosa, Head of Midwifery and Neonates; and
- Kerry Perkins Maternity Neonatal Matron.

01 - Executive Summary

Out of scope

This review did not sample check the operation of controls but sought to validate the evidence provided to support compliance with the MIS. We did not review the following safety actions as the Trust will obtain assurance over these safety actions from another external auditor:

- One
- Two
- Six, and
- Ten

Our assessment did not cover the whole period for MIS year six (i.e. 1 April 2024 to 31 March 2025). This is because our review only considered the qualifying time period, with our cut-off point for assessing evidence 30 November 2024. We did not review actions identified last year that are no longer relevant having been removed from the year six requirement.

Summary of key actions		
Governance group oversight and sign off for remaining standards	2.1	Review the Trust Board and governance sign off safety action requirements to ensure each is complete.
	2.2	After each governance sign off or oversight from the Trust Board and Safety Champions, document the evidence and ensure it is easily accessible.
	2.3	Review the NHS guidance and requirements for the different governance groups ahead of the compliance period for MIS Year 7 and develop a plan, including a timeline, for the meetings at which each requirement will be addressed.

02 – Findings and management actions

A Governance group oversight and sign off for remaining standards			
Low	Testing identified minimum evidence not available at the time of the audit to 30th November 2024, which will be required ahead Board declaration. Review of the minimum evidence required under the MIS Year 6 additional guidance found examples across four different safety actions whereby governance group oversight or sign off had not been recorded within the period at the time of the audit. These included: − SA4: The Trust Board is yet to formally record compliance of the neonatal unit to BAPM national standards of nursing using the Nursing Workforce Calculator (2020). Per management, this is scheduled for January 2025. − SA5: The Trust Board is yet to formally confirm the funded establishment is compliant with the outcomes of BR+ calculations. Per Management, this is scheduled for January 2025. − SA7: We found no action or progress updates on the outcome of the CQC Survey 2023 were presented to the Safety Champions in the period. We noted this was included within the December 2024 agenda. − SA9: We found Trust Board minutes were not able to demonstrate Board Safety Champions are meeting with Perinatal leadership team at least bi-monthly, and any support required of the Board has been identified and implemented. Additionally, progress updates presented with respect to the Maternity and Neonatal Culture Improvement Plan, which has been drafted. Per Management, both are scheduled for January 2025. The MIS Year 6 audit tool produced by the NHS to support Trusts includes guidance on the governance group sign off requirements for the Trust Board. We recommend the Trust cross reference each safety action requirement to ensure compliance can be demonstrated ahead of final Board declaration.	**Risk:** The evidence documented to support the Trust's self-assessment in MIS matters is not appropriate or sufficient. **Agreed management action:** 2.1) Review the Trust Board and governance sign off safety action requirements to ensure each is complete. 2.2) After each governance sign off or oversight from the Trust Board and Safety Champions, document the evidence and ensure it is easily accessible. 2.3) Review the NHS guidance and requirements for the different governance groups ahead of the compliance period for MIS Year 7 and develop a plan, including a timeline, for the meetings at which each requirement will be addressed.	**Evidence to confirm implementation:** 2.1) Evidence all governance group requirements within the audit tool guidance were met. 2.2) Minutes and agendas supporting receipt of the documentation and / or oversight as outlined in the finding areas within SA4, SA5, SA7, and SA9. 2.3) A plan written up before the 25/26 MIS compliance period mapping each governance group requirement to a meeting where this will be addressed. **Responsible person/title:** 2.1) Kerry Perkins, Interim Quality & safety Lead and Jodie da Rosa, Head of Midwifery and Neonates 2.2) Kerry Perkins, Interim Quality & safety Lead and Jodie da Rosa, Head of Midwifery and Neonates 2.3) Zita Martinez, Director of Midwifery and Neonates **Target date:** 2.1) and 2.2) - 5 February 2025 2.3) – 30 April 2025

Appendix A: Detailed findings – compliance testing

Using the MIS Year 6 Guidance published on the NHS website 2 April 2024, later updated 17 and 4 September, we reviewed the availability of the minimum evidence at the Trust to support the requirements for Safety Actions (SAs) 3,4,5,7,8 and 9. A summary of our findings has been laid out in the following slides. We have noted in green where we were able to confirm compliance to the minimum evidence required, amber for partial compliance, and red for non-compliance.

Safety Action	KPMG assessment of compliance with minimum evidence to meet standards	KPMG Commentary
SA3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?	Minimum evidence available	• The Neonatal and Maternity Clinical Guideline (Criteria for admission to Transitional Care Pathway (TCP)) references the BAPM 2015/2017 framework in Appendix 2. The TCP overlaps with further areas including a neonatal and maternity service provided across different locations, associated admission criteria and data collection using BadgerNet. • As with MIS Year 5, the Trust evidences meeting at least one element of HRG XAO4 through recording details within the BadgerNet database for those admitted onto the TCP. • We received a copy of the Quality, Service Improvement and Redesign (QSIR) project prepared by a Patient Safety Midwife aiming to address the increased mean of reported Datix incidents due to low cord pH, which included emerging actions due April to May 2024. Minute review confirmed this QI project was registered with the Safety Champions May 2024. • We also confirmed through minute review a progress update was presented to the Maternity and Neonatal Safety Champions (MNSCs) on 15th November 2024 and to LMNS on 19th November 2024, which included reference to the project's initial aims, source of identified issue and action plan update.

Appendix A: Detailed findings – compliance testing

Safety Action	KPMG assessment of compliance with minimum evidence to meet standards	KPMG Commentary
SA4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	Partially compliant	• Obstetric workforce: All short-term locums are members of training as per their RUH contract. Therefore, auditing compliance via Medical Human Resources (HR) is not applicable as short-term cover is within trainee contracts. • Obstetric workforce: We confirmed PQST reports monitor workforce compliance, including a slide on compliance to national guidance which recorded there was no requirement to use long term Locum obstetricians. • Obstetric workforce: The MIS Year 6 guidance outlines Trusts should be working towards RCOG guidance on compensatory rest for Consultants and Senior Specialist Doctors. The minimum evidence required was considered out of scope for our review as it will not be measured within Safety Action 4 for Year 6. – Obstetric workforce: The Trust's position on compliance of consultant attendance for clinical situations listed in the relevant RCOG workforce document are reported to Trust Board, Board-level safety champions and LMNS. We reviewed the Q2 Quarterly Quality Report and minutes for the Trust Board and confirmed receipt in October 2024. We confirmed the September 2024 Safety Champions minutes included oversight of an incident of non-attendance in August 2024 within the "Safe" metrics of the PQST report. We found further review and reflection on the event in the "Incident" slide, whereby two emerging outcomes and learning points were established to try prevent the root cause of the incident. Within the LMNS Programme Board meetings PQST reports are also presented from each provider. We reviewed minutes to confirm RUH were also presenting their reports alongside high level key themes or challenges. • Anaesthetic Workforce: We obtained a copy of the anaesthetist workforce rota from November 2024 showing an anaesthetist was allocated to each day to evidence compliance with ACSA standard 1.7.2.1. • Neonatal Medical Workforce: We confirmed the Trust Board formally recorded compliance of the neonatal unit to BAPM national standards of medical staffing in October 2024 minutes. – Neonatal Nursing Workforce: The Trust Board is yet to formally record compliance of the neonatal unit to BAPM national standards of nursing using the Nursing Workforce Calculator (2020). Per Management, this is scheduled for January 2025. **See Finding 2.A**

Appendix A: Detailed findings – compliance testing

Safety Action	KPMG assessment of compliance with minimum evidence to meet standards	KPMG Commentary
SA5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Partially compliant	• We reviewed the BirthRate+ (BR+) report from April 2023 outlining how midwifery staffing establishment levels were calculated, highlighting a systemic and evidence-based approach complete within the last 3 years. The Bi-Annual Midwifery and Neonatal Nursing Staffing Report presented to the Board of Directors in July 2024 for the period January-June 2024 was reviewed. The report confirmed: • Inclusion of performance monitoring on the midwife to birth ratio to the target of 1:24. We note performance reported substantive workforce only, as well as the ratios after the use of bank staff, demonstrating the use of mitigations to manage staffing shortfalls. • A summary of the Trust's workforce position in the "Specialist Midwives" section to the BR+ establishment work time equivalent recommended, which evidenced the Trust have addressed the original shortfall identified and is now compliant. • Inclusion of "Supernumerary status" and "1:1 care in labour" sections, using data collated from internal performance review. For the 6 months to June 2024, supernumerary labour ward coordinators achieved 100% compliance in being on duty at the start of every shift. Similarly, one-to-one care in active labour was provided 100% of the time, indicating full compliance. – The Trust Board is yet to confirm the funded establishment is compliant with the outcomes of BR+ calculations. Per Management, this is scheduled for January 2025. **See Finding 2.A.**

Appendix A: Detailed findings – compliance testing

Safety Action	KPMG assessment of compliance with minimum evidence to meet standards	KPMG Commentary
SA7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Partially compliant	• Evidence of continued funding of a Maternity and Neonatal Voices Partnership (MNVP) was provided via a letter sent from the Lead Midwife, BSW Local Maternity and Neonatal System, BSW ICB to the Director of Midwifery and Head of Midwifery and Neonates at RUH. • Engagement with families and parents with neonatal experience is reported and reviewed through the MNVP, captured within the "Responsive" section of monthly PQST reports. We confirmed 8/8 monthly reports included the responsive section with feedback. • We reviewed the MNSC ToR and minutes from April to November 2024 and found the MNVP Lead was present at 5/8 meetings. The minimum evidence suggests Trust's should work towards the MNVP Lead being a quorate member across safety and governance meetings, but it not a formal requirement. • We received a copy of the January 2024 MNVP Lead job description which was applicable for the period April-Nov 2024, supporting MNVP infrastructure being in place. • We received a copy of the Volunteer Policy issued May 2023 which states any volunteers can expect reimbursed out of pocked expenses subject to receipts or evidence of expenditure. • We reviewed a copy of the National Maternity Patient Experience Survey 2023 CQC Report presented by Maternity Governance January 2024, noting its inclusion of a slide with an action plan on areas for improvement. Although owners allocated, we found there were no completion dates or due dates for actions. – We reviewed minutes from LMNS 19th November 2024 and confirmed oversight of the emerging action plan referenced above. However, we found no action or progress updates were presented to the Safety Champions from April – November 2024, as required for the safety action 7. We noted this was included within the December 2024 agenda. **See Finding 2.A.**

Appendix A: Detailed findings – compliance testing

Safety Action	KPMG assessment of compliance with minimum evidence to meet standards	KPMG Commentary
SA8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Minimum evidence available	• Safety Action 8 required 90% completion across various staff groups to three different training types: Fetal monitoring, multi-professional maternity emergencies, and Basic Neonatal Life Support (BNLS). We reviewed Trust training system records and confirmed for all staff groups required within the MIS Year 6 technical guidance there was 90% or greater compliance. • We do note for the Advanced Neonatal Nurse Practitioners (ANNPs) we found only 1/8 had completed their BNLS, however we confirmed the remaining 7/8 had completed their NLS and therefore are still compliant in line with the MIS Year 6 technical guidance. • For Maternity Support Workers and Healthcare Assistants we were unable to review individual compliance rates to BNLS given this is a mandatory aspect of their PROMPT training. However, we reviewed the PROMPT training agenda and confirmed the inclusion of NBLS as a mandatory item of the timetable. As a result, we used the compliance rates for the PROMPT training to confirm their 90% BNLS compliance. • We did not review implementation of all six core modules of the Core Competency Framework as this will not be measured in SA8 and was therefore out of scope for this review.

SA9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Partially compliant	• We reviewed minutes from the monthly Maternity and Neonatal Safety Champions (MNSC) meetings and confirmed invitation of a Trust NED to 8/8 months, and attendance to 6/8, between April and November 2024.
		• Monthly PQST reports presented by Perinatal leadership to the MNSCs incorporated quality and safety review elements as per the MIS Year 6 guidance, including reporting on:
		  • Incidents: Ongoing and closed cases, along with any emerging learning or actions are recorded in the "Incidents" slides.
		  • Staff and service user feedback: Staff, friends, and family feedback along with complaints are included in the "Responsive" slide. Including Family Feedback Insights Triangulation group output.
		  • Training Compliance: Monitored within the "Well-led – Training" slide, with actions documented for shortfalls.

Appendix A: Detailed findings – compliance testing

Safety Action	KPMG assessment of compliance with minimum evidence to meet standards	KPMG Commentary
SA9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues? (continued)	Partially compliant (continued)	• Minimum Staffing Standards: Assessed in the "Safe" workforce monitoring metrics and "Compliance to National Guidance" slides. • Trust collaboration with the Local Maternity and Neonatal System (LMNS) and ICB lead was evidenced through representation and engagement at LMNS Safety Group meetings. Minutes from April to November 2024 identified instances of the Trust sharing updates and reflecting on completed work, including QI project outcomes, audit results, and service user feedback themes. • In addition to the staff feedback included within the PQST reports, visibility to Maternity and Neonatal staff on raised concerns or actions underway to address those is communicated through Maternity and Neonatal Senior Leadership Team Newsletters, with the first from November 2024. We reviewed and confirmed inclusion of concerns raised through the out of hours working update segment of the newsletter. Staff feedback collated at the 6 month period for work complete in the past 18 months, and from its launch November 2023. Additional evidence was provided in the form of the “8 Steps to Better Engagement” digital flyer, including reference to the live Maternity and Neonatal Forum Q&A 23rd November 2023. • We reviewed the Q1 an Q2 Maternity and Neonatal Safety Reports from June and Oct 2024 presented to the Board of Directors. We confirmed under the learning and improvement subheading, each considered to the Trust’s claims scorecard alongside incidents for the period. – We found Trust Board minutes were not able to demonstrate the evidence required under SA9 section c), which were required to show Board Safety Champions are meeting with Perinatal leadership team at least bi-monthly, and any support required of the Board has been identified and implemented. Additionally, there were no Board minutes or equivalent Trust Committee with delegated responsibility evidencing the progress made on the drafted Maternity and Neonatal Culture Improvement Plan. **See Finding 2.A.**

Appendix B: MIS Year 5 action follow up

We have reviewed the findings raised within the 23/24 Year 5 MIS review to assess whether these have been implemented.

Ref.	Risk	Finding	Original Management Action	KPMG Commentary
2.1	Low	No audit evidence showing approval of N&M Clinical Guidelines on criteria for admission to TCP. There is no audit trail to evidence that the Neonatal and Maternity (N&M) Clinical Guidelines on criteria for admission to Transitional Care Pathway (TCP) was approved by the Neonatal Clinical Lead and Neonatal Ratification Group in 2021.	**Agreed action:** Ensure that an audit trail of approval is established. The neonatal ratification group ToR, approved in June 2023, notes that it is reflective of practices and process which pre-date the publication. **Original due date:** N/A **Responsible officer:** Jodie Clement, Quality & Safety Lead Midwife	This action was closed on finalisation of the Year 5's report. **KPMG opinion: Closed**
2.2	Low	Lack of assurance from Trust Legal team There is a lack of assurance from the Trust Legal team to Maternity and Neonatal to confirm that cases that may require reporting to NHS Resolution's Early Notification Scheme have been submitted via the Reporting Claims Wizard.	**Agreed action:** Assurance mechanism from Trust Legal team to Patient Safety Lead Midwife. **Original due date:** 31 January 2023 **Responsible officer:** Jodie Clement, Quality & Safety Lead Midwife	The Patient Safety Lead now informs the Legal Team who are required to respond via email using a claim's wizard reference to confirm reportable cases had been submitted. As there had been no cases referred to NHSR in 2024/2025 we were only able to review the templated spreadsheet used to track reported case's and confirm it's suitable design. **KPMG opinion: Closed**
2.3	Low	Lack of target due dates in MNVP workplan. The MNVP workplan does not include target due dates against each action.	**Agreed action:** Inclusion of due dates within the workplan. **Original due date:** 31 January 2023 **Responsible officer:** Chaya Tagore, MNVP Lead for Bath & NE Somerset, Swindon and Wiltshire and MNVP Lead for RUH and Bath & NE Somerset.	The workplan was no longer required by the Trust for the Year 6 minimum evidence and therefore was out of scope for an action update to be provided. **KPMG opinion: Closed**

Appendix C: Glossary

- ANNP = Advanced Neonatal Nurse Practitioners
- BAPM = British Association of Perinatal Medicine
- BR+ = BirthRate Plus
- HRG XA04 = Healthcare Resource Groups XA04 criteria as per Neonatal Critical Care Minimum Data Set (NCCMDS).
- ICB = Integrated Care Board
- LMNS = Local Maternity and Neonatal System
- MIS = Maternity Incentive Scheme
- MNSC = Maternity and Neonatal Safety Champions
- MNVP = Maternity and Neonatal Voices Partnership
- PQST = Perinatal quality surveillance tool
- RCOG = Royal College of Obstetricians and Gynaecologists
- TCP = Transitional Care Pathway

Appendix D – Terms of reference extract

Background of the internal audit

The Maternity Incentive Scheme (MIS) from the NHS is ultimately aimed to improve the quality of care and to incentivise Trusts to actively adopt best practices and implement essential safety measures. The Royal United Hospitals Bath NHS Foundation Trust (Trust) through a self-certification scheme is required to demonstrate the achievement of 10 safety actions to recover their contribution to the MIS fund and for a share of any unallocated funds.

In December 2023, we reviewed the Trust's evidence to support the MIS for year five and made findings for the consideration of the Trust. The safety actions for MIS year six have been agreed and updated. This year we will build on the previous review. And as part of this we will follow up actions identified in our 2023 report to confirm whether they have been implemented. This review will have the objectives outlined below.

Objectives	
1 – Evidence to support certification	We reviewed the evidence available to support the requirements for MIS year six (safety actions 3, 4, 5, 7, 8 and 9).
2 – Follow-up of Management Actions	We assessed the status of management actions identified as part of the 2023 MIS review for MIS year five.

Our approach

Our work involved the following activities:

- Meetings with the key staff involved in the self-assessment process and
- Desktop review of documentation supporting compliance with the MIS.

Key potential risks considered	
Objective One	
1	The evidence documented to support the Trust's self-assessment in MIS matters is not appropriate or sufficient.
Objective Two	
2	Opportunities to improve associated controls have not been identified.

Appendix E – Staff interviewed and documents reviewed

We interviewed the following staff during the course of our work:

Name	Title
Jodie da Rosa	Head of Midwifery and Neonates
Kerry Perkins	Maternity Neonatal Matron

We reviewed the following items of minimum evidence during the course of work:

SA3

- Neonatal and Maternity Clinical Guideline
- Quality, Service Improvement and Redesign (QSIR) project (Low cord pH)
- Minutes from April – November 2024 for the MNSC and LMNS groups

SA4

- PQST reports from April – November 2024
- Quarterly Quality reports (Q1/2)
- Trust Board minutes October 2024
- Anesthetic workforce rota from November 2024

SA5

- BR+ calculations and report April 2023
- Bi-Annual Midwifery and Neonatal Nursing Staffing Report

SA7

- Letter sent from the Lead Midwife, BSW Local Maternity and Neonatal System, BSW ICB to the Director of Midwifery and Head of Midwifery and Neonates at RUH.
- MNSC ToR
- MNVP Lead Job description
- Volunteer Policy
- CQC Survey 2023 action plan

SA8

- Training completion rates for the Fetal monitoring, multi-professional maternity emergencies, and Basic Neonatal Life Support (BNLS) training modules across the following groups:

SA9

- Maternity and Neonatal Senior Leadership newsletter November 2024 and 8 steps to better engagement digital flyer.
- Q1 an Q2 Maternity and Neonatal Safety Reports

Appendix F – Rating definitions

We have set out below the overall report grading criteria and priority ratings used to assess each individual finding.

Level	Classification
Significant assurance	Means the system is well designed and only minor low priority management actions have been identified related to its operation. Might be indicated by priority three only, or no management actions (i.e. any weaknesses identified relate only to issues of good practice which could improve the efficiency and effectiveness of the system or process).
Significant assurance with minor improvement opportunities	Means the systems is generally well designed however minor improvements could be made and some exceptions in its operation have been identified. Might be indicated by one or more priority two management actions. (i.e. there are weaknesses requiring improvement but these are not vital to the achievement of strategic aims and objectives - however, if not addressed the weaknesses could increase the likelihood of strategic risks occurring).
Partial assurance with improvements required	Means both the design of the system and its effective operation need to be addressed by management. Might be indicated by one or more priority one, or a high number of priority two management actions that taken cumulatively suggest a weak control environment. (i.e. the weakness or weaknesses identified have a significant impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).
No assurance	Means the system has not been designed effectively and is not operating effectively. Audit work has been limited by ineffective system design and significant attention is needed to address the controls. Might be indicated by one or more priority one management actions and fundamental design or operational weaknesses in the area under review. (i.e. the weakness or weaknesses identified have a fundamental and immediate impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).

Priority	Description
Red – priority 1	A significant weakness in the system or process which is putting you at serious risk of not achieving its strategic aims and objectives. In particular: significant adverse impact on reputation; non-compliance with key statutory requirements; or substantially raising the likelihood that any of your strategic risks will occur. Any management actions in this category would require immediate attention.
Amber – priority 2	A potentially significant or medium level weakness in the system or process which could put you at risk of not achieving its strategic aims and objectives. In particular, having the potential for adverse impact on your reputation or for raising the likelihood of your strategic risks occurring.
Green – priority 3	Management actions which could improve the efficiency and / or effectiveness of the system or process but which are not vital to achieving your strategic aims and objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes.

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