Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**6 September 2023**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor(s):	**Alfredo Thompson, Director for People & Culture Niall Prosser, Interim Chief Operating Officer Toni Lynch, Chief Nurse Libby Walters, Director of Finance and Deputy Chief Executive**		
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Appendices	**Appendix 1: Integrated Performance Report**		

1. Executive Summary of the Report

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

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

Workforce

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

Actions are being taken to improve our workforce performance:

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

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

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

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

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

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

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

Urgent Care

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

Elective and Cancer

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

Quality

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Finance

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

2.	Recommendations (Note, Approve, Discuss)

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

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

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

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

6.	Equality and Diversity
None identified.	

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

8.	Freedom of Information
Private	

9.	Sustainability
None identified.	

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

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Integrated Performance Report

August 2023 (July 2023 Data)

The RUH, where you matter

22/23 Priorities

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

Business Rules

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

The people we work with

The RUH, where you matter

Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

August 2023 (July 2023 Data)

The RUH, where you matter

Executive Summary I

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

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

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

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

** Vacancy figures does not include reserves or QIPP

Measures requiring focus and a countermeasure summary this month are:

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

Executive Summary II

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Tracker	Global Majority likelihood of being appointed from shortlisting - comparative ratio to 1 White (WRES 2) - Rolling 3 months	0.8 - 1.25	<0.8 or > 1.25	0.63	Not Available	Not Available	Not Available	0.87	0.82	0.72	0.67	0.68	0.69	0.73	0.67
Contextual Information	% of Band 6/7 who are from Global Majority Background (WTE)			11.74%	11.98%	12.48%	12.47%	12.53%	12.83%	12.72%	12.81%	13.05%	13.00%	12.99%	12.93%
Contextual Information	% of Band8A+ who are from Global Majority Background (WTE)			4.42%	4.67%	4.76%	5.09%	5.08%	5.25%	5.21%	5.03%	5.13%	5.43%	5.99%	5.56%

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

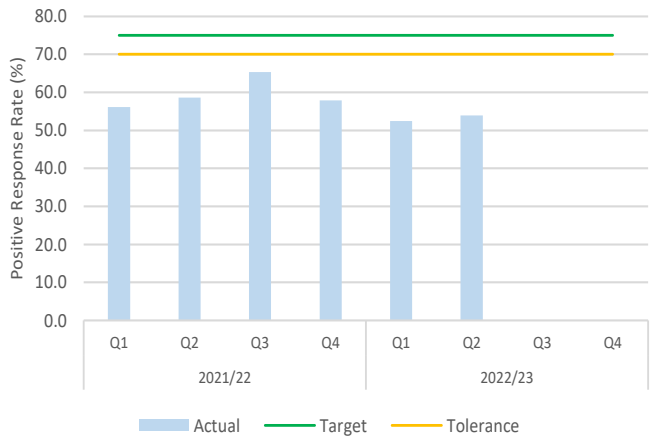
** Training data based on Learning Together from Jun-23

Measures requiring focus and a countermeasure summary this month are:

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

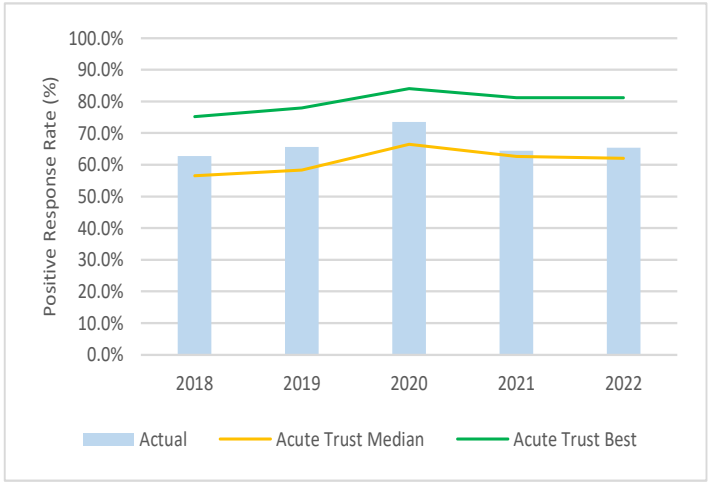
Trust Goal | Staff Recommend the Trust as a Place to Work

Making a Difference Survey Result



Latest Survey	53.9%

National Survey Results



Latest Survey	65.3%

Is standard being delivered?

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

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

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

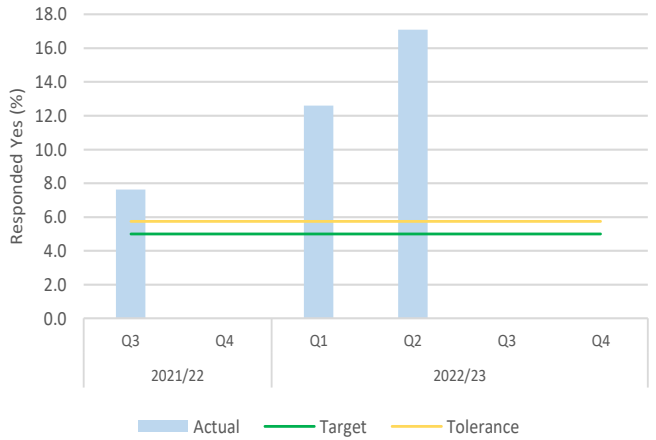
Countermeasure Summary

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

Breakthrough Goal |

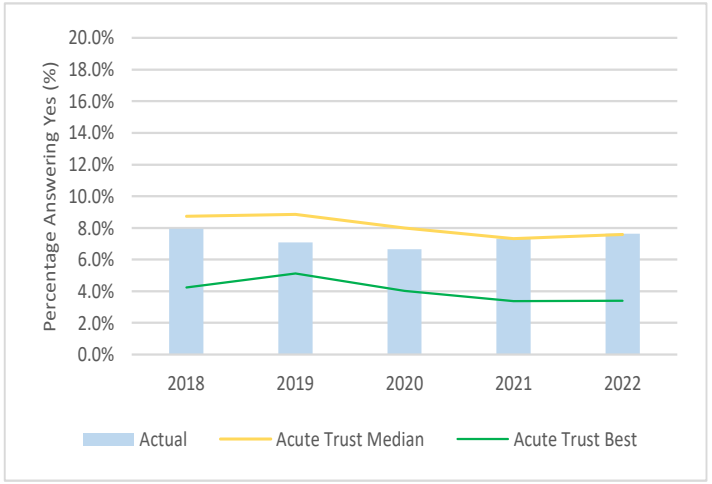
Reduce Proportion of Staff Reporting Experiencing Discrimination from Line Managers/ Colleagues

Making a Difference Survey Result



Latest Survey	17.10%

National Survey Results



Latest Survey	7.63%

Is standard being delivered?

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

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

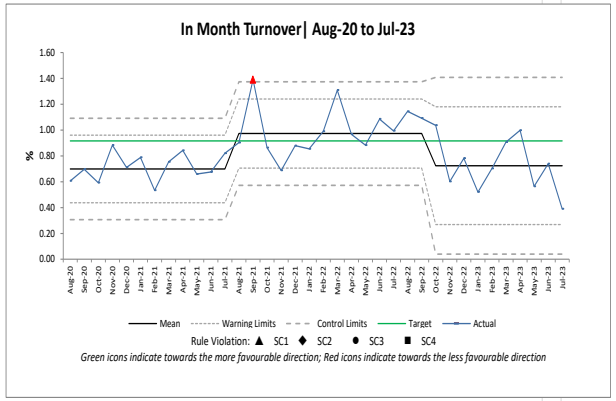
• In percentage terms, Facilities (26.5%) and Surgery (22.7%) had the highest proportion of staff reporting that they had experienced discrimination. However, this was only 13 and 17 people respectively. FASS (29), Corportate (29) and Medicine (30) all had a higher number of individuals reporting a negative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

Countermeasure Summary

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

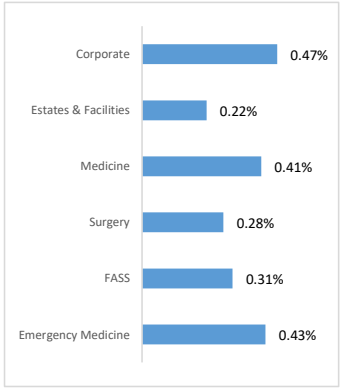
Key Standard| Turnover Rate

In Month Turnover - Trust

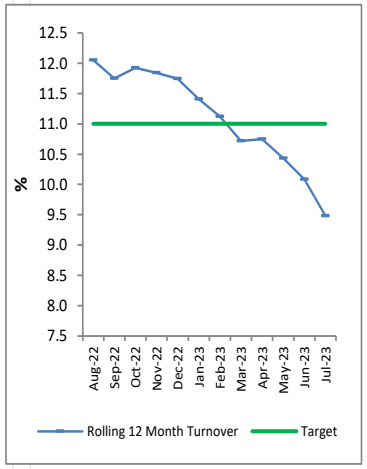


Turnover Rate	0.39%

In Month Divisional Turnover



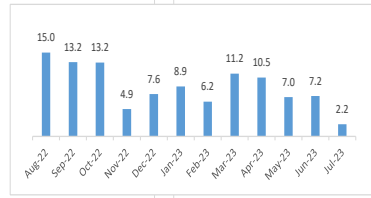
Rolling 12 Months Turnover - Trust



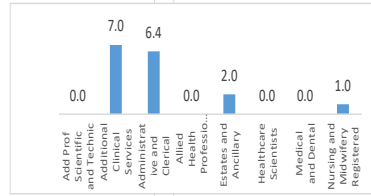
Turnover Rate	9.48%

Leavers Inside 1st Year (Permanent Contract)

Trust Trend



Staff Group - Last 3 Months



Is standard being delivered?

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

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

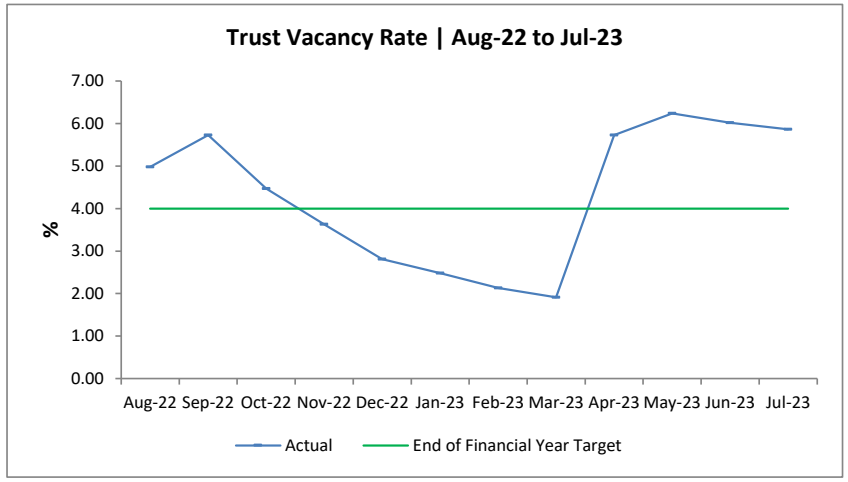
• Of the main Divisions, Estates and Facilities and Corporate are the only areas with rolling 12 month turnover rates exceeding 10% at 12.1% and 11.1% respectively.
• Although AHPs continue to have the highest 12 month turnover of all Staff Groups, recent in-month turnover has been lower.

Countermeasure Summary

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

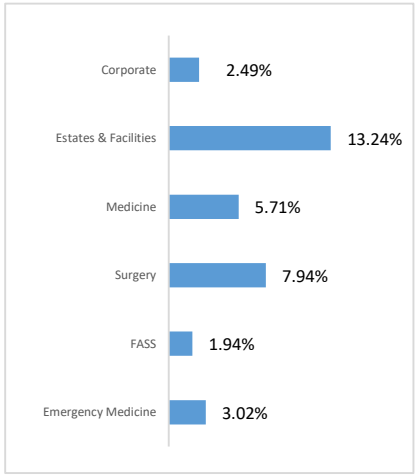
Key Standard| Vacancy Rate

Vacancy Rate - Trust

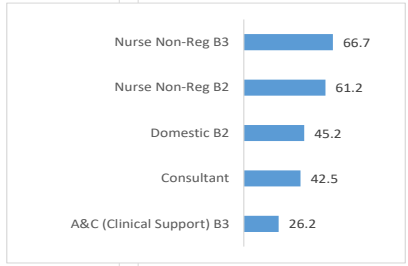


Vacancy Rate	5.86%

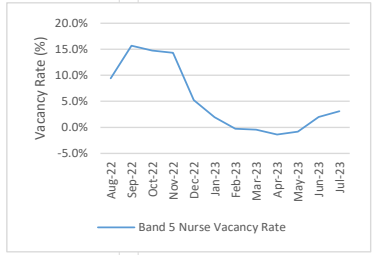
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

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

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

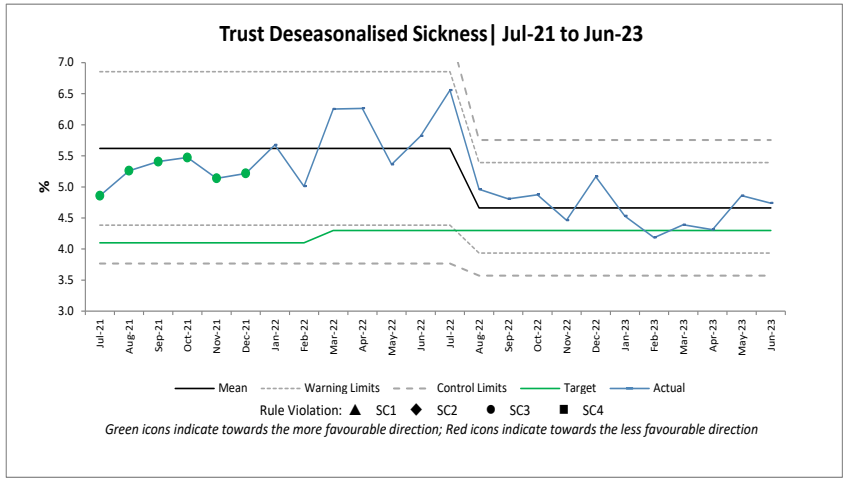
• G07B and G07C - which both relate to unregistered nursing continue to be the two codes with the highest vacancy WTE. However, this is likely to not be fully accurate. For example, 12 WTE were moved from G07C in Forrester Brown this month to C11C to reflect the correct coding following the HCA moves.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

Countermeasure Summary

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

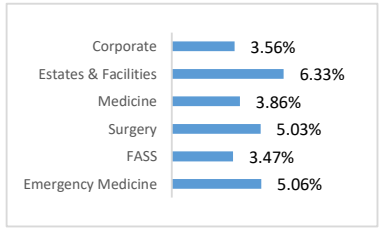
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

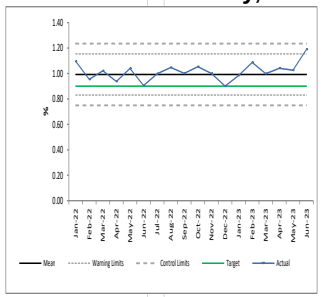


In Month Actual	In Month Deseasonalised	Rolling 12 Months
4.30%	4.74%	4.81%

In Month Divisional Sickness Rates



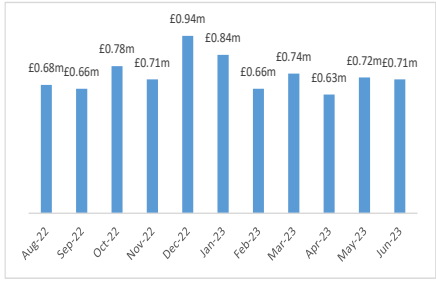
Anxiety, Stress & Depression - Trust



Absence Rate

1.05%

Estimated Absence Cost



RIDDOR Reporting - Employees

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

Is standard being delivered?

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

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

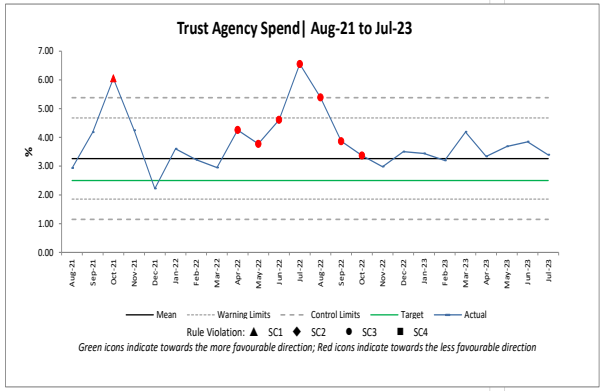
• After a period of relative stability, Anxiety, Stress and Depression rose from 1.03% to 1.19% in June. At this stage, it is plausible that this is simply natural variation, but this will be monitored.
• Estates and Facilities, Emergency Medicine and Surgery all had in month sickness absence rates above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

Countermeasure Summary

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

Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

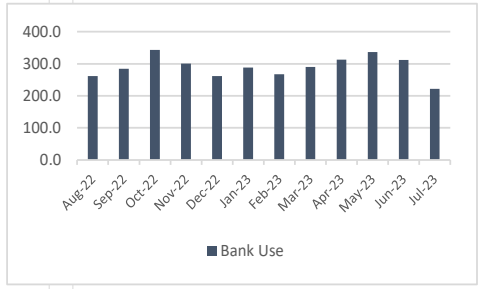


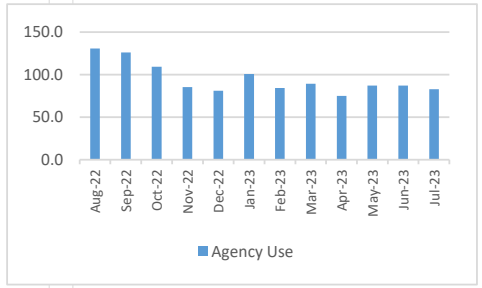
Proportion	3.39%

Agency Spend Breakdown

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

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

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

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

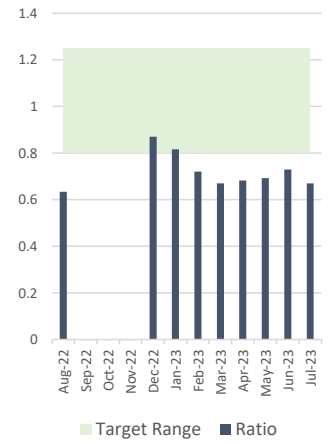
- Registered Nursing accounted for just over 40% of the in month agency spend and remain the highest area of spend for the financial year to date.
. Consultants (28.8%) and Non-Clinical staff (20.0%) were the next highest contributors.
- Nursing & Patient Care, Theatre Staff, Emergency Medicine Medical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

Countermeasure Summary

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

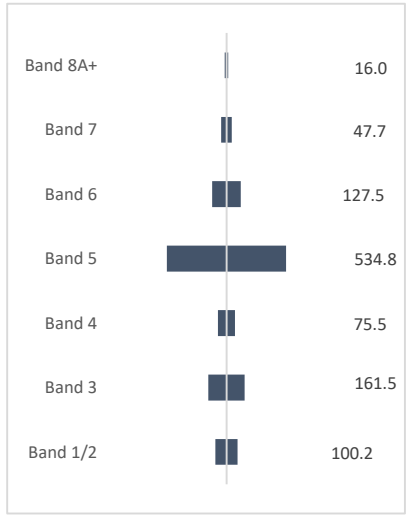
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

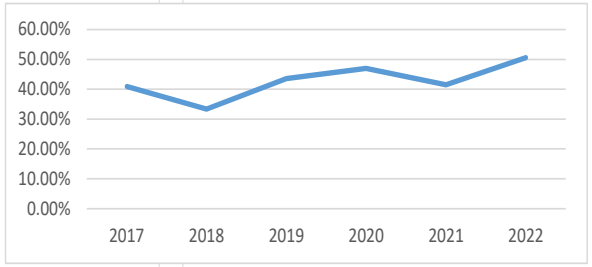


Proportion	0.67

Agency Spend Breakdown



Bank & Agency Use – Staffing Solutions Data



Is standard being delivered?

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

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

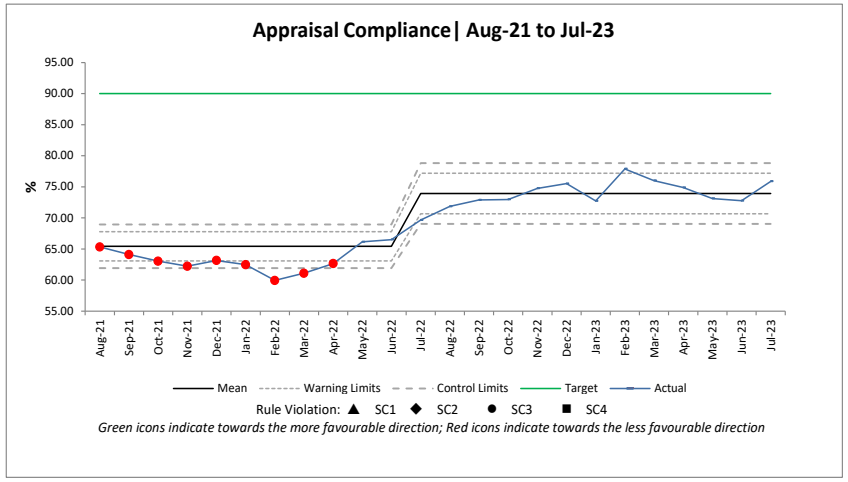
• The calculation does not factor in the recruitment of Overseas Nurses (due to who shortlists) which would inevitably increase that ratio.
• Candidate distribution across vacancies is masked by the aggregation and this has a significant impact in determining the overall figure.

Countermeasure Summary

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

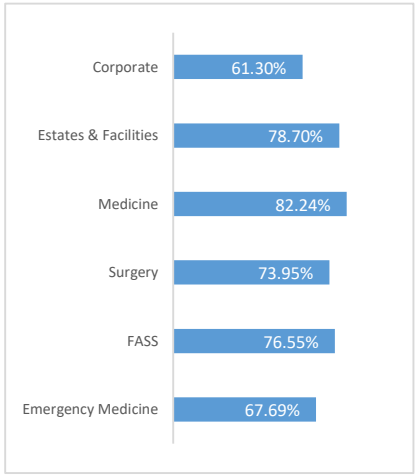
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	75.9%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff 75.7%

M&D Staff 78.2%

Consultants 79.4%

White 76.2%

BME 74.3%

Is standard being delivered?

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

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

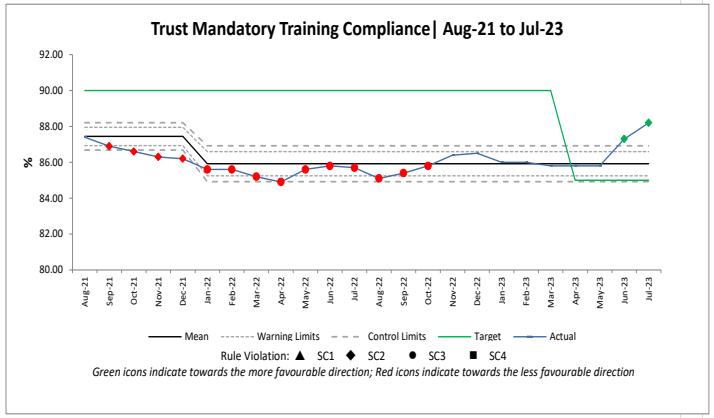
• Corporate has the lowest compliance rate of the main Divisions at 61.30%, with several Directorates currently showing a compliance rate below 40%.
• Emergency Medicine has the next lowest compliance of the Divisions at 67.69%

Countermeasure Summary

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

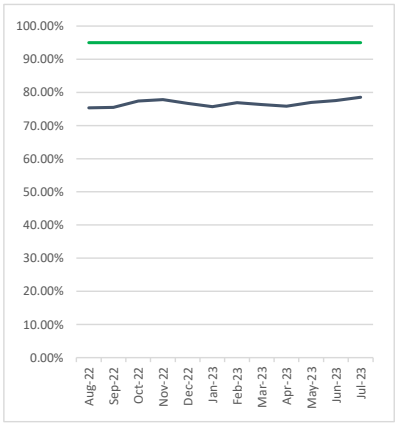
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



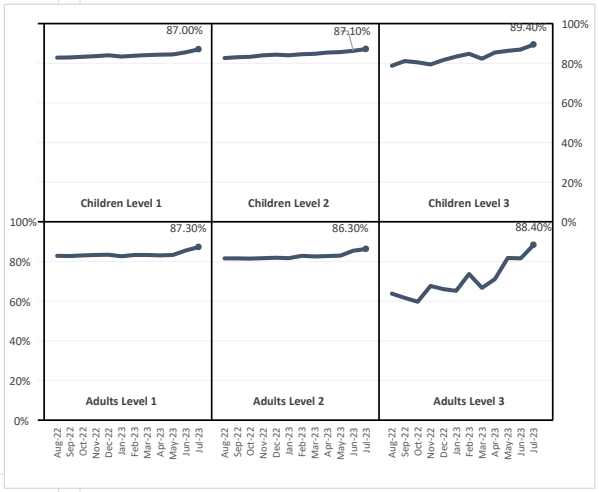
Compliance Rate	88.2%

Information Governance Training Compliance Rate - Trust



Compliance Rate	78.5%

Safeguarding Training Compliance Rates - Trust



Is standard being delivered?

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

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

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

Countermeasure Summary

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

The people we care for

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Operational Performance Report

August 2023 (July 2023 Data)

The RUH, where you matter

Executive Summary: Performance

Royal United Hospitals Bath NHS
NHS Foundation Trust

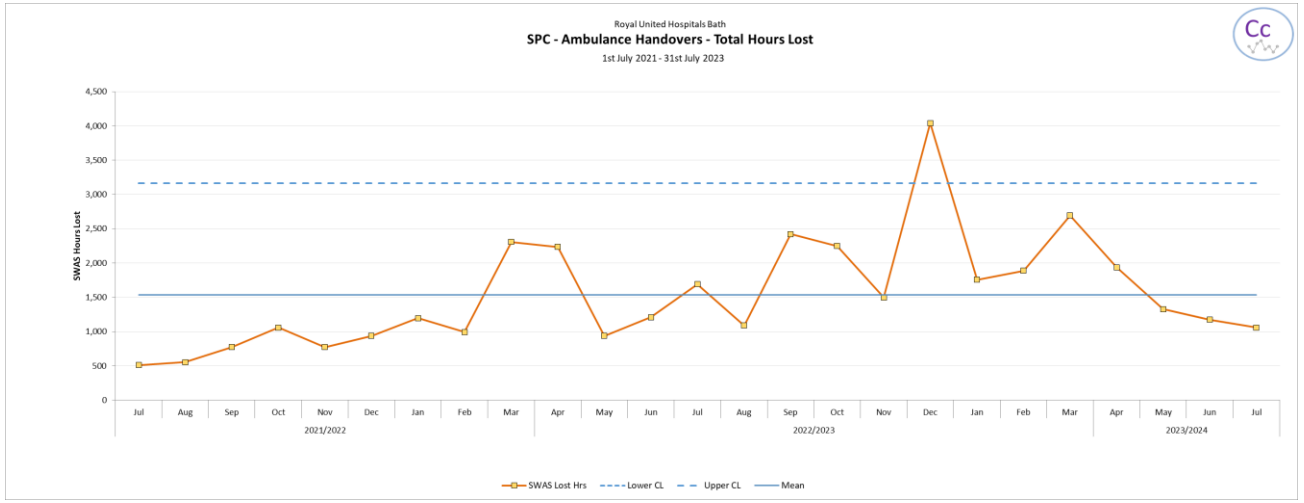
Strategic Goal		Performance Indicator	Target		2022/23						Trend	Movement From Previous Month
			Performing	Under Performing	Feb	Mar	Apr	May	Jun	Jul		
Trust Goals	People in our Community	Ambulance Handover Delays	>=39	<39	689	949	704	460	453	415		
Breakthrough Objectives	People We Care For	4 Hour Performance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

Measures requiring focus and a countermeasure summary this month are;

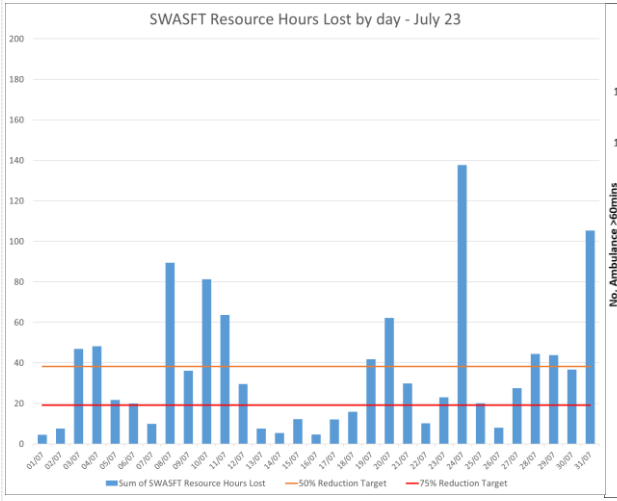
Measure	Change	Executive Summary
Ambulance Handover	↓	In July the Trust lost a total of 1,058 hours in ambulance handovers, a decrease on the previous month. This is the best performance for the last 14 months. The Trust has been making a number of changes within ED to support improved flow (such as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

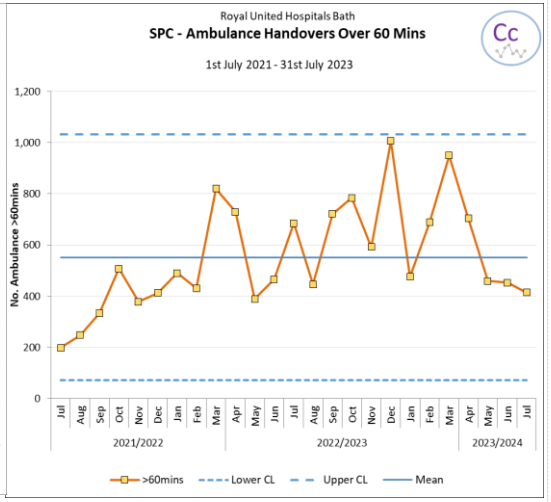
Trust Goal | Ambulance handover delays

Historic Data: hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

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

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

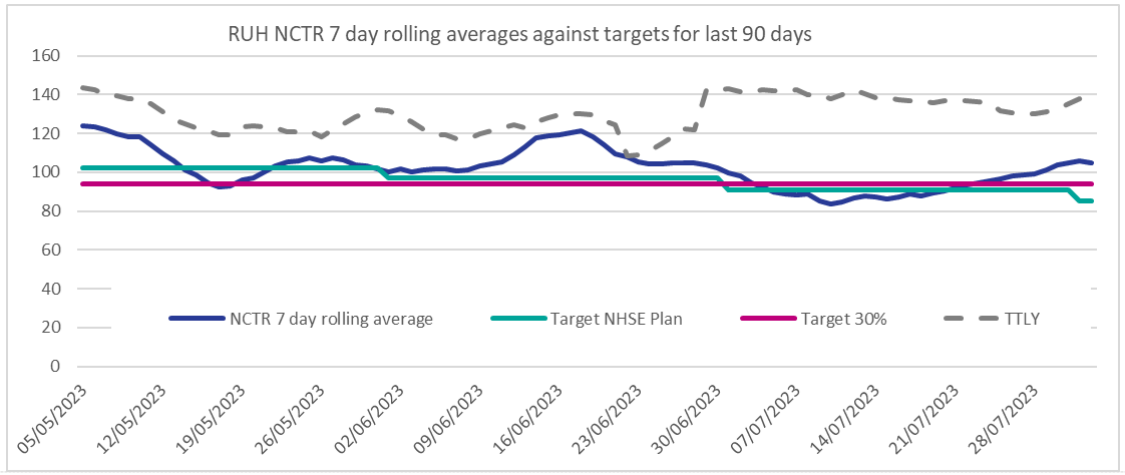
The Trust has continued to drive improvement within the ambulance handover, this is driven by

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

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

Breakthrough Goal | Non criteria to reside

Historic Data: as of 05/08/23



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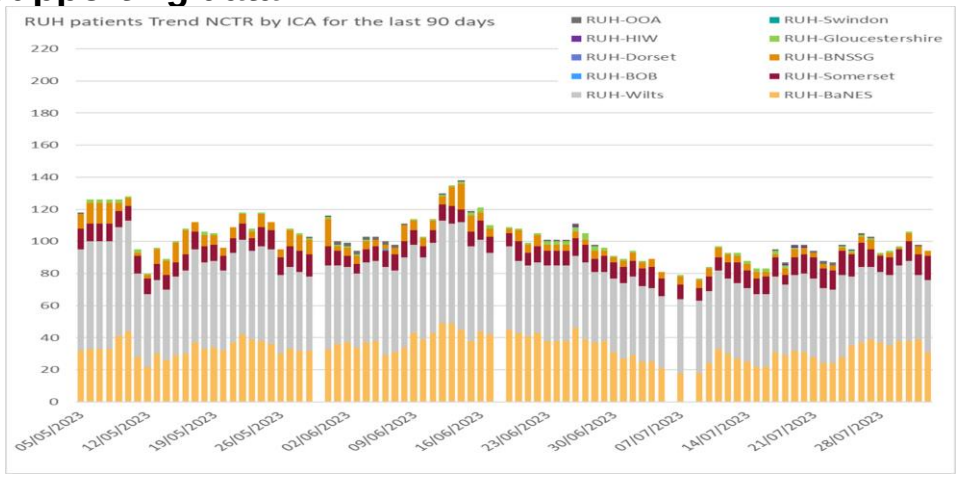


Is the standard being delivered?

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

This remains above the system target of 80.

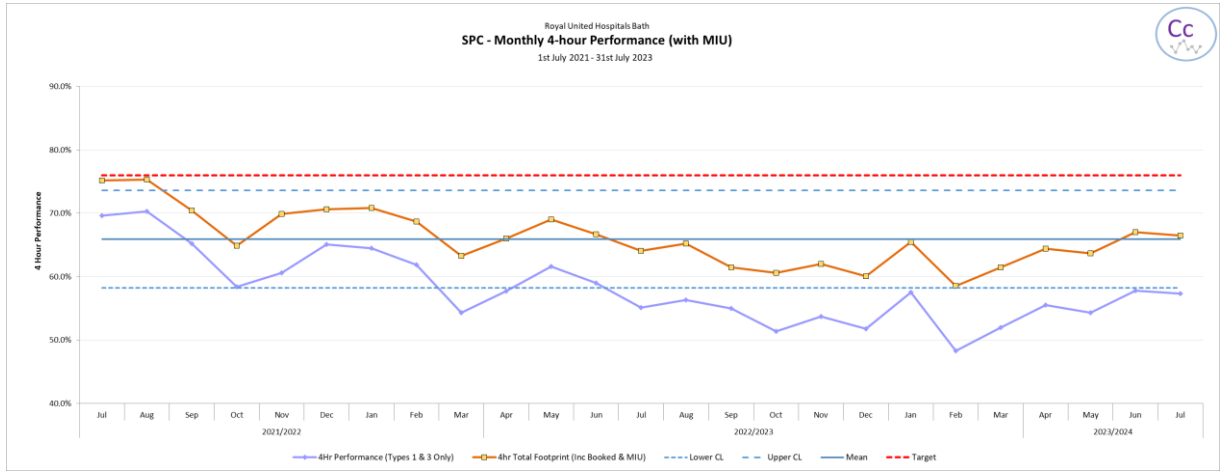
What's the top contributor for under/over achievement?

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

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

Key Standards | 4 hour Emergency Standard

Historic Data



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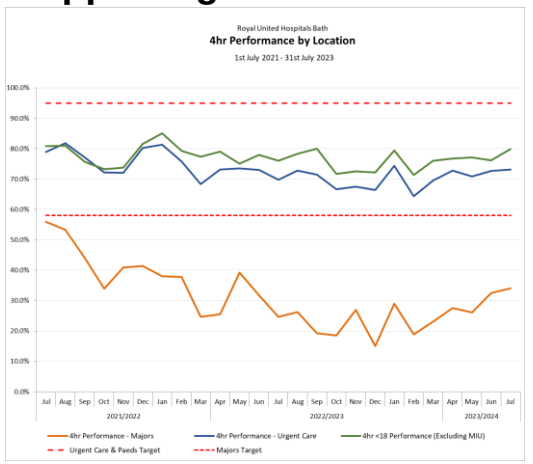
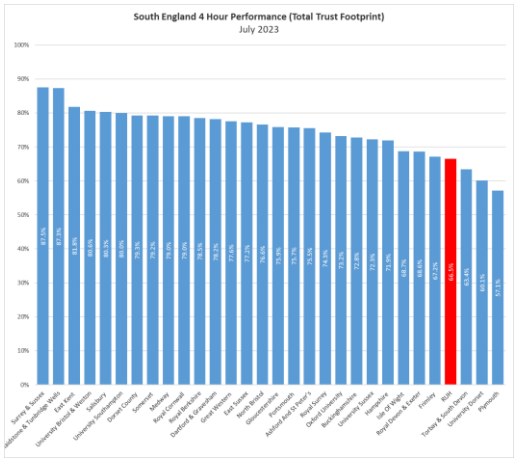




Is the standard being delivered?

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

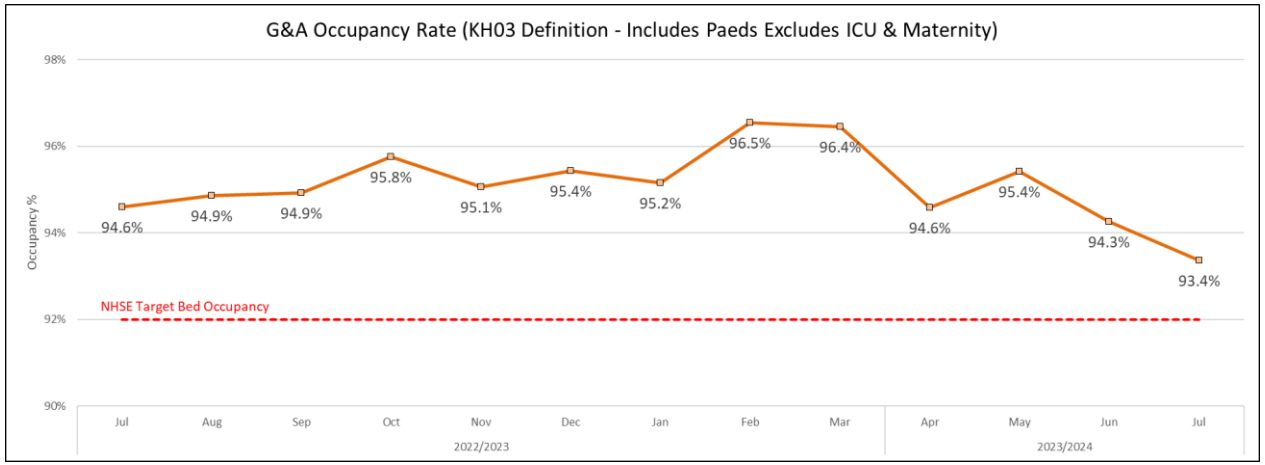
What's the top contributor for under/over achievement?

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

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

Key Standards | Bed Occupancy

Historic Data



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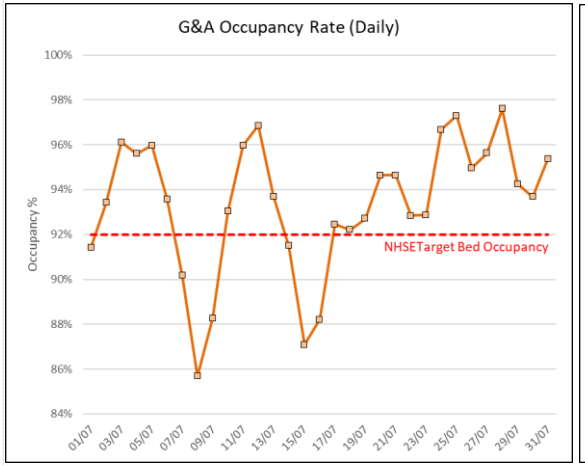
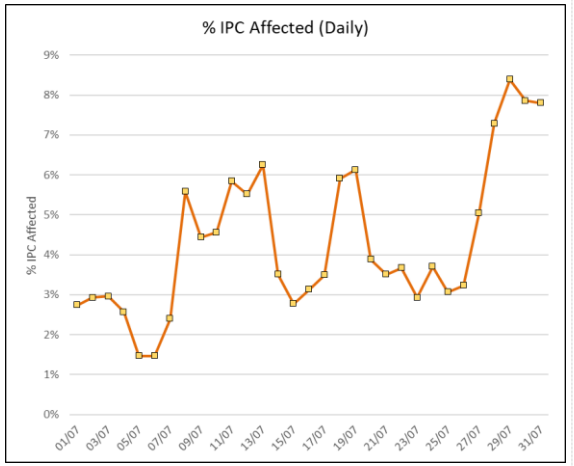




Is the standard being delivered?

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

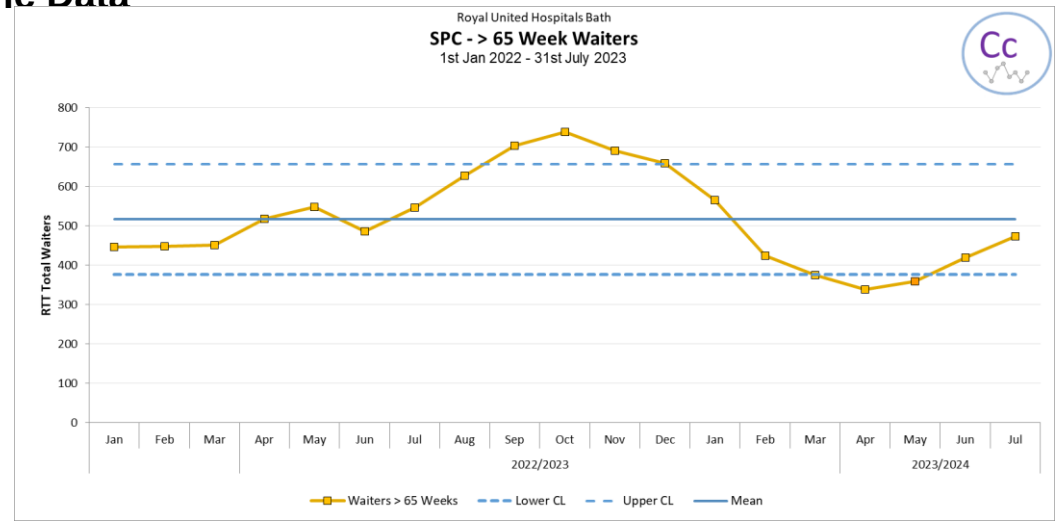
What's the top contributor for under/over achievement?

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

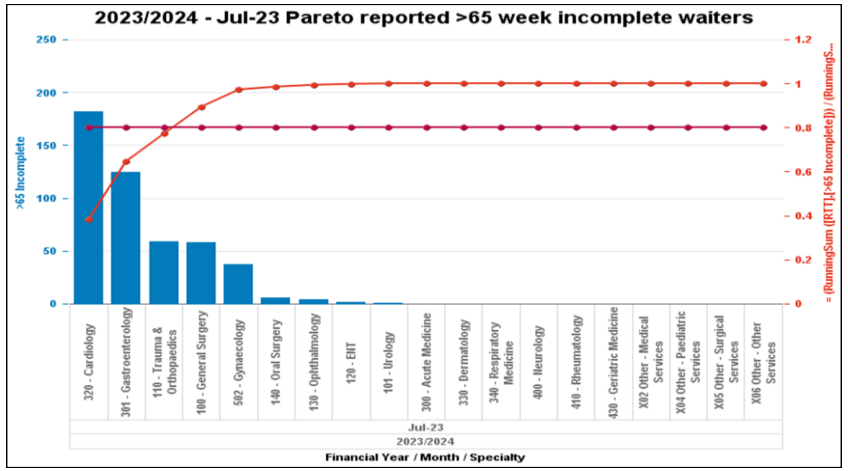
Countermeasures / Actions	Owner	Due Date
Recruiting to agreed business case expanding SDEC to support reaching 40% same day discharge	Medicine	Q3 23/24
Implementation of urgent care and patient flow strategy to support further bed reductions	Surgery	Q3 23/24
Midford ward reopened during May – third of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

Key Standards | Referral to Treatment

Historic Data



Supporting data - *Pareto 65+ by Specialty*



Is the standard being delivered?

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

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

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

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

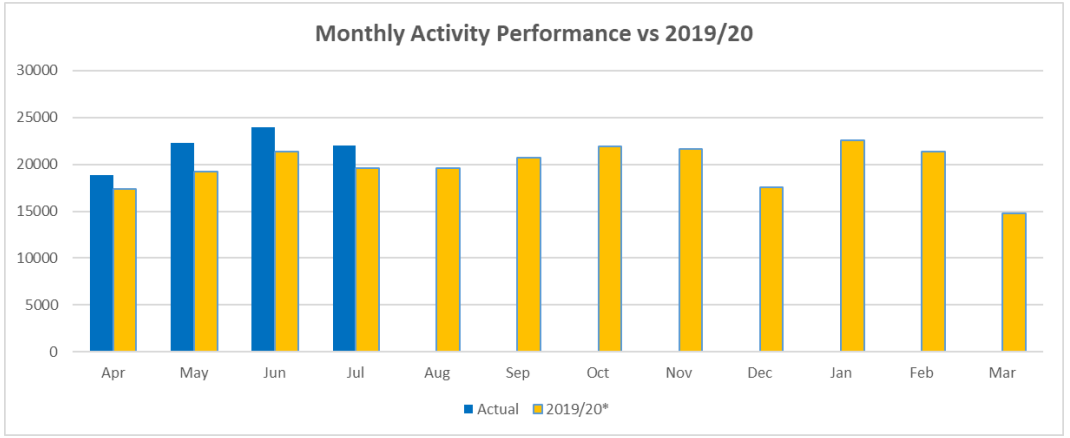
Key Standards | Elective Recovery

ERF Performance

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

Supporting data

ERF Activity Delivery



Is the standard being delivered?

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

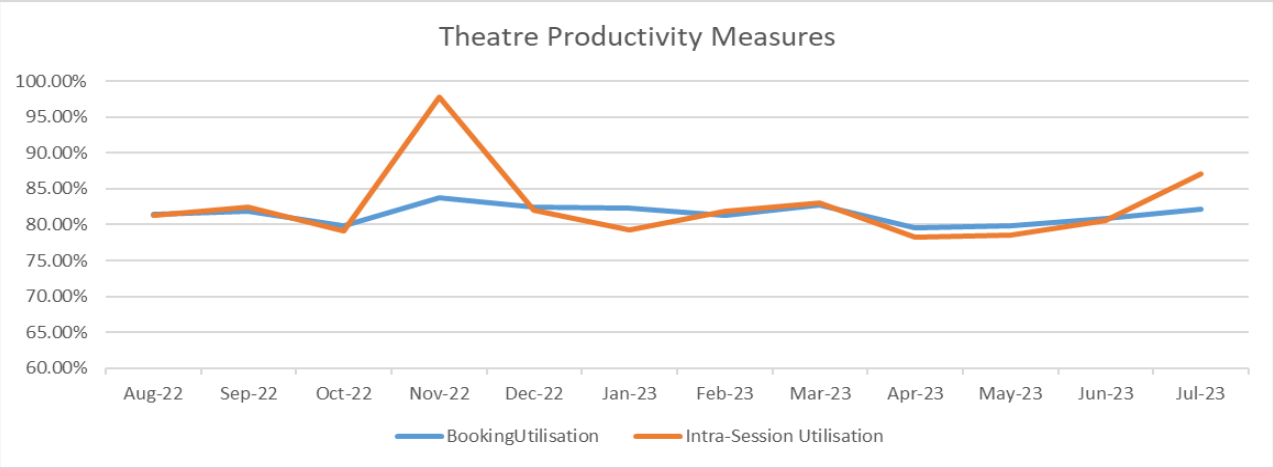
What's the top contributor for under/over achievement?

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

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

Key Standards | Productivity

Historic Data:



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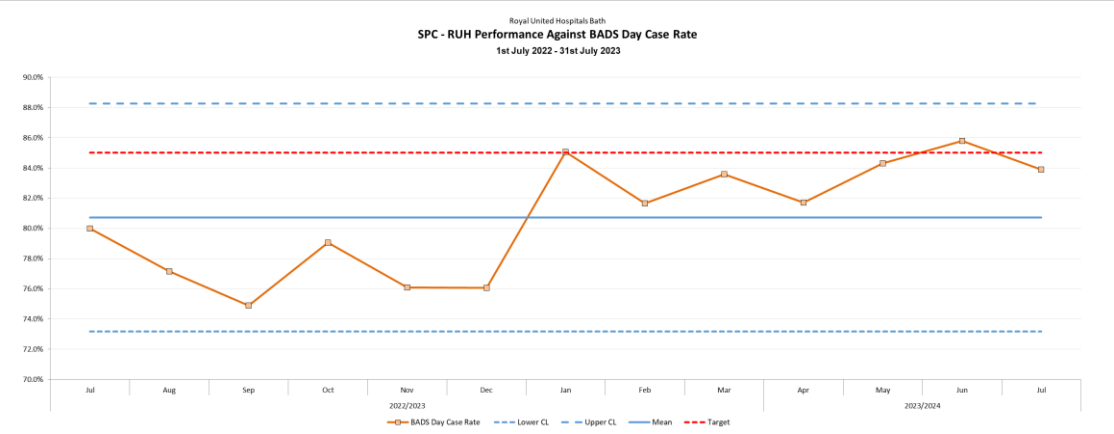


Is the standard being delivered?

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

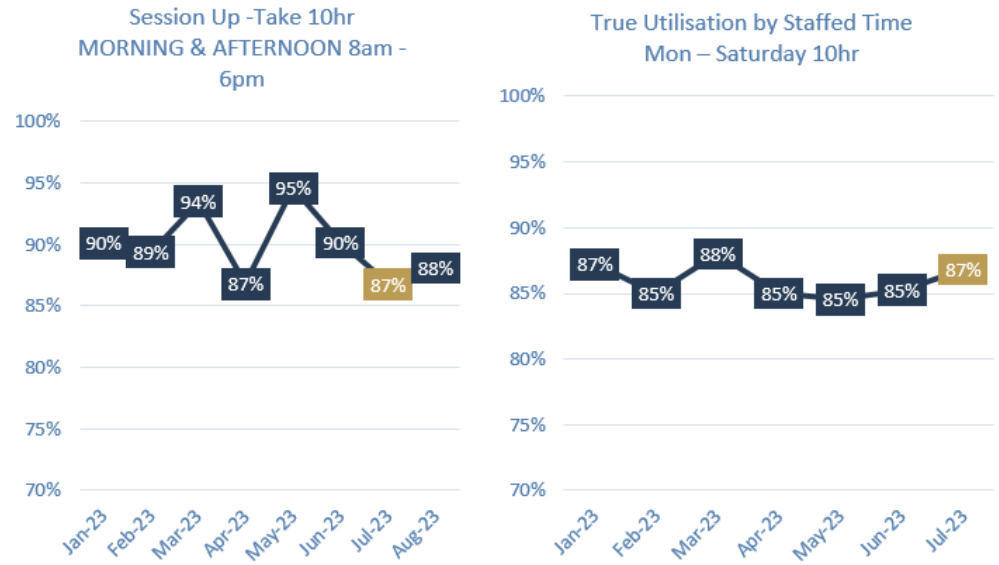
What's the top contributor for under/over achievement?

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

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

Key Standards | Sulis

Historic Data: Theatre vacant sessions



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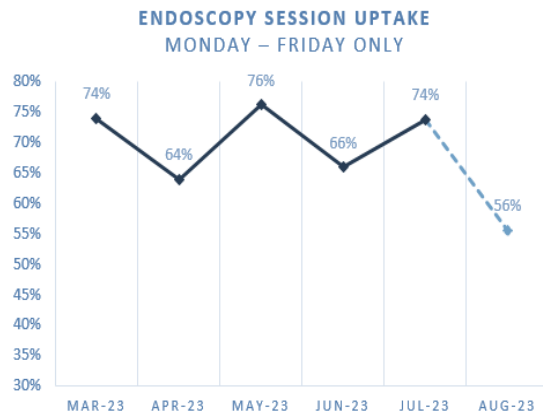
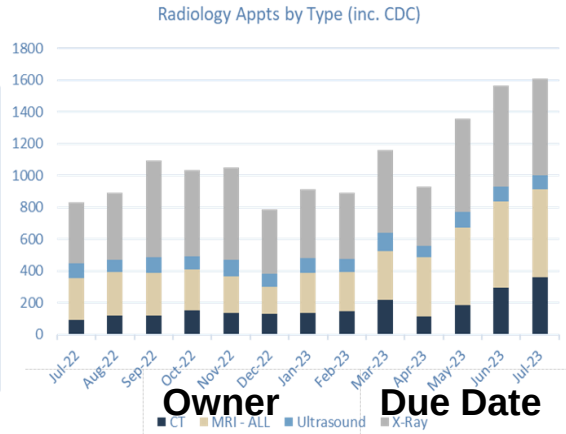




Is t

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

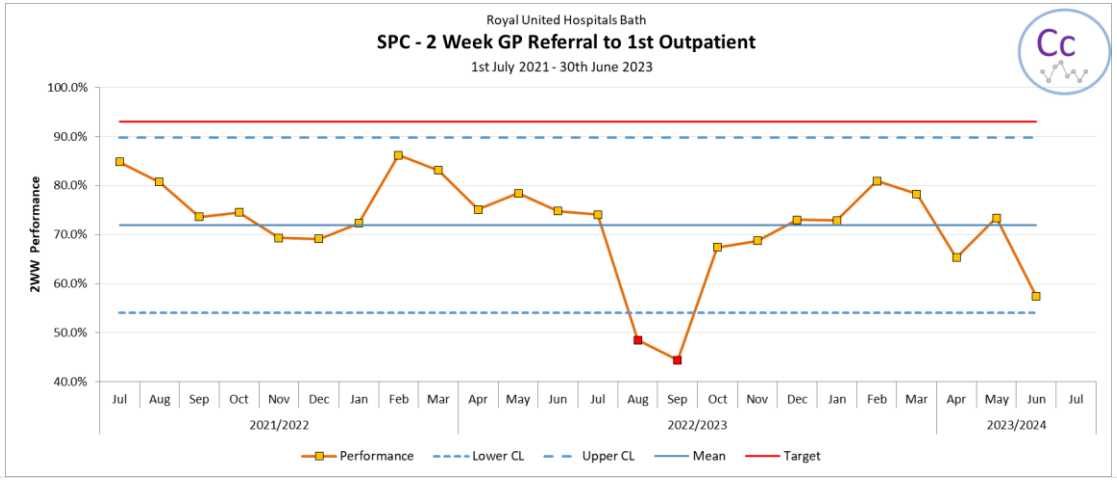
What's the top contributor for under/over achievement?

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

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

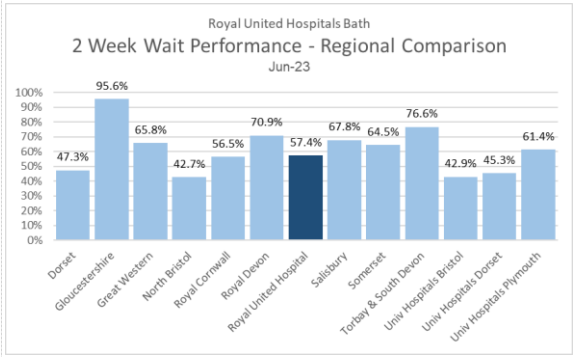
Key Standards | Cancer 2 week wait

Historic Data

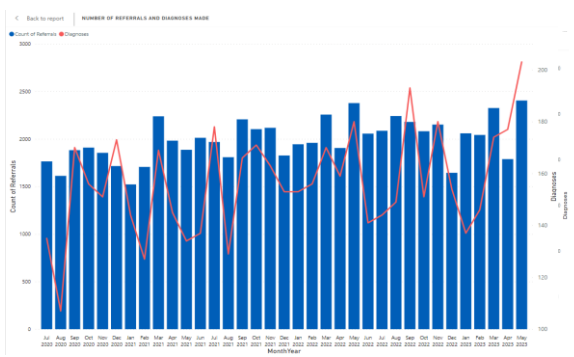


Supporting data

2 week wait Regional Comparison



2 week wait demand and diagnoses



Is the standard being delivered?

In June performance deteriorated to 57.4%.

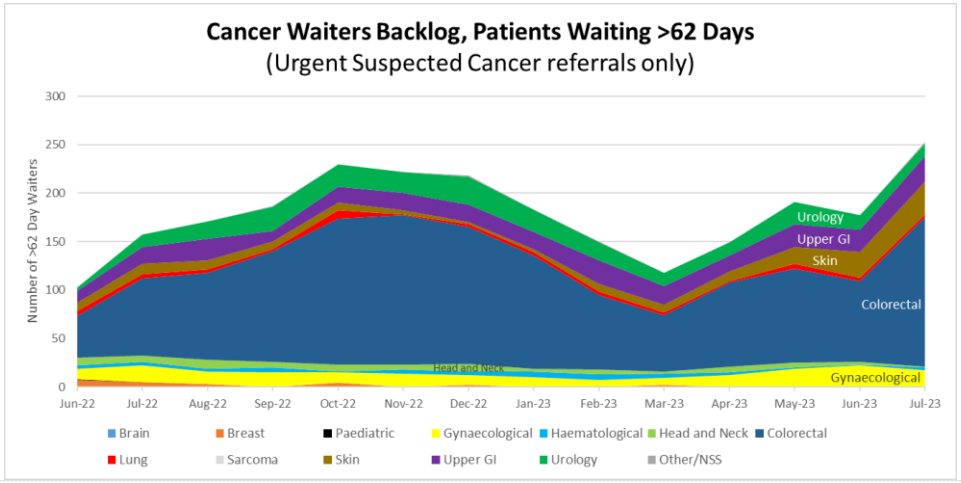
What's the top contributor for under/over achievement?

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

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

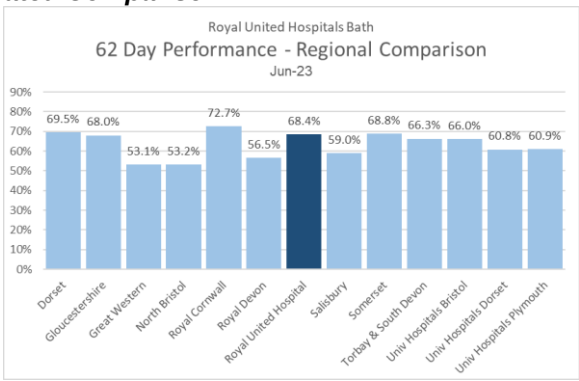
Key Standards | Cancer 62 days

Historic Data



Supporting data

Regional 62 Day Treated Comparison



Is the standard being delivered?

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

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

62 Day Treated:

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

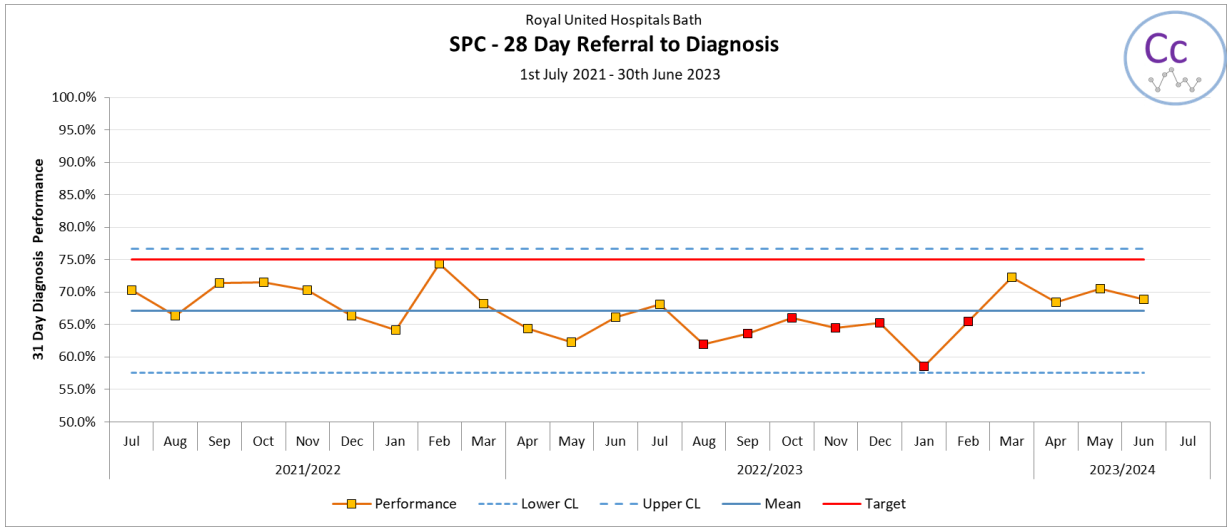
62 Day Waiters (backlog)

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

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

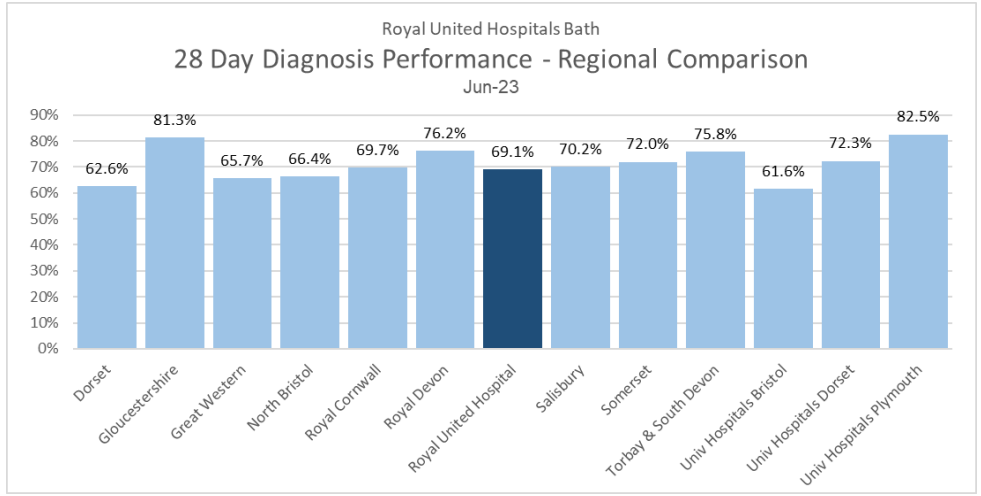
Key Standards | Cancer 28 days

Historic Data



Supporting data

28 Day Regional Comparison



Is the standard being delivered?

In June performance maintained at just below 70%.

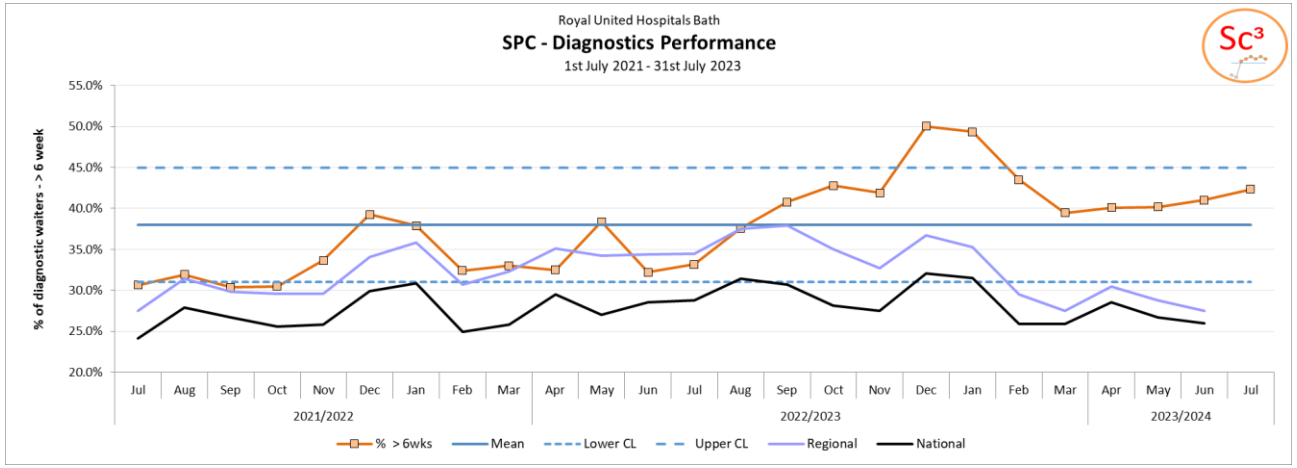
What's the top contributor for under/over achievement?

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

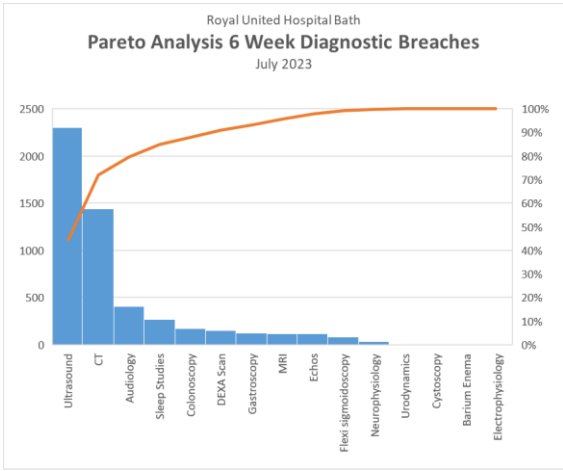
Countermeasures / Actions	Owner	Due Date
Colorectal – Endoscopy capacity increased from 40-47 lists per week in September following staff recruitment.	R Weston	Sept 2023
Endoscopy – Implement new booking software	R Weston	Nov 2023
Urology – Reorganise consultant outpatient capacity to increase joint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

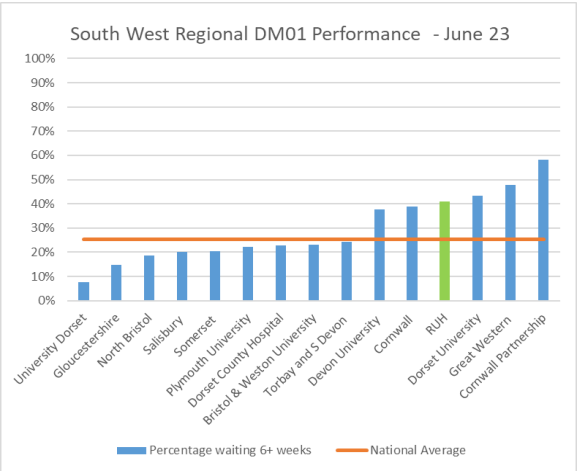
Key Standards | Diagnostics 6 weeks

Historic Data



Supporting data





Is the standard being delivered?

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

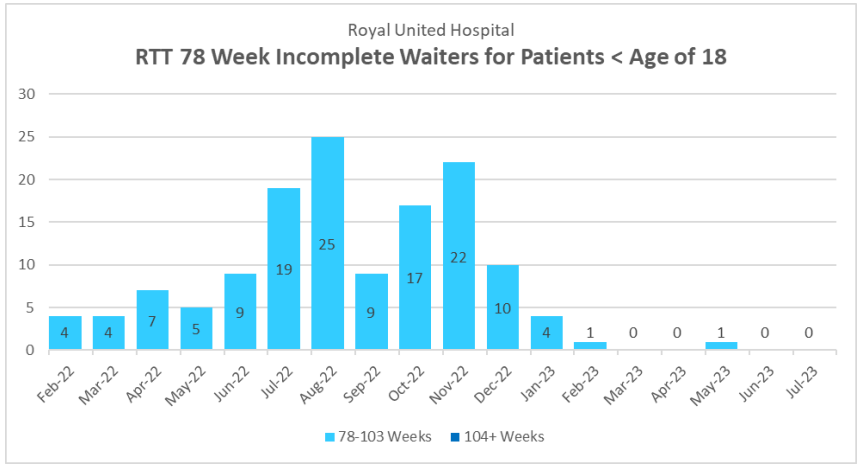
What's the top contributor for under/over achievement?

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

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

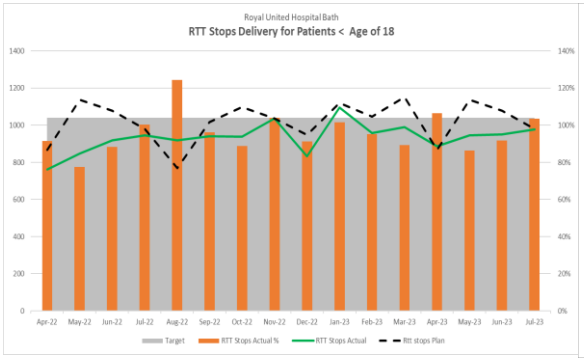
Key Standards | Paediatrics

Historic Data

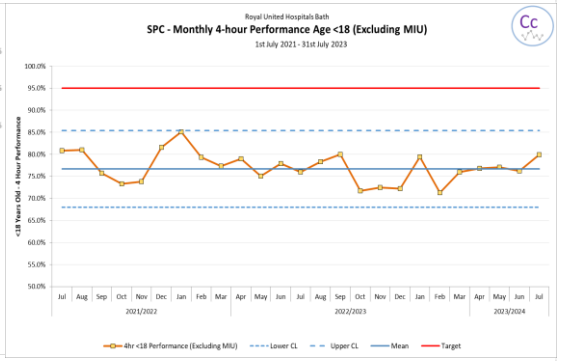


Supporting data

Stops v Plan



4 hr performance



Is the standard being delivered?

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

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

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

Royal United Hospitals Bath
NHS Foundation Trust

Quality Report

August 2023 (July 2023 Data)

The RUH, where you matter

Executive Summary | Quality

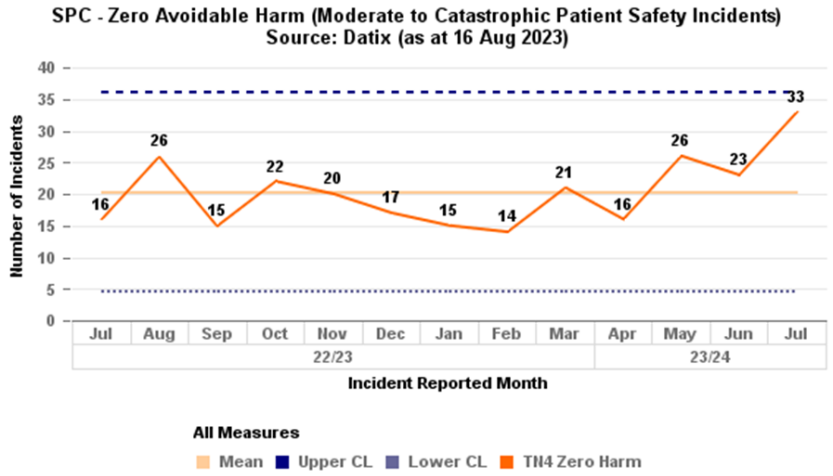
Strategic Goal		Performance Indicator	Description	Target		2022/2023												Trend
				Performing	Under Performing	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Trust Goals	People we care for	Connecting with you - helping you feel safe, understood and always welcome	Reported Patient Safety incidents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

Measures requiring focus and a countermeasure summary this month are;

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

Trust Goal | Zero avoidable harm

Historic Data

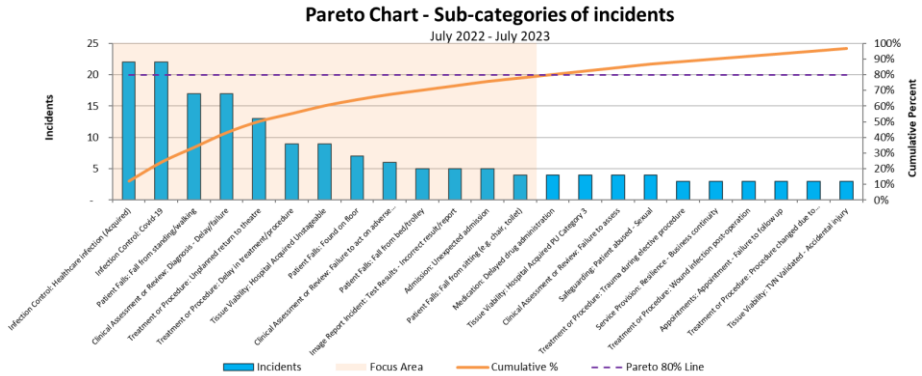


Is the standard being delivered?
In July 2023 there were 33 reported moderate to catastrophic incidents compared to a target of no more than 30 incidents.

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

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

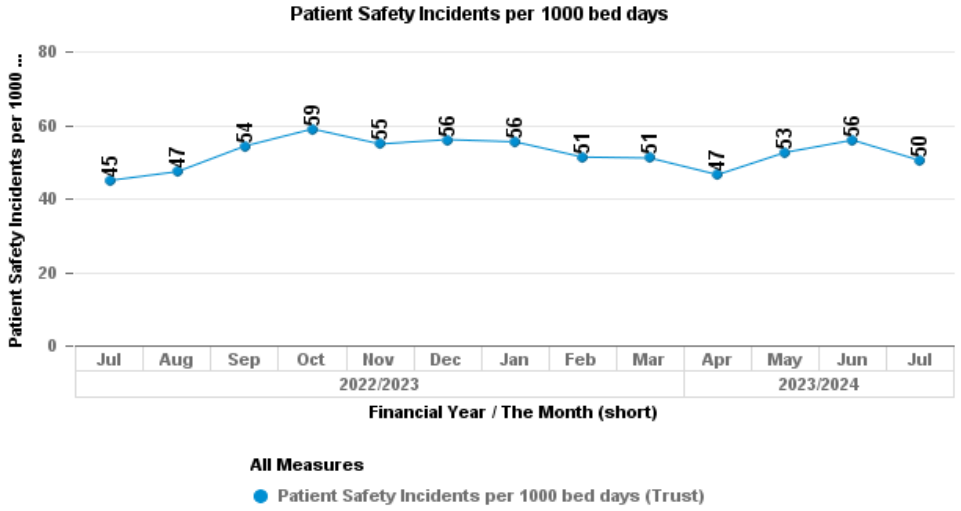
Supporting data



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

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

Historic Data

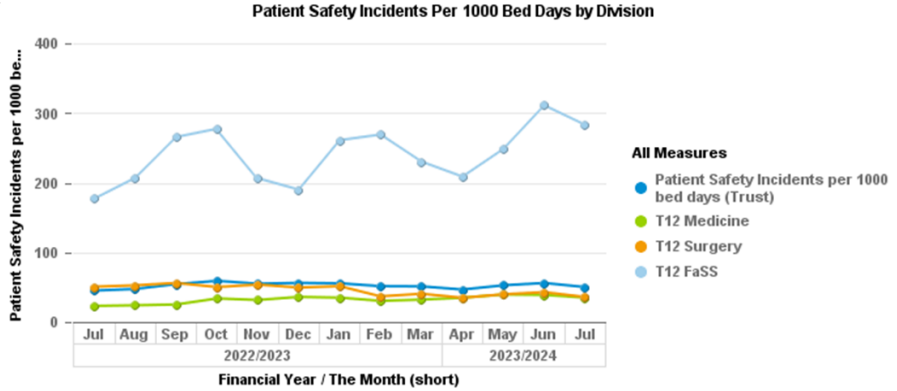


Is the standard being delivered?
There were 50 incidents reported per 1,000 bed days in July.

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

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

Supporting data



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

Tracker Measures | Serious incidents with overdue actions

Historic Data

Supporting data

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

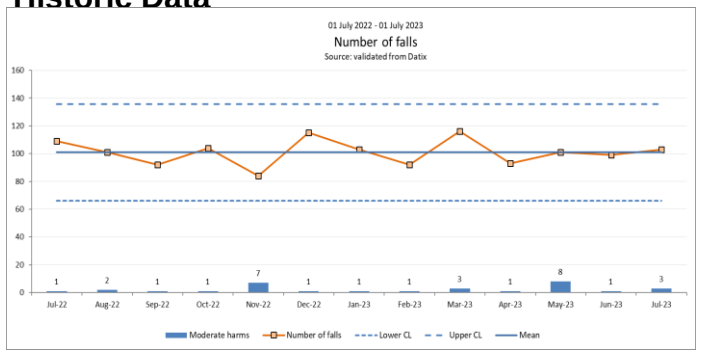
Is the standard being delivered?
There were 3 Serious Incidents with overdue actions for July 2023, compared to a target of less than 5.

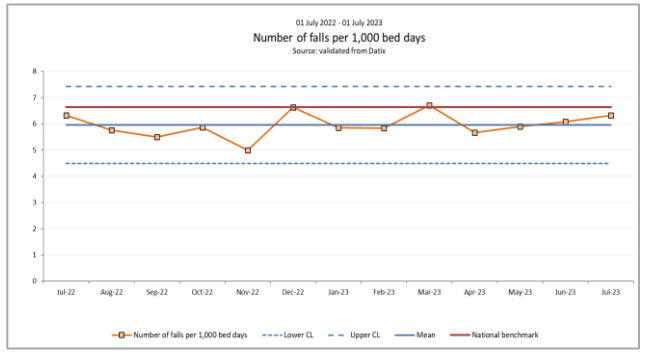
What's the top contributor for under/over achievement?
There are 6 SI actions that remain overdue from 3 SIs with 5 overdue actions for Surgery Division and 1 for Family and Specialist Services.

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

Tracker Measures | Falls

Historic Data

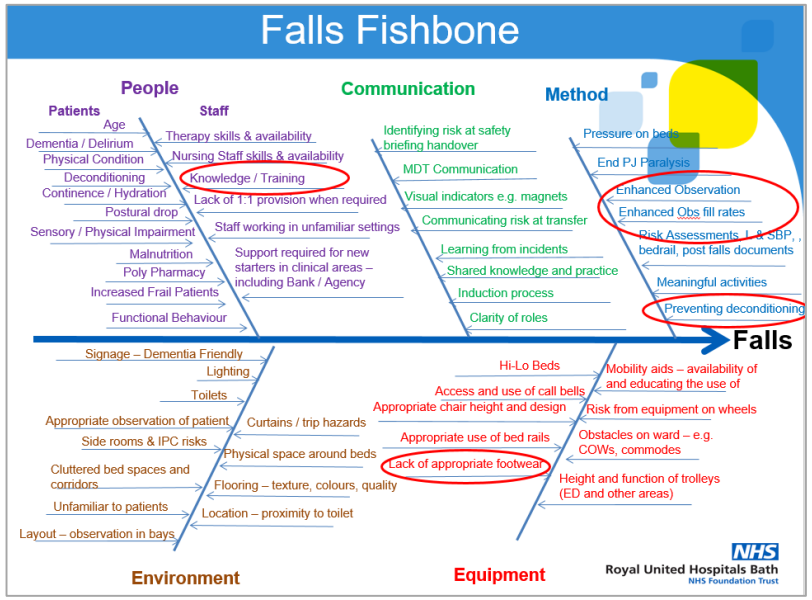




Is the standard being delivered?

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

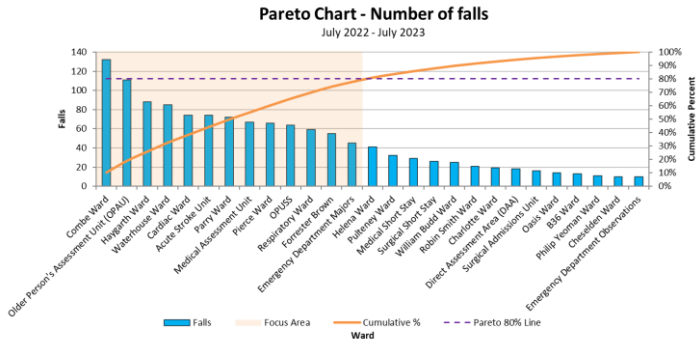
Supporting information : Revised Fishbone



Fishbone revised with Falls Steering group –
Main contributory factors

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

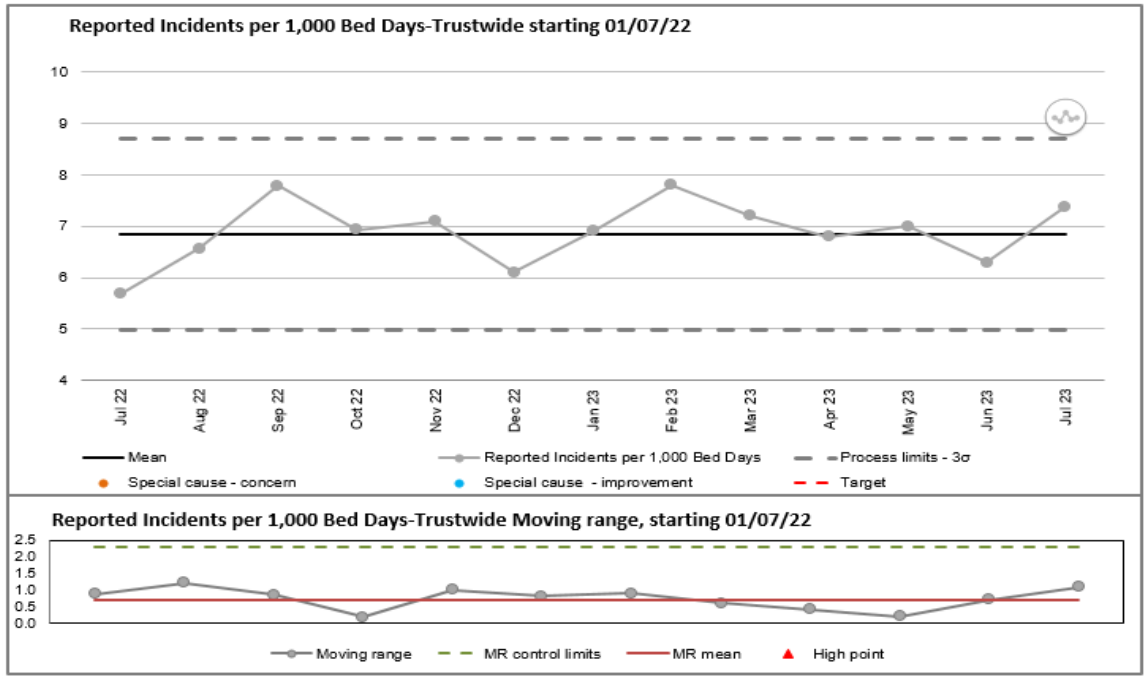
What's the top contributor for under/over achievement?

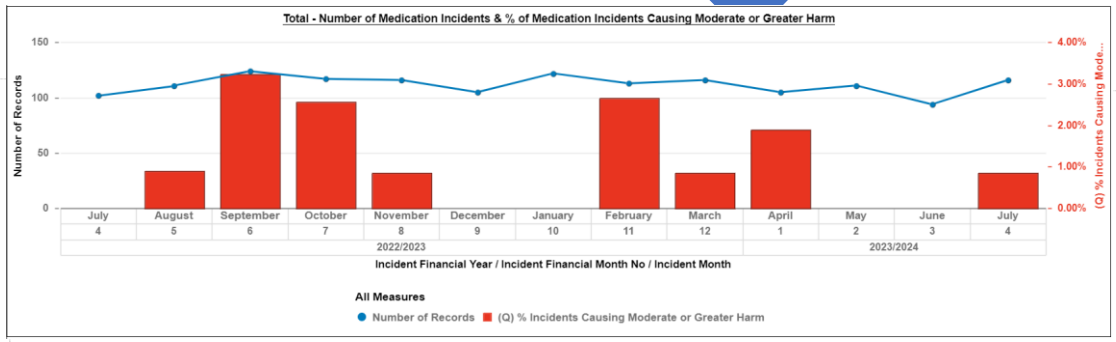


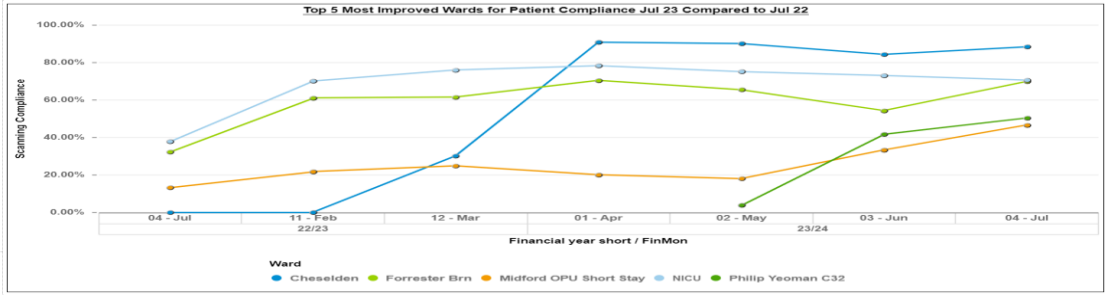
The Pareto chart shows the top contributors to falls. The Quality Improvement Team provide targeted support for the wards with high numbers of falls.

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

Quality| Medicines Safety







Is the standard being delivered?

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

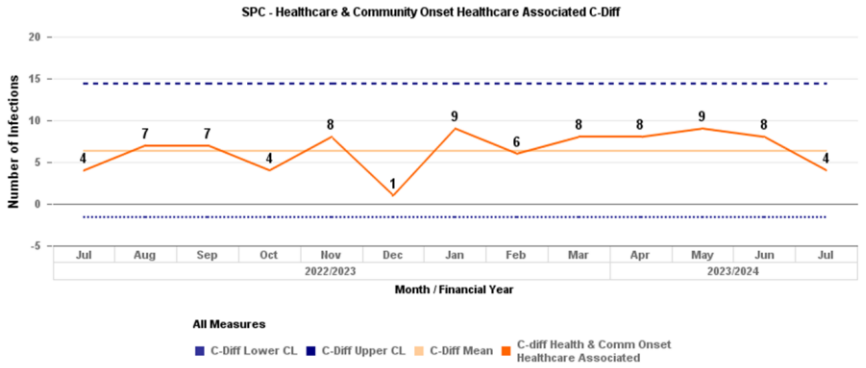
What's the top contributor for under/over achievement?

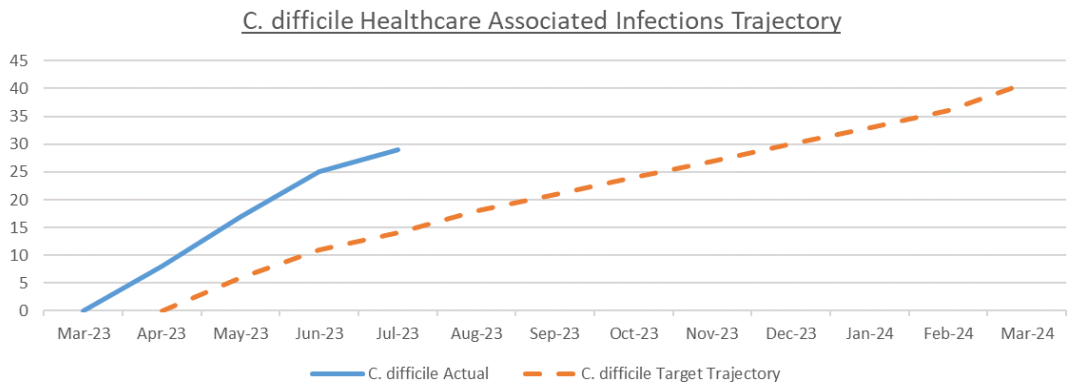
- Medication incidents: for information only – reported incidents/1,000 bed days incidents within normal variation.
- Barcode Scanning: Medicines compliance 18.6%. Cheselden top contributor (66.9%), most improved ward Medical Assessment Unit (MAU), (6.2% to 17.6%).

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

Breakthrough Objective | *Clostridioides Difficile*

Historic Data





Is the standard being delivered?

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

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

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

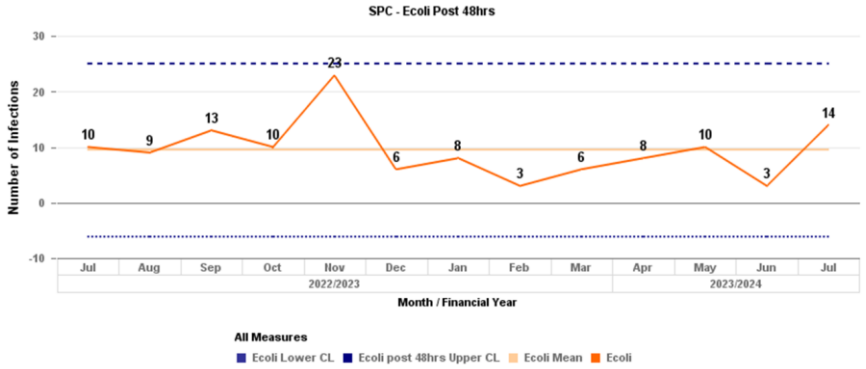
CDI Benchmarking data –

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

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

Breakthrough Objective | E coli

Historic Data



Is the standard being delivered?

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

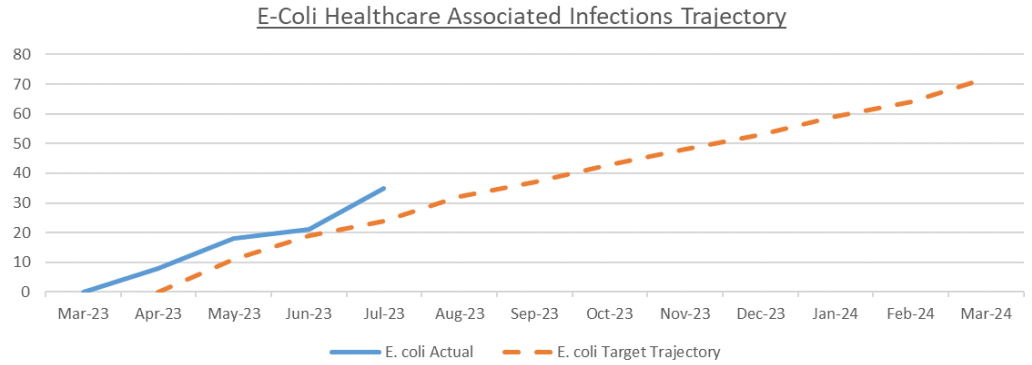
What's the top contributor for under/over achievement?

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

Benchmarking data:

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

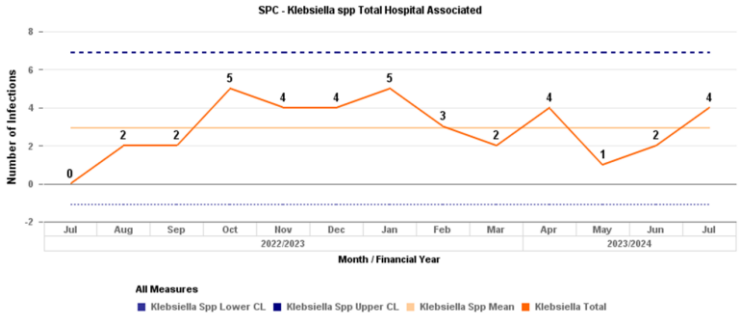
Supporting data

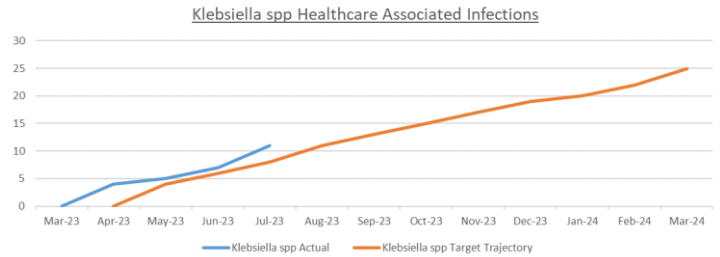


Countermeasures / Actions	Owner	Due Date
ICB Hydration Improvement Group commenced have now published the resource pack, which has been shared with the RUH for use.	Matron / Quality Improvement Centre	Aug-23
Review of urinary catheter insertion training and competency required, although this is not the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

Breakthrough Objective | Klebsiella and Pseudomonas

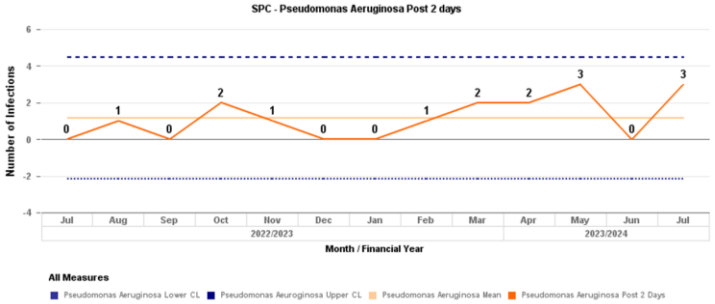
Performance (Klebsiella)

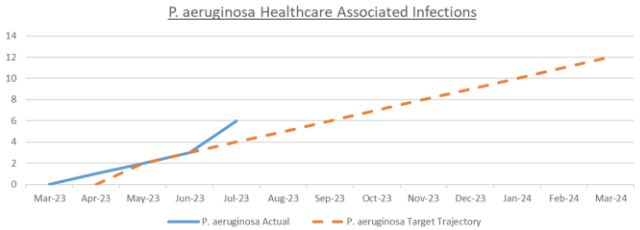




Trust	Rate (May 23)	Rate YTD
SW rate	**9.78**	**8.97**
RUH	**5.71**	**14.67**
GWH	16.76	19.93
SFT	14.19	10.76
Gloucester	3.78	9.71

Performance (Pseudomonas)





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

Is the standard being delivered?

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

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

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

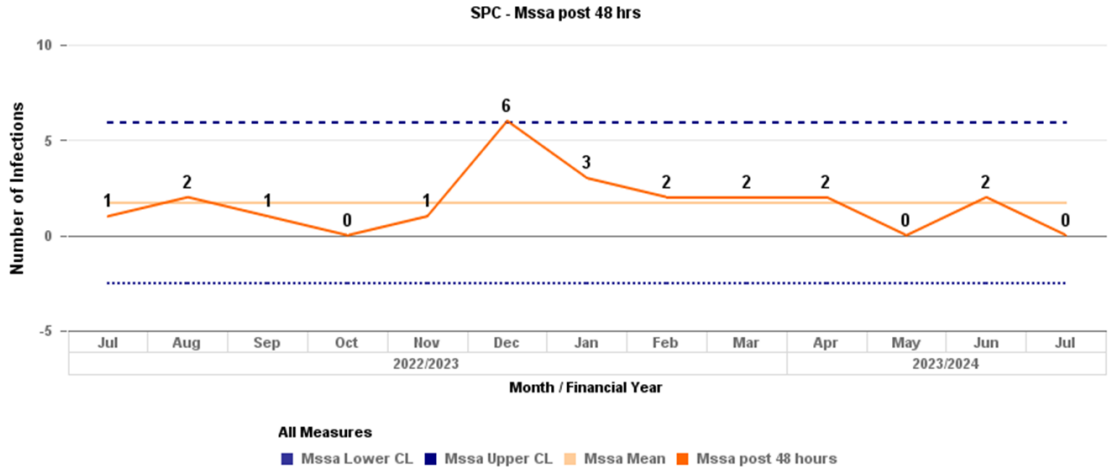
Klebsiella's were associated to: Lower urinary tract infection (n=1), Lower urinary tract infection with a catheter (n=1), Gastro (n=2), Hepatobiliary (n=1).

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

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

Breakthrough Objective | MSSA

Historic Data



Supporting data

Benchmarking data:

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

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

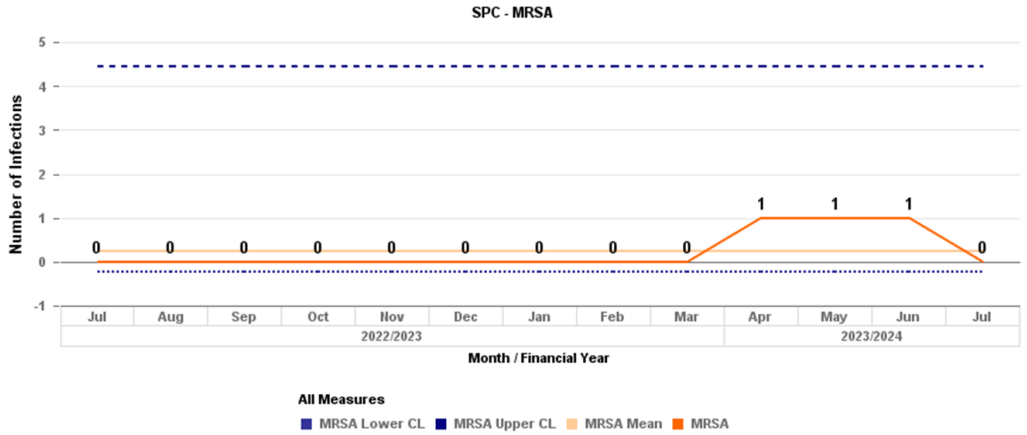
4 Trust cases have been reported to date, there are no thresholds for this infection.

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

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

Breakthrough Objective | MRSA

Historic Data



Is the standard being delivered?

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

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

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

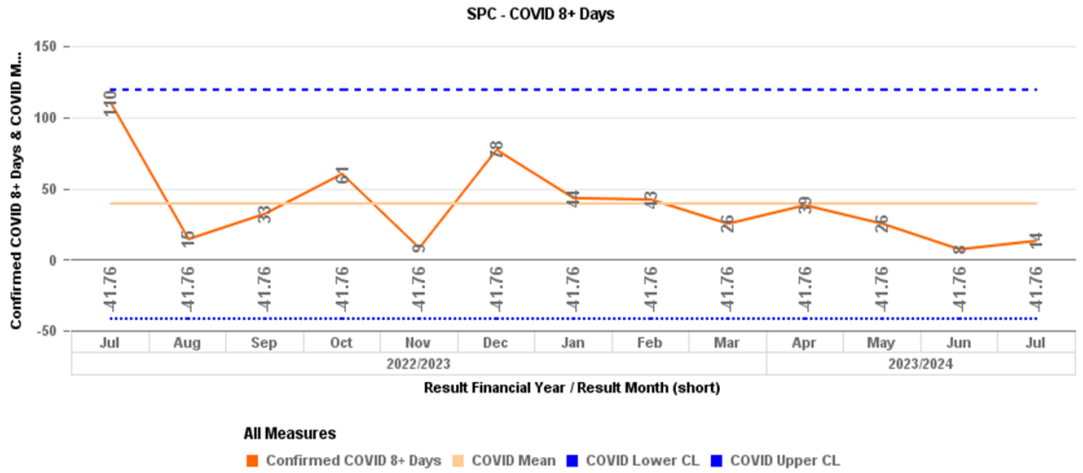
What's the top contributor for under/over achievement?

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

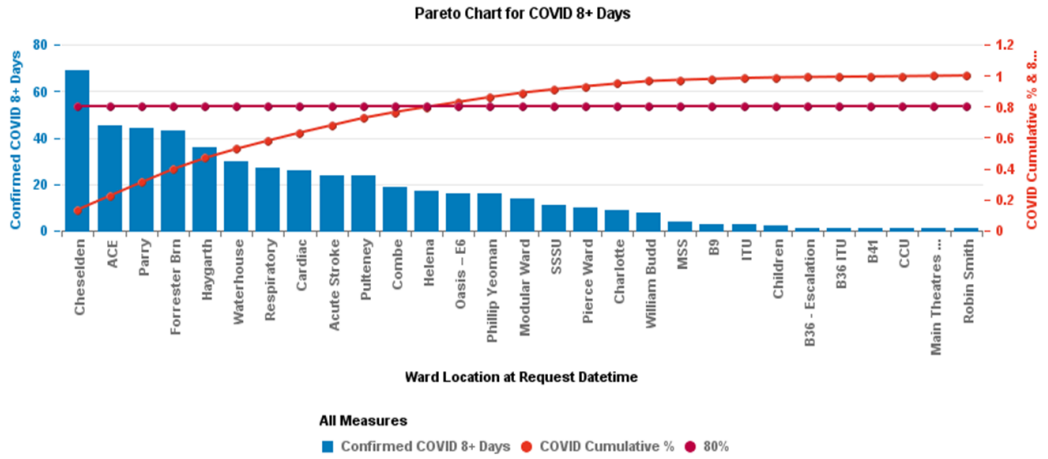
Trust	May 23	YTD
SW	0.95	1.13
RUH	5.71	5.81
GWH	0	0
SFT	0	0
Gloucester	0	0

Breakthrough Objective | Confirmed COVID-19

Historic Data



Supporting data



Is the standard being delivered?

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

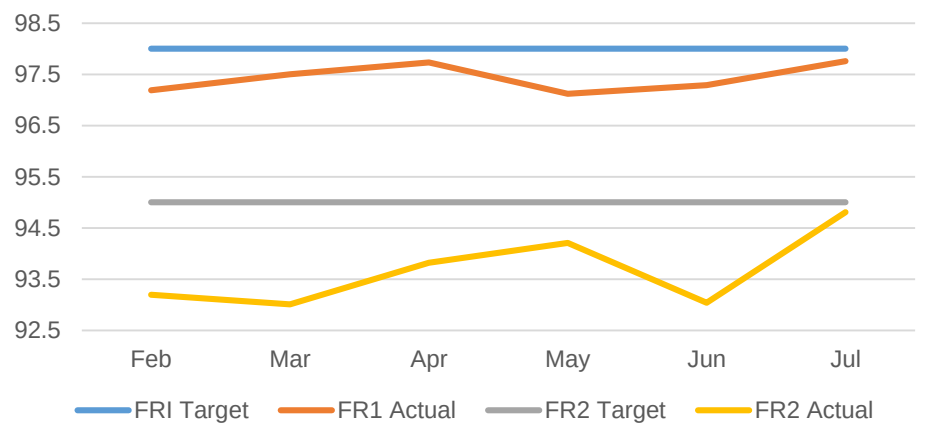
What's the top contributor for under/over achievement?

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

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

Breakthrough Objective | Cleaning

Historic Data – Cleaning Audit scores – FR1 and FR2



Is the standard being delivered?

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

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

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

Supporting Data – Cleaning Audit scores – all FR levels

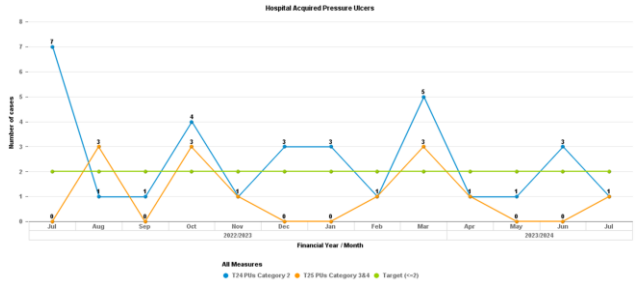
	Target	Frequency	Feb	Mar	Apr	May	Jun	Jul
FR1	98	Weekly	97.19	97.5	97.73	97.12	97.29	97.76
FR2	95	Monthly	93.2	93.01	93.82	94.21	93.04	94.81
FR3	90	Bi-monthly	90.77		83.11		91.57	
FR4	85	Quarterly	90.04	89.72	92.54	85.81	91.34	96.88
FR5	80	6m		87.06		86.82	95.12	
FR6	75	Annual	88.1	74.69	89.11	88.66	88.83	

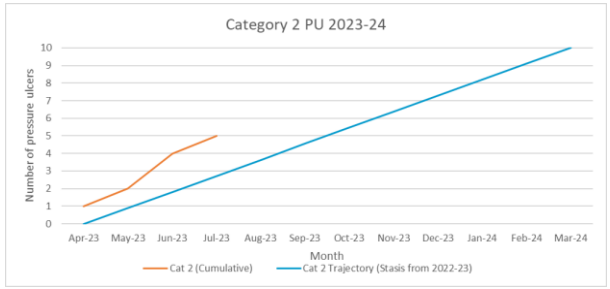
Countermeasures / Actions - Owner: Cleaning Transformation Team
Due Date - end of 2023

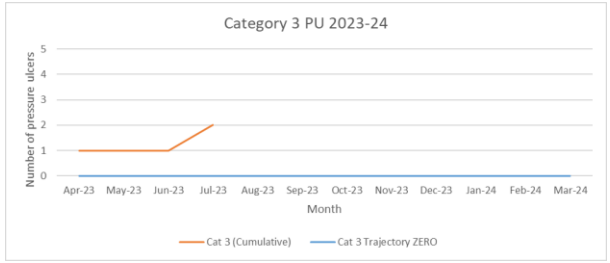
1. Vacancies: Rolling recruitment drives, refer a friend scheme, supervisor to work exclusively on driving forwards recruitment, recruitment events in surrounding region, internal events planned.
2. High sickness rate: Focus on supporting colleagues, increasing wellbeing support and promotion of a positive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

Tracker Measures | Pressure Ulcers

Historic Data







Is the standard being delivered?

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

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

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

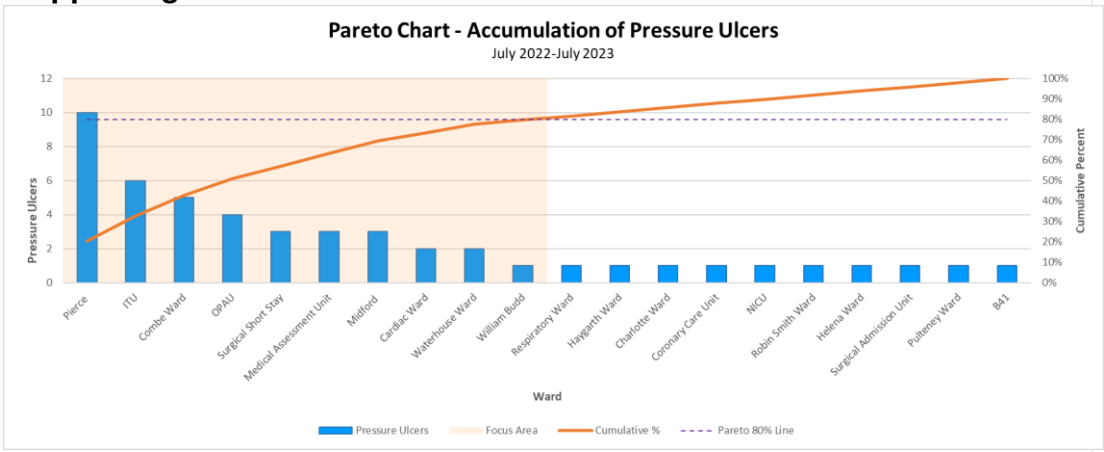
Benchmarking	Overall HA PU May 2023	Overall HA PU June 2023
RUH	1	3
UHBW	0	4
NBT	15	18
GWH	26	31
Salisbury	35	Unavailable

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

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

Key themes for July: inconsistent skin assessment and repositioning.

Supporting data



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

Quality | Mortality

Supporting data

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

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

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

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

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

Update on actions following unannounced CQC inspection of Medical care

Safeguarding Adults Level 2

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

Safeguarding Adults Level 3

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

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

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

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

Results from the daily Senior Sister / Matron checks

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

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

Executive Summary

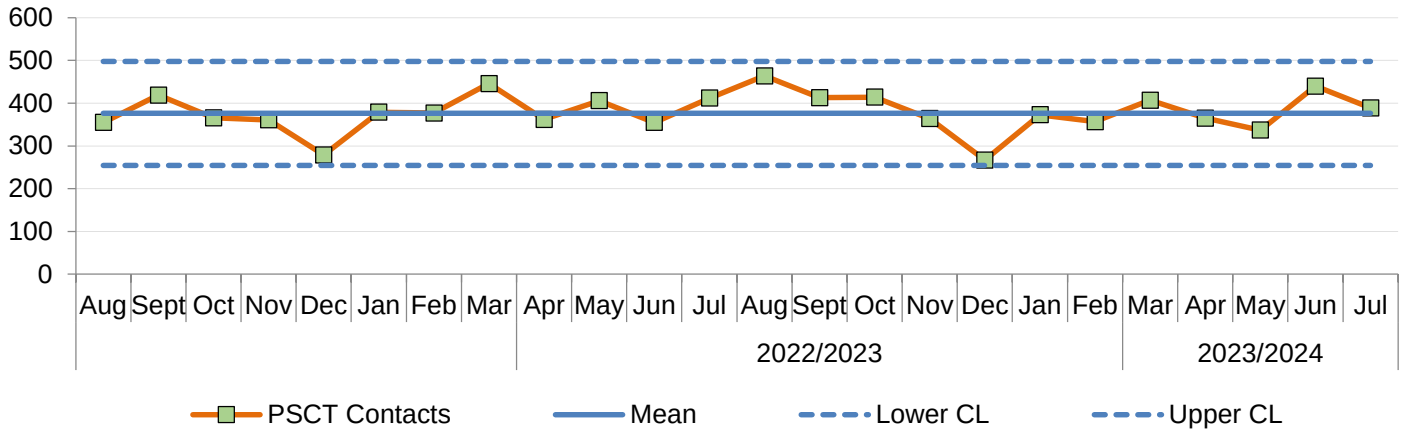
Strategic Goal		Performance Indicator	Description	Target		2022/2023												Trend
				Performing	Under Performing	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Tracker Measures	People we care for	% of Complaints responded to within target		>=90%	<90%	52.4%	60.9%	57.9%	64.5%	76.0%	77.3%	52.6%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

Measures requiring focus and a countermeasure summary this month are;

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

Tracker Measure | PSCT

Historic Data



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

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

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

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

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

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

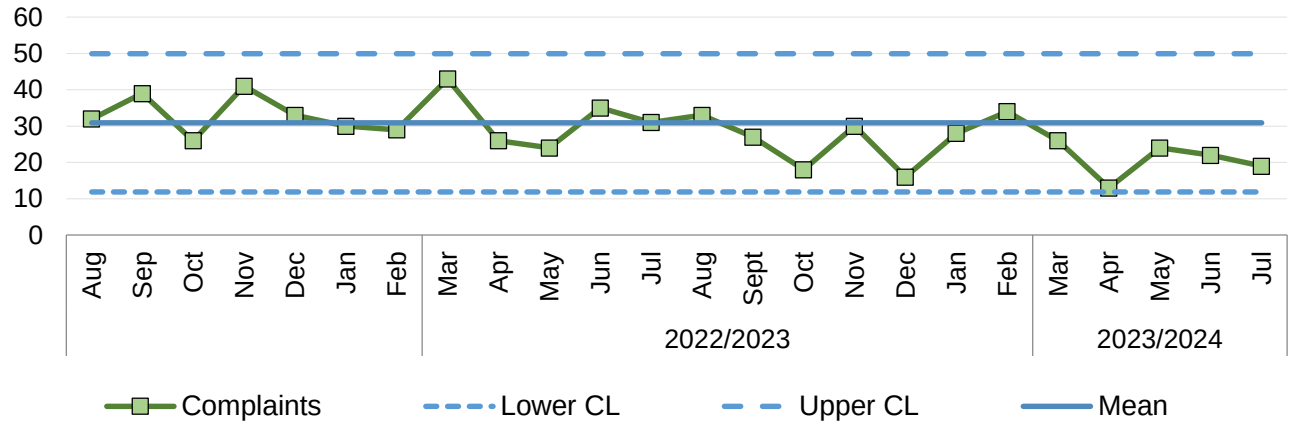
Supporting data

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

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

Trust Goal | Patient complaints

Historic Data



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

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

Is the standard being delivered?

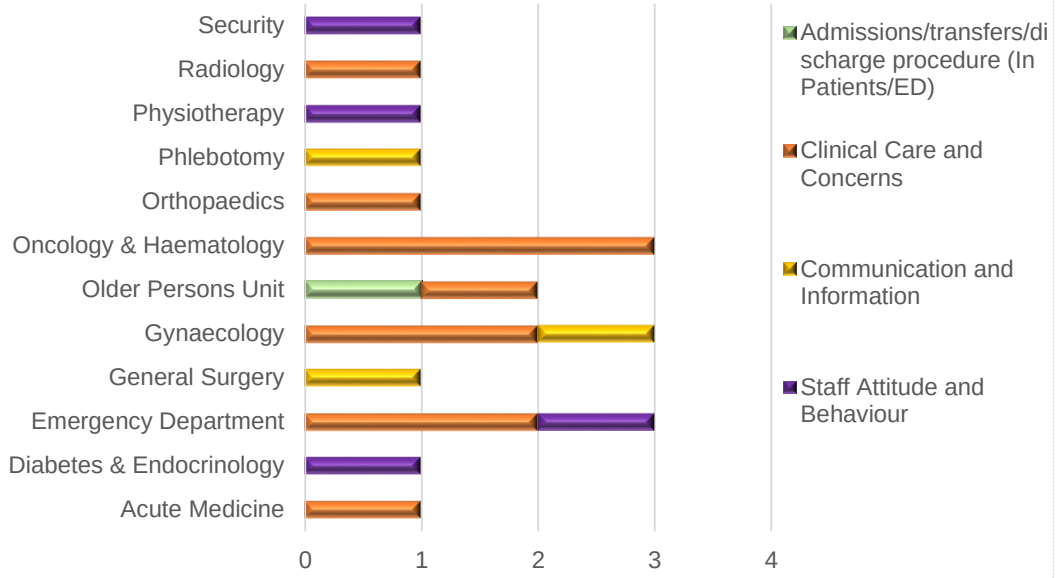
The Trust received 19 formal complaints in July 2023. The numbers of complaints is continuing to fall This is 12 less than the mean average for the rolling 24 months. Underperforming >=34, Performing <30.

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

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

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

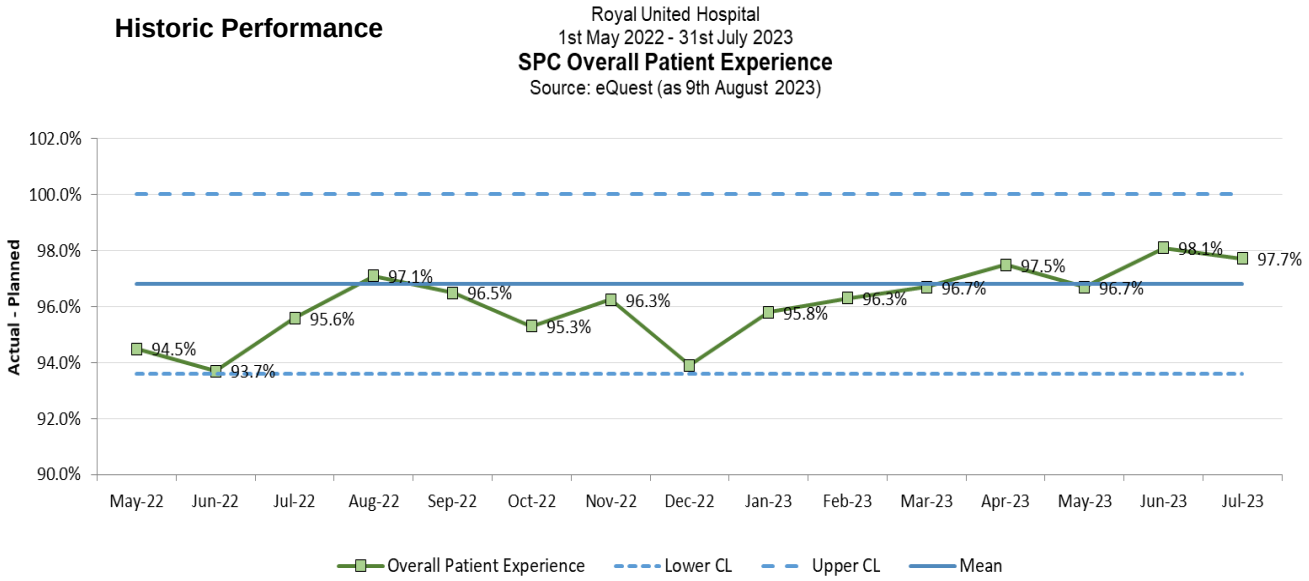
Supporting data

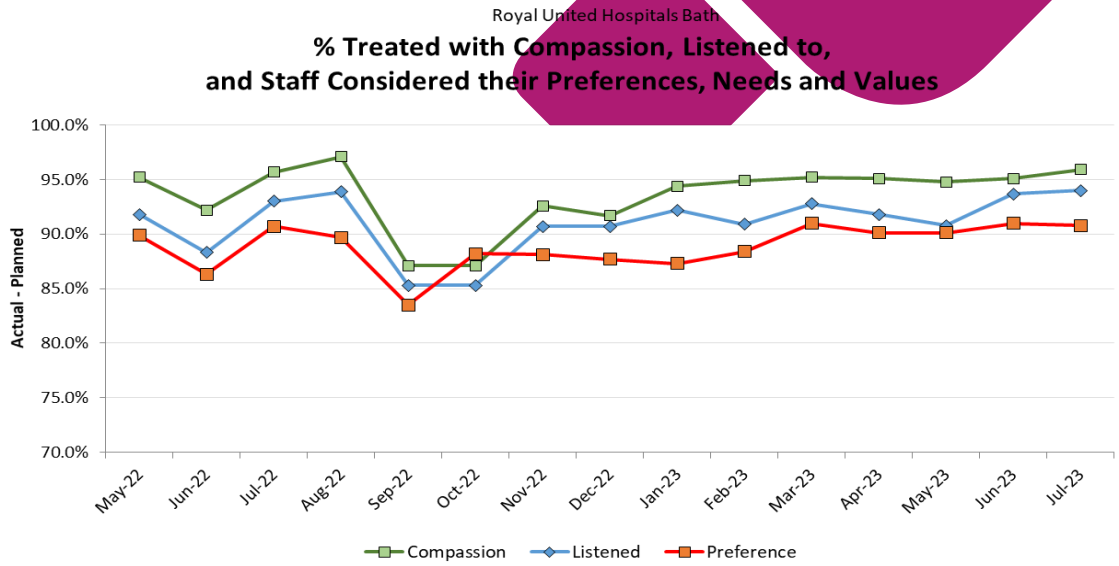


Countermeasures / Actions	Owner	Due Date
Continue with weekly Divisional complaints meetings.	Head of Complaints	Complete
Monitor benefits of single point of access and complexity of complaints.	HH/NE	Nov-23
Audit of complaint responses to be completed by Non- Executive Directors. This will focus on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

Patient | Friends and Family Test

Historic Performance





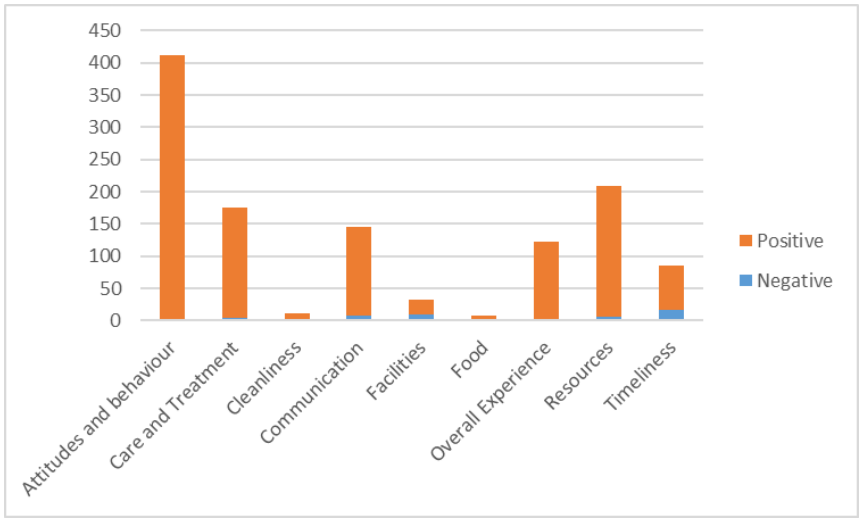
Is standard being delivered?

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

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

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

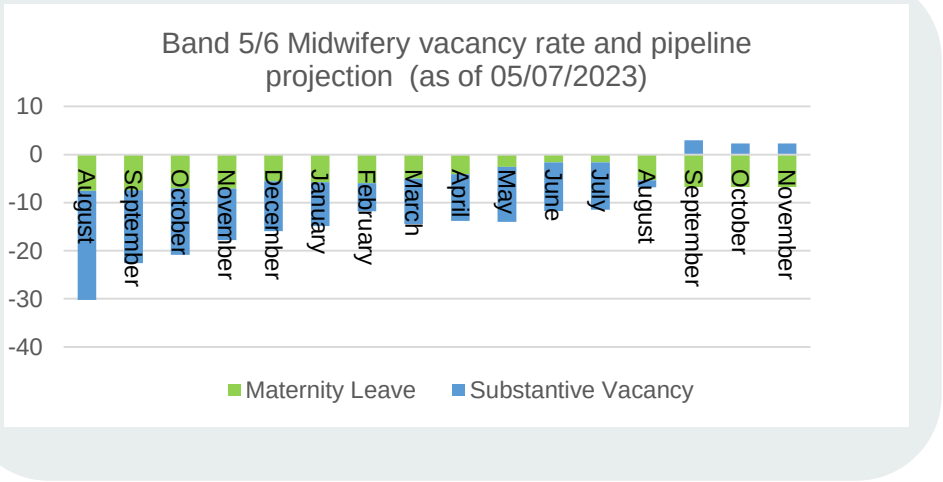
Themes - Patient experience comments collected via FFT in July 2023:



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

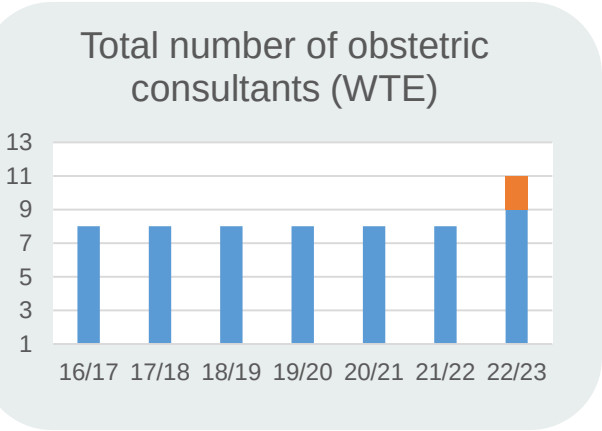
FFT Negative feedback – top three themes are:
Timeliness (n=17), Facilities (n=10) and Communication (n=8).

Safe – Maternity& Neonatal Workforce



Average Shift Fill Rates

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



The RUH, where you matter

Is the standard of care being delivered?

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

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

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

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

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

Safe – Workforce

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

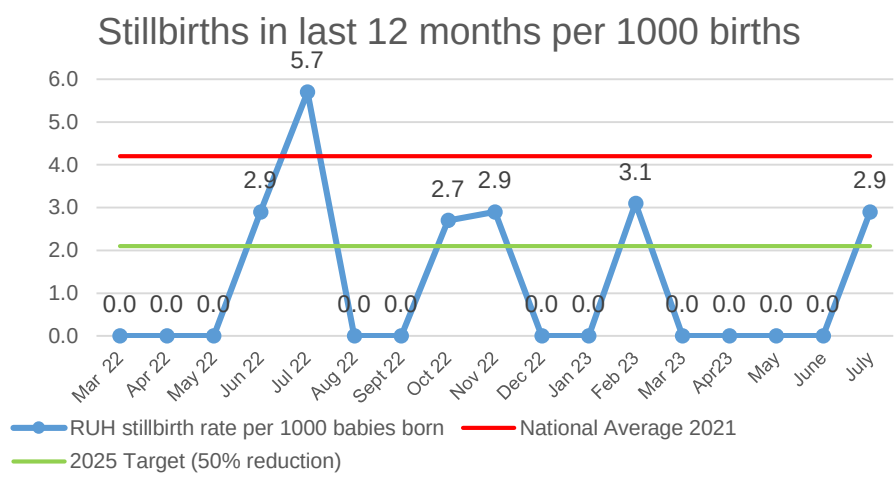
What is SPC?
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation to guide appropriate action. A recommendation of the East Kent Report, is that measures are analysed and presented using SPC to identify the 'signals among noise'.

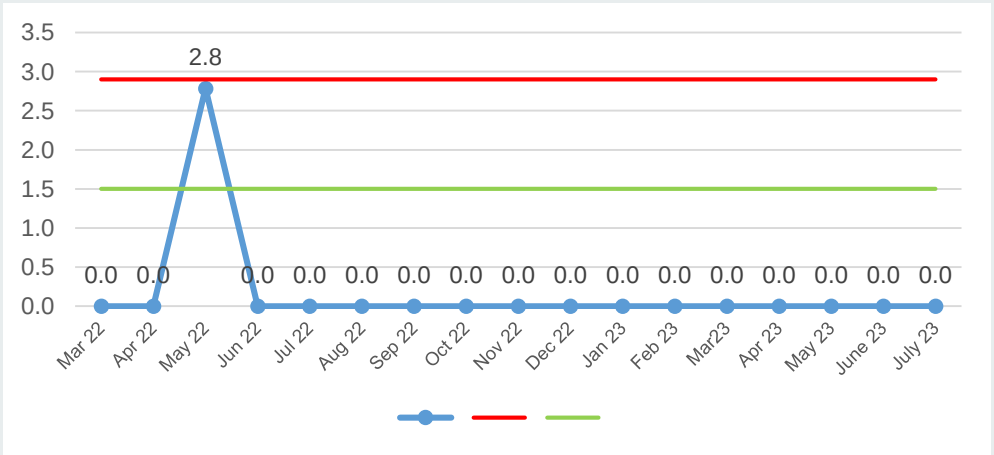
The RUH, where you matter

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

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

Safe- Perinatal Mortality Review Tool (PMRT)





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

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

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

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

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

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

Responsive

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

Positive:

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

Areas for improvement:

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

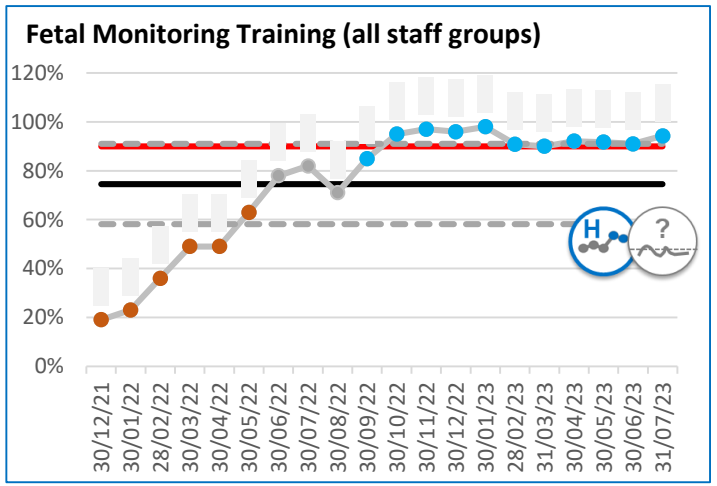
Feedback from Staff – Safety Champions

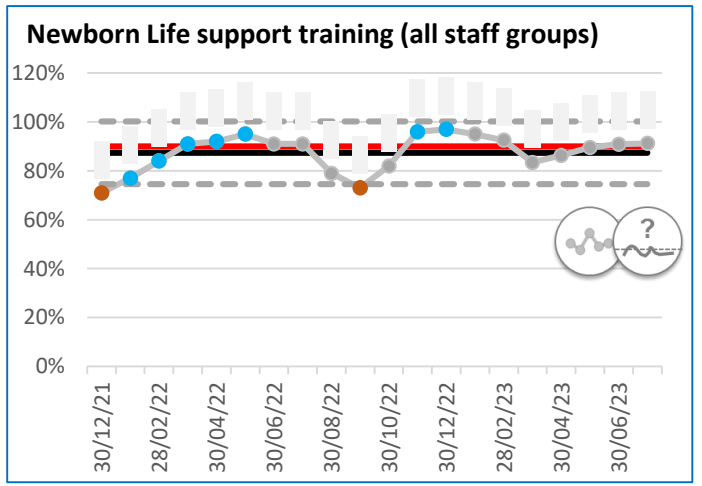
- Recruitment updates, positive on going recruitment – international midwives started in post.
- Self-rostering discussion from exit interviews feedback.
- Discussions regarding homebirth team and models of care.
- On call provisions specifically in community settings.

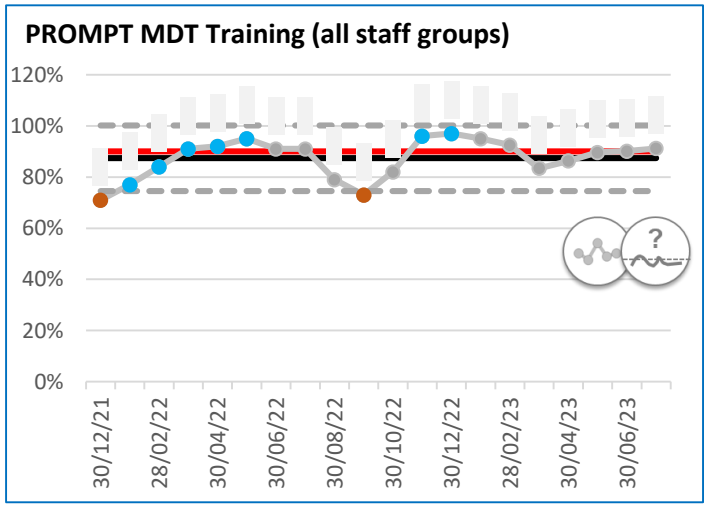
Feedback from families - PALS

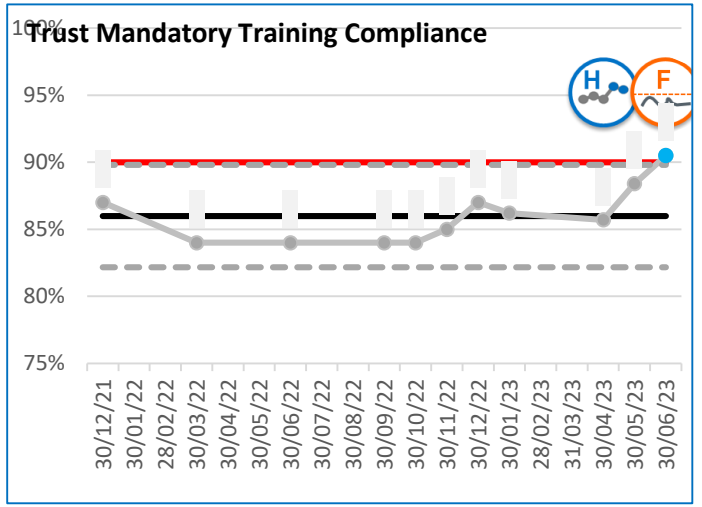
Compliments	1	Complaint and contacts in July 23: No complaints received in July PSCT: Car parking fines. Birthing outside of guidance. Call handling. Compliment: 'staff worked tirelessly to ensure our safety, wellbeing and comfort.'
Online compliments	-	
PALS contacts/concerns	6	
Complaints	0	

Well-led – Training







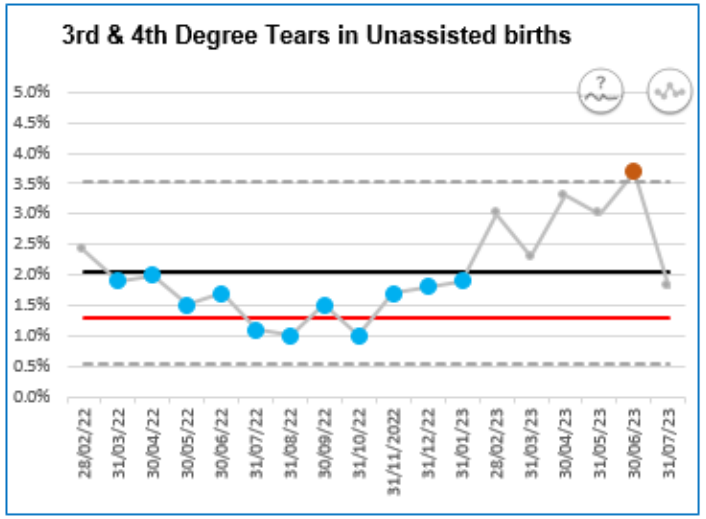


Training
Compliance monitoring and booking system now in place supporting future compliance. Updated Training Needs Analysis awaiting formal departmental ratification. Compliance data being sent to all multi-disciplinary team (MDT) leads monthly to ensure good information sharing between all staff groups.

Countermeasures/actions:
- Additional training dates secured for period of peak staffing changes (doctor change over/midwifery pins/new starters). These will run in Sept, Oct and Nov 2023. Long-term plans to introduce additional dates in Feb and March.
- Prompt train the trainer conducted on 22 March to develop faculty and improve standard of training for MDT teams.
- Bespoke refresher skills sessions available for community staff: Skills drills and new-born life support with dates booked for the next year. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs).
- Additional skills sessions available to newly qualified staff and senior students facilitated by the Retention and Education team.
- Continued with Practical Obstetric Multi-Professional Training (PROMPT) training in July despite doctor strikes, working with Consultant Leads to improve compliance amongst doctors relating to booking of training prior to arrival.

Risks:
- The use of our own compliance tracker opposed to using ESR data – ESR still reflects theatre teams which impacts on our compliance. Linking in with ESR and Theatres to find a resolution to this for transparency and information sharing.
- August staffing level projections anticipate a suspension of mandatory training dates for the month of August.
- Influx of new MDT staff in September, October & November please see countermeasure above.
- Obstetric registrar compliance currently 66.7%

Safe – Themes of low and No harm

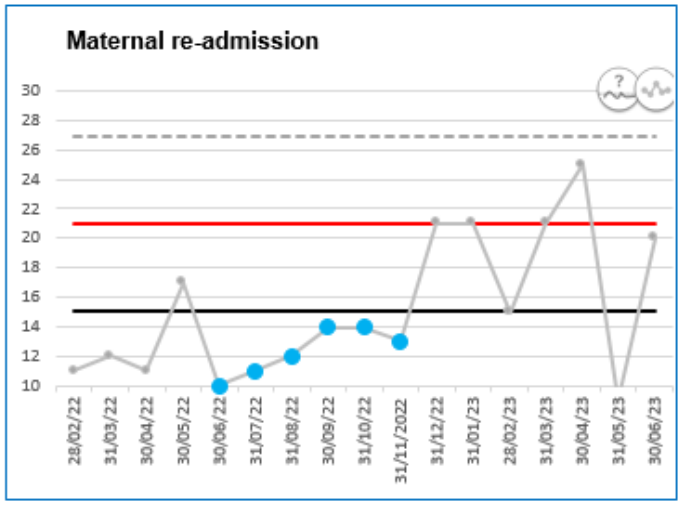


Is standard being delivered?

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

Countermeasure/actions:

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

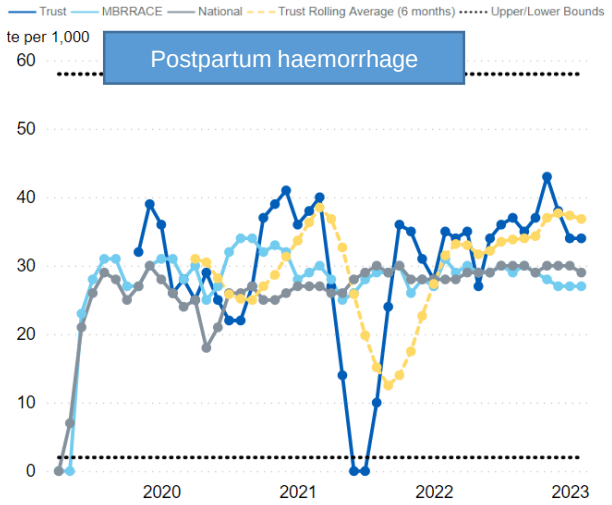


Is standard being delivered?

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

Countermeasure/actions:

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



Is standard being delivered?

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

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

Countermeasure/actions:

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

Responsive

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

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

Maternity Incentive Scheme Year 5

Is standard being delivered?

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

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

Key areas of risk to compliance are:

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

Responsive – Health Inequalities

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

The people in our community

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 4

The people in our community

The RUH, where you matter

Summary

Overall Position

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

Operational Pressures

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

Financial Variances

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

Emerging risks and Forecast Outturn

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

BSW

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

Executive Scorecard

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

True North | Breakeven position

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

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

Tracker Measure | Sustainability – Workforce

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

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

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

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

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

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

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

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

Countermeasures completed last month

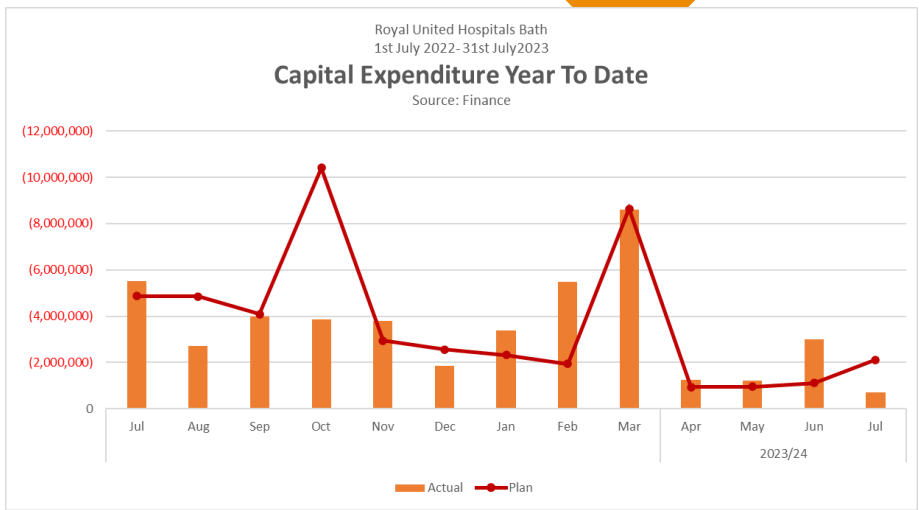
Countermeasures for the month ahead

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

Tracker Measure | Sustainability – Capital (RUH and SULIS)

Capital Programme

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



Is standard being delivered? No

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

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

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

Countermeasures completed last month

Countermeasure /Action	Owner
N/A	

Countermeasures for the month ahead

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

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

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

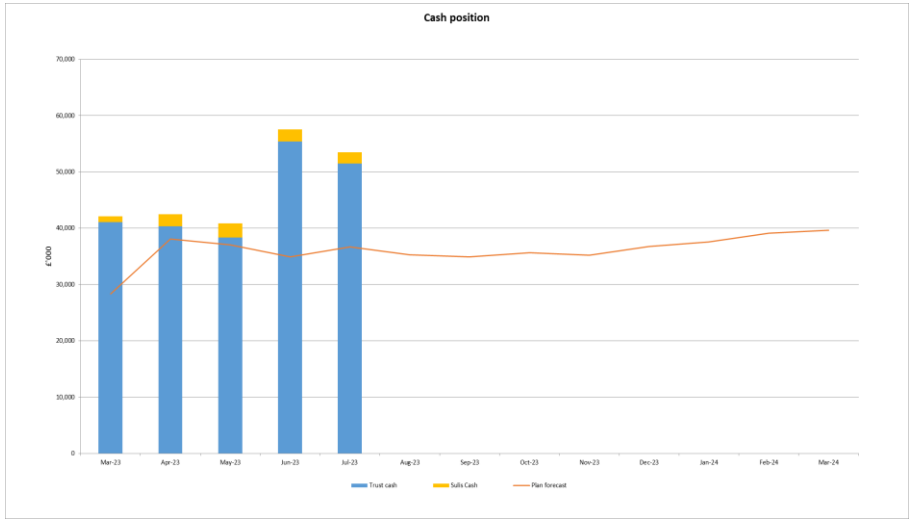
The Group Balance Sheet (RUH and Sulis)

Month 4 against plan:

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

Tracker Measure | Sustainability – Cash (RUH and SULIS)

Group Cashflow Statement Month 4



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

Is standard being delivered for cash? No

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

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

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

Countermeasures completed last month

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

Countermeasures for the month ahead

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

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

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

Overview by NHSI reporting - £23.5 million

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

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