NHS
Royal United Hospitals Bath
NHS Foundation Trust

# Integrated Performance Report

October 2022 (September 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<br>Patient engagement strategy | Zero avoidable harm<br>Number of complaints | Reduce hospital acquired infections | Improving patient flow programme<br>Better care better value projects<br>IPC estates plan |
| The people in our community | Estates strategy<br>Digital strategy<br>BSW Health and Care Model | Delivery of breakeven position<br>Ambulance handover delays<br>Carbon footprint | Reduce the number of patients waiting in hospital (non criteria to reside) | Elective recovery programme<br>Patient safety 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

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# Workforce Report

Month 6

The RUH, where you matter

# Executive Summary I

| | | | | 2021/22 | | | | 2022/23 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Performance Indicator | Performing | Outside Tolerance | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| True North | Positive Response Rate: *There are enough staff in this organisation for me to do my job* | >=40.0% | <28.5% | | | 28.9% | 35.7% | 25.4% | 26.6% | | |

No Making a Difference Survey being run in Q3 - True North for this quarter will reflect National Staff Survey result when available.

| | | | | Last 12 Months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Performance Indicator | Performing | Outside Tolerance | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 |
| Breakthrough Objective | Trust Vacancy WTE | <=275.2 | >301.8 | 238.6 | 245.4 | 223.4 | 210.9 | 153.3 | 166.1 | 398.9 | 316.8 | 322.0 | 347.3 | 267.2 | 307.3 |
| Contextual Information | Substantive WTE on ESR at EoM | | | 4906.8 | 4936.6 | 4926.1 | 4968.6 | 4966.5 | 4938.2 | 4971.4 | 4985.5 | 4977.0 | 5004.5 | 5007.1 | 5077.9 |
| Key Standard | Vacancy Rate | <=5.2% | >5.7% | 4.62% | 4.75% | 4.32% | 4.08% | 2.97% | 3.21% | 7.41% | 5.95% | 6.05% | 6.47% | 4.98% | 5.72% |
| Tracker | Band 5 Nurse Vacancy Rate | <=7.7% | >8.7% | 7.93% | 8.59% | 7.37% | 6.55% | 6.24% | 5.48% | 14.75% | 10.20% | 9.41% | 15.69% | 14.75% | 14.33% |
| Key Standard | In Month Turnover | <=0.92% | >1.00% | 0.86% | 0.69% | 0.86% | 0.85% | 0.92% | 1.31% | 0.97% | 0.88% | 1.06% | 0.99% | 1.14% | 1.02% |
| Key Standard | Rolling 12 Month Turnover | <=11.0% | >12.0% | 9.83% | 9.63% | 9.78% | 9.86% | 10.25% | 10.88% | 11.00% | 11.23% | 11.61% | 11.81% | 12.05% | 11.68% |
| Contextual Information | Bank Use (Staffing Solutions Data) | | | 338.0 | 357.2 | 322.7 | 322.1 | 258.3 | 266.3 | 279.4 | 281.1 | 256.8 | 278.4 | 261.5 | 284.3 |
| Contextual Information | Agency Use (Staffing Solutions Data) | | | 118.1 | 139.5 | 124.1 | 132.2 | 104.3 | 142.9 | 122.3 | 129.9 | 146.9 | 138.0 | 130.9 | 126.0 |
| Key Standard | Agency Spend as Proportion of Total Pay Bill | <=2.5% | >3.5% | 6.06% | 4.24% | 2.22% | 3.60% | 3.22% | 2.95% | 4.26% | 3.78% | 4.61% | 6.56% | 5.40% | 3.87% |
| Key Standard | Nurse Agency Spend as Proportion of Registered Nursing Pay Bill | <=3.0% | >4.0% | 7.60% | 8.43% | 7.78% | 8.45% | 6.58% | 8.12% | 11.66% | 7.09% | 9.36% | 11.04% | 12.08% | 8.46% |
| Key Standard | In Month Sickness Rate (Actual) - Reported 1 month behind | <=3.9% | >4.4% | 5.63% | 5.31% | 5.81% | 6.24% | 5.50% | 6.69% | 6.10% | 4.66% | 5.28% | 6.28% | 4.57% | |
| Key Standard | In Month Sickness Rate (Deseasonalised) - Reported 1 month behind | <=4.3% | >4.8% | 5.46% | 4.99% | 5.47% | 5.68% | 4.67% | 6.39% | 6.65% | 5.26% | 5.76% | 6.71% | 4.90% | |
| Key Standard | Rolling 12 Month Sickness Rate - Reported 1 month behind | <=4.3% | >4.8% | 4.60% | 4.69% | 4.73% | 4.81% | 4.87% | 5.10% | 5.31% | 5.38% | 5.48% | 5.62% | 5.59% | |
| Tracker | Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind | <=0.9% | >1.0% | 1.10% | 1.19% | 1.23% | 1.22% | 1.19% | 1.17% | 1.11% | 1.05% | 0.99% | 0.98% | 0.99% | |
| Contextual Information | In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind | <=0.9% | >1.0% | 1.26% | 1.43% | 1.24% | 1.10% | 0.95% | 1.02% | 0.94% | 1.04% | 0.90% | 1.00% | 1.05% | |

| | | | | 2021/22 | | | | 2022/23 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Performance Indicator | Performing | Outside Tolerance | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Tracker | Overall Wellbeing Score | >=3.50 | <3.25 | | | 3.20 | 3.21 | 3.19 | 3.21 | | |

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

## Measures requiring focus and a countermeasure summary this month are:

| Measure | Executive Summary | Recommendation to Board |
|---|---|---|
| Vacancy | The overall vacancy stands at 307.3 WTE, which equates to a vacancy rate of 5.7%. This is above the targeted trajectory if the vacancy rate is to be cut to 4% by the end of the financial year. | Band 5 nurses and Cleaning continue to have highest vacancy rate, this will be support by overseas recruitment work and bespoke recruitment campaigns in cleaning. |
| Turnover | For the seventh month out of the past eight, in month turnover exceeded target and currently stands at 1.02%. Rolling 12 month turnover is projected to be at or above 12% in the next few months. | A3 work to commence to understand true root causes |
| Sickness Absence | Although the overall sickness rate in August reduced to 4.57%, reflecting a drop off in Covid cases, it remains above target and the chance of achieving a rolling 12 month sickness rate of 4.3% by the end of the financial year would seem very low. | Focused work continues in hot spot areas, increase in Stress and anxiety being analysed |
| Agency Spend | Both the agency and nurse agency spend rates have reduced on the previous month, but continue to be well above target | RUH is a regional outlier for off framework agencies. Weekly agency scrutiny at Executive Team meetings focusing on RMNs |

# Executive Summary II

| | | | | National Staff Survey Result | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Performance Indicator | Performing | Outside Tolerance | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| Tracker | BME Positive response rate: Organisation provides equal opportunities for career progression or promotion (WRES 7) | | | 40.9% | 33.3% | 43.6% | 47.0% | 41.5% | |
| Contextual Information | Trust Positive response rate: Organisation provides equal opportunities for career progression or promotion (WRES 7) | | | 58.4% | 55.7% | 57.0% | 57.4% | 55.7% | |

| | | | | 2021/22 | | | | 2022/23 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Performance Indicator | Performing | Outside Tolerance | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Tracker | Personal Development Theme Score - BME respondents | >=3.75 | <3.50 | 3.74 | 3.69 | 3.00 | 3.75 | 3.46 | 3.49 | | |
| Contextual Information | Personal Development Theme Score - All respondents | >=3.75 | <3.50 | 3.71 | 3.68 | 3.66 | 3.63 | 3.53 | 3.62 | | |
| Tracker | Perceived Fairness Theme Score - BME respondents | >=3.50 | <3.25 | 3.18 | 3.24 | 2.70 | 3.53 | 3.17 | 3.13 | | |
| Contextual Information | Perceived Fairness Theme Score - All respondents | >=3.50 | <3.25 | 3.39 | 3.31 | 3.33 | 3.35 | 3.23 | 3.25 | | |
| Tracker | Civility Theme Score - All Respondents | >=4.00 | <3.75 | | 3.72 | 3.71 | 3.66 | 3.57 | 3.57 | | |

*No MAD Survey will be run in Q3*

| | | | | Last 12 Months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Performance Indicator | Performing | Outside Tolerance | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 |
| Tracker | BME likelihood of being appointed from shortlisting - comparative ratio to 1 White (WRES 2) - Rolling 3 months | >=1.0 | <0.8 | 0.52 | 0.51 | 0.55 | 0.53 | 0.57 | 0.63 | 0.72 | 0.66 | 0.62 | 0.64 | 0.63 | Not Available |
| Contextual Information | BME WTE at Band 6 or7 | | | 125.3 | 136.0 | 137.5 | 139.8 | 146.6 | 145.6 | 143.4 | 143.7 | 143.8 | 146.8 | 152.3 | 153.7 |
| Contextual Information | BME WTE at Band 8A to 9 | | | 8.3 | 8.3 | 8.3 | 8.3 | 8.3 | 8.3 | 9.3 | 9.7 | 11.6 | 11.6 | 11.6 | 12.6 |

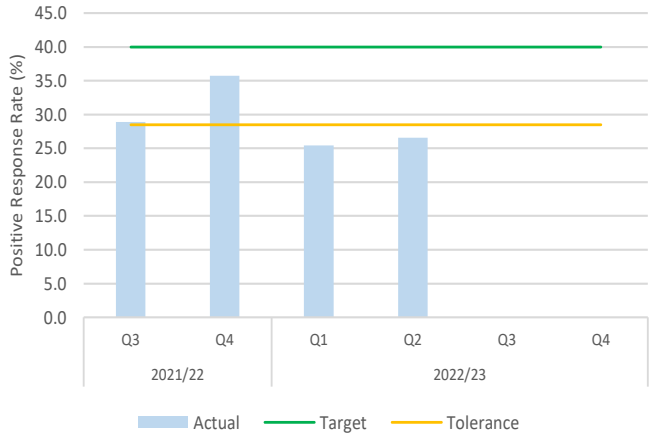
| | | | | Last 12 Months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Performance Indicator | Latest Month Target | Outside Tolerance | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 |
| Key Standard | Appraisal Compliance Rate | >=75.6% | <70.6% | 63.04% | 62.23% | 63.16% | 62.48% | 59.94% | 61.10% | 62.66% | 66.14% | 66.50% | 69.65% | 71.85% | 72.88% |
| Contextual Information | BME Appraisal Compliance Rate | >=75.6% | <70.6% | 67.99% | 66.15% | 64.49% | 62.75% | 58.64% | 61.05% | 64.77% | 68.51% | 69.09% | 71.73% | 74.00% | 72.95% |
| Key Standard | Mandatory Training Compliance | >=90.0% | <85.0% | 86.60% | 86.30% | 86.20% | 85.60% | 85.60% | 85.20% | 84.90% | 85.60% | 85.80% | 85.70% | 85.10% | 85.40% |
| Key Standard | IG Training Compliance | >=95.0% | <90.0% | 82.10% | 81.70% | 81.90% | 80.40% | 79.50% | 77.20% | 75.80% | 76.70% | 77.20% | 75.80% | 75.30% | 75.50% |

## Measures requiring focus and a countermeasure summary this month are:

| Measure | Executive Summary | Recommendation to Board |
|---|---|---|
| Training Compliance | Mandatory Training, which now excludes bank, compliance has further fallen and now stands at 85.40%, Information Governance training compliance has fractionally improved to 75.50%. Both rates are considerably below their respective targets of 90% and 95%. | • HRBPs continue to support divisional focus around IG compliance<br>• Business case for new Learning Management Solution approved<br>• Importance of Training compliance being picked up at monthly Performance Review meetings |

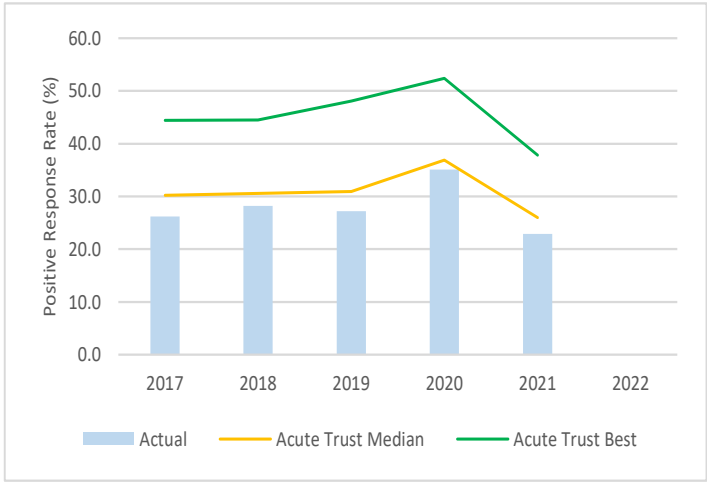
# True North | There are enough staff in this organisation for me to do my job

## Making a Difference Survey Result




| | |
|---|---|
| Latest Survey | 26.6% |

## National Survey Results




| | |
|---|---|
| Latest Survey | 22.9% |

## Is standard being delivered?

'• The percentage who responded positively that there are enough staff in this organisation for them to do their job increased to 26.6% in the Q2 survey. However, despite this improvement, this proportion would still not be sufficient for the Trust to place in the top quartile of Acute Trusts based on the 2021 National Staff Survey results.

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

• Professional clinical staff were least likely to respond positively: Medical & Dental (19.1%); Nursing and Midwifery (20.0%) and AHP (20.5%). Additional Clinical Services had a positive response rate of 41.7%, but this is based on only 24 respondents. In addition, as around half of the I don't know group who had a positive response rate of only 17.4% reporting being Band 2 or 3, it is likely that some of these respondents would fall into the Additional Clinical Services group and lower the positive response rate.
'• Given who is responding less positively, it is unsurprising that Medicine (20.0%), FASS (20.6%) and Surgery (23.4%) are the poorest scoring Divisions.

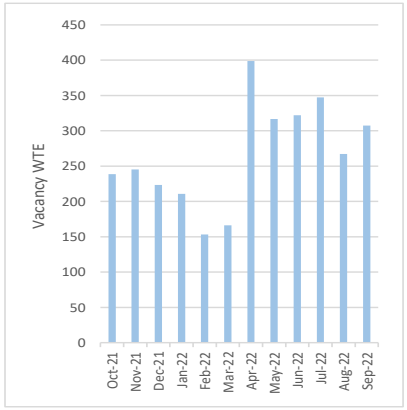
## Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| Communication around staffing establishment and plans to be shared as part of vision launch. | HRBPs |
| FASS: Oncology and Haematology and Breast business cases successful, therefore this supports the increase in workforce establishment for these areas. Currently all vacant posts in other areas across FaSS being recruited to and Pharmacy aseptic and maternity recruitment going well.<br>Recruiting to Nursing safer staffing Trajectory as agreed in April 2022 via a phased implementation plan.<br>Progress monitored via divisional PRM's on a monthly basis | Katy Coulam<br><br>David Mawdesley. |
| Develop plans to recruit to establishment plus turnover in 23/24 for overseas nurses | Mandy Rumble |

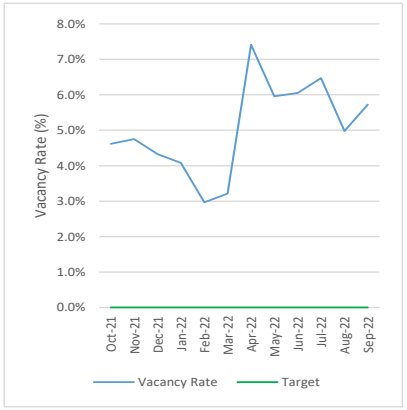
# Breakthrough Objective| Reduction in Vacancy WTE

## Trust Vacancy Position

WTE

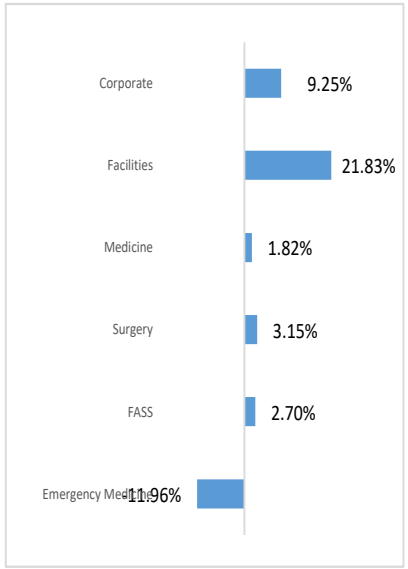



Vacancy Rate

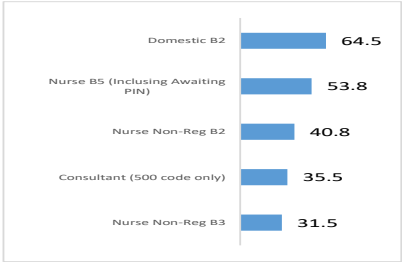



| | | | |
|---|---|---|---|
| Current Vacancy WTE | 307.3 | Current Vacancy Rate | 5.72% |

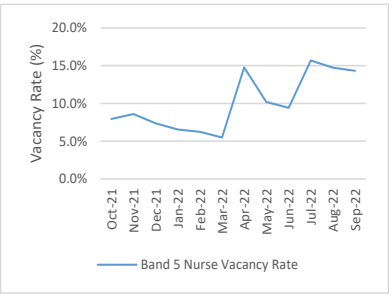
## Divisional Vacancy Rates




## Top 5 Roles by Vacancy Rate




## B5 Nurse Vacancy Rate




## Is standard being delivered?

• Based on Finance data, vacancies currently stand at 307.3 WTE, which equates to 5.7%. This is above the targeted position for the month given the trajectory outlined to reduce the vacancy rate to 4% by the end of the financial year.

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

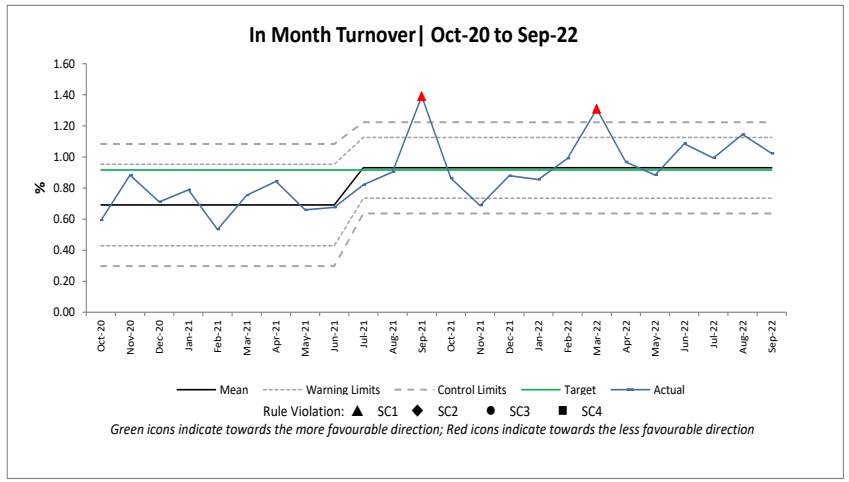
• Facilities has the highest vacancy rate at 21.8%. The vast majority of this relates to the Cleaning & Accommodation directorate and this is reflected in that account code pertaining to Band 2 domestics has the highest vacancy of individual account codes.
• Band 5 nurses has the next highest vacancy at 53.8 WTE, although there are a significant number of international nurses due to start in October (42 arrivals) and November (40 arrivals).

## Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| Recruitment drive is continuing in Cleaning – Paid Facebook advert is live for Cleaning Supervisors. Attended Job Centre again in October and exploring the SWAP scheme.<br>Specific resource in recruitment to be allocated to E&F to help process 20 WTE currently in Trac | Holly Hitchcock/Philip Watson<br><br>Jenny Turton |
| Specific recruitment campaigns for Pharmacy and Maternity Services and Paeds/NICU Nursing. Paeds have been doing recruitment videos that have proved successful. Maternity Services campaigns include mulitmedia touchpoint, through Google, Facebook and Instragram, RCM Magazine (Sept 2022 issue), Maternity & Midwifery Forum mailing and e-shot. Bid for international Midwives recruitment taking place. | Katy Coulam, Pharmacy Business Manager, Speciality Manager/Rec Midwife/Leads for Maternity Services |
| | |

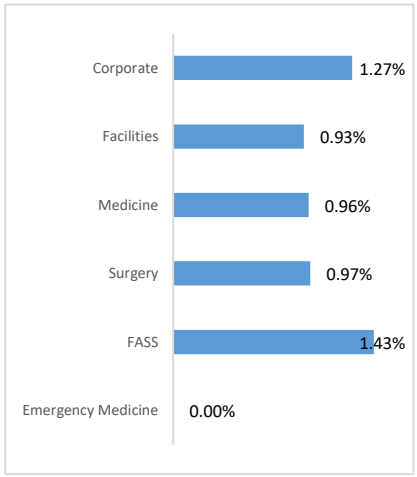
# Key Standard| Turnover Rate

## In Month Turnover - Trust

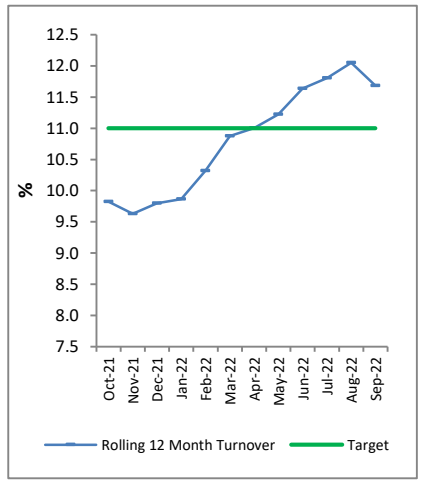



| | |
|---|---|
| Turnover Rate | 1.02% |

## In Month Divisional Turnover




## Rolling 12 Months Turnover - Trust




| | |
|---|---|
| Turnover Rate | 11.68% |

## Is standard being delivered?

• As it stands, In Month Turnover was 1.04% in September. This means that for 7 out of the past 8 months, turnover has exceeded the target.
'• Turnover in September was, however, lower than that 12 months previously which has resulted in a reduction in the 12 month rolling turnover rate to 11.68%. Nonetheless, based on recent months' turnover and what is due to roll off over the next four months this is not likely to be the start of a downward trend. Rather, a return to 12%+ is quite possible.

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

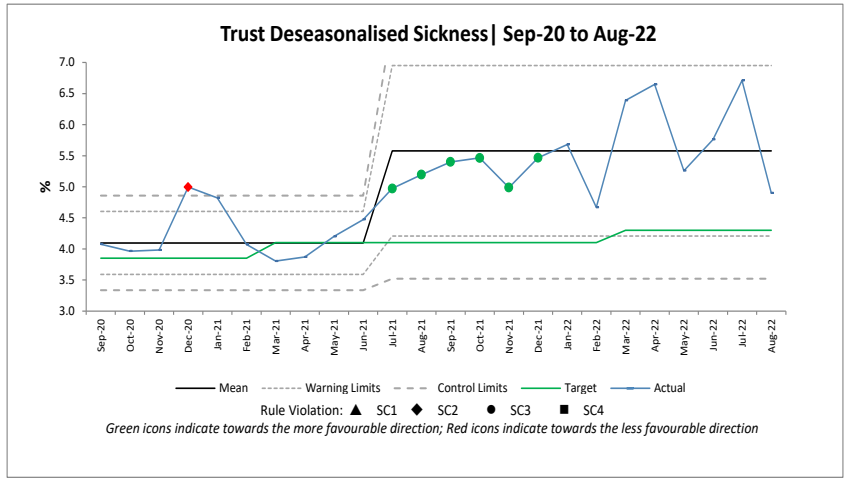
• Only Emergency Medicine (which is a relatively small division) and Medicine, all other main divisions have a rolling 12 month turnover comfortably above the 11% target.
• AHP, Additional Clinical Services and Professional Scientific and Technical staff groups all have a 12 month turnover rate above 14%, with Estates and Ancillary and Administrative and Clerical staff groups also above 12%. Countermeasure summary details specific actions that are taking place to address.

## Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| Deep dive into what professions make up AHP vacancy gap | Workforce information |
| HCA and Admin and Clerical listening events planned November 2022 | Helen Back/Ana Gleghorn |
| Commence A3 looking at turnover, focus on top contributors | Helen Back |
| 3 Leavers in E&F in month. Leaving reasons for Estates and Ancilliary staff are monitored on a monthly basis via E&F Board and exit interviews are being offered with HR for staff who are leaving. | Holly Hitchcock |

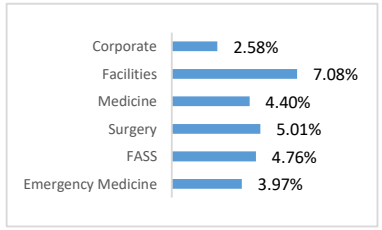
# Key Standard| Sickness Absence Rate

## Deseasonalised Sickness Absence Rate - Trust

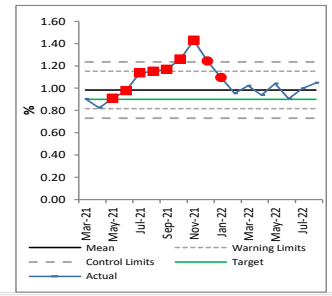



| In Month Actual | 4.57% | In Month Deseasonalised | 4.90% | Rolling 12 Months | 5.59% |
|---|---|---|---|---|---|

## In Month Divisional Sickness Rates



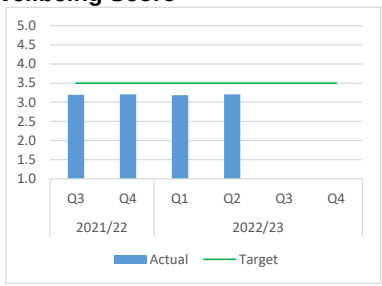

## Anxiety, Stress & Depression - Trust




Absence Rate

0.99%

## Wellbeing Score




## RIDDOR Reporting - Employees

| | 2021/22 | | | | 2022/23 | | | |
|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Dangerous Occurrence –release or escape of biological agents | - | - | - | - | - | - | | |
| Exposed to harmful substance/ Work acquired Infection | - | 1 | - | 1 | 2 | 2 | | |
| Lifting and handling injuries | - | 2 | 2 | 2 | 3 | 1 | | |
| Physical assault | - | 1 | - | - | 1 | 1 | | |
| Slip, trip, fall same level | 3 | 3 | 3 | - | 3 | 2 | | |
| Struck against | - | 1 | - | - | - | - | | |
| Struck by object | 2 | 1 | - | - | 1 | - | | |
| Fell from height | - | - | 1 | - | - | - | | |
| Another kind of accident | - | 1 | 1 | - | - | - | | |

## Is standard being delivered?

• Sickness absence rate reduced in August by 1.7 percentage points to 4.57%. This reduction was, however, essentially a reflection of a drop off in the COVID absence rate from 2.77% to 0.95%. The non-Covid absence rate was relatively static, rising 0.1 percentage points on July's position.

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

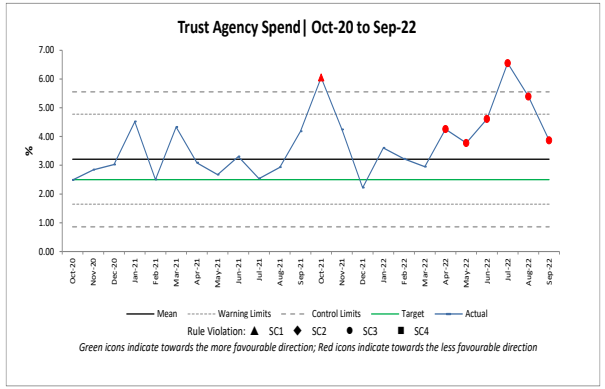
• Chest and Respiratory (which includes COVID) continues to be the main cause of absence (23.24%), despite the reduction mentioned above. The WTE days lost, however, is down from 4467.0 to 1650.5.
'• Anxiety, Stress and Depression is the next most frequently cited reason (22.88%). WTE days lost has been on the increase in the past few months; however the current figure of 1624.9 is well below the high levels that were beginning to be observed at this stage last year.

## Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| Deep dive into anxiety stress and depression data | Workforce information |
| H&WB facilitators continue to support hot-spot areas – drop-in wellbeing session held in E&F | H&WB facilitators |
| A3 to be completed on Theatres sickness | Helen Back / Lilly Cowan |

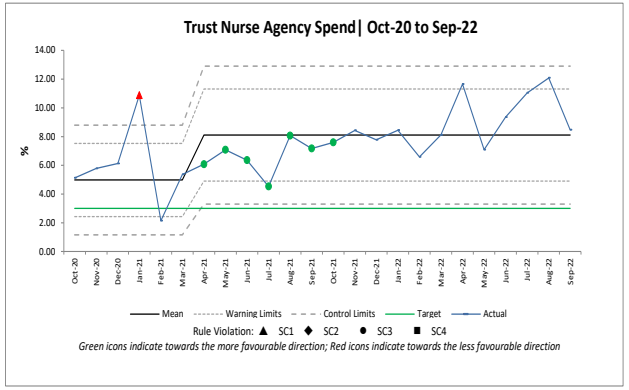
# **Key Standard**| Agency Spend & Bank and Agency Use

## Agency Spend as Proportion of Total Pay Bill



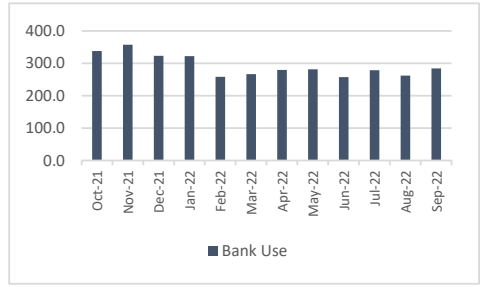

| | |
|---|---|
| Proportion | 3.87% |

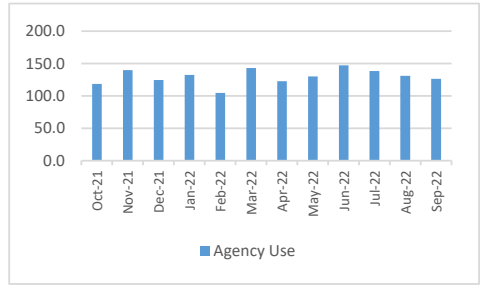
## Nurse Agency Spend as Proportion of Total Registered Nursing Pay Bill




| | |
|---|---|
| Proportion | 8.46% |

## Bank & Agency Use – Staffing Solutions Data




### Is standard being delivered?

- Although Agency spend as a proportion of the pay bill continues on a downward trend, it continues to exceed target at 3.87% and as the sixth successive point above the mean triggers an SPC rule.
- Nurse agency spend has also improved as a percentage on last month's position at 8.46%. Although this data point does not trigger any SPC rules, the current parameters ought to be noted as the target falls below the lower control limit suggesting this target is very unlikely to be realised, especially on a consistent basis.

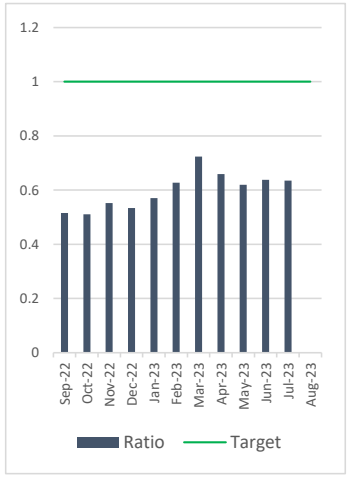
### What is the top contributor for under/over-achievement?

- Over 60% of agency spend was related to registered nursing, with a further 20% pertaining to Consultants.
- Nursing & Patient Care, Paediatric Inpatients and COVID-19 Mass Vaccination Programme had the highest nurse agency spend at cost centre level.

| Countermeasure/Action | Owner |
|---|---|
| Recruitment drive in Cleaning should result in a reduction in the agency spend of the department – additional recruitment resource to be allocated to support with processing candidates through Trac<br>As and when new recruits start in Maternity Services and other Clinical areas in which bank/agency spend is high this should result in a reduction in bank/agency spend. | Holly Hitchcock / Philip Watson / Recruitment<br>Katy Coulam/Fass Lead Clinicians and Speciality Managers |
| Growing the Bank: Auto enrolment onto the Bank at the point of recruitment went live for new joiners from 1st July for Nursing Band 2-7 and Medical Staff | Eugenie Mellon |
| Weekly pay for Bank workers to commence 4th November – The approach aims to attract and retain valued bank workers by levelling the playing field amongst competitors | Eugenie Mellon |
| Locums Nest pilot live to trial new ways of working with Medical Locums to improve access to bank opportunities. | Eugenie Mellon |
| RMN Agency spend remains high in comparison with previous years demand. To mitigate risk a review for the RMN Assessment form and escalation process is underway | Ana Gleghorn |

# **Key Standard**| Agency Spend & Bank and Agency Use

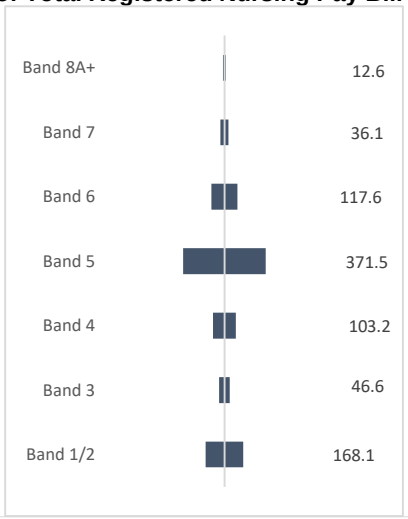
### Agency Spend as Proportion of Total Pay Bill




Proportion

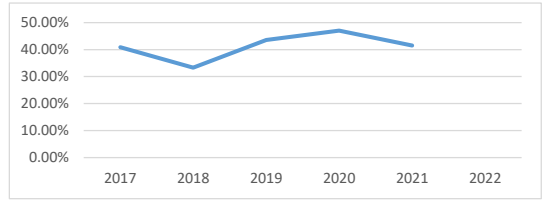
Not Available

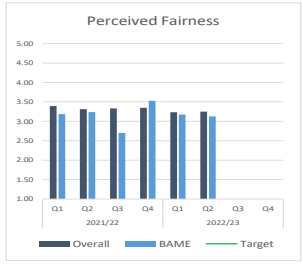
### Nurse Agency Spend as Proportion of Total Registered Nursing Pay Bill

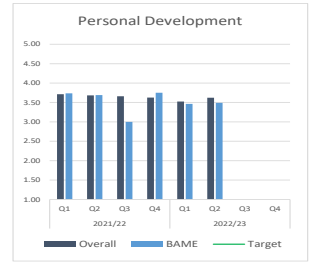



Proportion

### Bank & Agency Use – Staffing Solutions Data




### Is standard being delivered?

- Our Workforce Race Equality Scheme data shows you are 1.55 times more likely to be appointed from short-listing if you White then Black, Asian and ethnic minority. We are aiming for monthly data to be accessible from Trac as we develop this data.

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

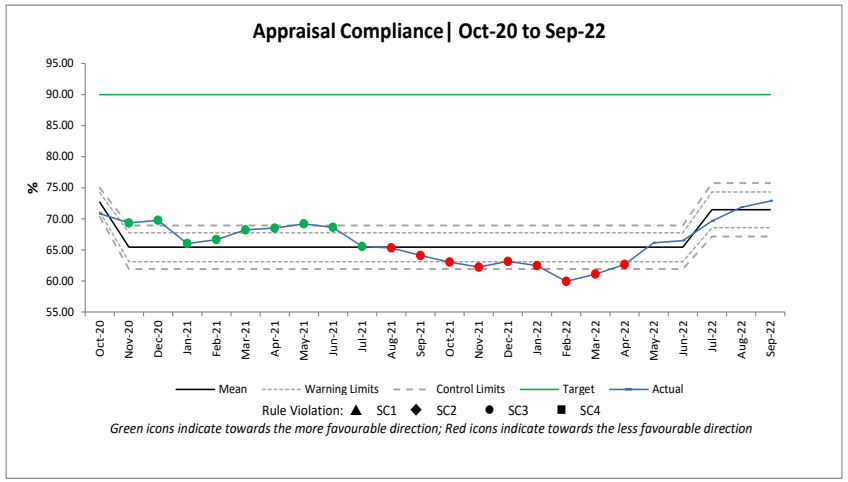
Currently we have an overall figure as derived from our Workforce Race Equality scheme, we are working to replicate this data at a divisional level to be able to ascertain contribution. See countermeasure.

### Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| Working with Kineo to develop inclusive recruitment. | Head of ED&I |
| Development of Divisional level data to understand top contributors | Head of ED&I and workforce |
| Head of ED&I prioritising positive actions linked to WRES/WDES | Head of ED&I |
| ED&I recruitment focus group in situ | Head of ED&I |
| Job description final checks | Hannah McCoid |

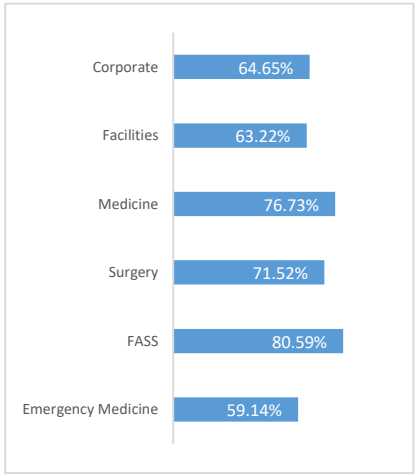
# **Key Standard**| Appraisal Compliance

## Appraisal Compliance - Trust




| | |
|---|---|
| Compliance Rate | 72.9% |

## Divisional Appraisal Compliance




## Selected Group Compliance Rates

| | |
|---|---|
| AfC Staff | 73.0% |
| M&D Staff | 71.6% |
| Consultants | 78.1% |
| White | 73.0% |
| BME | 72.9% |

## Is standard being delivered?

• The methodology for calculating appraisal compliance has been amended and now excludes staff on maternity leave, long term sick. and career breaks. This has fractionally boosted the compliance rate to 72.88% which is still considerably below the long-term target of 90%.

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

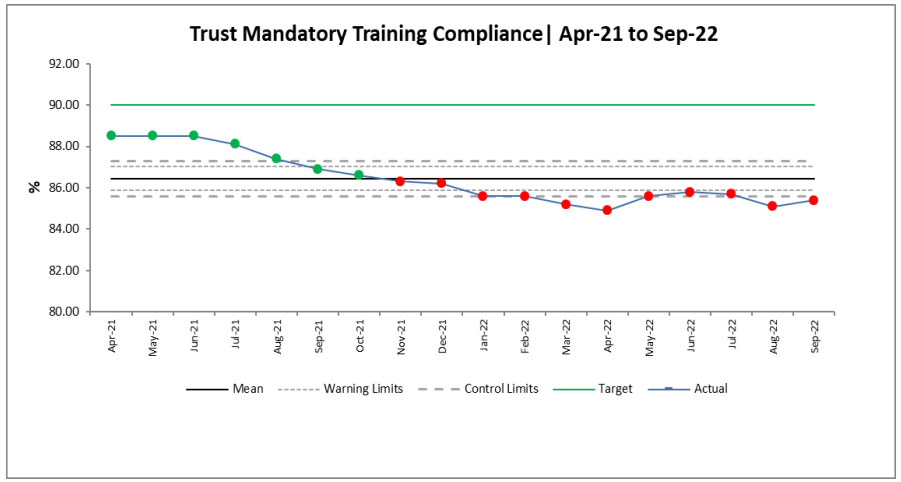
• Appraisal compliance is lowest in Emergency Medicine (59.14%), followed by Facilities (63.22%) and Corporate (64.65%).
'• AfC staff compliance (72.99%) is now fractionally above that of M&D staff (71.59%), reversing the recent trend.

## Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| Appraisal recovery plans sent out by the HR Advisor to the areas with the lowest compliance rate. Appraisal compliance flagged at E&F Board and through 1:1 meetings. | Holly Hitchcock / Sam Deere / E&F Managers |
| FaSS Division a new Appraisal Driver has been drawn up, currently the Division is showing the highest compliance since September 202. Trajectories are currently being worked up to support outstanding appraisals being completed as soon as possible. | Katy Coulam/ FaSS Speciality Managers |
| Medicine Division appraisal rate has improved by 17% since April 2022 and continues on an upward trajectory. Appraisal set as driver for all specialties where compliance less than 90% | David Mawdesley |
| Appraisals is a driver for Surgery and has improved by 13% since April 2022. Appraisal compliance being monitored at monthly speciality PRM and Nursing Performance Reviews | Lilly Cowan / Surgery speciality Managers |
| FTC project post to develop new appraisal platform to be hosted on new Learning Management System being recruited to. Aim new appraisal process for beginning 23/24 | Tracy Elvins |

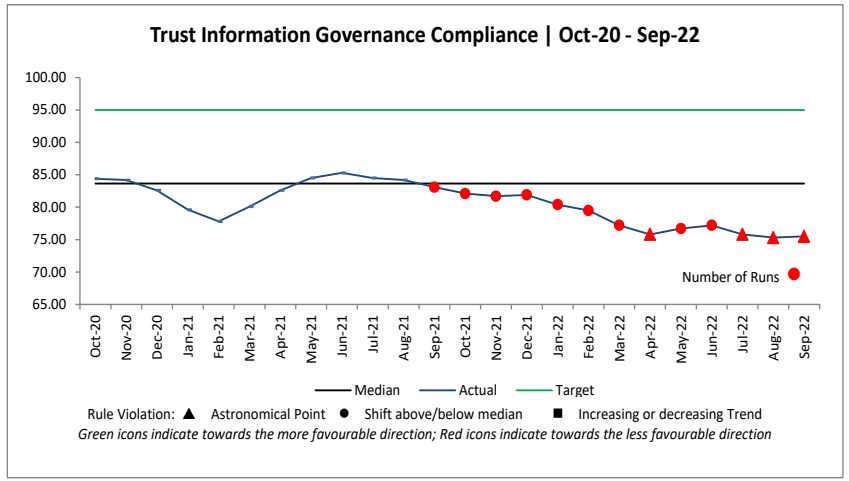
# **Key Standard**| Mandatory Training Compliance

## Mandatory Training Compliance Rate - Trust




| | |
|---|---|
| Compliance Rate | 85.4% |

## Information Governance Training Compliance Rate - Trust




| | |
|---|---|
| Compliance Rate | 75.5% |

## Is standard being delivered?

- At 85.40%, Mandatory Training compliance, which now excludes bank, has continued on its downward trajectory and for a second successive month falls below the lower control limit, triggering an SPC rule.
- Information Governance compliance has fractionally improved to 75.50%. However, this continues to be just under 20 percentage points below the Trust's target.

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

- Continuing the trend of the past few months, Facilities and Emergency Medicine have the two lowest compliance rates of the main Divisions for both overall mandatory training and IG training.

## Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| Mandatory training compliance flagged at E&F Board and through 1:1 meetings. Training on new Cleaning systems took priority in August 2022 | Holly Hitchcock / E&F Managers |
| FaSS Division a new Mandatory Training Driver has been drawn up to also include Doctors in Training, with a key priority for the Division over the coming months being Safeguarding Adults and Children's training alongside IG training. | Katy Coulam/FaSS Speciality Managers |
| Addressing via Medicine specialty PRM meetings, highlighting subjects and areas where compliance is low and reviewing improvement on a monthly basis. | David Mawdesley |
| Being reviewed at Surgery Speciality PRM and New Nursing Performance Reviews | Lilly Cowan / Surgery Speciality Managers |
| Continued procurement process to support implementation of New learning management system which will ease access and understanding of mandatory training. | Nardina Storey |

# The people we care for

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

# Performance Report

Month 6

The RUH, where you matter

# Executive Summary: Performance

Royal United Hospitals Bath NHS
NHS Foundation Trust

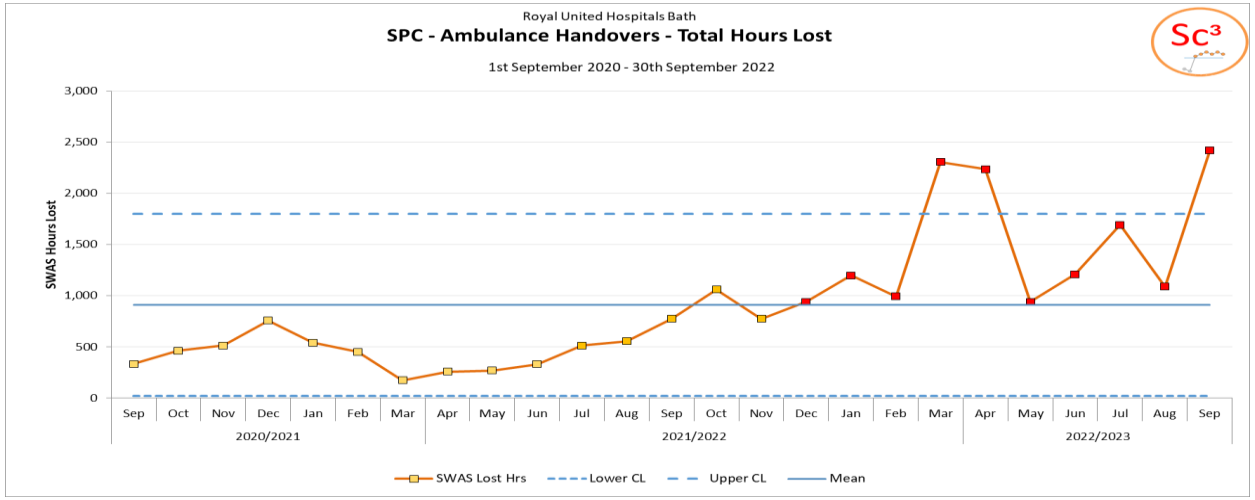
| Strategic Goal | | Performance Indicator | Target | | 2021/22 | | | | | | Trend | Movement From Previous Month |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Performing | Under Performing | Apr | May | Jun | Jul | Aug | Sep | | |
| Trust Goals | People in our Community | Ambulance Handover Delays | >=39 | <39 | 729 | 389 | 466 | 685 | 446 | 722 | | |
| Breakthrough Objectives | People We Care For | 4 Hour Performance (Total RUH Footprint, including MIU & Booked) | >=95% | <95% | 66.0% | 69.0% | 66.7% | 64.1% | 65.2% | 61.5% | | |
| | People in our Community | Non Criteria to Reside | <=62 | >62 | 156 | 128 | 128 | 137 | 135 | 129 | | |
| Key Standards | People We Care For | RTT - Incomplete Pathways in 18 weeks | >=92% | <92% | 63.5% | 63.9% | 62.5% | 61.8% | 61.1% | 59.4% | | |
| | | 62 day urgent referral to treatment of all cancers | >=85% | <85% | 66.7% | 69.3% | 71.7% | 75.4% | 62.1% | (LAG 1) | | |
| | | Diagnostic tests maximum wait of 6 weeks | <=1% | >1% | 32.5% | 38.4% | 32.2% | 33.2% | 37.6% | 40.8% | | |

Measures requiring focus and a countermeasure summary this month are;

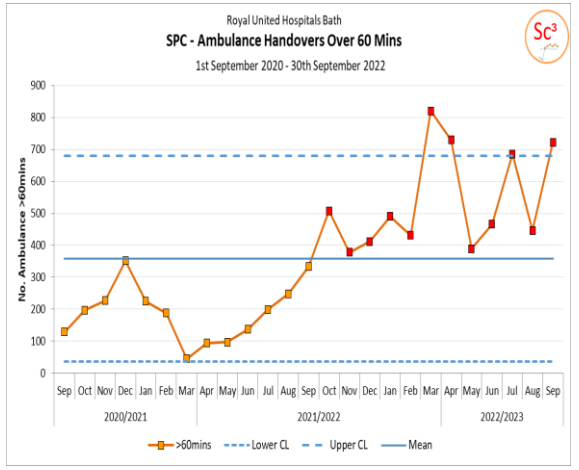
| Measure | Change | Executive Summary |
|---|---|---|
| Ambulance Handover | ↑ | In September the Trust lost a total of 2,420 hours in ambulance handovers, which is a significant deterioration on August. ED are continuing to increasing the Pit Stop model into being able to provide Rapid Assessment and Treatment (RAT) service. Flow based challenges are still impacting on the department's ability to release capacity to support new arrivals. |
| 4 Hours | ↓ | RUH 4 hour performance during September was 63.98%, a slight deterioration on last month. Demand remained above the mean with patients arriving within ED, paediatric attendances being the highest increase of over 200 in month . Urgent care performance 71.5% against an internal 80% target. |
| Non Criteria to Reside (NC2R) | ↑ | During September, the Trust had an average of 129 patients waiting who had no criteria to reside, however, in the first two weeks of October, the number of NCtR has increased falling outside of the system modelling trajectories. Additional capacity, both bedded and home based due to come on line over the next 3 months. |
| Referral to Treatment | ↓ | During September the Trust had no patients waiting longer than 104 weeks. The number of pts waiting over 78 weeks increased to 184. This continues to be driven by gastroenterology, general surgery and oral surgery. |
| Cancer 62 Days | ↓ | Performance in August fell to 64.6%. The largest number of breaches were recorded in Colorectal, Urology and Breast. Colorectal breaches were predominantly due to long waiting times for diagnostics (colonoscopy, CT). Performance is expected to recover in September. Trust 62 backlog had increased slightly by the end of September; 60% of patients are Colorectal. |
| Diagnostics | ↓ | September > 6 week performance 40.8% , deterioration of 3.2%. Main issue remains demand for clinically urgent and planned scans for patients on treatment (oncology) coupled with increased demand for dating scans in ultrasound. Recovery trajectories in place to recover to 15% by March 2023. |
| Elective Recovery | ↑ | The national target has been updated for 22/23, with Trusts now being asked to deliver 104% elective activity. During September the Trust delivered 110% of costed activity against the ERF target. This means performance YTD is currently at 106%. Strong performance continues in Day cases including endoscopy. Challenges in outpatient procedures are being resolved. Level of uncoded spells a noted issue. |

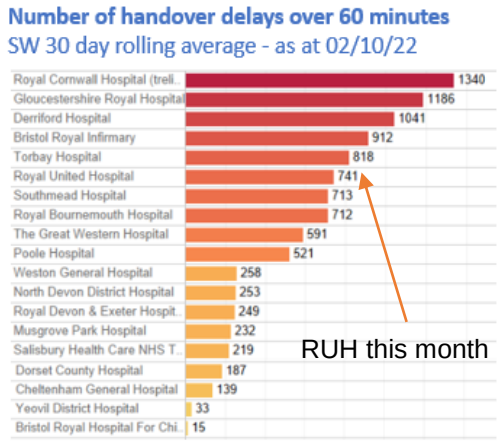
# Trust Goal | Ambulance handover delays

## Historic Data: hours lost to Ambulance handover




## Supporting data




## Is the standard being delivered?

In September the Trust lost a total of 2,420 hours in ambulance handovers. This included the Trust having over 1,000 patients waiting more than 30 min to handover.

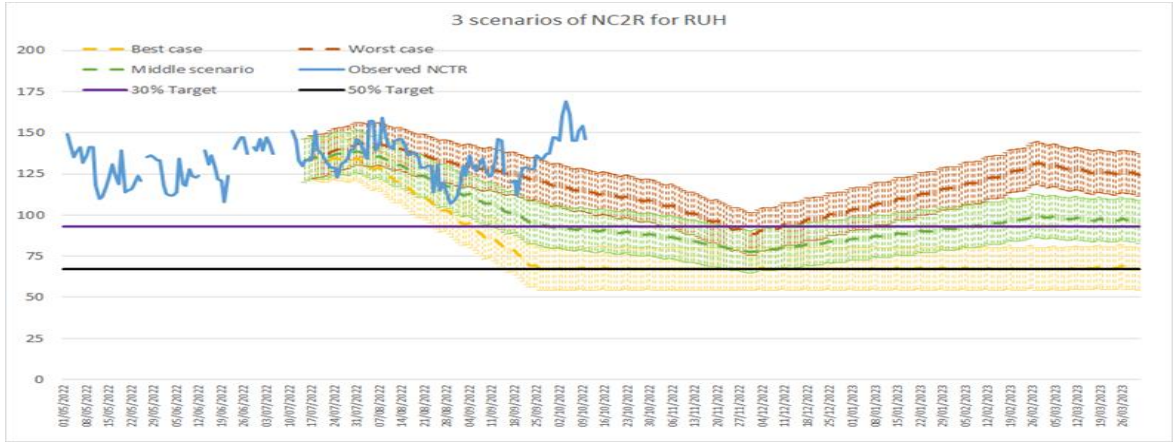
## What's the top contributor for under/over achievement?

- The Trust continued to have significant impact on its bed availability, which is limiting the organisation's ability to pull patients out of ED, in turn leading to delays in getting patients into ED.
- Front door group being established to allow closer working with specialities to try and identify how patients, who are suitable, can wait within the assessment units instead of in a full ED or on ambulances. Considerations as part of winter funding to support staffing these areas.
- Continuing the use of ACA to support Trust position and utilising Pit Stop to maintain patient safety when on the back of an ambulance

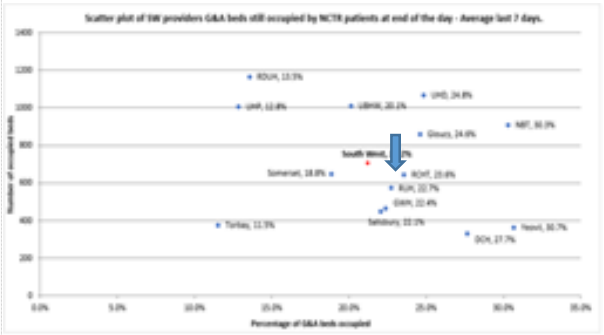
| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Working with Bristol Ambulance to expand scope and hours of ACA | H Cox | Nov-22 |
| Continuing weekly review meeting with SWAST | Prosser | Ongoing |
| Launching work to increase percentage of pts moved out of ED within 15 minutes of bed being allocated | ED Majors Working Group | In progress |
| Delivery of winter schemes to further support flow | ED team | Quarter 4 |
| | | |

# Breakthrough Goal | Non criteria to reside

## Historic Data: as of 13/10/22




## Supporting data




## Is the standard being delivered?

During September, the Trust had an average of 129 patients waiting who had no criteria to reside. This is a reduction from an average of 135 patients in August, however, in the first two weeks of October, the number of NCtR has increased falling outside of the system modelling trajectories

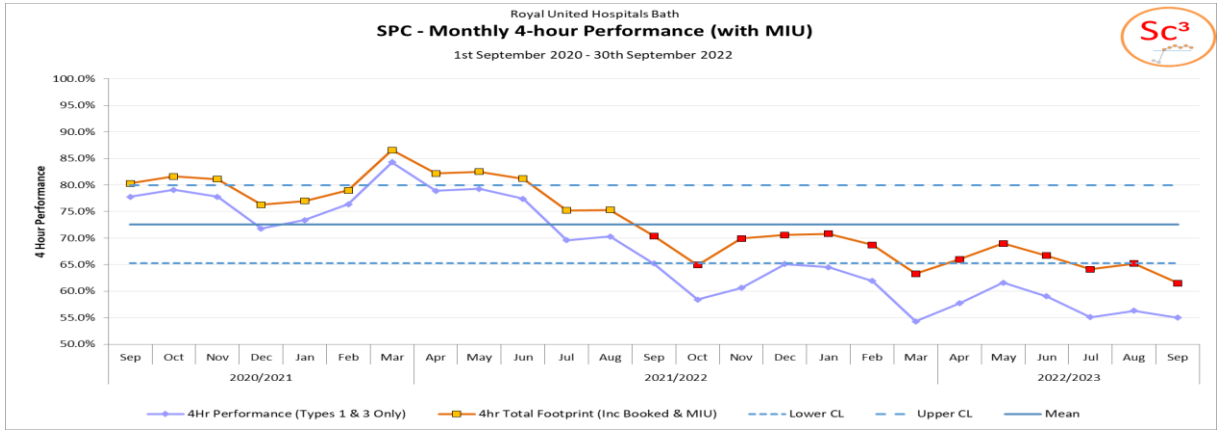
## What's the top contributor for under/over achievement?

- The impact of increased covid numbers in hospital and closures of care homes due to covid has impacted on community discharges.
- A lack of home care capacity is impacting discharges from community and hospital beds.
- Higher number of patients being discharged on a pathway 2 increasing demand for bedded care.
- Capacity caps in social care and brokerage impacting on the timeliness of discharge processes.

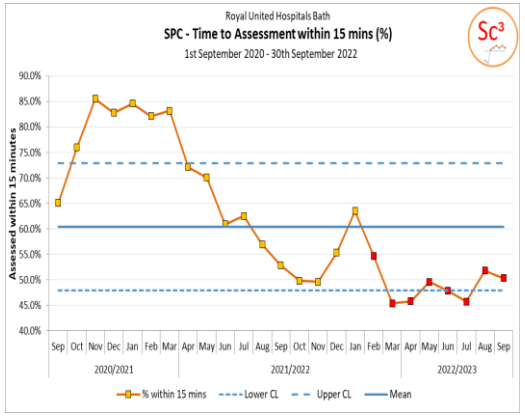
| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Complex discharge list reviews to ensure plans in place | Goddard | On going |
| Continuing to develop United Care BaNES. Service and recruit to establishment | Dolman-Sellars | Nov-22 |
| Self-funding team launched to support pathways out | Goddard | Oct-22 |
| Ward 4 and South Newton opening to provide addition community beds | HCRG / WH&C | Oct-22 |
| Implementation of winter schemes including a Mobilisation Team, 7-day DLN cover, Increased discharge coordinators and further expansion of Art and Reablement | Project Leads | Quarter 4 |

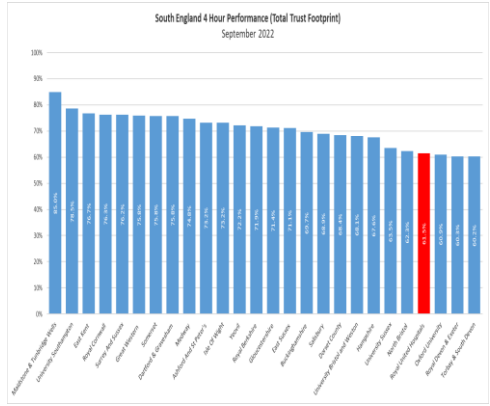
# Key Standards | 4 hour Emergency Standard

## Historic Data




## Supporting data




## Is the standard being delivered?

RUH 4 hour performance during September was 63.58%. This is a deterioration in performance since last month.

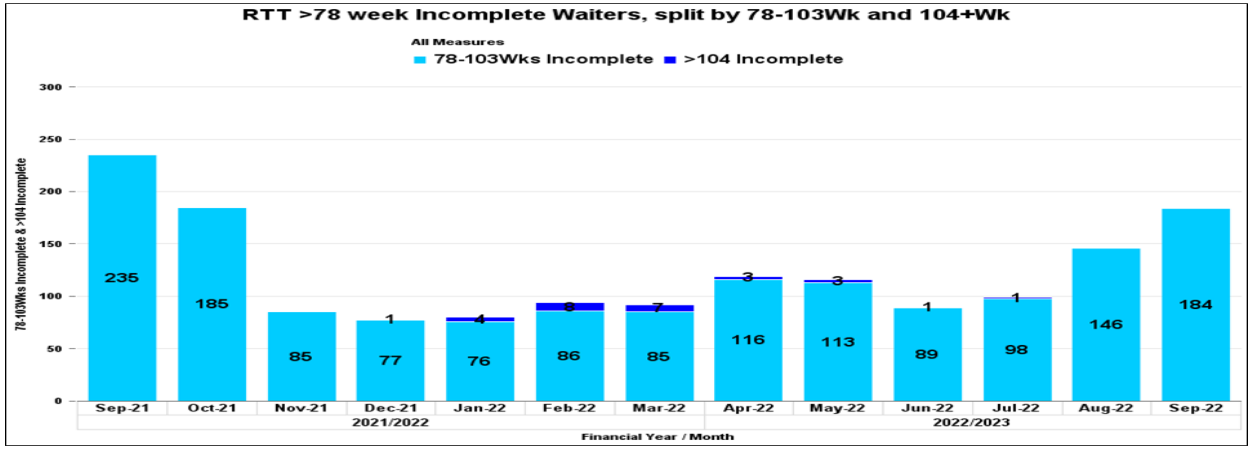
## What's the top contributor for under/over achievement?

- Flow within the hospital has continued to remain challenging during September. This has been driven by challenges with the;
  - Non Criteria to Reside that was an average of 129, it peaked at 138
  - COVID numbers have increased in September with an average of 23 beds occupied, although this has increased to 55 in October
- The Trust has continued to see high levels of activity through Urgent Care in September, with an additional 300 attendances per week compared to the beginning of the year. Urgent care performance was 71.5% against a target of 80%. This has been driven by rota gaps (Vacancies and Supernumerary staff).
- Majors performance was 19.27%, against a target of 45%, mainly driven by the challenges with hospital wide flow.

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Relaunching majors Improving Together huddles and Majors Working Group | Hills, Whittock, Tate | In progress |
| Launched, although not yet full coverage, RATing within ED to supplement pit stop | Jones, Furse | Quarter 4 |
| Understanding impact of staff being supernumerary while training on Practitioner rota in Urgent Care to discuss mitigations | Cox, Fouracre | Nov-22 |
| Launching pilot for streaming within urgent care | Fouracre | In progress |
| Review and prepare to launch Winter Schemes to support Flow | ED Team | Quarter 4 |

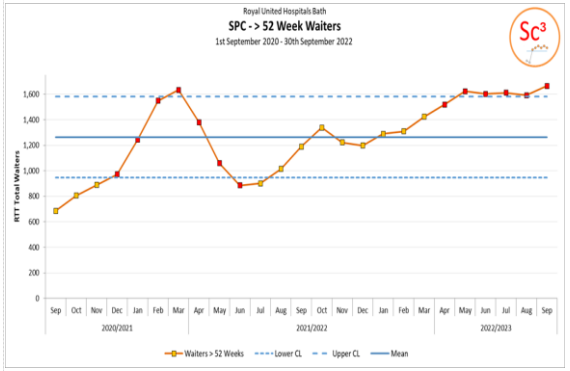
# Key Standards | Referral to Treatment

## Historic Data

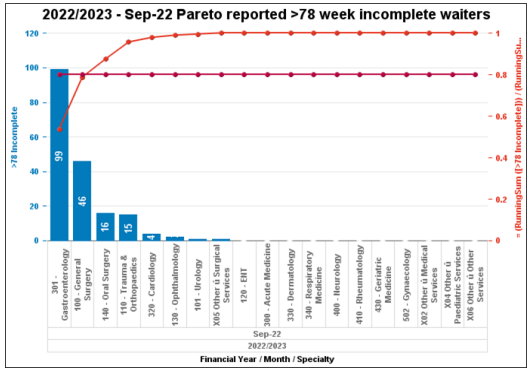



## Supporting data

***SPC 52+ Waiters***




***Pareto 78+ (inc. 104+) by Specialty***




## Is the standard being delivered?

- In September the Trust had 184 patients waiting over 78 weeks but no patients waiting over 104 weeks.
- 52+ Waiters were 4.5% of all RUH Waiters in September, versus National Avg 5.5% in August (RUH 4.4% in Aug, GWH 4.6%, Salisbury 1.9%).

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

- Incomplete 78+ Hotspots are General Surgery and Gastro.
- Overall +38 increase in 78+ Waiters mainly due to +41 Gastro

- 52+ Hotspots are Gastro, Oral Surgery, General Surgery and Cardiology.
- Overall, +72 increase in 52+ Waiters. Biggest increases from Cardiology +32, Gastro +33, General Surgery +38. These mask sizeable decreases –21 Oral Surgery and –16 Orthodontics

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| General Surgery patients transferring to Practice Plus | S Roberts | In progress |
| Locum in post from end of October to support additional activity | B Isaac | Oct-22 |
| Recruitment underway for 1 x replacement General Surgeon and 1 x additional colorectal surgeon | N Lepak | Nov-22 |
| 48 additional clinics being provided in Gastro up to end of November. Recruitment in process for Consultant Endoscopist and Locum Gastroenterologist. | N Aguiar/R Weston | Nov-22 |
| Locum in post from end of October to support additional activity | B Isaac | Oct-22 |

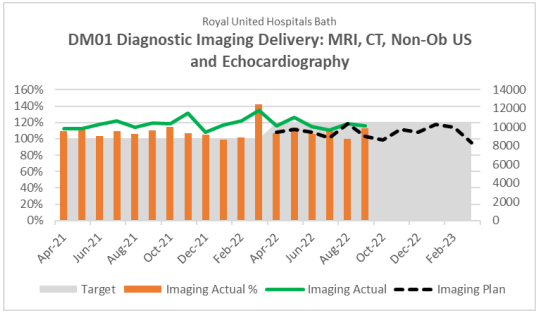
# Key Standards | Elective Recovery

**RUH In Month Performance Against 2019/20 Activity**

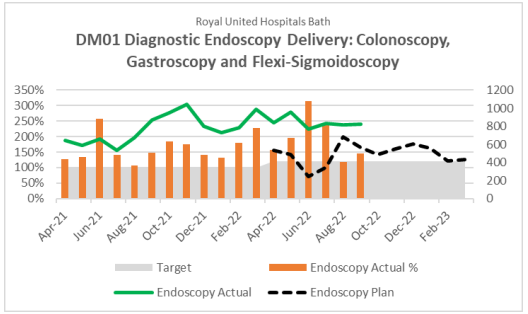
| | M6 | | | | YTD | | | |
|---|---|---|---|---|---|---|---|---|
| Division | 2019/20 £ | 2022/23 £ | Variance £ | | 2019/20 £ | 2022/23 £ | Variance £ | |
| FASS | 1,716 | 2,204 | 488 | 128% | 10,024 | 12,334 | 2,310 | 123% |
| Medicine | 2,038 | 2,354 | 315 | 115% | 12,122 | 13,886 | 1,765 | 115% |
| Surgery | 3,893 | 3,836 | (57) | 99% | 23,468 | 22,154 | (1,314) | 94% |
| **RUH** | **7,647** | **8,393** | **746** | **110%** | **45,613** | **48,374** | **2,761** | **106%** |

## Supporting data

**Diagnostic Imaging (DM01)**




**Diagnostic Endoscopy (DM01)**




## Is the standard being delivered?

- RTT Stops delivery 91% against target of 110%
- Trust delivered 110% in month against the 104% ERF financial target.

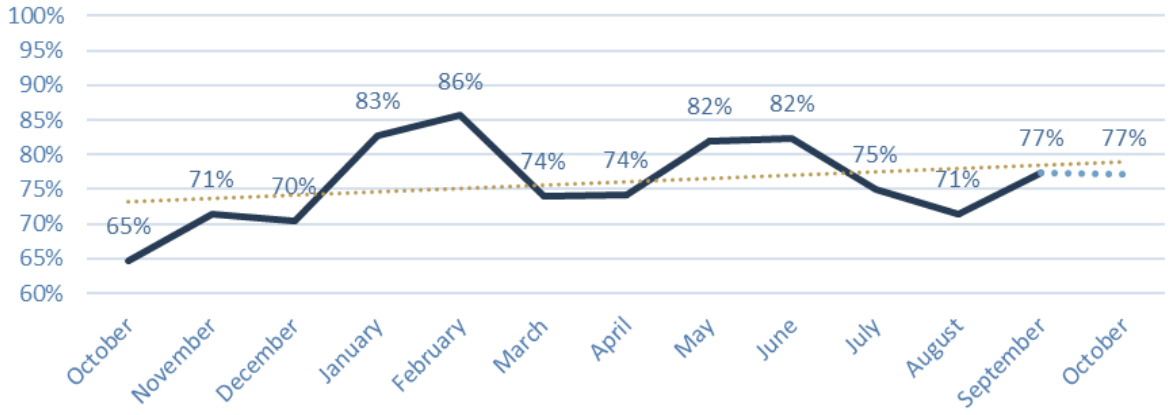
## What's the top contributor for under/over achievement?

- Endoscopy volumes continue to be above 2019/20 levels particularly in Colonoscopy and associated 6 week breaches much reduced
- DC activity has continued to be good this month particularly Urology. Oncology continues to be high. IP activity up on August and over 2019/20 overall.
- Orthopaedics lower activity due to loss of beds
- Outpatient news highest volumes all year with notably high volumes in Breast, Orthopaedics, Dermatology and Oncology
- OP Follow Ups continue to be high at 92% of 2019/20, noting NHSE requirement to cap at 75%
- Improvements in ENT OP Procedure recording have increased volumes year to date. OP Procedures up to 83% of 2019/20.

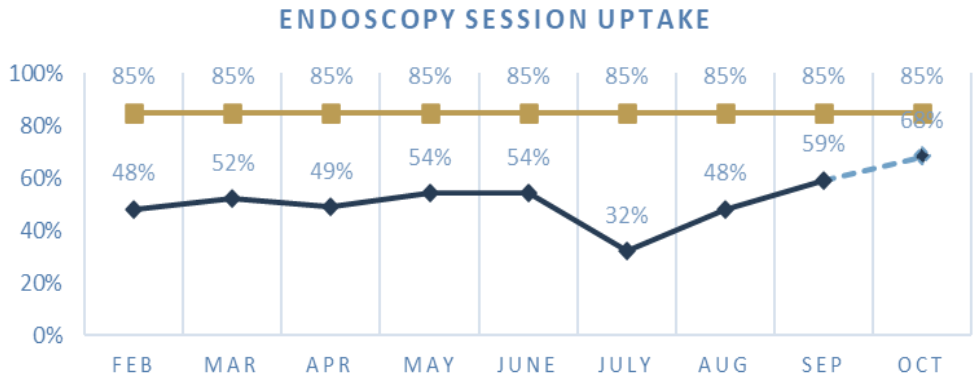
| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Outsourcing of skin cancers to clear BCC backlog | S Roberts | In progress |
| ENT and Ophthalmology procedure recording recovery plan in place | S Roberts | In place |
| Recruitment of additional middle grade surgeons in OMFS to allow reduction in insourcing and provide continuity of care at reduced cost | S Roberts | Quarter 3 |
| Ophthalmology recovery plan – additional patients added to outpatient clinics and theatre lists | S Roberts | Quarter 3 |
| Mobilisation of elective recovery programme | Sethi | On going |

# Key Standards | Sulis

## Historic Data: Theatre vacant sessions




## Supporting data




## Is the standard being delivered?

- Sulis had 74 theatre sessions cancelled from schedule. 22 of 79 session closed The business managed to retain 72% of cancelled sessions.
- Annual leave, consultant availability (inc anaesthetist) and availability of kit caused some session to be closed
- Other sessions closed due to consultant illness and private volumes due to patient choice.

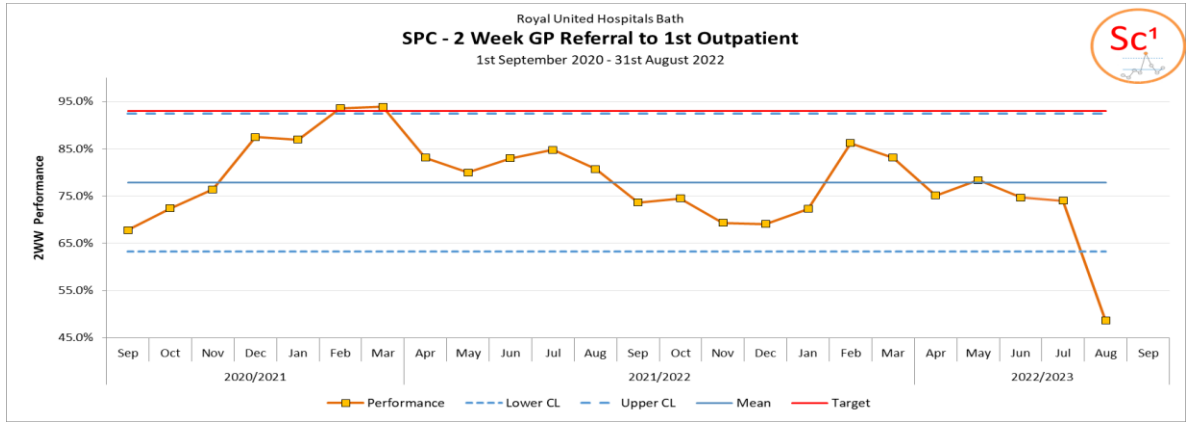
## What's the top contributor for under/over achievement?

- Theatre session uptake improved due to consultant availability. Oct 77%
- Endoscopy session uptake improved due to improved scheduling model and increased Urology sessions now established. October tracking high due to enrolling new endoscopist. Currently 59% tracking to 66%.
- Radiology CT volumes recovering from June & July – More activity displaced away from RUH mobile CT. X-Ray volumes increased as we continue to support wider providers (Paulton).

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| NHS RTT and ERS slot management improving viability and attractiveness on ERS system | Milner / Harrison | On going |
| Increase Urology IPT volumes from RUH to utilise additional Endoscopy sessions. | Harrison | Quarter 3 |
| Review opportunities to increase theatre capacity to accommodate displaced activity – Options include Sunday initiatives | Milner | Quarter 3/4 |
| Review theatre schedule utilization and option for three consultant in single day. | Milner | Quarter 3 |
| | | |

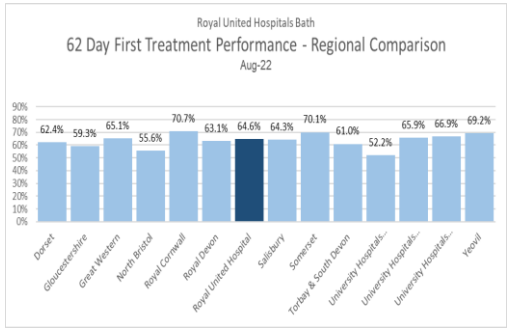
# Key Standards | Cancer 2 week wait

## Historic Data

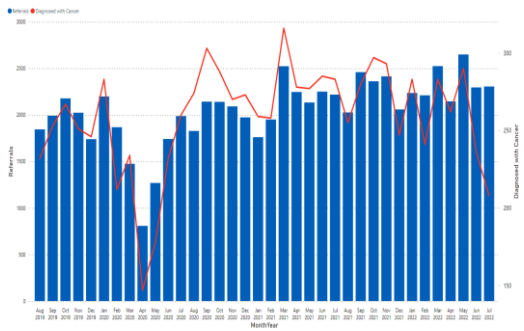



## Supporting data

***2week wait Regional Comparison***




***2week wait demand and diagnoses***



## Is the standard being delivered?

In August performance deteriorated significantly to 48.7%.

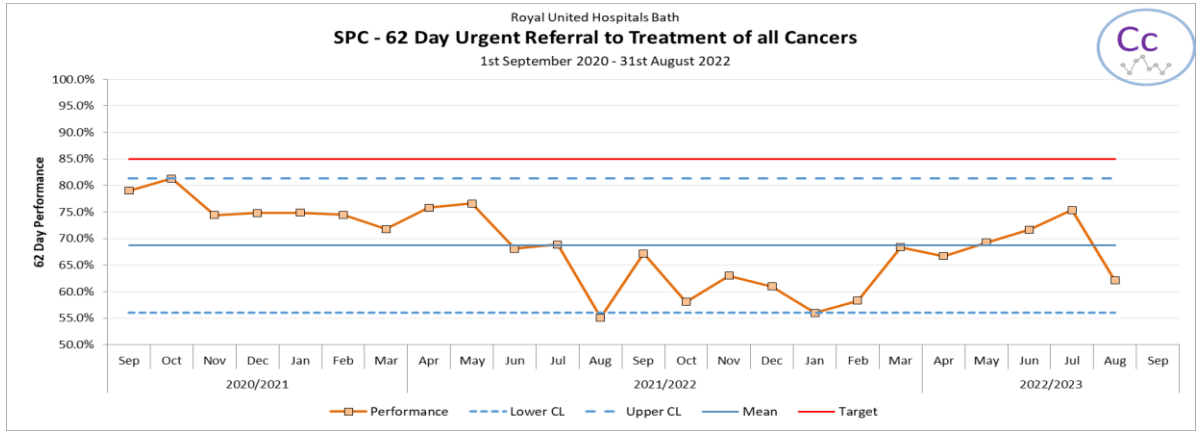
## What's the top contributor for under/over achievement?

- Skin breaches were sustained following previous clinician sickness and additional long term sickness and summer annual leave in the team which coincided with a period of high demand.
- Skin performance is expected to improve from September.
- Colorectal demand continued to rise with the service receiving the most referrals ever in one month.
- Waiting times for Colorectal telephone appointments have extended. Recruitment for clinical staff to manage the 2ww pathway continues.
- Gynaecology performance improved significantly in month following several months of lower performance.

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Gynaecology – Nurse practitioner hours increased | S Fowler | Completed |
| Colorectal – Permanent nurse practitioner recruited | N Lepak | Completed |
| Colorectal – Review of current pathway to increase number of patients going straight to test | N Lepak | Nov-22 |
| Colorectal – Review of straight to test criteria, reducing the need for telephone appointments | S Richards<br>B Colleypriest | Nov-22 |
| Skin – Recruiting consultant fixed term for six months | C Croxton | Nov-22 |

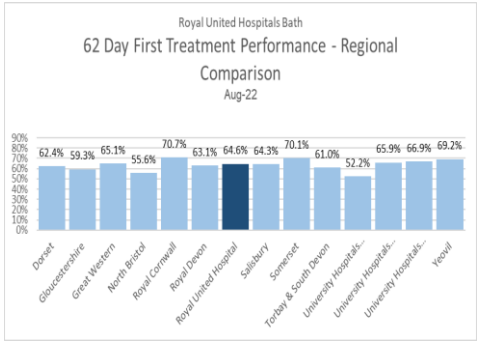
# Key Standards | Cancer 62 days

## Historic Data

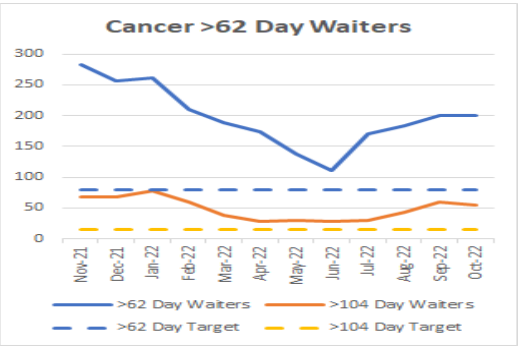



## Supporting data

***62 Day Regional Comparison***




***RUH 62 Day Backlog***




## Is the standard being delivered?

August performance was to 64.6%, a deterioration following significant improvement in June and July. The place the RUH in the middle of other Trusts across the Cancer Alliance and BSW.

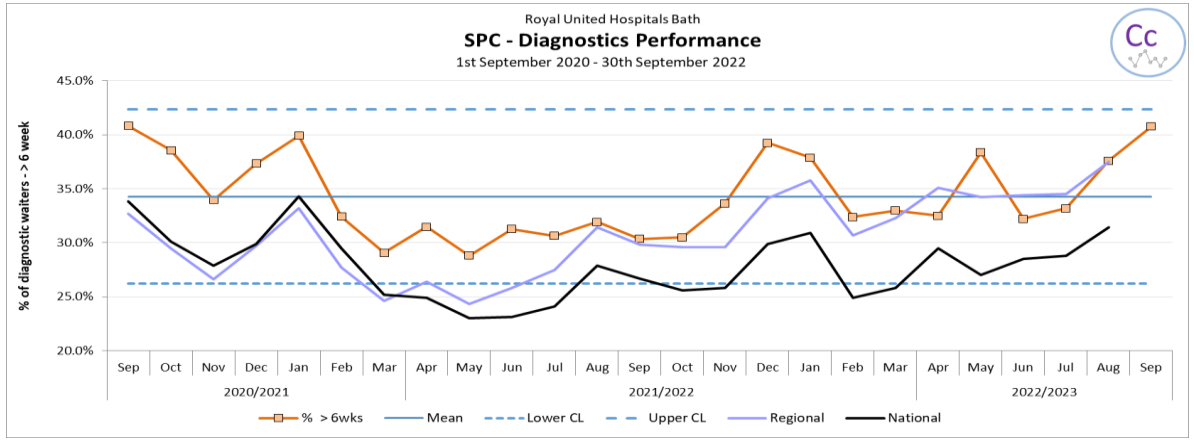
## What's the top contributor for under/over achievement?

- Colorectal accounted for the most breaches. Waiting times for key diagnostics was the main contributor, with some patient choice/delays adding to longer waiting times for some patients.
- Urology performance deteriorated slightly. Breaches were impacted by waiting times for MRIs and reporting but also due to patient choice delays in the diagnostic pathway.
- Breast contributed the next largest number of breaches with the biggest contributory factory being waiting times for imaging following surgical clinics. An increase in breast radiology capacity is reducing the imaging waiting times.
- Trust performance is expected to improve in September.

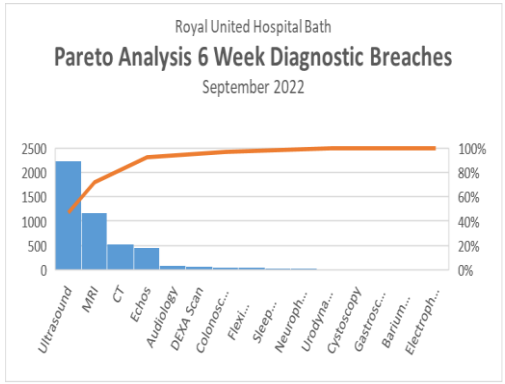
| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Breast – Locum Radiologist appointed | H Wheeler | Completed |
| Colorectal – Referrals Administrator appointed to support improvement in referral quality/STT rate | N Lepak | Completed |
| Colorectal – Additional permanent Colorectal Surgeon being recruited – interviews September | N Lepak | Nov-22 |
| Colorectal – STT pathway to be reviewed | Richards / Colleypriest | Nov-22 |
| Urology – Additional LATP lists to mitigate the longer waiting times for MRI reporting | McFarlane | Oct-22 |

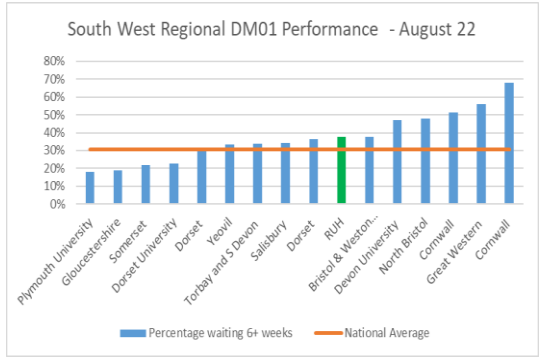
# Key Standards | Diagnostics 6 weeks

## Historic Data




## Supporting data




## Is the standard being delivered?

September >6 week performance was 40.8%. This represents a deterioration of 3.2% compared to August 2022.

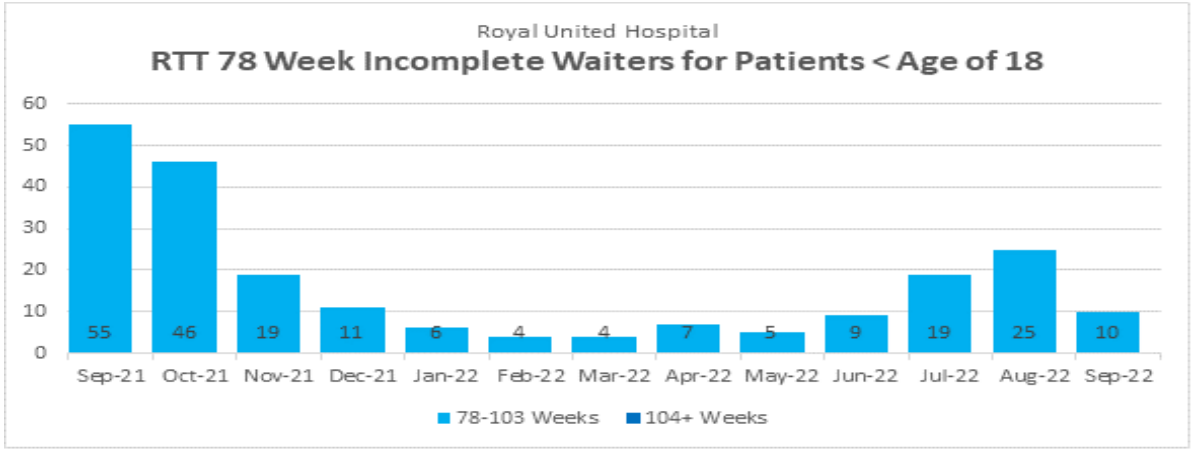
## What's the top contributor for under/over achievement?

- Top contributors; Ultrasound, MRI, CT and echocardiography.
- Increase in both clinically urgent and planned scans (on treatment oncology) reducing capacity for routine investigations within Radiology.
- High demand for dating scans in ultrasound moving sonographers away from non-obstetric ultrasounds as well as reduction in Consultant capacity for MSK USS.
- Reduction in uptake of WLIs.
- Transfer of mobile scanner from fully CT to CT & MRI reducing overall capacity for CT until additional scanner available at Sulis.
- Reduction in capacity within DEXA due to vacancies.

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Mobile scanner to be converted to CT & MRI | N Aguiar | Completed |
| Clinical triage of 52+ waiters - Endoscopy | J Pegram | On going |
| Service review commenced within Respiratory labs | Warner-Holt / C Forster | In progress |
| Action plan and recovery trajectory to be drafted for USS | N Aguiar | Oct-22 |
| All referrals for ECHO to be added to the waiting list | Beech / B Isaac | Quarter 3 |
| Triage process review - ENT & Audiology | K Rye | Nov-22 |
| Transfer Neurophysiology waiters to NBT | C Croxton / J Usher | Oct-22 |

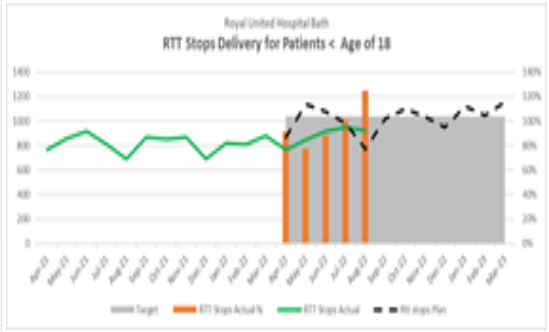
# Key Standards | Paediatrics

## Historic Data

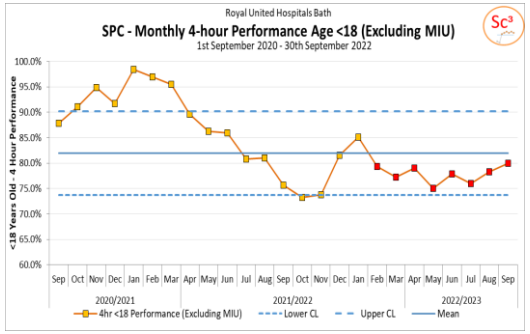



## Supporting data

***Pareto of 6 week performance***




***4 hr performance***




## Is the standard being delivered?

- RTT non-compliant – September reflected 10 paediatric patients over 78 weeks. This is an improvement of 15 patients from August position
- Cancer 2WW non-compliant – In August we saw 5 two week wait referral paediatric patients with 1 patient breaching the standard - performance of 80%
- Cancer Diagnostics non-compliant – In August we diagnosed 7 paediatric patients with 4 being diagnosed within 28 days giving a performance of 57.1%. The breaches were all for patients seen in the breast unit who waiting longer for imaging following assessment in a surgical clinic first. All were diagnosed non-cancer.

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

- Oral surgery continue to be the biggest contributors to paediatric waiting over 78 weeks. Work continuing to ensure patients are treated as quickly as possible.
- Waits for ENT paediatric patients requiring sleep studies continue to be lengthy as these are provided by UHBW.

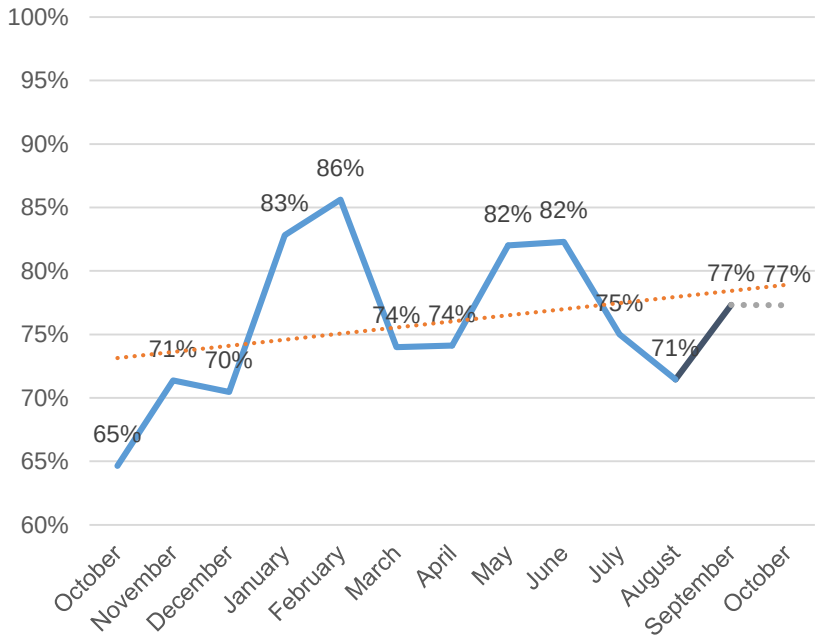
| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Launched new day case recovery area within paediatric ward | Griffiths | Completed |
| Robust cross divisional PTL management continue on a weekly basis to minimise non-capacity delays in pathways | Dando | In progress |
| ED paediatric team and PAU working closer together to improve pathways and processes | Gilby / Potter | In progress |
| Utilise winter funding to increase the number of paediatric nurses to three to support ED during peak periods of demand | Whittock | Quarter 4 |

Month Position

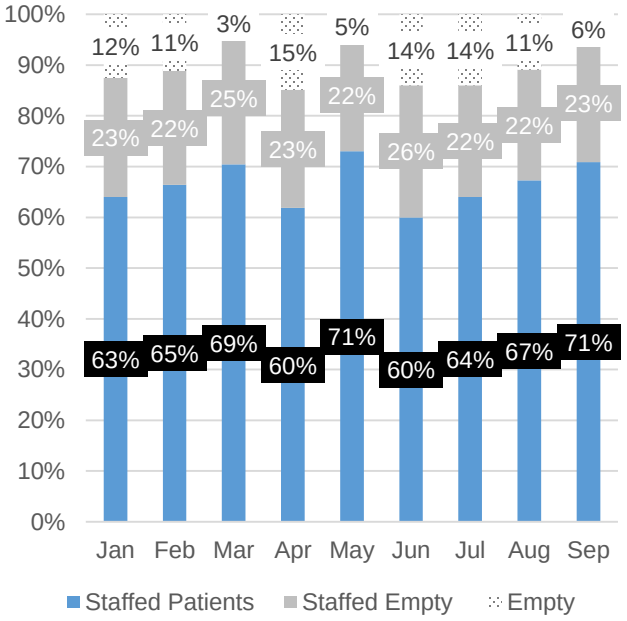
# Key Standard | Sulis Hospital - SEPT

SULIS HOSPITAL BATH

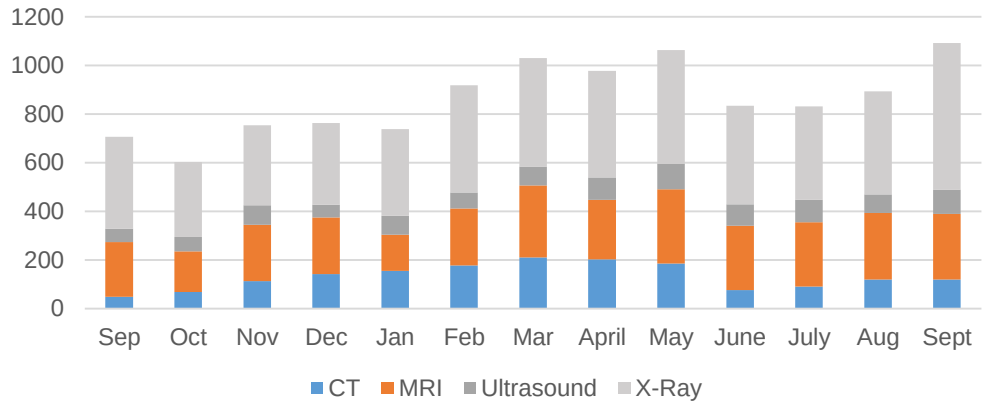
## Session Uptake



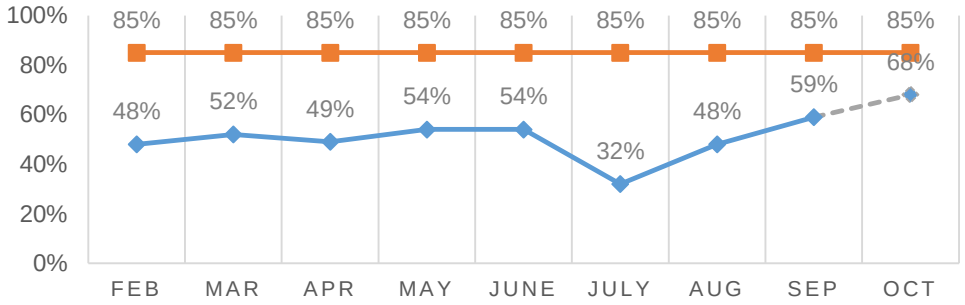

## True Utilisation by Time
Mon – Saturday 11hr




## Diagnostic Appointment Volumes (MRI,CT,XRAY,US)




## ENDOSCOPY SESSION UPTAKE




Data based on four theatres 6 days per week. Utilisation refers to a session which has consultant allocated and one or more patients booked. Includes evening sessions Mon-Friday.

**Initial business case objectives**

. (CLOSED = left empty CANCELLED = Plan Consultant changed planned SESSION = Half Day)

- 79 theatre sessions cancelled from schedule.
- 22of79 session closed The business managed to retain 72% of cancelled sessions.
  - Closed causes: ( 2 Annual Leave, 5 No Pts, 2 Consultant Sick, 2 Kit Issues, 2 Staffing, 8 HRH Funeral, 1 Vacant)
- Theatre session uptake improved due to consultant availability. Oct – Tracking at 77%
- Endoscopy session uptake improved due to improved scheduling model and increased Urology sessions now established. Oct tracking high due to enrolling new endoscopist. Currently 59% tracking to 66%.
- Radiology CT volumes recovering from June & July – More activity displaced away from RUH mobile CT. X-Ray volumes increased as we continue to support wider providers (Paulton).

| Counter measure/Action (Completed this month) | Owner |
|---|---|
| NHS RTT and ERS slot management improving viability and attractiveness on ERS system. | |
| **Counter measure/Action (Planned this month)** | **Owner** |
| Increase Urology IPT volumes from RUH to utilise additional Endoscopy sessions. | |
| Review opportunities to increase theatre capacity to accommodate displaced activity (July/July) – Options include Sunday initiatives. – Staffing is our concern | |
| Review theatre schedule utilization and option for three consultant in single day. | |

NHS
Royal United Hospitals Bath
NHS Foundation Trust

# Quality Report

Month 6

The RUH, where you matter

# Quality | Executive Summary

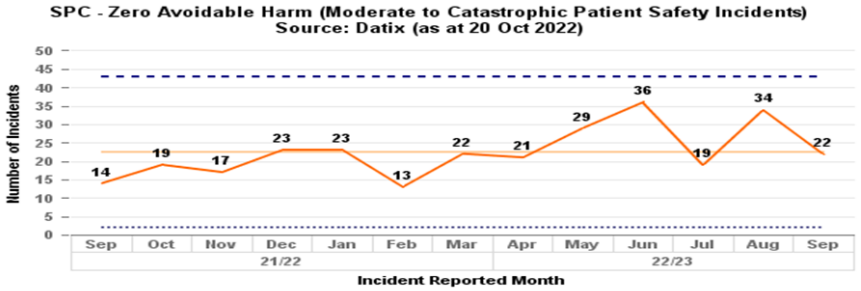
| Strategic Goal | | Performance Indicator | Description | Target | | 2021/22 | | | | | | | 2022/23 | | | | | | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Performing | Under Performing | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | |
| Trust Goals | People We Care For | Zero Avoidable Harm | Reported Patient Safety incidents resulting in significant harm (moderate to catastrophic), excl. rejected | | | 14 | 19 | 17 | 23 | 23 | 13 | 22 | 22 | 29 | 36 | 19 | 34 | 22 | |
| Breakthrough Objectives | People We Care For | Healthcare Associated Infections | MRSA, MSSA, E coli, C diff (Healthcare Onset and Community Onset), Klebsiella spp, Pseudomonas aeruginosa, COVID, Norovrus & Flu | <=11 | >11 | 16 | 24 | 18 | 36 | 37 | 44 | 68 | 51 | 26 | 47 | 125 | 37 | 56 | |
| 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 | 44 | 42 | 43 | 43 | 47 | 44 | 49 | 51 | 41 | 44 | 45 | 48 | 55 | |
| | | Serious Incidents with Overdue Actions | All non-rejected serious incidents reported on Datix with incomplete actions at month end. | <5 | >=5 | 6 | 4 | 1 | 3 | 5 | 3 | 2 | 2 | 3 | 2 | 1 | 2 | 1 | |
| | | Number of falls resulting in significant harm (Moderate to Catastrophic) | | <=1 | >=3 | 1 | 3 | 6 | 6 | 2 | 4 | 2 | 5 | 3 | 7 | 1 | 2 | 1 | |
| | | ED time to triage | Percentage of ED attendances triaged within 15 minutes | | | 57.0% | 54.2% | 53.1% | 57.7% | 65.7% | 57.0% | 47.7% | 48.1% | 51.8% | 50.2% | 48.2% | 54.7% | 53.5% | |
| | | Falls per 1000 bed days | Includes all falls | | | 5.9 | 7.0 | 8.6 | 7.9 | 7.2 | 6.0 | 6.9 | 7.0 | 6.9 | 6.5 | 6.5 | 6.1 | 6.0 | |
| | | Medication Incidents per 1000 bed days | All Incidents | | | 5.7 | 6.5 | 6.3 | 6.2 | 6.5 | 7.9 | 5.7 | 5.9 | 6.0 | 5.2 | 5.7 | 6.6 | 7.5 | |
| | | Number of Patients given medication by scanning device | | | | 18.6% | 18.0% | 19.4% | 17.0% | 13.2% | 14.5% | 13.3% | 11.6% | 14.8% | 14.5% | 14.3% | 14.8% | 16.4% | |
| | | Early Identification of Deteriorating Patient | | | | 21.3% | 18.9% | 21.5% | 19.6% | 17.7% | 20.3% | 20.3% | 19.9% | 18.0% | 17.7% | 19.4% | 20.8% | 21.0% | |
| | | Number of COVID nosocomial infections | | | | 7 | 10 | 3 | 21 | 18 | 23 | 43 | 31 | 8 | 34 | 110 | 16 | 33 | |
| | | Number of Hospital Acquired Pressure Ulcers Category 2 | Includes Medical Device Related | <=2 | >2 | 2 | 1 | 1 | 5 | 2 | 4 | 3 | 0 | 5 | 5 | 7 | 1 | 2 | |
| | | Number of Hospital Acquired Pressure Ulcers Category 3 & 4 | Includes Medical Device Related | 0 | >0 | 0 | 0 | 2 | 3 | 1 | 0 | 0 | 0 | 1 | 3 | 0 | 3 | 0 | |

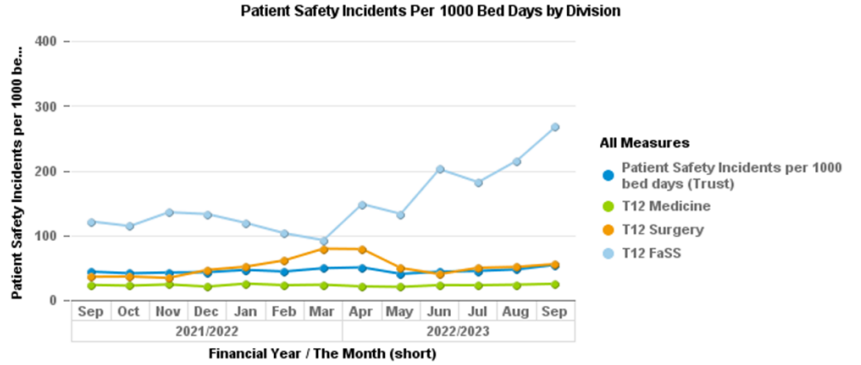
Measures requiring focus and a countermeasure summary this month are;

| Measure | Executive Summary |
|---|---|
| Healthcare Associated Infections | There were 56 Healthcare Associated Infections in September 2022.<br>o There were 7 cases of Clostridioides Difficile reported during September against a monthly trajectory of 3.<br>o There were 13 hospital associated E coli infections reported during September, above the monthly trajectory of 6.3<br>o There were 33 COVID nosocomial infections for September. |

# Quality | Avoidable Harm

**Historic Performance**



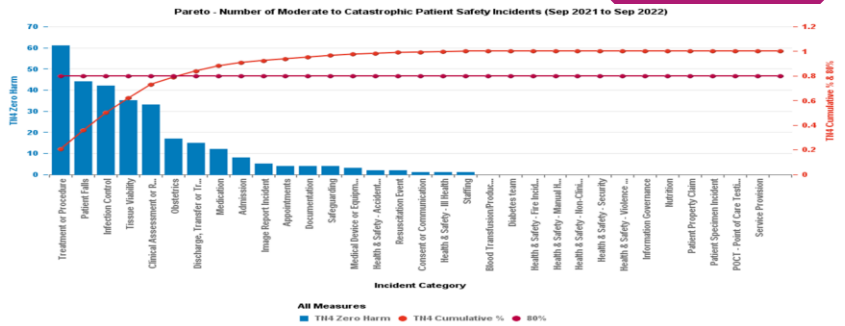



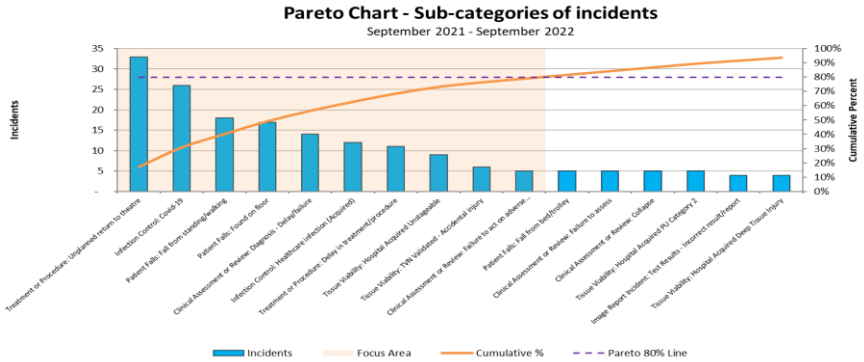

**Is the standard being delivered?**
In September 2022 there were 22 reported moderate to catastrophic incidents compared to a target of no more than 30 incidents.

**What is the top contributor for under/over-achievement?**
The top contributors for incidents reported for September 2022 were: Clinical Assessment or Review (n=4), Treatment or procedure (n=3), and Infection Control (n=3).

For Clinical Assessment or Review, the incidents reported were diagnosis – delay / failure (n=2) and collapse (n=2). For Treatment or Procedure, there were 3 unplanned returns to theatre.

The most frequently types of reported incidents between September 2021 and September 2022 are unplanned returns to theatre (n=33), COVID-19 (n=26), falls – from standing / walking (n=18) and falls – found on floor (17).

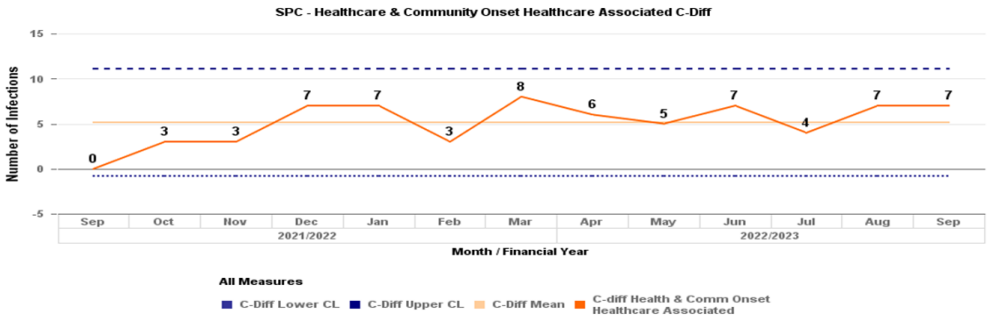


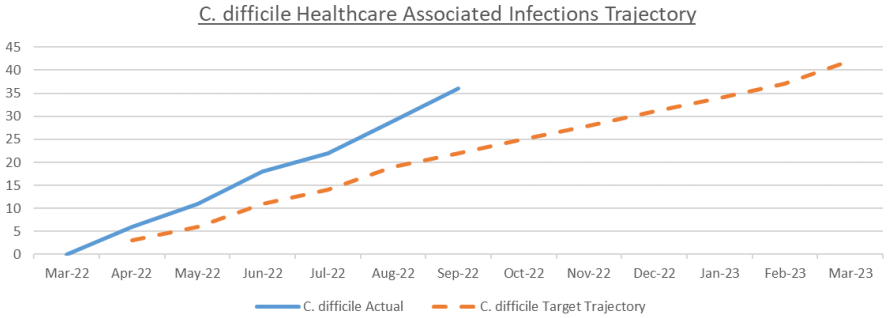




| Countermeasure /Action (planned this month) | Owner |
|---|---|
| Process for review RTT in general surgery confirmed and shared with addition of identification of deterioration and time to RTT | General surgery Governance lead |
| PSIRF Task and Finish group performing gap analysis and investigating national training packages | Trust Patient Safety Lead |
| Review of all incidents up to August 2022 to be shared with Divisions in October | Risk Lead |
| Patient Safety Priorities on project wall awaiting project support. | Transformation Lead |
| Launch Patient Safety Programme (PSP) with 5 priorities w/c 31 November with film and tea trolley training and cafes | Priority Leads |
| Outcome and process measures to be developed for each PSP for review at (Patient Safety Steering Group) SSG. To be aligned to Divisional performance measures | Trust PS Lead / Improving Together Lead /Divisional triumvirates |

# Breakthrough Objective | Clostridioides Difficile

**Performance**




**Is standard being delivered?**
There were 7 cases of *Clostridioides difficile* (CDI) reported during September, 5 were healthcare onset infections and 2 were community onset healthcare associated. YTD 36 cases against the trajectory of 42.

**What is the top contributor for associated risk factors?**
Pulteney ward was placed under a period of increased incidence (PII) in September as there were 2 cases of hospital onset healthcare associated CDI reported. No lapses in care were identified at the post infection review meeting.

**Learning:** Ribotyping confirmed there was no cross infection between the two cases, with R087 and R014 being detected, the PII will be closed if there are no further cases within 28 days.

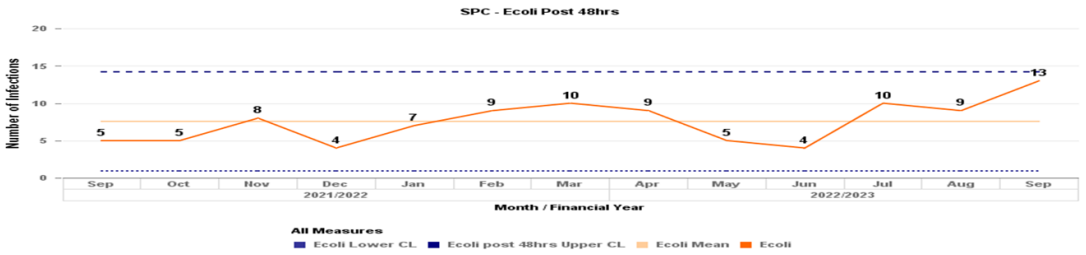
**CDI Benchmarking**

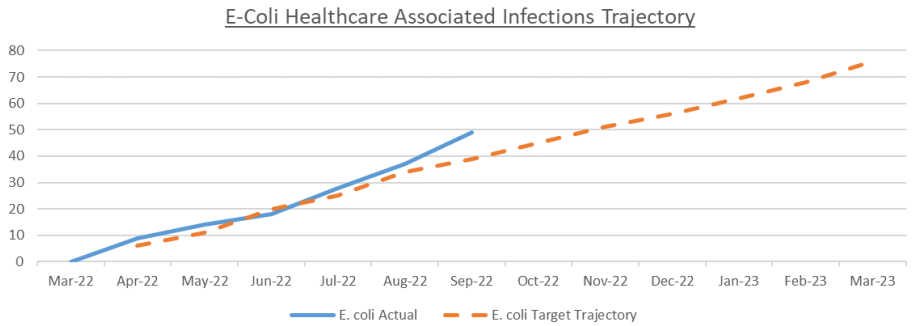
| Trust | Rate (Aug 22) | Rate YTD |
|---|---|---|
| **SW rate** | **34.9** | **30.5** |
| **RUH** | **39.12** | **32.9** |
| GWH | 17.3 | 17.61 |
| SFT | 28.17 | 21.36 |
| Gloucester | 38.8 | 37.94 |

| **Countermeasure/Action (completed last month)** | **Owner** |
|---|---|
| Cleaning Standards Group established, to be chaired by the Deputy Director of Estates and Facilities to gain enhanced oversight of cleaning standards. First meeting held on the 19 October. | Estates & Facilities |
| **Countermeasure/Action (planned this month)** | **Owner** |
| A thematic review will be undertaken of all of cases reported to date to look for any additional themes and trends. | IPC |

# Breakthrough Objective | E Coli

**Performance**




**Is standard being delivered?**
There were 13 healthcare associated E coli infections reported during September 2022, which is above the monthly trajectory of 6.3 cases per month, with the annual trajectory being no more than 76 infections during 22/23.

**What is the top contributor for associated risk factors?**
The cases were associated to hepatobiliary (n=4), lower urinary tract infection (n=4), lower urinary infection with a catheter (n=1), gastrointestinal (n=1) and no root cause identified (n=3).

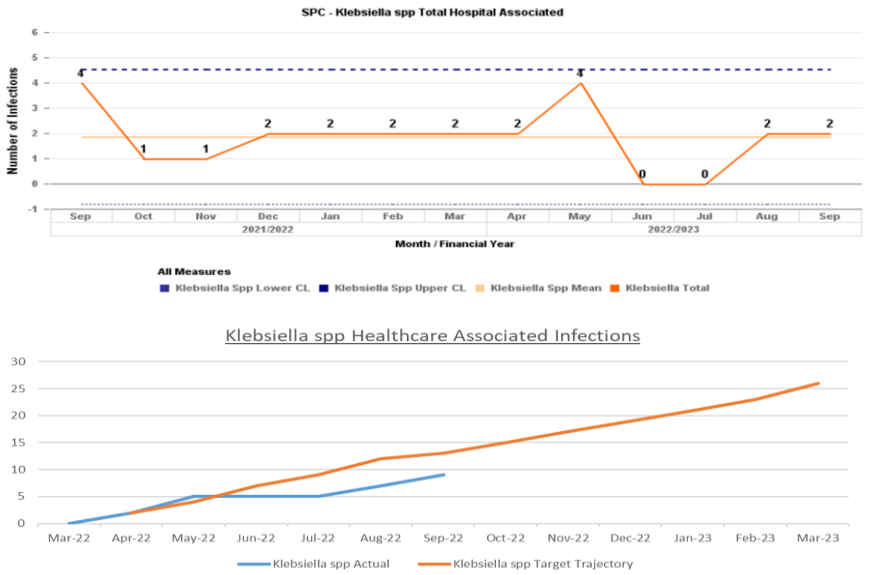
**Benchmarking data:**

| Trust | Rate (Aug 22) | Rate YTD |
|---|---|---|
| **SW rate** | **32.26** | **33.32** |
| **RUH** | **50.3** | **43** |
| GWH | 74.97 | 53.78 |
| SFT | 14.08 | 15.63 |
| Gloucester | 23.28 | 27.6 |

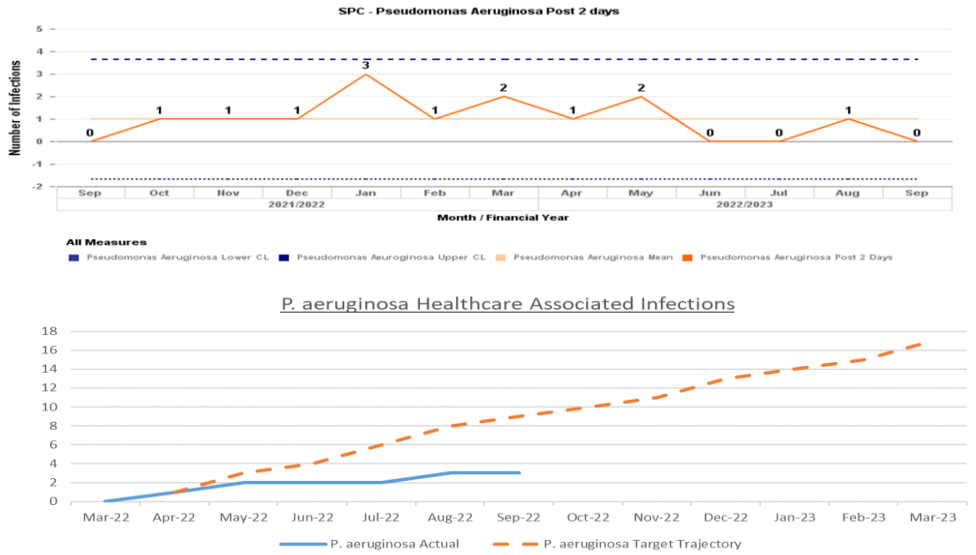
| **Countermeasure/Action (completed last month)** | **Owner** |
|---|---|
| Improve urinary catheter care, continence care and hydration | Continence team / Matrons |
| **Countermeasure/Action (planned this month)** | **Owner** |
| Promotion of hydration and catheter care during Infection Control Week | IPC |
| Review the policy for the insertion and management of lines, taking into account the Practice versus Guidelines assessment of cannulation and Peripheral Vascular Cannula (PVC) care/maintenance findings | Training Department / Matrons |

# Breakthrough Objective | Klebsiella and Pseudomonas

**Performance (Klebsiella)**




**Performance (Pseudomonas)**




**Is standard being delivered?**
There were 2 hospital associated Klebsiella infections reported during September 2022 against the annual trajectory of no more than 26 infections during 22/23.

The cases were associated to: lower urinary tract infection with no catheter (n=1), lower urinary tract infection with a urinary catheter (n=1).

There was 0 *Pseudomonas Aeruginosa* reported during September against the trajectory of 17 for 22/23.

**Benchmarking**

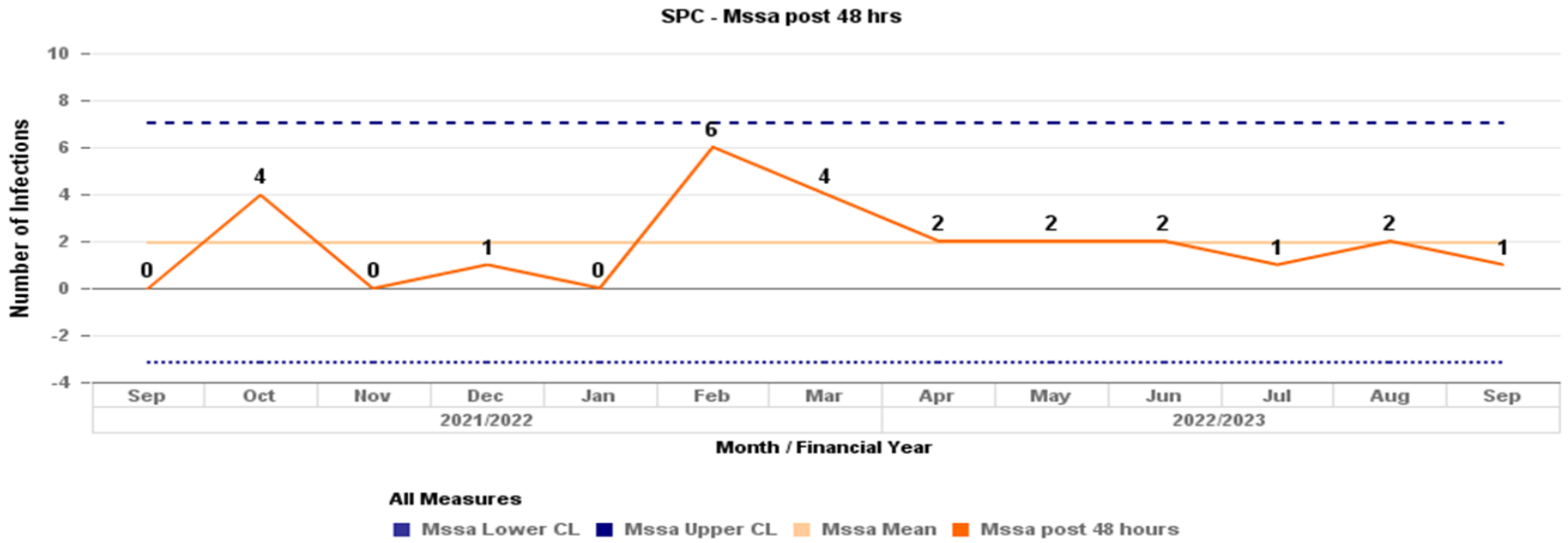
| Trust | Klebsiella Rate (Aug 22) | Rate YTD |
|---|---|---|
| **SW rate** | **14.82** | **16.92** |
| **RUH** | **11.18** | **7.9** |
| GWH | 11.53 | 11.69 |
| SFT | 0 | 5.73 |
| Gloucester | 11.64 | 7.01 |

| **Countermeasure/Action (completed last month)** | **Owner** |
|---|---|
| Promotion of urinary catheter, continence care and hydration | Continence team / Matrons |
| **Countermeasure/Action (planned this month)** | **Owner** |
| Review the policy for the insertion and management of lines, taking into account the Practice versus Guidelines assessment of cannulation and PVC care/maintenance findings | Training Department / Matrons |

| Trust | Pseudomonas Rate (Aug 22) | Rate YTD |
|---|---|---|
| **SW rate** | **14.82** | **10.92** |
| **RUH** | **11.18** | **7.9** |
| GWH | 11.53 | 11.69 |
| SFT | 0 | 5.73 |
| Gloucester | 11.64 | 7.01 |

# Breakthrough Objective | MSSA

**Performance**




**Is standard being delivered?**
There was 1 hospital onset Methicillin-Susceptible Staphylococcus Aureus (MSSA) blood stream infection during September 2022.

**What is the top contributor for associated risk factors?**
The case was associated with septic arthritis.

**Benchmarking**

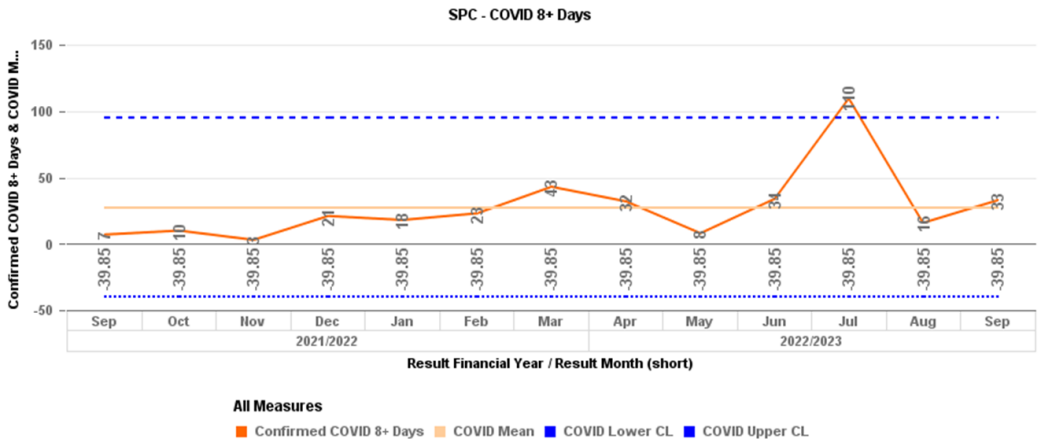
| Trust | Rate (Aug 22) | Rate YTD |
|---|---|---|
| **SW rate** | **18.44** | **17.21** |
| **RUH** | **11.18** | **11.36** |
| GWH | 34.6 | 30.49 |
| SFT | 21.13 | 11.36 |
| Gloucester | 38.8 | 21.98 |

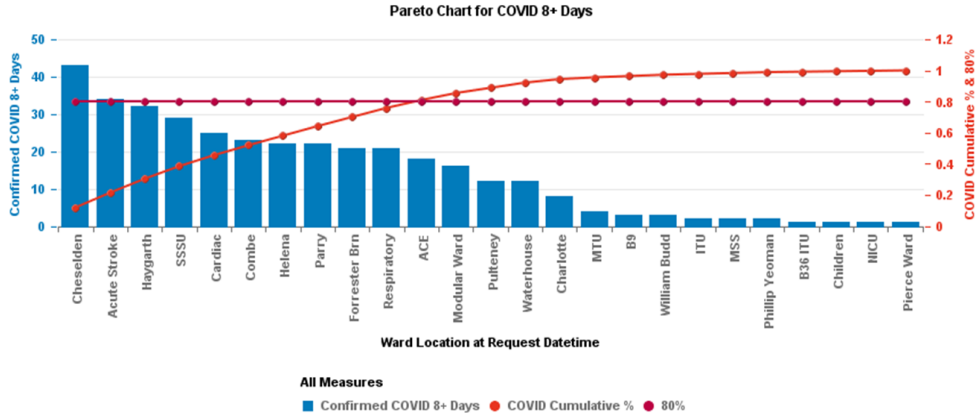
| Countermeasure/Action (completed last month) | Owner |
|---|---|
| Take the Practice versus Guidelines assessment of cannulation and PVC care/maintenance findings through the October Infection Control Committee (ICC) for wider learning | IPC |

| Countermeasure/Action (planned this month) | Owner |
|---|---|
| Promotion of line care and skin prep during IPC week and patient safety week | IPC |
| Review the policy for the insertion and management of lines, taking into account the Practice versus Guidelines assessment of cannulation and PVC care/maintenance | Training Department / Matrons |

# Breakthrough Objective | Confirmed COVID-19

**Performance**



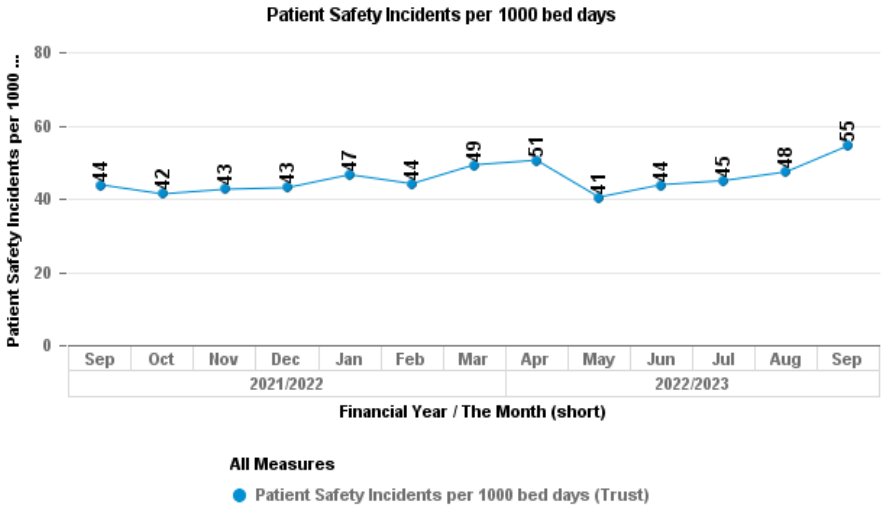

**Is standard being delivered?**
There were 33 confirmed COVID-19 8+ days infections in September 2022. This was reflective of the increasing community rate and a small number of symptomatic cases being detected on wards as inpatients.

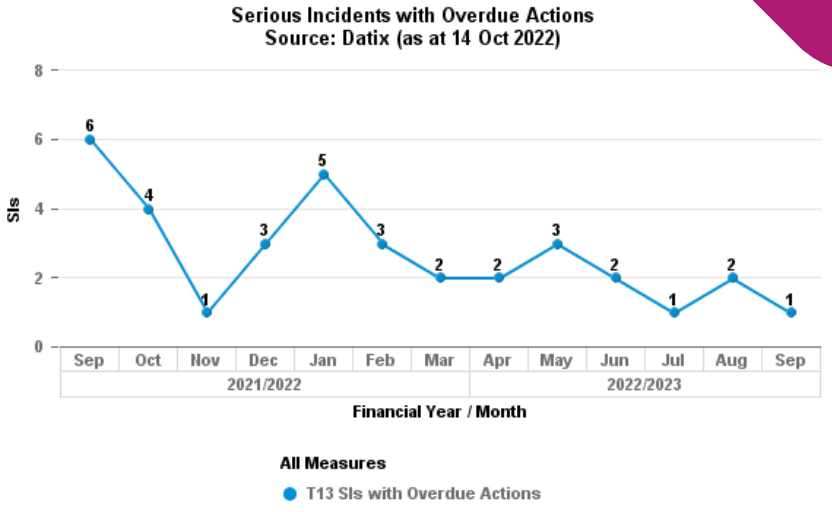
There were 2 deaths in patients who had nosocomial COVID-19 infection and 1 patient with indeterminate nosocomial infection during September 2022 however COVID-19 was not recorded as a cause of death on the death certificate.

Whilst the BANES COVID-19 rate reduced to 37.77 at the end of August 2022, by the end of September the South West rate had increased to 118.88 and the BANES rate had increased to 74.50.

| **Countermeasure/Action (completed last month)** | **Owner** |
|---|---|
| Mask wearing has been reinstated due to increasing rates. | IPC |
| **Countermeasure/Action (planned this month)** | **Owner** |
| 2 cohort areas created to manage increasing COVID-19 demands. | Site Management Team |
| Contact bays being maintained with exposure testing on days 3 and 5. | IPC |

# Quality | Tracker Measures

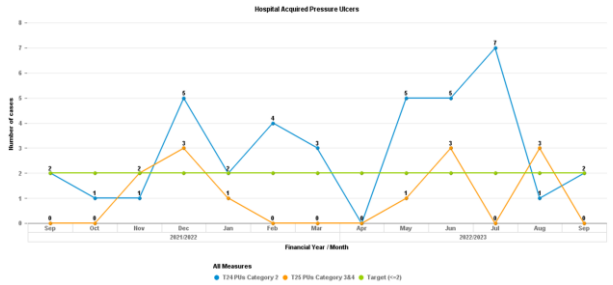


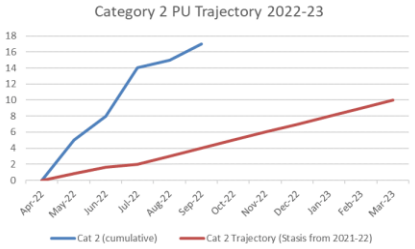



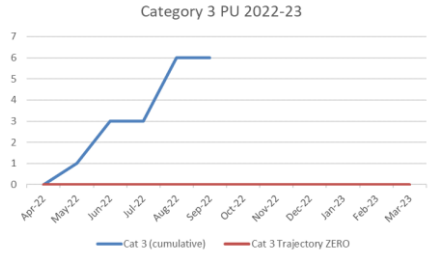

| Measure | Top contributor for red/green performance this month | Action |
|---|---|---|
| Incident Reporting | The top reported categories of incidents are: admission (including long trolley waits), patient falls, medication incidents and discharge, transfer or transport.<br><br>The top reporter of incidents are General Surgery followed by Maternity and Acute Medicine. | There has been an increase in incident reporting for September with 55 incidents reported per 1,000 bed days compared to 48 in August and 45 in July.<br><br>Incident reporting will be promoted through the e-learning training for staff, linked to the launch of the new Patient Safety Incident Response Framework (PSIRF). A working group has been established to agree and roll out new processes to meet the requirements of the PSIRF, published in August 2022. |
| Serious Incidents | There were 1 Serious Incidents with overdue actions in September 2022. | A report is produced monthly for each Division summarising any overdue actions and these are followed up with the leads for each action. A review is being undertaken into the process of incident review, actions, feedback and learning from incidents. The new processes will be aligned to the Patient Safety Incident Response Framework (PSIRF), published in August 2022. This will include a separate action plan meeting for each Serious Incident following a review of findings from the initial investigation. This will allow better consultation with key stakeholders to ensure that appropriate improvement actions are agreed. |

# Quality | Pressure Ulcers

**Historic Performance**

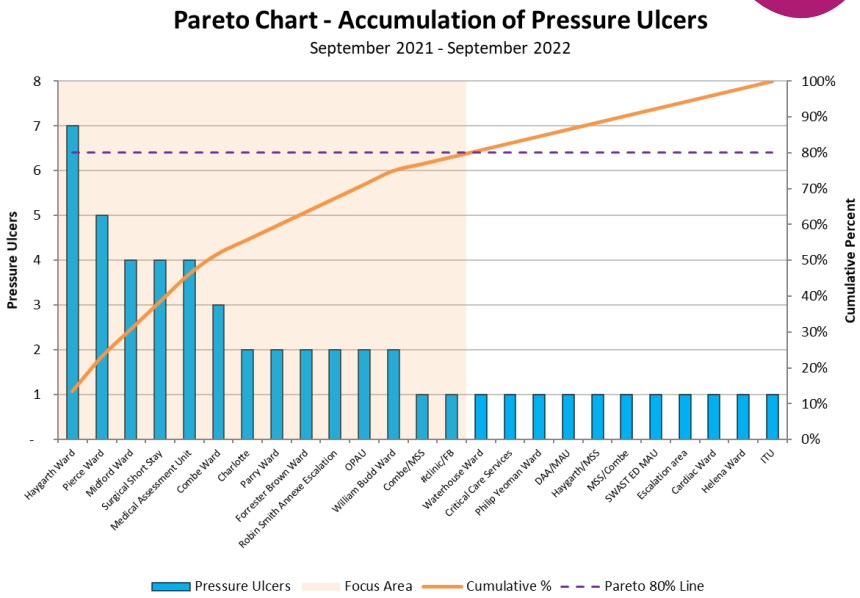



**Is standard being delivered?**
The ambition for 2022-23 is to have no more than 10 category 2 pressure ulcers, no more than 4 device related pressure ulcers and no category 3 or 4 pressure ulcers.
There were 2 category 2 pressure ulcers in September. The Trust is above trajectory for category 2 and 3 pressure ulcers.
Benchmarking a similar size and demographic hospital indicates the RUH remains a flag ship for prevention despite an increase in pressure ulcer.

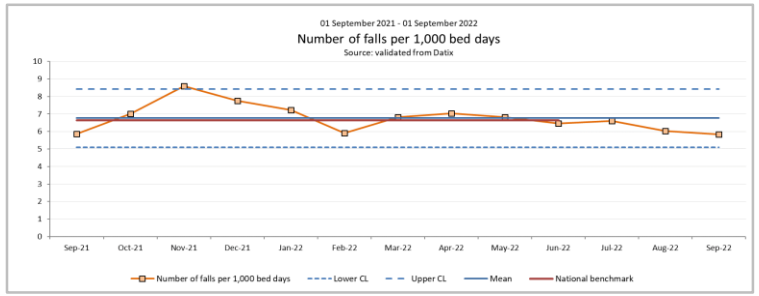
**What is the top contributor for under/over-achievement 2022-23**
The Pareto chart demonstrates the top 5 contributors for total number of pressure ulcers are: Haygarth, Pierce, Midford, Surgical Short Stay Unit and Medical Assessment Unit.

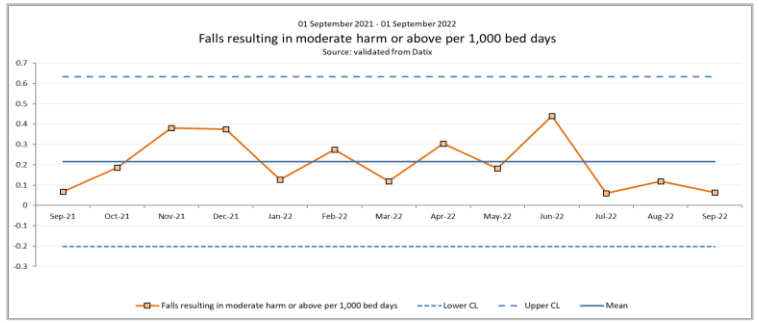



| Countermeasure/Action | Owner |
|---|---|
| Introduce the red flag system to Combe ward; a system to clearly identify those at extreme risk who require regular nursing interventions in the face of reduced staffing levels. Also in use now on Midford, Haygarth and plans for Pierce ward. | TVN Team |
| Tissue Viability Steering Group: Monitor learning and actions from acquired pressure ulcer investigations. Thematic appraisal of all pressure ulcers to date has identified the top 3 (64%) contributors to pressure ulcer development. Improvements are focussed on the use of Repose Foot Protection, managing patient non-concordance and patient nutrition. | TV Steering group |
| "Wound Warriors" launched – a series of training sessions across the wards on the principles of wound healing. | TVNs and TV Ambassadors |

# Quality | Falls

## Historic Performance




**Is standard being delivered?**
There was 1 moderate harm fall in September , against a target of 3 per month: MSS (n=1). Falls per 1000 bed days remain within the expected confidence intervals with a slight decrease in falls for September.

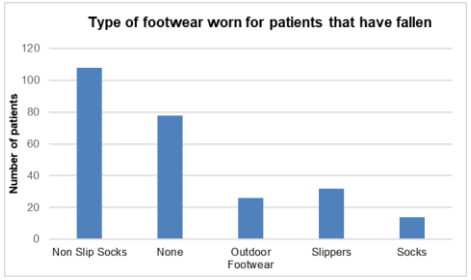
**What is the top contributor for under/over-achievement?**
Since July, data is recorded on Datix on the location of the fall in the ward, type of footwear and enhanced observation level. Three months review of this data highlights the following:

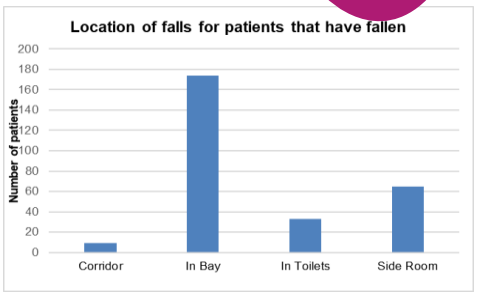
- 62% of falls occur in bays
- 42% of patients wore slipper socks and 30% no footwear

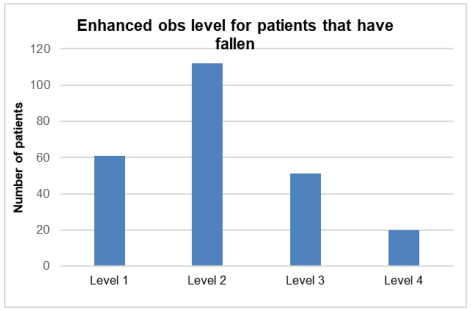
Working with 1 ward - Midford to test use of this data in identifying trends and improvements.

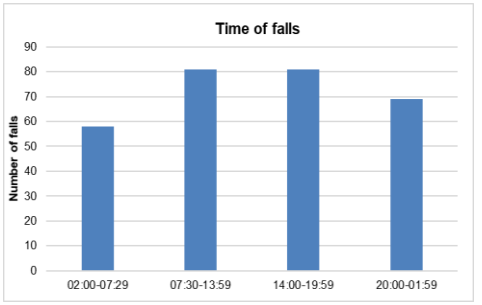
Planned quarterly report for PSSG November.

## Further data on falls recorded on Datix



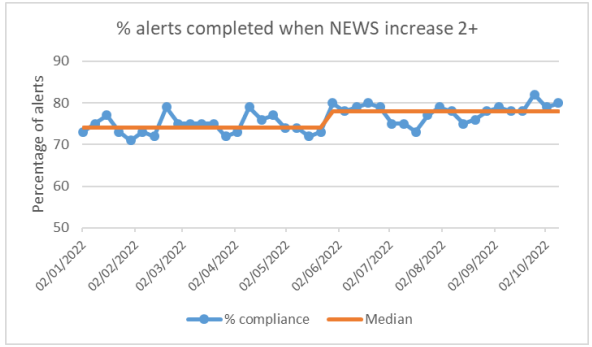

| Countermeasure / Action (completed last month) | Owner |
|---|---|
| Analysis of datix fields for the areas included in the weekly safety huddles – commenced with Midford ward. | QI Team |
| Launch of Enhanced Observation training video. | QI Team |
| Falls Awareness Event 20 September including interactive training. | QI Falls lead |
| Launch of “safe use of bed rail “guidance. | QI Falls lead |
| Working group being established to develop guidance for appropriate footwear to prevent falls in hospital. | QI Falls lead |

| Countermeasure / Action (planned this month) October | Owner |
|---|---|
| Continue work with Midford – use of data in identifying trends and improvements. | QI Team |
| Develop tracker measure for falls and 1 to 1 support. | QI Team |
| Audit effectiveness of bed rail guidance. | QI Falls lead |
| Quarterly Falls Champion update – first session 20 October. | QI Falls lead |

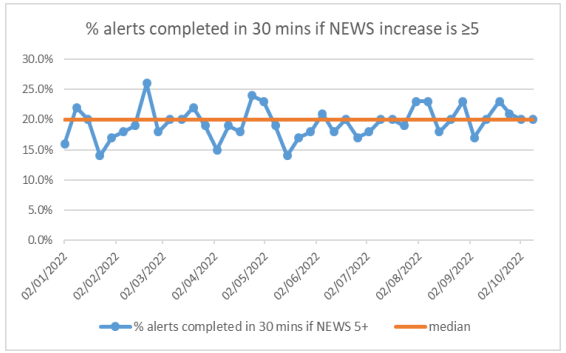
# Quality | Deteriorating Patient

## Historic Performance

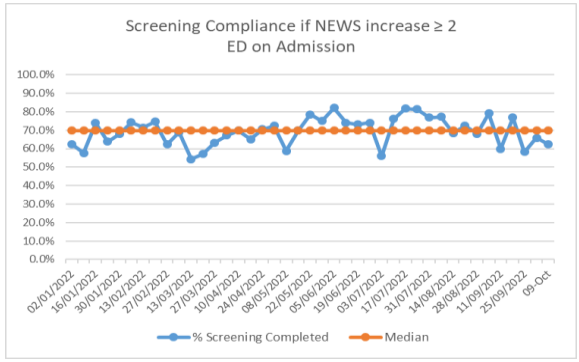
**Screening completed if NEWS increases by 2 or more trust wide 2022 (Figure 1)**




**% alert complete in 30 mins if NEWS increases > 5 trust wide (Figure 2)**




**Sepsis screening on admission in emergency department (Figure 3)**



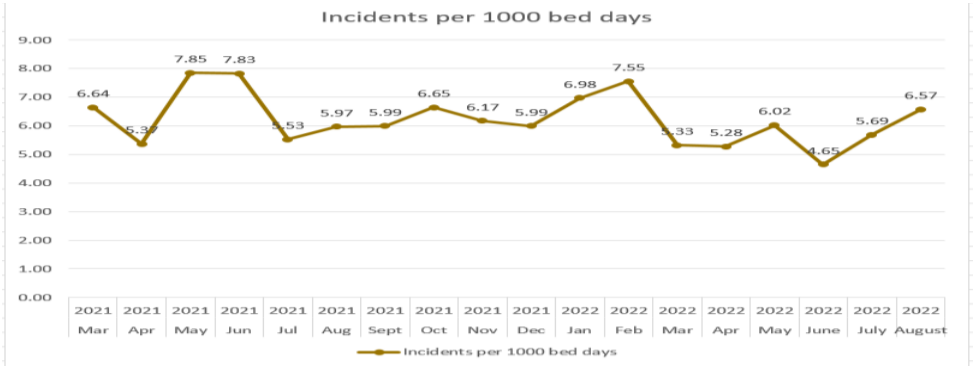

**Is standard being delivered?**
Trust-wide screening from E-obs for early deterioration based on NEWS increase ≥ 2 for 2022 is 78% (Figure 1). Compliance is slowly increasing.
Compliance with response within 30 minutes of NEWS increase ≥ 5 is 20% (Figure 2) against a target of ≥ 80%.
ED Sepsis screening from electronic recording has decreased to median of 70% (Figure 3) against a target of ≥ 90%, with a decreasing trend.

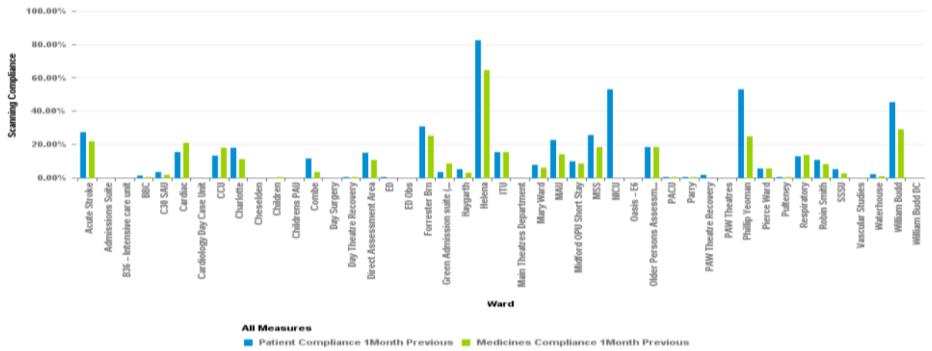
**What is the top contributor for over-achievement?**
Median compliance for ASU, Cheselden, Helena, Midford, Combe, Parry and Pulteney is ≥ 90%.
Haygarth and Cardiac have achieved >90% compliance for the last 6 weeks.
Forrester Brown and Charlotte have increased compliance to >85%. For last 6 weeks.
Wards with higher screening compliance have compliance within 30 minutes if NEWS 5 or more of 30-70%.

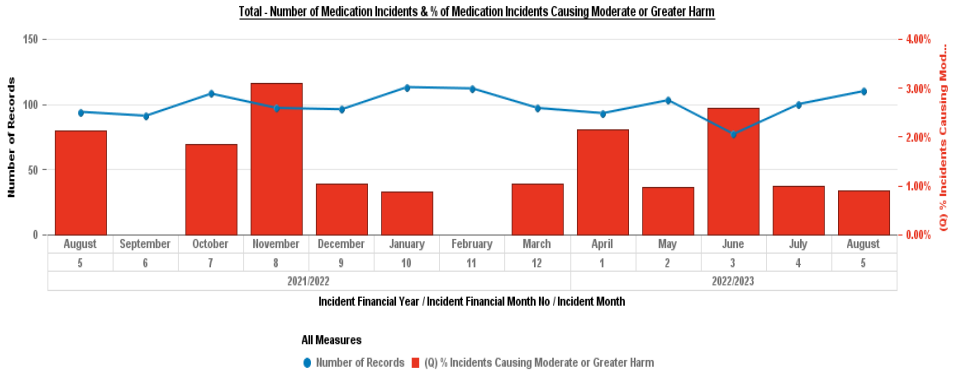
**Top contributors to Under achievement**
Pierce and SSSU have decreased compliance of 58% and 55% respectively.

| **Countermeasure / Action (completed last month)** | **Owner** |
|---|---|
| Focused training on highlighted wards. | SKIP team |
| Review Night Sister role and JD. | Hospital @ Night group |
| Whiteboard default use by wards. | Digital Nurses |
| **Countermeasure / Action (planned this month)** | **Owner** |
| 'Be Curious' tea trolley training with launch of PS Priority campaign. | Consultant Anesthetist/SKIP |
| ED nurse trainers for sepsis / Acute Kidney Injury deteriorating patient. | ED Education Nurse / SKIP |
| New E observation deteriorating patient form to go live. | IT/ Digital Nurse Lead |
| Funding awaited for hand-held devices to start testing in ED. | CNIO / CMO |
| Restart ward awards system / link to ward accreditation scheme. | Consultant Anesthetist/SKIP |
| Review availability Cerner options for ward dashboard/escalation. | CNIO |
| Review CQUIN metrics on unexpected ICU admissions and metrics for response to deterioration | Consultant Anaesthetist/ Critical Care Lead |

# Quality | Medicines Safety




| Subject | Refresher Period (Years) | Current Target | Compliance at Census | | | | | | Change Since Last Month | No. of Staff Requiring Training | No. of Staff Trained | No. of Staff Not Trained | Due in Next 3 Months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2021/2022 | | | 2022/2023 | | | | | | | |
| | | | Q2 | Q3 | Q4 | May | Q1 | July | | | | | |
| | | | 30/09/2021 | 31/12/2021 | 31/03/2022 | 31/05/2022 | 30/06/2022 | 31/07/2022 | | | | | |
| AKI Level 2 | 3 | 90.0% | 77.7% | 79.6% | 80.2% | 80.7% | 81.4% | 81.2% | ▼ | 4191 | 3401 | 790 | 109 |
| Antibiotic Review Kit (ARK) | once only | 90.0% | 56.6% | 60.7% | 61.6% | 63.4% | 63.3% | 65.0% | ▲ | 857 | 557 | 300 | 0 |
| Antimicrobial Stewardship Level 1 * | once only | 90.0% | 85.9% | 87.2% | 87.4% | 87.9% | 87.9% | 88.1% | ▲ | 2998 | 2641 | 357 | 1 |
| Antimicrobial Stewardship Level 2 | 3 | 90.0% | 59.4% | 63.2% | 63.2% | 64.3% | 64.0% | 64.6% | ▲ | 872 | 563 | 309 | 17 |
| End Of Life Care (Adult) | once only | 90.0% | 84.2% | 83.8% | 84.0% | 84.3% | 83.5% | 84.1% | ▲ | 1822 | 1531 | 291 | 0 |
| Insulin Safety | 2 | 90.0% | 75.2% | 74.4% | 71.5% | 71.0% | 71.3% | 70.9% | ▼ | 1841 | 1305 | 536 | 70 |
| Medical Gas Safety | 2 | 90.0% | 79.3% | 78.2% | 77.6% | 77.4% | 77.3% | 77.3% | ● | 3121 | 2410 | 711 | 107 |
| Sepsis Level 2 | 3 | 90.0% | 84.8% | 85.2% | 84.4% | 84.6% | 84.8% | 83.1% | ▼ | 4294 | 3566 | 728 | 304 |
| VTE | once only | 90.0% | 85.1% | 85.8% | 85.3% | 85.3% | 85.1% | 85.4% | ▲ | 2895 | 2472 | 423 | 0 |

**Is 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.

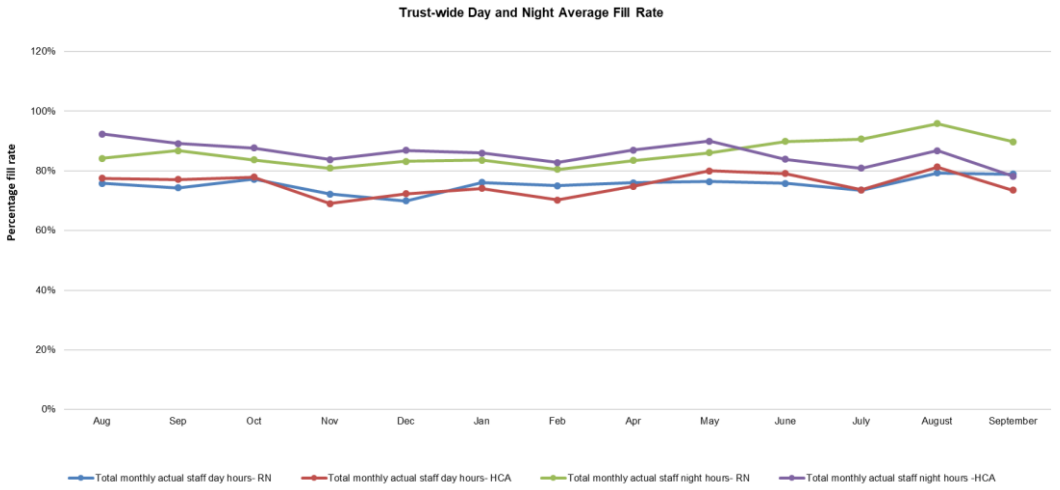
**What is the top contributor for under/over-achievement?**

- Medication incidents: for information only-reported incidents within normal variation.
- Barcode Scanning: Medicines compliance 10.79%. Helena top contributor (45.74%).
- Medicines training: for information: Declining training compliance across all divisions with key metrics- Antimicrobial Stewardship, ARK level 2, Medical Gas safety, VTE.

| Countermeasure /Action (completed last month) | Owner |
|---|---|
| Approach to Ward Accreditation (Gold / Silver) threshold agreed – to include barcode scanning and incident reporting | Chief Pharmacist / Senior Nurse QI / Head of Quality Assurance |
| Escalation of medical gas training deficit and incident profile to Divisional Governance Leads. | Chief Pharmacist |
| **Countermeasure /Action (planned this month)** | **Owner** |
| Begin medical gas improvement plan with Medical Gas Committee/Divisional Clinical Governance Leads. | Chief Pharmacist/MGC Lead/CG Leads |
| Medicines Safety Brief to be shared with Divisional Governance leads on a monthly basis to highlight areas of good practice/for improvement. | Chief Pharmacist |

# Quality | Safer Staffing

**Historic Performance**




**At a glance for September 2022: Wards with fill rate <=75% (shaded Red) for RN and/or HCA (by Day and Night shifts)**

| | Day | | Night | |
|---|---|---|---|---|
| **Ward / Dept** | **RN** | **HCA** | **RN** | **HCA** |
| Acute Stroke Unit | 85% | 61% | 94% | 59% |
| Cardiac Ward | 83% | 91% | 117% | 80% |
| Charlotte Ward | 59% | 75% | 67% | 100% |
| Cheselden Ward | 71% | 47% | 100% | 93% |
| Children's Ward | 87% | 46% | 87% | 60% |
| Combe Ward | 111% | 87% | 129% | 84% |
| Coronary Care Unit | 94% | | 103% | |
| Emergency Department | 90% | 82% | 91% | 62% |
| Forrester Brown Ward | 71% | 63% | 85% | 82% |
| Haygarth Ward | 70% | 82% | 96% | 84% |
| Helena Ward | 70% | 104% | 66% | 133% |
| ITU | 60% | 63% | 82% | 56% |
| MAU | 67% | 76% | 90% | 75% |
| Medical Short Stay | 101% | 81% | 100% | 87% |
| Midford OPUSS | 80% | 80% | 104% | 74% |
| NICU | 59% | 67% | 71% | 24% |
| OPAU | 94% | 85% | 93% | 85% |
| Parry Ward | 102% | 90% | 118% | 91% |
| PAW Mary / BBC | 88% | 63% | 89% | 60% |
| Philip Yeoman Ward | 91% | 80% | 97% | 56% |
| Pierce Ward | 67% | 59% | 101% | 85% |
| Pulteney Ward | 55% | 88% | 72% | 79% |
| Respiratory Ward | 53% | 52% | 59% | 85% |
| Robin Smith Ward | 81% | 69% | 77% | 68% |
| SAU | 72% | 78% | 81% | 90% |
| Surgical Short Stay | 80% | 87% | 85% | 111% |
| Waterhouse Ward | 94% | 60% | 102% | 75% |
| William Budd Ward | 75% | 70% | 59% | 76% |

**Is standard being delivered?**

Compared to the 90% target, in September 2022:

- The percentage fill rate for registered nurses was 79% for day hours and 90% for night hours
- The percentage fill rate for HCAs was 74% for day hours and 78% for night hours

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

Wards with low percentage fill rate highlighted in the at a glance section above. Key drivers for this position are:

- Vacancy rate and fill rate
- Sickness due to COVID-19 (Isolation & positive cases)
- Variation in e-roster compliance/e-roster knowledge
- Robin Smith are working to dependency and occupancy so as a planned sole elective ward this will impact on their daily planned numbers against establishment

| **Countermeasure /Action (completed last month)** | **Owner** |
|---|---|
| Light touch establishment reviews completed and work continues to recruit into the new establishments. | ADON for Workforce |
| Finalise the recruitment dashboard detailing International and Domestic recruitment. | Workforce team |
| Scoping of an electronic agency authorisation process is complete | ADON for workforce |

| **Countermeasure /Action (planned this month)** | **Owner** |
|---|---|
| Work with Psych Liaison team to revamp the RMN job description, risk Matrix and escalation process. Scoping of a dedicated staff training program commenced. | DDoN – Medicine & ADON for workforce |
| Scope centralised recruitment, liaising with other Trust where this is in operation, determine the resource needed and the program of activities required. Plan to roll out a centralised approach for HCSW this month. | AD of HR & ADON for workforce |
| 1st Cohort of 4 wards due to go live in November with the additional eRoster training programme. | Workforce Utilization & Safe Staffing Lead |
| Develop a dedicated support program for Internationally Educated Nurses (IEN) following NMC registration, recruitment into this new team is planned. | IR Lead & ADON for workforce |

# Patient | Executive Summary

| Strategic Goal | | Performance Indicator | Description | Target | | 2021/22 | | | | | | | 2022/23 | | | | | | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Performing | Under Performing | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | |
| Trust Goals | People We Care For | Number of Formal Complaints | | <30 | >=30 | 38 | 36 | 44 | 38 | 29 | 32 | 44 | 27 | 28 | 34 | 31 | 33 | 27 | |
| Tracker Measures | People We Care For | Overall Patient Experience (FFT) | Proportion responding 'good' or 'very good' | >=95% | <95% | 96.1% | 95.1% | 97.6% | 96.7% | 98.2% | 96.6% | 95.7% | 96.4% | 94.5% | 93.7% | 95.7% | 97.1% | 96.5% | |
| | | % of Complaints responded to within target | | >=90% | <90% | 36.4% | 47.1% | 25.6% | 40.7% | 42.3% | 44.4% | 52.4% | 61.1% | 69.4% | 82.4% | 52.4% | 60.9% | 57.9% | |
| | | Number of re-opened complaints | | <=3 | >3 | 7 | 5 | 1 | 6 | 2 | 3 | 4 | 3 | 3 | 3 | 2 | 2 | 1 | |
| | | PALS Response Time | % of Responses within 2 days | | | - | - | - | - | - | - | - | 79.6% | 80.5% | 64.0% | 72.0% | 65.0% | 62.0% | |
| | | Number of Compliments | | | | 100 | 118 | 58 | 28 | 44 | 15 | 18 | 15 | 15 | 92 | 36 | 31 | 58 | |
| | | Number of Family Liaison Service Contacts | | | | - | - | - | 27 | 722 | 996 | 1243 | 858 | 934 | 698 | 357 | - | - | |

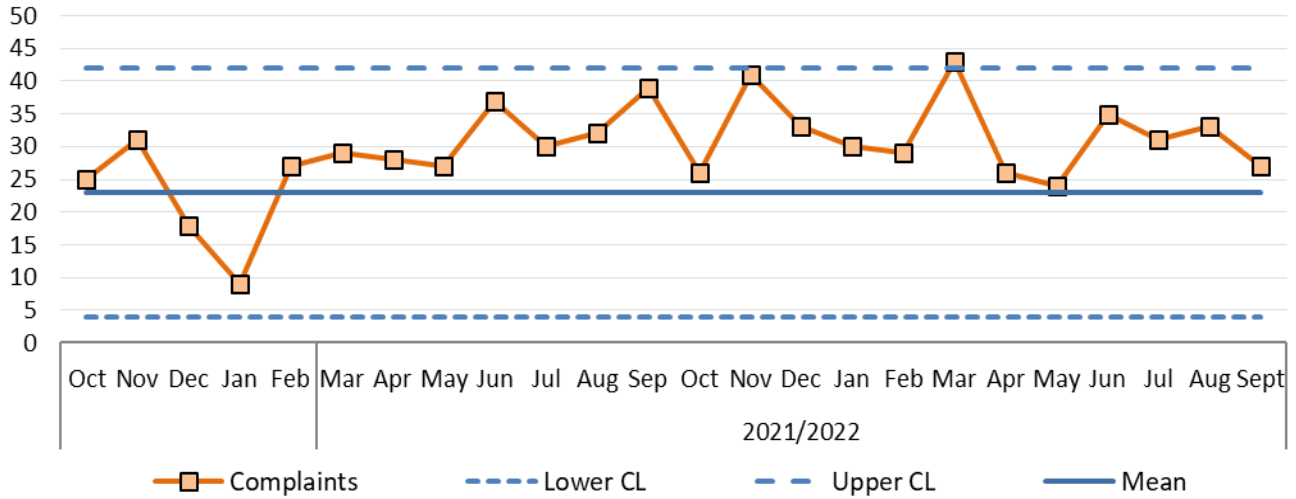
## Measures requiring focus and a countermeasure summary this month are;

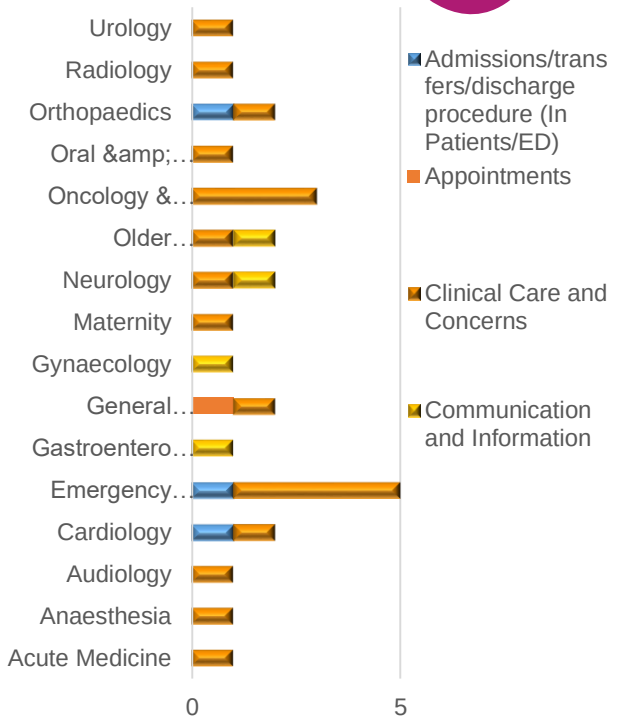
| Measure | Executive Summary |
|---|---|
| **Percentage of complaints responded to within target** | This measure has shown an decrease in September. Overall**, 58% of complaints closed during September met the required timescale of 35 working days (11/19).** This is an decrease from last month (61% met timescale). Numbers of re-opened complaints remains low.<br><br>Weekly Divisional Complaint meetings are held with the Head of Complaints and this is helping support ongoing improvements to the response times. The reasons for the timeframe exceptions are varied but predominantly:<br><br>• Workload of clinicians causing delays in providing statements/investigating<br>• Increased volume over recent months together with the complexity of complaints<br>• Enhanced scrutiny by Executive team delaying sign off.<br><br>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 will be approved and signed by the Divisional Triumvirate. |
| **PALS response time** | The national standard for responding to PALS cases is 5 working days. The RUH standard for responding to PALS cases is 2 working day.<br>The numbers of PALS contacts in September was 413**.** The reasons for the timeframe exceptions are mostly due to:<br><br>• Workload of clinicians causing delays in responding<br>• The volume, complexity and logging of cases for a small team<br>• A review of the team resources and benchmarking with other Trusts is being undertaken<br><br>73% of PALS enquiries were responded to within 5 working days.<br>62% of PALS enquiries were responded to within 2 working days. |

# Patient | Complaints

**Historic Performance**

**Number of Complaints – October 2020 to September 2022**




| Response Rate | Medicine | Surgery | F&SS | Corporate |
|---|---|---|---|---|
| Completed within timescale | 60% (3/5) | 57% (4/7) | 33% (1/3) | 75% (3/4) |

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

**Is standard being delivered?**
The Trust received 27 formal complaints in September 2022. This is 12 less than September 2021 and 4 more than the mean average for the rolling 24 months. Underperforming >=34, Performing <30.

**What is the top contributor for under/over-achievement?**
**Clinical Care and Concerns accounted for 70%** (n=19) of complaints. Emergency Department (n=4) and Oncology & Haematology (n=3) account for 37% of Clinical Care complaints. Complaints relate to inappropriate care/treatment, co-ordination of medical treatment, error performing a procedure, wait for treatment and test results lost or mislaid.

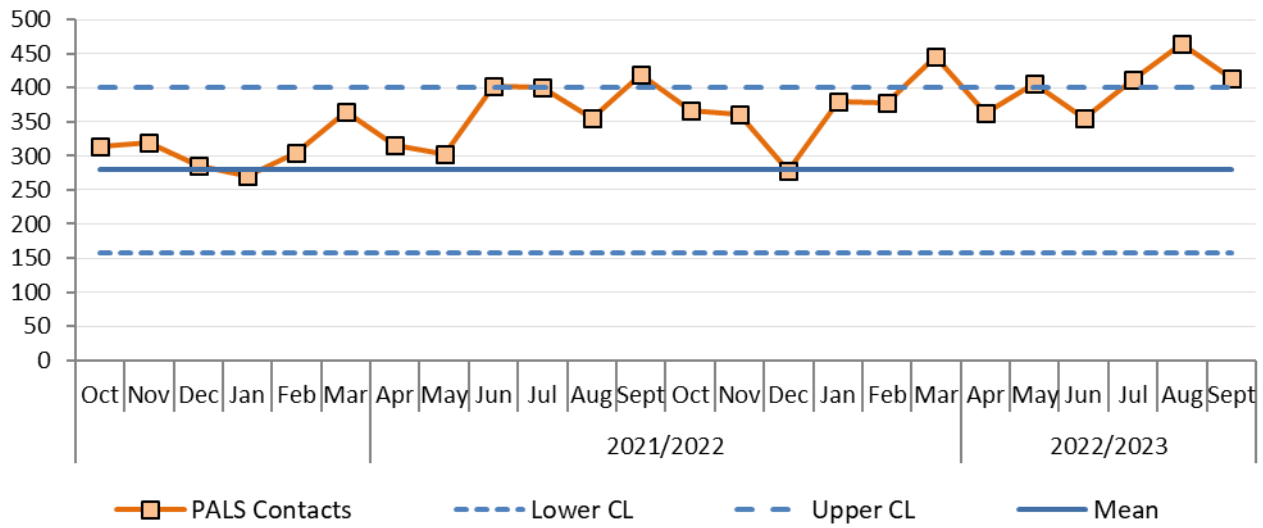
**58% of complaints closed during September met the required timescale of 35 working days** (11/19). This is a decrease from last month (61%).

| Countermeasure /Action (planned this month) | Owner |
|---|---|
| • **Work towards improvements in response times** by continuing with weekly divisional meetings. | HH |
| • **Triage system for complaint responses** to be introduced on Monday 17 October. Complaints assessed as low and medium risk will be approved and signed by the Divisional Triumvirate. | HH |
| • **Monitor implementation of action logs** within the divisions to provide assurance that actions are completed. | HH |

# Patient | Advice and Liaison Service

**Historic Performance**

**Number of PALS Contacts – October 2020 to September 2022**




**Is standard being delivered?**

**Situation report**: There were **413 contacts with PALS in September 2022.**

**KPI: Performance against 48hr standard resolution timeframe** 62% of cases were resolved in 48 hours or less; a further 15% were resolved in 6 days and 7% between 7-14 days. 16% of the complex cases took more than 14 days.

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

**Appointments** (n=66). The highest number of enquiries related to the length of time patients were waiting for new and follow up appointments 56% (n=37). A further 18% (n=12) were patients requesting to change their appointment date.

**Communication and information** (n=45). The highest number of contacts were general enquiries/communication 36% (n=16). A further 31% (n=14) concerned telephones not being answered.

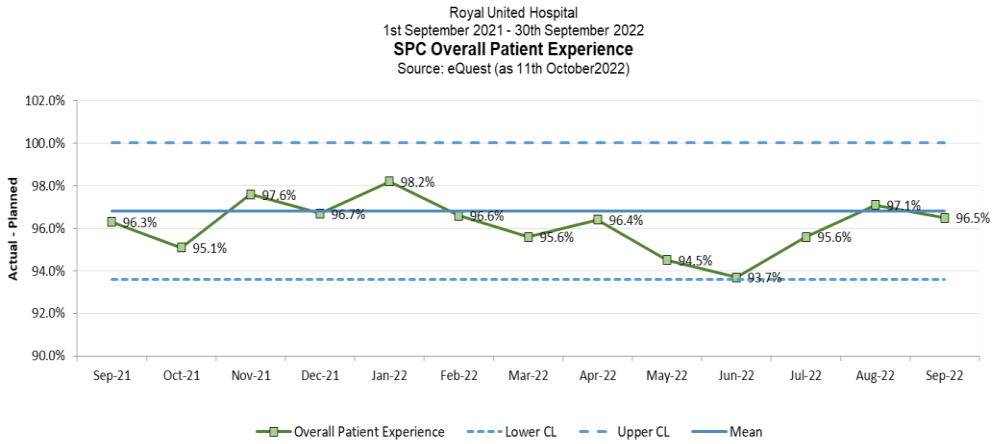
**Clinical care and concerns** (n=62). The highest number of contacts concerned inappropriate care or treatment 19% (n=12) a further 12% (n=8) were patients chasing test results. No trends were identified.

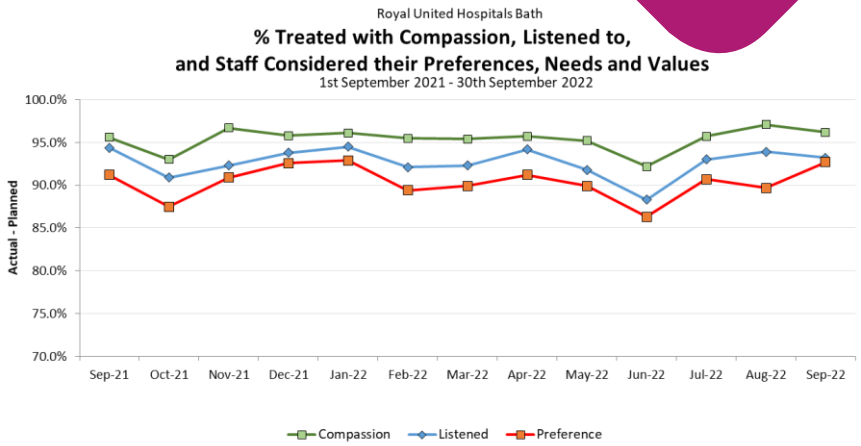
- 265 Required resolution (64%)
- 108 Requested advice or information (26%)
- 25 Compliments (6%)
- 15 Provided feedback (4%)
- 66 Appointments
- 62 Clinical Care and Concerns
- 45 Communication and information

| Countermeasure/Actions | Owner |
|---|---|
| Outpatient departments are continuing to hold weekend clinics to support the backlog in appointments. Virtual and telephone appointments are being held where possible. | Specialty Managers |
| PALS met with Radiology and Gastroenterology Manager to understand the challenges the department is currently facing in order to support communication with patients around appointment and test result waiting times. | Specialty Managers/PALS and Reception Manager |

# Patient | Friends and Family Test

**Historic Performance**



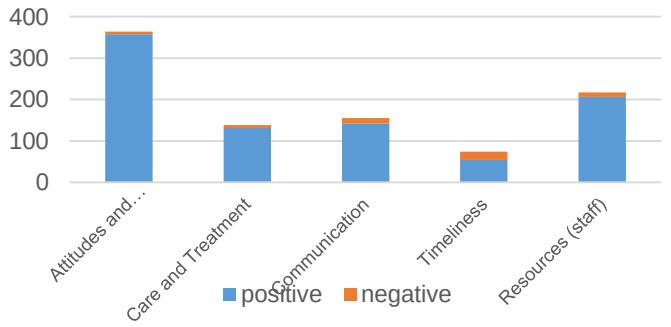

**Is standard being delivered?**

In September 2022 the proportion of patients across the Trust that responded positively (very good or good) about their overall experience was **96.5%. Above the 95% target on the scorecard.** Below shows this broken down for each clinical division.

**What is the top contributor for under/over-achievement of the standard?**
The numbers of responses in ED remain very low. 'Hello Lampost' is being used in ED to get patient feedback on their experience. The information from this will be included in future quarterly reports.

| FFT responses September 2022 | 'Overall how was your experience of our service?' | | | |
|---|---|---|---|---|
| | Medicine Division | Surgery Division | F&SS | Corporate (ED) |
| Very good/ good | **96% (352)** ↑ | **97% (226)** ↓ | **98% (204)** ↓ | **73% (11)** ↓ |
| Poor/ very poor | 2.4% (7) | 1.5% (3) | 0.5% (1) | 20% (3) |
| Neither good nor poor | 1.6% (6) | 1.5% (3) | 1.5% (3) | 7% (1) |

**Themes - Patient experience feedback comments collected via FFT in September 2022:**




**As in September 2022 FFT Positive feedback – top three themes are:**
Attitudes and behaviour of staff (n=358), Resources (Staff) (n=206) and Communication (n=142).

**As in September 2022 FFT Negative feedback – top three themes are:**
Timeliness (n=20), Communication (n=13) and Resources (staff) (n=11).

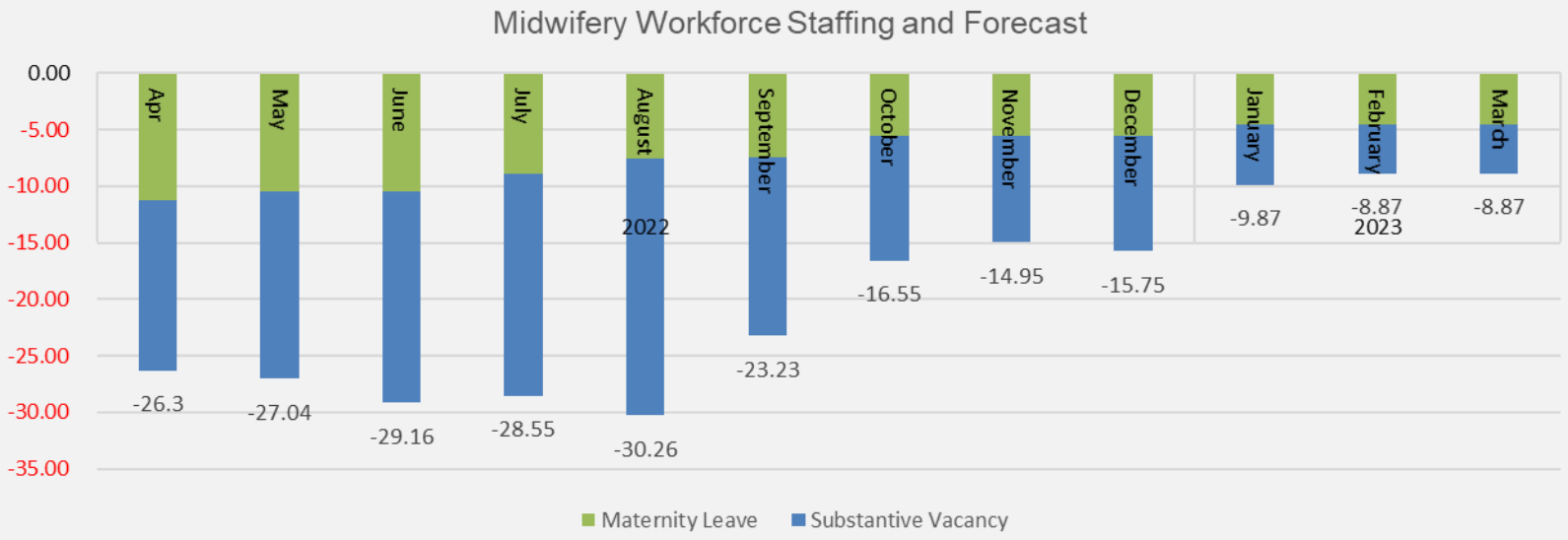
# Patient Safety | Maternity Workforce

| Measures | Summary |
|---|---|
| Minimum safe staffing in maternity to include Obstetric cover on Delivery Suite | Budget vs actual midwifery staffing.<br>-23.23 whole time equivalent (WTE) (of which 7.44 WTE is maternity leave). **Substantive vacancy rate -15.79 WTE**<br>Currently 60 hours/week consultant cover for obstetrics and gynaecology. Royal College of Obstetrics and Gynaecology (RCOG) recommendation that for a unit supporting 4-5000 births this should be 98 hours per week. Obstetric workforce review underway. |

| Measure | Aim/target | September 22 |
|---|---|---|
| Midwife to birth ratio | ≤1:27 | 1:35 |
| Midwife to birth ration (including bank staff) | ≤1:27 | 1:31 |
| Supernumerary labour ward coordinator status | 100% | 99% |
| 1:1 care not provided | 0 | 1 |
| Consultant presence on BBC (hours/week) | ≥60 hours | 60 |
| Twice Daily MDT ward round | 100% | X2 100% |
| Consultant non-attendance when clinically indicated (in line with RCOG guidance) | 0 | 0 |

**Actions:**
Ongoing review of 1 episode when 1:1 care was reported as not provided to identify cause. No harm resulted.
Staffing challenges have continued throughout September, which is improving in October as new midwives complete their supernumerary period.

Recruitment – midwifery pipeline



# Patient Safety | Maternity Workforce

| Measures | Summary |
|---|---|
| Shift fill rates (in-patient services) | |

| | Day | | | | Night | | | | Care Hours Per Patient Day (CHPPD) | | | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Registered midwives/nurses | | Care Staff | | Registered midwives/nurses | | Care Staff | | Cumulative count over the month of patients at 23:59 each day | Registered midwives/ nurses | Care Staff | Overall | Average fill rate - registered nurses/ midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/ midwives (%) | Average fill rate - care staff (%) |
| | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | | | | | | | | |
| Jul-22 | 7155.42 | 5555.67 | 5468.00 | 3336.50 | 5530.50 | 4484.50 | 1849.00 | 1149.00 | 688.00 | 14.6 | 6.5 | 21.1 | 77.6% | 61.0% | 81.1% | 62.1% |
| Aug-22 | 7188.50 | 5463.92 | 5510.00 | 3413.25 | 5560.50 | 4701.00 | 1860.00 | 1314.00 | 625.00 | 16.3 | 7.6 | 23.8 | 76.0% | 61.9% | 84.5% | 70.6% |
| Sep-22 | 6994.75 | 6160.50 | 5318.25 | 3344.50 | 5364.00 | 4762.23 | 1785.00 | 1067.00 | 743.00 | 14.7 | 5.9 | 20.6 | 88.1% | 62.9% | 88.8% | 59.8% |

**Is standard being delivered?**

- 1 to 1 care in labour was not achieved on one occasion
- 99% of shifts have a supernumerary Labour Ward coordinator
- The Midwife to birth ratio is not being met
- There is a 20.31 WTE midwifery workforce gap.

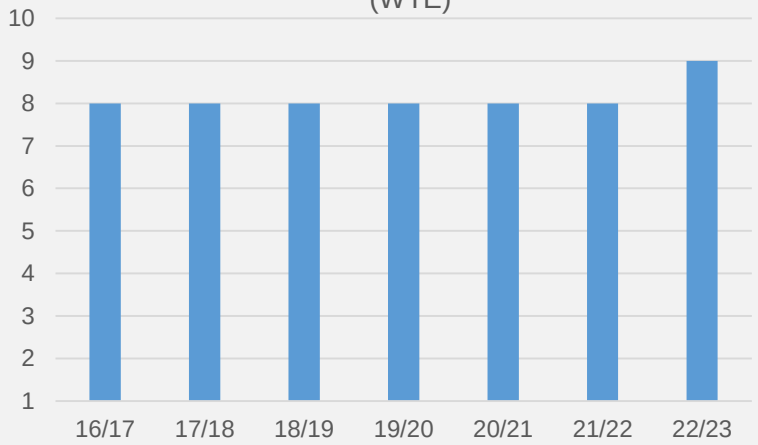
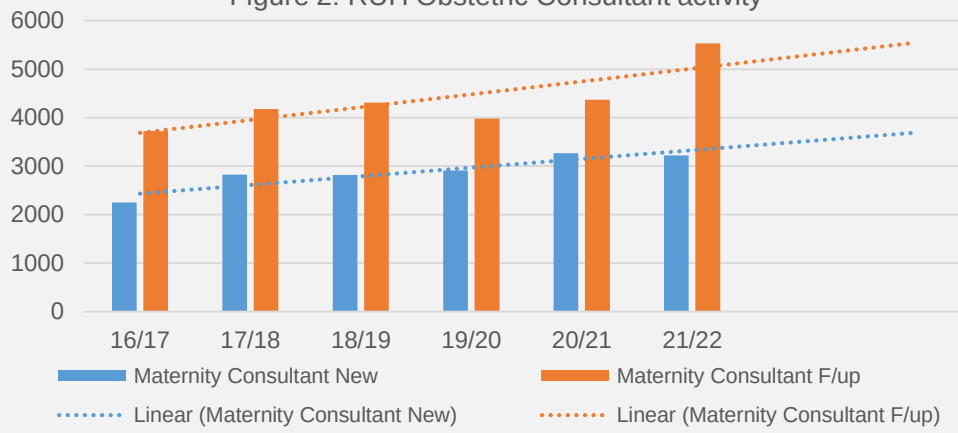
**What is the top contributor for under/over-achievement?**

- Vacancy rate
- Maternity leave
- Challenges in recruiting midwives
- Challenges with retaining midwives.

| **Countermeasure /Action (completed last month)** | **Owner** |
|---|---|
| Recruited a Director of Midwifery – commences in post on 7 November. | CNO |
| Recruited Registered Nurses to work in maternity services<br>Recruited newly qualified midwives<br>Preceptorship programme established<br>Recruit to maternity leave (n=8). | DOM<br><br>Retention Midwife |
| Incentives introduced in June 2022. | DOM/DDO |
| Bid to recruit 8 International Midwives approved. | DOM |

| **Countermeasure /Action (planned this month)** | **Owner** |
|---|---|
| Working with NHSI to establish the longer term workforce plan for acute/community sites & Continuity of Carer. | DOM |
| Working with BSW Academy to widen routes into Midwifery. | DOM |
| Investigate red flag staffing episodes reported in September. | Matron |

# Patient Safety | Maternity Workforce

| Measures | Summary |
|---|---|
| Obstetric Staffing | Figure 1: Total number of obstetric consultants (WTE)<br>  <br><br>Figure 2: RUH Obstetric Consultant activity<br>  <br> |
| Recruitment – Obstetric Consultant pipeline | 2022-2023 / 2023-2024<br>Aug: 8; Sept: 8; Oct: 8; Nov: 8; Dec: 8; Jan: 9; Feb: 10; Mar: 11; April: 11; May: 11; Jun: 11; Jul: 11; Aug: 11; Sept: 11<br>The current funded establishment is 9 WTE Obstetric Consultants, 8 WTE are in post. An additional Consultant will commence in January 2023.<br>• A workforce review is being undertaken to enable:<br>• Moving from 60hrs to 98hrs Consultant presence as per Royal College of Obstetrics and Gynaecology (RCOG) recommendations<br>• Splitting the on-call rota between Obstetrics and Gynaecology as per Ockenden recommendations<br>• Further PAs are required to support the 43-48% increase in maternity consultant clinic appointments over the last 5 years. |

# Patient Safety | Perinatal Quality Surveillance Tool

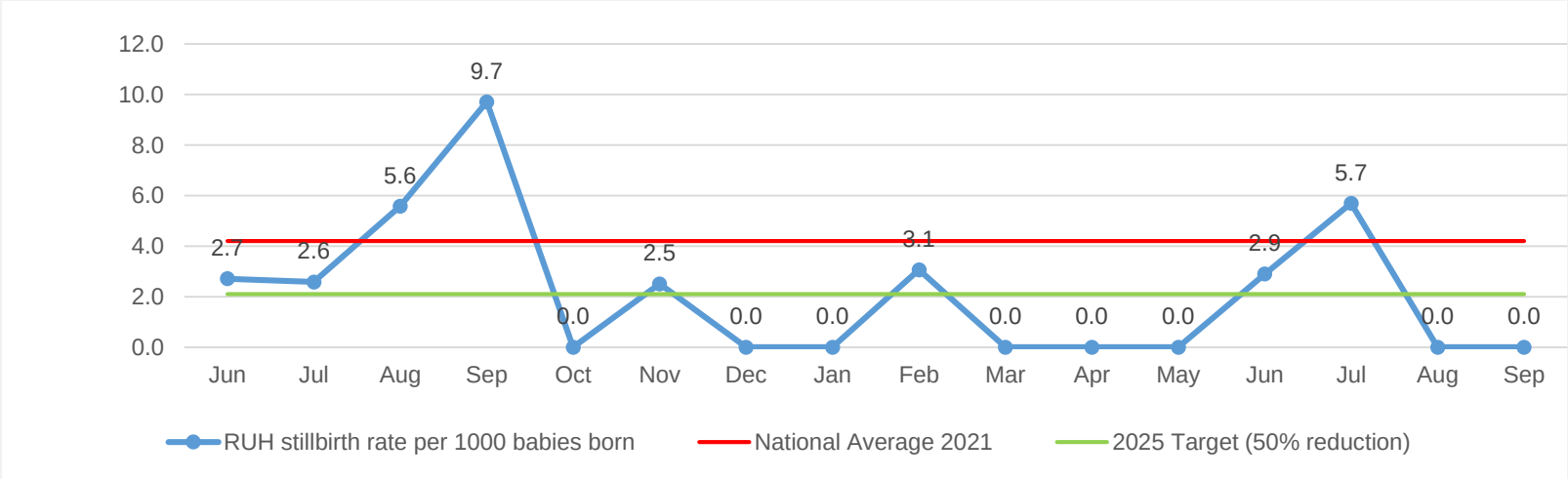
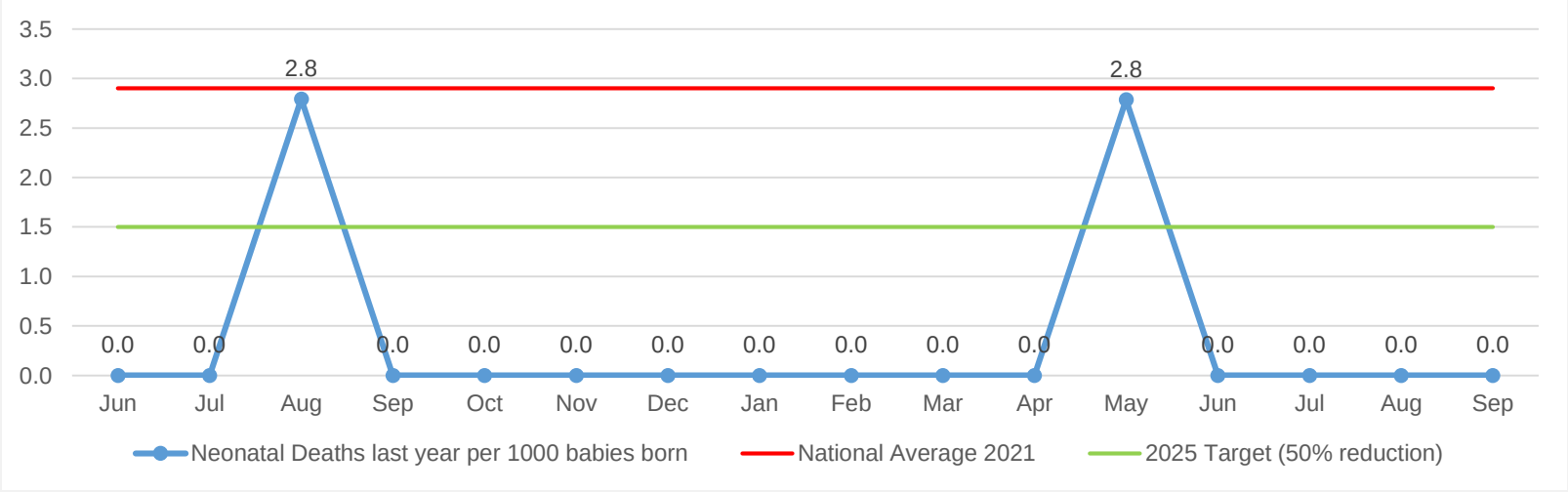
*The information on the following slides form part of the new Quality Surveillance Model implemented nationally to ensure consistent oversight of Maternity and Neonatal Services at Board level on a monthly basis*

| Measures | Summary |
|---|---|
| Concerns or requests for actions from national bodies | Following National recommendations following Ockenden Report and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). Ockenden report including additional requirements published 30th March 22. Amended MIS year 4 standards published May 2022. |
| CNST 10 Maternity Standards (NHSR) | Amended MIS year 4 published May 2022. **Further amendment to submission date announced Sept 22 – Reporting period now 5/5/22 - 2/2/23** Some standards altered in line with Ockenden, which has affected Trust compliance.<br>SA5 – Workforce planning must now demonstrate funding is in place to support full Birthrate Plus staffing recommendations, or action plan to achieve, including timescales, agreed at Board level.<br>SA6 – CO monitoring level at 36 weeks average <80% via electronic reporting. Manual audit underway.<br>SA8 – Risk to compliance due to late start of new fetal monitoring course and PROMPT compliance. Education Lead vacancy impacting delivery and reporting. Change within MIS: All trainees included within PROMPT training. See training update. |
| Review of all perinatal deaths using the real time data monitoring | All perinatal deaths within the Trust have been reported using the Perinatal Mortality Review Tool (PMRT) tool since 2018. PMRT reporting is Safety Standard 1 of the NHSR Maternity Incentive Scheme year 4. No postmortems will be routinely offered to 22 and 23 weeks late miscarriages effective from 1 September 2022. The Trust will continue to offer genetic testing and placental histology to all late miscarriages.<br>There were 0 perinatal deaths reported in September. The PMRT action was to review the triage process for the Day Assessment Unit (DAU). This is underway. |

| RAG rating | |
|---|---|
| RED | Not expecting compliancy |
| AMBER | Expecting compliancy – plan in place to achieve |
| GREEN | Currently compliant |

| Safety Action Detail | RAG |
|---|---|
| **SA1**: Are you using the National PMRT to review perinatal deaths to the required standard? | Green |
| **SA2**: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | Green |
| **SA3**: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? | Green |
| **SA4**: Can you demonstrate an effective system of clinical workforce planning to the required standard? | Green |
| **SA5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard? | Amber |
| **SA6**: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two? | Amber |
| **SA7**: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? | Green |
| **SA8**: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support, starting from the launch of MIS year 4? | Amber |
| **SA9**: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? | Green |
| **SA10**: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22? | Green |

# Patient Safety | Perinatal Quality Surveillance Tool

| Measures | Summary |
|---|---|
| Perinatal mortality rate | The following graphs demonstrate how Royal United Hospital NHS Trust is performing against the national ambition to reduce stillbirths by 50% by 2025.<br>*RUH NHS Trust Stillbirth rate per 1000 births over last year:*<br>  <br>*RUH NHS Trust Neonatal Death rate per 1000 births over last year*<br>  |

# Patient Safety | Perinatal Quality Surveillance Tool

| Measures | Summary |
|---|---|

**Service User Feedback**

| Feedback | Sept 22 |
|---|---|
| Number of compliments | 2 |
| Online compliments captured | |
| Number of PALs contacts/concerns | 7 |
| Complaints | 1 |

**Themes from September:**

The theme for all PALS contacts expressing concerns related to issues around clinical care (failure to predict large baby, retained products post birth and waiting time for LSCS) and communication (difficulty with telephone contact).

**CQC Ratings**

| CQC Maternity Ratings last assessed September 2018 | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| | Good | Good | Outstanding | Outstanding | Outstanding | Outstanding |

**Maternity Safety Support Programme**

N/A

**Coroner's Regulation 28**

N/A

**Moderate Harm Incidents: The number of incidents graded moderate or above and the actions taken.**

**2**

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI) which may account for an increase in the number of SIs reported in Maternity, although the outcome may not have been avoidable.

1. Term baby born rapidly following spontaneous labour with shoulder dystocia and cord tight around neck. Transferred for cooling. Referred to HSIB which is being triaged/
2. Postnatal Eclampsia

**Serious Incidents (SI) reported in month**

| Serious Incidents (SI) reported in month | | | |
|---|---|---|---|
| Case ref | | Date | Case Update |
| 108058 | HSIB – being Triaged | 13/09/22 | Referred and being Triaged by HSIB |
| 108198 | SI | 22/02/22 | Postnatal Eclampsia- RCA Investigation in progress |

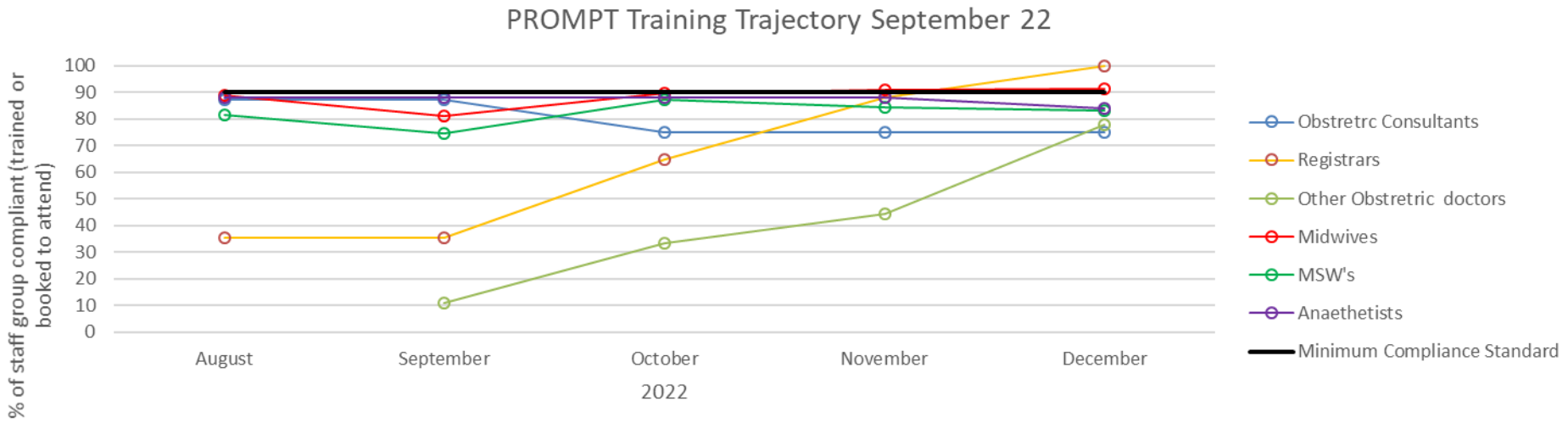
**Ongoing SI Investigations update**

| Stage of Investigation | September 2022 |
|---|---|
| HSIB logged | 1 |
| HSIB active cases | 3 |
| SI logged* | 2 |
| SI approved by Trust panel | 1 |
| Active Trust SI investigations to date** | 2 |

*HSIB cases are automatically an SI but an RCA investigation is not completed by the Trust

**most SI investigations take approximately 3 months to complete so may feature in multiple months. This is not including HSIB cases, only Trust SI investigations

# Patient Safety | Perinatal Quality Surveillance Tool




| Background and underlying issues | Improvement actions planned, timescales, and when will improvements be seen | Risks to delivery and mitigations |
|---|---|---|
| 90% compliance for all staff groups working in maternity have been mandated in the Clinical Negligence Scheme for Trusts (CNST) 2021-2022 guidance.<br>Virtual training may be included if required, however face to face training will continue to be offered preferentially to focus on multi-disciplinary collaboration and effective team working.<br>The revised CNST standards for year 4 mandate 90% compliance for all staff groups with fetal monitoring training. Including a competency-based assessment has been mandated by CNST 2021-22. | Clarity required from LMNS about doctors carrying over their PRoMPT and Fetal monitoring training from other Trusts. This is not done in other regions or Trusts.<br>New B7 Quality and Education Midwife recruited full time to commence in November. PRoMPT and Fetal monitoring curriculum content rewritten ready to deliver for next 12 months.<br>One training log document for trajectory and compliance ensures reporting is completely accurate and up to date.<br>Overall **PRoMPT** compliance is currently below 90% and falls short of the standard; this is a result of new doctors, Midwives and MCAs starting in September. There are two PRoMPT sessions running in October to improve compliance and over 60 staff booked on. Not all new Doctors can be released at the same time to attend.<br>**Fetal Monitoring** compliance is currently below 90%; but over 90% have attended the study day since the start of the training. K2 forms the competency based assessment part of training and staff are not marked as compliant until completed this. Places available at all sessions. | New requirement within MIS year 4 states that GP and sub-specialty trainees must be included in training if any obstetric commitment on rota. Addressing within specialty teams. Escalated within Division.<br><br>All new doctors in training and GP and Specialist trainees within Obstetrics have been identified, and all are booked to attend PRoMPT and Fetal Monitoring training. Suggestion that training forms part of Doctors induction<br><br>Sufficient places to service the demand and achieve over 90% compliance are available and booking staff on has been strengthened.<br><br>Vacant Band 8 Patient Safety post recruited to. Deputy Director of Midwifery providing interim cover for the post. |

# MIS Year 4 Maternity Scorecard (Sep 170321- Sep 22)

## *(Mandated criteria taken from Maternity Dashboard)*

| | | Nat. ave/ standard | Sep 21 | Oct 21 | Nov 21 | Dec 21 | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Workforce | Red flags: 1:1 care in labour not provided (BBC only) | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |
| | Percentage of supernumerary labour ward co-ordinator status (%) | 100% | 90 | 95 | 98 | 100 | 100 | 100 | 98 | 100 | 97 | 97 | 98 | 100 | 99 | |
| | Rostered consultant cover on BBC - hours per week | <60 hours | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | |
| | Consultant non-attendance when indicated in RCOG Roles and Responsibilities (as reported via Datix) | 0 | | | | | | | | | | | | 0 | 0 | New metric |
| | Bath Birthing Centre twice daily round achieved (%) | | 77 | 77 | 67 | 84 | 81 | 79 | 94 | 93 | 90 | 93 | 97 | 94 | X2 100<br>X3 83 | TIMING OF ROUNDS – to be adjusted following obstetric staffing review (in progress) |
| | Midwife to birth ratio (establishment) | >1:27 | 1:35 | 1:35 | 1:33 | 1:31 | 1:35 | 1:30 | 1:32 | 1:34 | 1:34 | 1:34 | 1:34 | 1:38 | 1:35 | Linked to vacancy rate. Including bank staff rate 1:31 |
| | Number of women booked onto a Continuity of Carer pathway (%) | >=35% | 52.3 | 43.3 | 50.0 | 42.3 | 43.2 | 40.0 | 40.9 | 40.5 | 43.8 | 41.3 | 36.2 | 37.0 | 41.7 | No. of women booked onto a CoC pathway (AN & PN only). No national standard in place from Sept 22. |
| Safety | Risk assessment at every contact (Antenatal) (%) | | 50 | 54 | 54 | 61 | 56 | 55 | 78 | 56 | 71 | 51 | 51 | 47 | 48 | Risk assessment at Booking 100%. Documentation focus. Digital solution not possible. |
| | Stillbirth number | Actual | 3 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 2 | 1 | 0 | N.B. 1x SB incorrectly reported here in Aug. |
| | Neonatal Deaths | Actual | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | |
| | Moderate Datix and above | | 2 | 2 | 3 | 3 | 2 | 0 | 2 | 5 | 2 | 3 | 0 | 1 | 0 | |
| | HSIB | | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 4 | 2 | 0 | 0 | 1 | 2 | |
| Feedback | Number of compliments | | 1 | 1 | 2 | 0 | 4 | 1 | 1 | 1 | 1 | 4 | 3 | 0 | 2 | |
| | Online compliments | | | | | | | | 291 | | | | * | * | * | Social media feedback temporarily paused |
| | Number of PALS contacts/concerns | | 6 | 8 | 9 | 4 | 15 | 8 | 6 | 8 | 18 | 9 | 6 | 6 | 7 | |
| | Complaints | | 2 | 1 | 2 | 2 | 1 | 3 | 2 | 1 | 1 | 3 | 1 | 1 | 1 | |

# MIS Year 4 Maternity Scorecard (Jun 21- Jul 22)

*(Taken from Maternity Dashboard)*

| | | Alert nat. ave/ standard | Sep 21 | Oct 21 | Nov 21 | Dec 21 | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Training | PROMPT/Emergency skills all staff groups (%) | >90% | 71.9 | 74.3 | 71.98 | 71.34 | 76.6 | 84.0 | 91.2 | 91.8 | 95 | 91.4 | 91 | 78.7 | 79.5 | See detail on training update page |
| | Percentage staff received fetal monitoring in labour training **(new from Sept 2021)** (%) | >90% | 4.22 | 9.28 | 15.61 | 19.49 | 22.88 | 36.44 | 49.3 | 49.3 | 63.2 | 78* | 82* | 71.1 | 83.1 | |
| | New-born life support (NBLS) (%) | >90% | 78.25 | 79.65 | 79.15 | 80.20 | 77.8 | 89.0 | 91.2 | 92.2 | 96 | 91 | 91 | 77.5 | 79.5 | |
| | Percentage of staff who have successfully completed mandatory CTG fetal monitoring annual competency assessment (%) | >90% | 4.22 | 7.59 | 16.46 | 19.83 | 26.06 | 36.44 | 49.3 | 49.3 | 63.2 | 70.39 | 73 | 71.1 | 83.1 | |
| | Coroner Regulation 28 made directly to Trust | | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | |
| | HSIB/CQC etc. with concern or request for action | | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | 1 | Nil | Nil | Nil | Working with HSIB in view of increased referrals March-May |

# The people in our community

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

# Finance Report

Month 6

The RUH, where you matter

# Finance Director Focus

**RUH Position**
The Trust is £1.4m worse than plan at the end of September which is an improvement of £800,000 in the month.
There are some variances in the position which are being focussed on to reduce run rates and prevent a deviation from plan by the end of the year. A focussed recovery plan has been put in place for a number of areas where run rates increase and these include: ED medical staff back in line with budget; ensuring nursing expenditure is in line with allocated budget through a reduced use of agency hours, the deliver of QIPP and management of inflation costs. Progress is being made on these schemes and the run rate has reduced in some areas.

**Elective Recovery**
The elective recovery position improved significantly in September and was at 110% of 19/20 levels, which improved the year to date position to 106% (target 104%). Additional costs incurred to create further elective capacity have been covered by the additional elective recovery income.

**Emerging risks and Forecast Outturn**
The RUH is managing a number of risks within the financial plan that relate to the volume of Covid admissions; an increase demand on emergency services and a continued high number of patents in the hospital with no criteria to reside which reduces the available bed base for emergency admissions. Further costs will be spent to maintain the safety of the site over winter and the funding source is yet to be confirmed. The financial plan is expected to deliver with the implementation of the recovery plan £6m and further funding being available for winter.

**BSW**
The BSW system set a balanced plan for 2022/23 with a total of £51m of deficits across the three providers offset by a £51m of surplus with the ICB. We agreed that if the system was in balance each organisation is in balance and therefore a one off non-recurrent payment will be made to each provider to offset their deficit. The funding is non-recurrent and it is aimed to manage the cash implications of such deficits. Therefore the RUH will continue to monitor against the £19.3m deficit and will show the extra £19.3m as a bottom line adjustment to demonstrate the break-even position.

**National Focus**
The financial pressures impacting on the whole NHS are around increasing demand for emergency services with regular peaks being seen in Covid admissions which also create increased staff absenteeism, together with an increasing number of non criteria to reside patients on acute sites. This has a cost to the NHS and on top of the increasing inflation rates is leading to significant pressures being managed. There is no indication that further funding will be allocated to the NHS to manage these pressures and therefore we must continue to ensure we are focussing on achieving value for money. The commitment remains on reducing elective waiting times but this is becoming increasingly challenging due to the pressures highlighted. NHS England are looking at pension rules try and support the clinical workforce to stay within the NHS.

# Executive Score Card

| | Performance Indicator | Description | Target | | Baseline | Actual 2022/23 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Performing | Under Performing | | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 |
| Sustainability Tracker Metrics | Delivery of Group financial plan | Variance from year to date plan | <=0 | >0 | £0 | £(148)k | £(188)k | £(464)k | £(1505)K | £(2214)K | £(1,398)k |
| | Forecast delivery of Group financial plan | Forecast variance from year to date plan | <=0 | >0 | £0 | £0 | £0 | £0 | £0 | £0 | £0 |
| | Group delivery of breakeven | Total year to date financial performance | <=0 | >0 | £0 | £(2.5)m | £(4.5)m | £(6.8)m | £(9.9)m | £(12.7)m | £(13.96)m |
| | Delivery of QIPP | Total QIPP delivery | N/A | N/A | N/A | £483k | £1.108M | £2.209M | £2.533 M | £3.110 M | £3.998m |
| | Delivery of QIPP against plan | Performance against plan | <=100% | >100% | 48.0% | 61.0% | 115.0% | 137.6% | 116.0% | 96.0% | 96.0% |
| | Reduction in agency expenditure | Agency costs as a % of total pay costs | <= 3% | > 3% | 3.0% | 3.0% | 6.0% | 6.1% | 5.0% | 4.6% | 4.4% |
| | Sickness against plan | Actual levels of sickness against average pre-pandemic levels | <= 4.1% | > 4.1% | 7.7% | 5.0% | 2.8% | 3.5% | 4.9% | 2.6% | 2.4% |
| | Reducing no criteria to reside patients | No criteria to reside to reduce by 40% from December 2021 | <= 90 | > 90 | 149 | 155 | 129 | 128 | 138 | 136 | 129 |
| | No COVID admissions | Average number of beds occupied by COVID patients | <=30 | >30 | 64 | 35 | 19 | 28 | 72 | 26 | 24 |
| | Reducing staff vacancies | Total vacancies reported each month | <=7.4% | >7.4% | 7.40% | 7.41% | 6.00% | 6.10% | 6.47% | 5.98% | 5.70% |
| | Net impact of high cost drugs and devices | Total expenditure and income against plan for high cost drugs and devices (YTD) | <=0 | >0 | £0 | £230k | £514k | £1.126m | £1.060m | £1.638m | £1.611m |
| | Increase productivity | Implied productivity based on financial and operational performance (Quarterly) | >=3% | 3% | -20% | -15% | TBC | -22% | -22% | -22% | -22% |
| | Elective recovery | In Month Performance against 19/20 levels of activity (Value based) | >= 104% | < 104% | n/a | 101% | 108% | 108% | 95.0% | 116% | 110% |
| | Non elective activity | Performance against planned levels of activity (Value Based) | >= 100% | < 100% | n/a | 92.0% | 102% | 103% | 107% | 108% | 114% |
| | Delivery of capital programme | Variance from year to date planned capital expenditure | + or - 1% | ><1% | n/a | 13.6% | 15.0% | 17.4% | 7.5% | 16.4% | 14.1% |
| | Forecast delivery of capital programme | Forecast variance from annual planned capital expenditure | + or - 1% | ><1% | n/a | 0 | 0 | 0 | 0 | 0 | 0 |
| | Delivery of planned cash balance | Variance from year to date planned cash balance | + or - 10% | ><10% | n/a | (8.8%) | (6.4%) | (7.3%) | 12.5% | 30.2% | 8.6% |

# Executive Summary

- The RUH delivered a deficit of £13.96 m against a plan of £12.56. The number of non-criteria to reside patients has reduced slightly but remains high with an average of 129, 39 above the planned level. High agency usage continues in the month with plans in place to target reductions in the use of mental health nurses. In the month an increase in elective activity resulted in activity being at 110% of 2019/20 levels which is above the 104% target. The year to date is also above target at 106% of 2019/20 levels. The focus remains on the financial recovery plan and management of risks to ensure the deficit plan can be achieved.

- The Trust is managing risks through the finance recovery plan totalling £6m. The key schemes are reducing agency mental health nurses; reducing agency usage for cleaning; ED medical staff rosters; QIPP plans; inflation management and Sulis reducing agency and increasing revenue. The run rates improved in the month for ED, cleaning and inflation costs, but due to the RMN usage not reducing as planned the run rate was not reduced in line with the recovery plan in September.

- £4.0m of savings have been delivered year to date against a plan of £4.1m of which £0.8m were non-recurrent. This is broken down into under-recovery of £0.4m against transformation programmes and £0.3m over-recovery against divisional programmes. Against the £14.8m QIPP plan for the year, £12.0m of plans have been identified to date. £10.8m of the QIPP savings are due to be delivered in the last half of the year. A number of new schemes, totalling £0.7m, have been identified during the month to help support the recovery plan.

- Pay for the RUH is over plan in month by £4.6m (£9.5m year to date). In part this had been driven by an additional £3.2m of pay awards being paid in September, with a corresponding increase in income. The main pay pressures for the month is for agency mental health nurses with an overspend of £0.3m (£1.8m year to date).

- Expenditure for the first six months of 2022/23 for drugs and devices was £2.9m below plan, £1.3m of this is offset by a corresponding reduction in income with the remaining £1.6m improving the Trusts position.

- Capital expenditure was £20.7m at Month 6 which was £3.4m less than planned.

- The closing cash balance for the Group was £40.4m which is £3.2m higher than planned.

# True North I Breakeven Position

| Statement of Comprehensive Income Period to 202206 | Total | | | | | |
|---|---|---|---|---|---|---|
| | 202206 | | | YTD | | |
| | Budget £'000 | Actual £'000 | Variance £'000 | Budget £'000 | Actual £'000 | Variance £'000 |
| Commissioner Income (NHSE/CCG) | 32,675 | 37,053 | 4,379 | 195,810 | 199,765 | 3,955 |
| Other Patient Care Income | 1,854 | 2,659 | 805 | 10,730 | 12,915 | 2,186 |
| Other Operating Income | 2,530 | 3,320 | 790 | 14,872 | 17,355 | 2,482 |
| **Income Total** | 37,059 | 43,032 | 5,973 | 221,412 | 230,035 | 8,623 |
| Pay | (24,518) | (29,322) | (4,804) | (145,997) | (156,298) | (10,301) |
| Non Pay | (12,272) | (12,727) | (455) | (74,115) | (73,996) | 119 |
| Depreciation | (1,795) | (1,725) | 70 | (10,588) | (10,514) | 74 |
| **Expenditure Total** | (38,585) | (43,775) | (5,190) | (230,700) | (240,807) | (10,107) |
| **Operating Surplus/(Deficit)** | (1,526) | (742) | 784 | (9,288) | (10,773) | (1,485) |
| Other Finance Charges | (592) | (575) | 17 | (3,556) | (3,603) | (47) |
| **Finance Charges** | (592) | (575) | 17 | (3,556) | (3,603) | (47) |
| **Surplus/(Deficit)** | (2,118) | (1,317) | 801 | (12,844) | (14,376) | (1,532) |

| **Adjusted Financial Performance** | | | | | | |
|---|---|---|---|---|---|---|
| Surplus/(deficit) before impairments and transfers | (2,118) | (1,317) | 801 | (12,844) | (14,376) | (1,532) |
| Remove capital donations/grants I&E impact | 47 | 63 | 16 | 282 | 415 | 133 |
| Adjusted financial performance surplus/(deficit) including PSF as per accounts | (2,071) | (1,254) | 817 | (12,562) | (13,960) | (1,398) |
| **Adjusted financial performance surplus/(deficit)** | **(2,071)** | **(1,254)** | **817** | **(12,562)** | **(13,960)** | **(1,398)** |

| **Adjusted financial performance for the purposes of system achievement** | **(2,071)** | **(1,254)** | **817** | **(12,562)** | **(13,960)** | **(1,398)** |
|---|---|---|---|---|---|---|

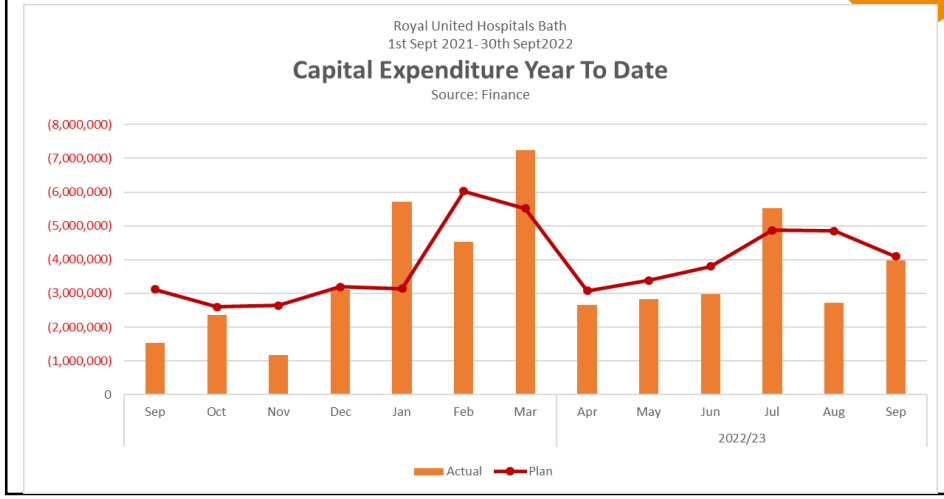
**Key Points**

The Group delivered a deficit of £13.96m year to date which is £1.4m adverse to plan.

# Tracker Measure I Sustainability – Capital (RUH & SULIS)

## Capital Programme

| Capital Position as at 30th Sept 2022 | Annual Plan | Forecast | Year to Date Plan | Year to Date Actuals | Year to Date Variance |
|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s |
| **Trust Funded** | (19,031) | (19,031) | (6,837) | (6,302) | 535 |
| **External Funded (PDC & Donated):** | | | | | |
| Cancer Centre PDC | (22,530) | (22,530) | (17,089) | (14,361) | 2,728 |
| Other PDC | (85) | (85) | 0 | 0 | 0 |
| Donated | (7,531) | (7,531) | (150) | (14) | 136 |
| **Total** | **(49,177)** | **(49,177)** | **(24,076)** | **(20,677)** | **3,399** |




**Is standard being delivered? No**
**What is the top contributor for under/over-achievement?**
**Trust funded programme** is £0.5m under plan to date.

Currently still awaiting national confirmation for cover related to existing IFRS16 leases. A further national return is due in late October.

**External PDC funded schemes** The Cancer Centre works are £2.7m behind plan at the end of September. Delays in the dry lining have subsequently delayed M&E works, Kier have issued a revised programme and cash-flow which shows the works catching up over the year

**Countermeasures completed last month**

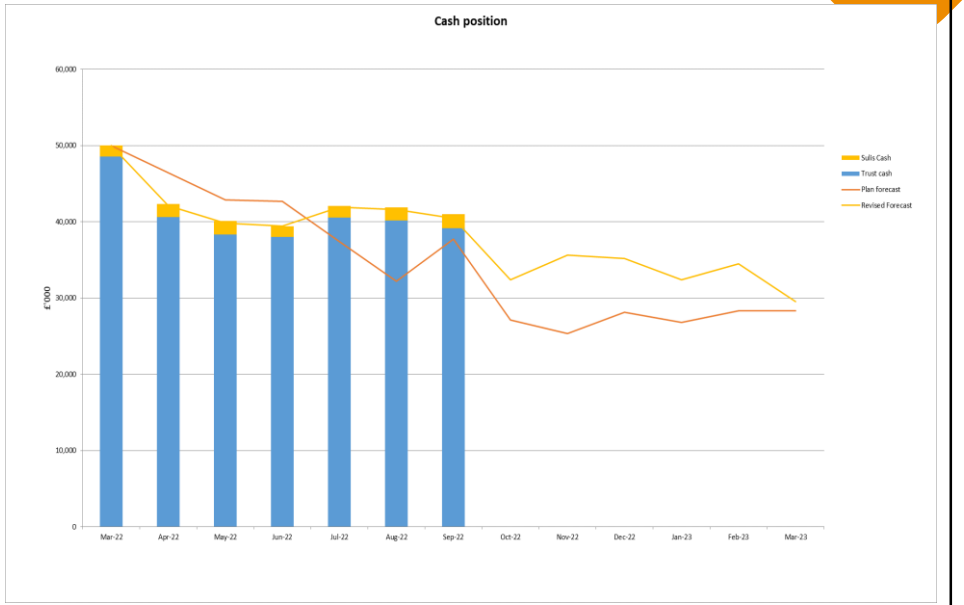
| Countermeasure /Action | Owner |
|---|---|
| NA | NA |

**Countermeasures for the month ahead**

| Countermeasure /Action | Owner |
|---|---|
| CPMG to continue to monitor and mitigate for any risks arising | Director of Finance |
| Capital cover for IFRS16 leases to be determined with region | Deputy Director of Finance & Head of Financial Services |

# Tracker Measure I Sustainability – Cash (RUH & SULIS)

| Cashflow statement | £'000 |
|---|---|
| Operating Surplus/(deficit) | (10,773) |
| Depreciation & Amortisation | 10,514 |
| Income recognised in respect of capital donations (cash and | (6) |
| Impairments | 0 |
| Working Capital movement | 2,297 |
| Provisions | 17 |
| **Cashflow from/(used in) operations** | **2,049** |
| | |
| Capital Expenditure | (20,485) |
| Cash receipts from asset sales | 0 |
| Donated cash for capital assets | 0 |
| Interest received | 255 |
| **Cashflow before financing** | **(20,230)** |
| | |
| Public dividend capital received | 14,196 |
| Movement in loans from the DHSC | (156) |
| Capital element of finance lease rental payments | (1,128) |
| Interest paid | 0 |
| Interest element of finance lease | (124) |
| PDC dividend (paid)/refunded | (3,605) |
| **Net cash generated from/(used in) financing activities** | **9,183** |
| **Increase/(decrease) in cash and cash equivalents** | **(8,998)** |
| | |
| **Opening Cash balance** | **49,989** |
| | |
| **Closing cash balance** | **40,991** |




**Is standard being delivered for cash? Yes**
The cash balance has decreased by £923,000 in month to £41m which is £3.2m higher than planned.

**Countermeasures completed last month**

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

**Countermeasures for the month ahead**

| Countermeasure /Action | Owner |
|---|---|
| Continual monitoring of cash flow | Head of Financial Services |
| Develop a 24 month cashflow and update cash assumptions to reflect actuals | Financial Accountant |

# Tracker Measure I Sustainability – Balance Sheet (RUH & Sulis)

| | 31/08/2022 Actual £'000 | 30/09/2022 Actual £'000 | Mv't in month £'000 |
|---|---|---|---|
| **Non current assets** | | | |
| Intangible assets | 7,586 | 7,382 | 204 |
| Property, Plant & Equipment | 257,745 | 260,628 | (2,883) |
| Right of use assets - leased assets for lessee | 30,303 | 29,872 | 432 |
| Investments in associates and joint ventures | | | 0 |
| Trade and other receivables | 2,852 | 2,866 | (14) |
| **Non current assets total** | **298,486** | **300,748** | **(2,261)** |
| | | | |
| **Current Assets** | | | |
| Inventories | 7,562 | 7,235 | 327 |
| Trade and other receivables | 16,586 | 20,009 | (3,423) |
| Cash and cash equivalents | 41,923 | 40,991 | 931 |
| **Current Assets total** | **66,070** | **68,235** | **(2,165)** |
| | | | |
| **Current Liabilities** | | | |
| Trade and other payables | (62,976) | (65,556) | 2,583 |
| Other liabilities | (9,739) | (8,893) | (846) |
| Provisions | (131) | (187) | 56 |
| Borrowings | (4,997) | (5,023) | 27 |
| **Current Liabilities total** | **(77,843)** | **(79,659)** | **1,817** |
| | | | |
| **Total assets less current liabilities** | **286,715** | **289,324** | **(2,610)** |
| | | | |
| **Non current liabilities** | | | |
| Provisions | (1,857) | (1,857) | 0 |
| Borrowings | (33,761) | (33,270) | (491) |
| | | | |
| **TOTAL ASSETS EMPLOYED** | **251,097** | **254,196** | **(3,100)** |
| | | | |
| **Financed by:** | | | |
| Public Dividend Capital | 217,122 | 221,539 | (4,417) |
| Income and Expenditure Reserve | (5,932) | (7,249) | 1,317 |
| Revaluation reserve | 39,906 | 39,906 | 0 |
| | | | |
| **Total Equity** | **251,096** | **254,196** | **(3,100)** |

**The Group Balance Sheet (RUH and Sulis)**

**Month 6 against month 5 movement:**

- Capital has increased in line with reported capital spend plan less depreciation.

- Cash has decreased between months.

# Tracker Measure | Sustainability Savings

| | Target Areas | Internal Annual Plan | Identified to date | Gap to identify | YTD Plan | YTD actual | YTD variance | Forecast Outturn | Forecast Variance to Plan | Recurrent | Non-Recurrent (NR) Mitigation |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| Transformation Schemes | | | | | | | | | | | |
| Outpatient Productivity | 315 | 158 | 158 | 0 | 0 | 0 | 0 | 158 | 0 | 0 | 0 |
| Home First | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medicines Management | 779 | 779 | 779 | 0 | 293 | 46 | 247 | 779 | (0) | 46 | 0 |
| Agency and Recruitment - Nursing | 1,461 | 1,461 | 1,461 | (0) | 235 | 246 | (11) | 1,460 | 1 | 246 | 0 |
| Agency and Recruiment - RMNs | 0 | 0 | 0 | 0 | 0 | (216) | 216 | 0 | 0 | (216) | 0 |
| Agency and Recruitment - Medical | 500 | 500 | 500 | 0 | 167 | 0 | 167 | 500 | 0 | 0 | 0 |
| Theatre Efficiency | 383 | 383 | 383 | 0 | 0 | 0 | 0 | 383 | 0 | 0 | 0 |
| ICU Capacity | 1,300 | 1,300 | 1,000 | 300 | 186 | 673 | (487) | 1,000 | 300 | 673 | 0 |
| ICU Transformation Target | 1,500 | 1,500 | 0 | 1,500 | 0 | 0 | 0 | 0 | (1,500) | 0 | 0 |
| Investment Review - TIG | 934 | 934 | 934 | (0) | 526 | 466 | 60 | 934 | 0 | 466 | 0 |
| Elective Recovery (Orthopaedics) | 200 | 200 | 200 | 0 | 0 | 0 | 0 | 200 | 0 | 0 | 0 |
| Cleaning / Catering Income | 275 | 275 | 275 | 0 | 140 | 138 | 3 | 275 | 0 | 138 | 0 |
| Portering | 75 | 75 | 75 | 0 | 0 | 0 | 0 | 75 | 0 | 0 | 0 |
| Sulis Transformational Target | 500 | 500 | 0 | 500 | 160 | 0 | 160 | 0 | (500) | 0 | 0 |
| Workforce Processes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| To be identified | 281 | 149 | 0 | 149 | 81 | 0 | 81 | 870 | (721) | 0 | 0 |
| **Sub Total Transformation** | **8,503** | **8,214** | **5,765** | **2,449** | **1,787** | **1,353** | **435** | **6,634** | **(2,420)** | **1,353** | **0** |
| | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| Divisional / Sulis QIPP | | | | | | | | | | | |
| Surgery | 1,420 | 1,420 | 1,420 | 0 | 605 | 683 | (78) | 1,264 | 156 | 273 | 410 |
| Medicine | 1,678 | 1,678 | 836 | 842 | 385 | 527 | (142) | 1,615 | 63 | 184 | 344 |
| Emergency Medicine | 249 | 249 | 0 | 249 | 0 | 0 | 0 | 249 | (0) | 0 | 0 |
| FaSS | 775 | 775 | 821 | (46) | 304 | 317 | (13) | 775 | 0 | 317 | 0 |
| ERM | 325 | 325 | 278 | 47 | 141 | 83 | 58 | 325 | 0 | 83 | 0 |
| Corporate | 639 | 639 | 318 | 321 | 164 | 245 | (82) | 639 | 0 | 227 | 18 |
| Sulis stretch target | 500 | 500 | 500 | 0 | 160 | 0 | 160 | 500 | 0 | 0 | 0 |
| Procurement stretch target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| COVID | 1,000 | 1,000 | 800 | 200 | 600 | 791 | (190) | 800 | 200 | 791 | 0 |
| **Sub Total Divisional** | **6,586** | **6,586** | **4,973** | **1,613** | **2,359** | **2,645** | **(287)** | **6,166** | **420** | **1,874** | **772** |
| | | | | | | | | | | | |
| ERF Efficiency | 1,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Non Recurrent slippage | 2,000 | 0 | 2,000 | (2,000) | 0 | 0 | 0 | 2,000 | 2,000 | | |
| | | | | | | | | | | | |
| **Total QIPP** | **18,589** | **14,800** | **12,738** | **2,062** | **4,146** | **3,998** | **148** | **14,800** | **(0)** | **3,226** | **772** |