Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**1 March 2023**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor:	**Simon Sethi, Chief Operating Officer** **Libby Walters, Director of Finance & Deputy CEO** **Alfredo Thompson, Director for People & Culture** **Toni Lynch, Chief Nurse**		
Author:	**Niall Prosser, Deputy Chief Operating Officer** **Tom Williams, Head of Financial Management** **Jenny Turton, Associate Director HR** **Rob Eliot, Lead for Quality Assurance**		
Appendices	**Appendix 1: Integrated Performance Report**		

1. Executive Summary of the Report

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

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

Operations

January had periods of significant pressure but across every measure within the Trusts performance measures in the IPR the Trust delivered performance improvements. During the month the Trust had an average of 37 COVID cases, although peaking at 71 and 141 Non Criteria to Reside patients. There were also a number of strikes that took place.

- The Trust lost a total of 1,756 hours in ambulance handovers. This is more than half of the previous month
- RUH 4 hour performance during January was 65.5%, which is a 5% improvement on December and the strongest performance for the last 6 months.
- The Trust had an average of 141.6 patients waiting who had no criteria to reside. The Trust has seen a reduction in the length of time it is taking for patients to be discharged within BaNES as improvements in pathway and capacity come on line.
- Cancer 62 day performance in December improved to 68%. The Trust continues to remain one of the strongest performers within the South West Region.
- During January the Trust reported zero patients waiting over 104 weeks and an improved number of patients waiting over 78 weeks with it further falling to 146.
- The Trust delivered 106% of costed activity against the ERF target in month. This means performance YTD is currently at 106% against the national target of 104%.

Within the February performance data we will be able to highlight the impact of both

RCN and Ambulance strikes.

Finance

- The RUH delivered a deficit of £21.0 million against a plan of £17.1 million.
- The number of Non Criteria to Reside patients remains high with an average of 142, which was above the planned level. Work is happening across BSW to focus on reducing the number of patients with no criteria to reside at the RUH.
- Agency usage is 3.6% of total pay costs and is therefore above the 3% target.
- Elective activity of 106% of 2019/20 levels has been achieved year to date.
- £11.1 million of savings have been delivered against a plan of £11.1 million year to date.
- 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 have been spent to maintain the safety of the site over winter and non-recurrent funding has been confirmed to cover these costs. The financial plan is expected to deliver with the implementation of the recovery plan and the identification of mitigations for £2.0 million of outstanding financial risks.

Workforce

- The RUH establishment in January stands at 5368.70 whole-time equivalents (WTE) at month 10.
- Vacancies at the end of January were 133.3; the vacancy rate has decreased to 2.48%, which is a positive variance against the target of 4.00%. International nursing recruitment continues to contribute significantly to the improved position.
- Staff turnover is at 11.39%, against a target for staff turnover at 11.00%; the Facilities team are developing a number of initiatives which is anticipated will help with the retention of staff across the Trust, if successful.
- Sickness absence in December was 5.75% against the target of 4.20% which is a marked increase on 4.61% in December. Anxiety, stress and depression were the main causes of sickness absence during the month. The Trust has the lowest sickness rates in the South West.
- The Nurse Agency spend as a proportion of the Registered Nursing pay bill is showing a significant increase from 3.07% in December to 7.65% in January.
- The percentage figure for Appraisal completion is 90%; all parts of the RUH remain significantly below this target. Reporting and value added remain issues for non-compliance. Focussed work still continues to support completion.
- Mandatory and Statutory Training (MaST) training compliance levels are at 86.0%, against a revised target of 85.00%. Information governance compliance has reduced fractionally to 75.7%.

Quality

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

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

- Patient safety incidents – rate per 1,000 bed days
- Serious incidents with overdue actions
- Number of falls resulting in significant hard (Moderate to Catastrophic)
- Number of Hospital Acquired Pressure Ulcers Category 4
- Pseudomonas Aeruginosa

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

- Healthcare Associated Infections

  The Trust remains above trajectory for *Clostrioides Difficile*, E coli and Klebsiella infections. There were 9 *Clostrioides Difficile* reported in January 2023, 8 E coli and 5 Klebsiella infections.

  COVID-19: There were 137 COVID-19 positive cases detected during January 2023 with 44 of these confirmed as COVID-19 8+ days infections. There were 2 mortalities associated to a nosocomial COVID-19 infection. Both cases have COVID recorded on part 1 of the death certificate.

  A number of actions are being undertaken to reduce Hospital Acquired Infections, which include:
  - The creation of 23 additional new en-suite facilities across wards, which is scheduled to be completed by the end of March 2023.
  - The Cleaning Standards Group commenced to oversee and improve compliance of cleaning standards across the Trust chaired by the Deputy Director of Estates and Facilities and the Deputy Director of Infection, Prevention and Control.
  - A thematic review has been undertaken for the RUH C-difficile hospital onset cases reported to date. This was reported to the Quality Governance Committee in February 2023. There is no evidence of cross infection between cases on wards during periods of increased incidence.
  - IPC team members remain active members of the Bath, North East Somerset, Swindon and Wiltshire, Healthcare Acquired Infection reduction collaborative. Four workshops are scheduled to progress a system wide approach to addressing the issues.
  - A plan to improve patient hydration within the Trust is being taken forward by working in collaboration with Public Health to launch a hydration campaign across BaNES. A Hydration Improvement Group has commenced within the Trust.
  - Procurement are trialling a new cannula. If successful the company will provide a comprehensive training and support package to staff.
  - The Trust continues to apply NHSIE guidance underpinned by local risk assessment to reduce COVID-19 spread.
  - Review of the Root Cause Analysis (RCA) template for COVID-19 mortality to focus on omissions or gaps in care that could result in a serious incident.

- Number of Hospital Acquired Pressure Ulcers
  There were 3 category 2 pressure ulcers in January 2023, increasing the total to 22, which is 12 over trajectory. There were 2 medical device related pressure ulcers reported and one related to the inappropriate application of anti -embolic stockings on a high risk patient.

  A number of actions are being undertaken to further reduce pressure ulcers which include:
  - Increasing awareness of the correct process for requirement, measurement and care of a patient with anti-embolic stockings.
  - Refreshing awareness of the non-concordance with pressure ulcer care protocol.

Other Quality Metrics of note:

- Falls
  There was one fall resulting in moderate harm in January 2023. This incident is being investigated as part of the falls serious harm process and part of the weekly tracker measures linking falls data with safer staffing analysis.

  A number of actions are being taken to reduce falls which include:
  - Continuation of a working group to develop guidance for alternative footwear to slipper socks – 'Stop the Socks' campaign.
  - Weekly tracker measures are in place linking falls data with safer staffing analysis.
  - 5 wards signed up to Reconditioning Games with the Emergency Care Improvement Support Team (ECIST). A total of 8 Gold medals have been awarded across 4 wards.
  - The improvement Cycle of Plan, Do, Study, Act, has been applied on one ward to create an advice checklist for carers/relatives of personal belongings to support the safety of patients (e.g. footwear, clothing).
  - Changes to the recording of Lying and Standing Blood pressure on Millennium - to launch Feb 2023.

- Safeguarding actions
  The safeguarding slide focuses on the actions required following the Unannounced CQC inspection of Medical Care including meeting Levels 2 and 3 Adult Safeguarding Mandatory Training targets. The Trust remains below target for levels 2 and 3. Face to face training sessions for Level 2 commenced in February 2023. All staff still requiring Level 3 training are booked onto future training sessions with 26 staff booked on to a session on 21 February. In addition to this, the Senior Sisters, Charge Nurses and Matrons undertake daily, weekly and monthly inspections of care to deliver improvements to safeguarding requirements for mental capacity, best interest decisions and Deprivation of Liberty safeguards. The Clinical Friday session on 17 February will be focused on assessing adherence and understanding of these safeguarding requirements.

- Patient Experience

- The Trust received 28 formal complaints in January.
- 53% of complaints closed during January met the required timescale of 35 working days. This has deteriorated since December.
- The number of PALS contacts in January was 373 - key themes are: Appointments, Communication and Information, and Clinical Care and Concerns

- Maternity
  - The Midwife to Birth Ratio is 1:33, which reduces to 1:30 when bank staff are included against a standard of 1:27.
  - The Daily multidisciplinary team ward round was 77% for January 2023, compared to 100% in November and December 2022, the reason for this is being investigated.
  - The Maternity Fill rate for December was 90.4% for day staff and 95.9% for night staff which shows an improvement from December. The average fill rate for care staff has also increased with 66.5% for day staff and 98.5% for night staff.
  - The Midwifery Band 5/6 vacancy rate is -12 WTE, inclusive of maternity leave, which is forecasted for Feb to be -13.40 WTE.

2.	Recommendations (Note, Approve, Discuss)

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

3.	Legal / Regulatory Implications

Trust Single Oversight Framework.

Quality: It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

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

The Integrated Performance Report is linked to the Board Assurance Framework and Risk Register.

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

5.	Resources Implications (Financial / staffing)

Operational and financial risks as set out in the paper.

Quality: Funding awaited for hand-held devices in ED for deteriorating patient safety priority.

6.	Equality and Diversity
None identified.	

7.	References to previous reports
Standing agenda item. Quality: Monthly updates to Quality Board and Trust Management Executive.	

8.	Freedom of Information
Private	

9.	Sustainability
None identified.	

10.	Digital
None identified. Quality: Deteriorating patient priority identifies actions requiring IT input that links to the Trust's Digital Strategy. New E obs Deteriorating patient form to go live.	

Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report – February 2023

(January 2023 Data)

The RUH, where you matter

22/23 Priorities

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

The RUH, where you matter

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Workforce Report

Month 10

The RUH, where you matter

Executive Summary I

	Performance Indicator	Performing	Outside Tolerance	Last 12 Months											
				Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Breakthrough Objective	Trust Vacancy WTE (Unit 4)	<=233.6	>260.2	153.3	166.1	398.9	316.8	322.0	347.3	267.2	307.3	240.0	194.9	150.9	133.3
Contextual Information	Trust Establishment WTE (Unit 4)			5167.5	5167.5	5382.5	5320.7	5320.7	5368.7	5368.7	5368.7	5368.7	5368.7	5368.7	5368.7
Contextual Information	Substantive WTE (Unit 4)			5014.3	5001.4	4981.6	5003.8	4998.6	5021.4	5101.4	5061.4	5128.7	5173.8	5217.7	5235.4
Key Standard	Vacancy Rate	<=4.4%	>4.9%	2.97%	3.21%	7.41%	5.95%	6.05%	6.47%	4.98%	5.72%	4.47%	3.63%	2.81%	2.48%
Key Standard	In Month Turnover	<=0.92%	>1.00%	0.92%	1.31%	0.97%	0.88%	1.06%	0.99%	1.14%	1.09%	0.83%	0.55%	0.78%	0.50%
Key Standard	Rolling 12 Month Turnover	<=11.0%	>12.0%	10.25%	10.88%	11.00%	11.23%	11.61%	11.81%	12.05%	11.75%	11.72%	11.78%	11.74%	11.39%
Contextual Information	Bank Use (Staffing Solutions Data)			258.3	266.3	279.4	281.1	256.8	278.4	261.5	284.3	343.6	300.4	261.9	288.6
Contextual Information	Agency Use (Staffing Solutions Data)			104.3	142.9	122.3	129.9	146.9	138.0	130.9	126.0	109.1	85.3	80.8	100.7
Key Standard	Agency Spend as Proportion of Total Pay Bill	<=2.5%	>3.5%	3.22%	2.95%	4.26%	3.78%	4.61%	6.56%	5.40%	3.87%	3.37%	2.98%	3.50%	3.44%
Key Standard	Nurse Agency Spend as Proportion of Registered Nursing Pay Bill	<=3.0%	>4.0%	6.58%	8.12%	11.66%	7.09%	9.36%	11.04%	12.08%	8.46%	11.46%	5.50%	3.07%	7.65%
Key Standard	In Month Sickness Rate (Actual) - Reported 1 month behind	<=4.6%	>5.1%	5.50%	6.69%	6.10%	4.66%	5.28%	6.28%	4.57%	4.44%	5.02%	4.61%	5.75%	
Contextual Information	In Month Sickness - Estimated Cost (£m)			£0.74m	£1.05m	£0.92m	£0.70m	£0.81m	£1.00m	£0.68m	£0.66m	£0.78m	£0.71m	£0.94m	
Key Standard	Rolling 12 Month Sickness Rate - Reported 1 month behind	<=4.3%	>4.8%	4.87%	5.10%	5.31%	5.38%	5.48%	5.62%	5.59%	5.55%	5.49%	5.43%	5.43%	
Tracker	Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.23%	1.22%	1.19%	1.17%	1.11%	1.05%	0.99%	0.98%	0.99%	0.99%	1.01%	
Contextual Information	In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.24%	1.10%	0.95%	1.02%	0.94%	1.04%	0.90%	1.00%	1.05%	1.00%	1.05%	

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Sickness Absence	Overall sickness data levels have improved again, to 4.61%, whilst the annual rate remains above target at 5.43%; the proportion attributable to anxiety, stress and depression has risen slightly.	The data shown includes the impact of seasonal flu and by the COVID pandemic and seasonal flu. Vaccination continues to be encouraged. Where sickness absence is attributable to stress / burnout staff are encouraged to access the wellbeing support made available. Work to develop a 'Wellness Centre' at the RUH has begun.
Agency Spend	Overall agency spend as a proportion of the total pay bill deteriorated slightly (from 2.98% to 3.50% in December), this being driven, to some extent, by strike action. Nursing agency as a proportion, improved to 3.07%.	Work continues to find alternatives to bringing in Registered Mental Health nurses through agencies and to increase the proportion of substantive staff, particularly through International Nurse Recruitment.

Executive Summary II

	Performance Indicator	Performing	Outside Tolerance	Last 12 Months											
				Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Tracker	BME likelihood of being appointed from shortlisting - comparative ratio to 1 White (WRES 2) - Rolling 3 months	>=1.0	<0.8	0.57	0.63	0.72	0.66	0.62	0.64	0.63	Not Available	Not Available	Not Available	0.87	0.86
Contextual Information	BME WTE (%) at Band 6 or7			11.51%	11.49%	11.65%	11.47%	11.57%	11.43%	11.74%	11.98%	12.48%	12.47%	12.53%	12.83%
Contextual Information	BME WTE (%) at Band 8A to 9			3.24%	3.23%	3.56%	3.67%	4.39%	4.41%	4.42%	4.67%	4.76%	5.09%	5.08%	5.25%

	Performance Indicator	Latest Month Target	Outside Tolerance	Last 12 Months											
				Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Key Standard	Appraisal Compliance Rate	>=90.0%	<85.0%	59.94%	61.10%	62.66%	66.14%	66.50%	69.65%	71.85%	72.88%	72.96%	74.75%	75.51%	72.73%
Contextual Information	BME Appraisal Compliance Rate	>=90.0%	<85.0%	58.64%	61.05%	64.77%	68.51%	69.09%	71.73%	74.00%	72.95%	73.93%	75.07%	76.37%	75.00%
Key Standard	Mandatory Training Compliance (exc Bank)	>=90.0%	<85.0%	85.60%	85.20%	84.90%	85.60%	85.80%	85.70%	85.10%	85.40%	85.80%	86.40%	86.50%	86.00%
Key Standard	IG Training Compliance	>=95.0%	<90.0%	79.50%	77.20%	75.80%	76.70%	77.20%	75.80%	75.30%	75.50%	77.40%	77.80%	76.70%	75.70%

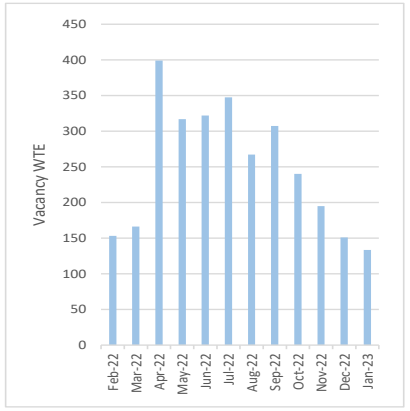
Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Equality and Diversity – BME staff at Band 8a	The rise in proportion of BME staff at Band 8a has stalled.	This indicator is being discussed at the RUH Diversity and Inclusion Steering Group to further promote work to support positive action for BME staff through wider advertising, improved recruitment and selection processes, and development programmes to support BME staff to participate in succession planning.
Appraisal rates	A modest increase in appraisal rates to 75.51%, however, appraisal rates are significantly below the 90% target	A planned deep-dive into appraisal rates by Division and team has begun. The intention will be to continue the upward trajectory such that appraisal rates increase steadily in Q4 and that 90% is attained and can be maintained during 2023/24.

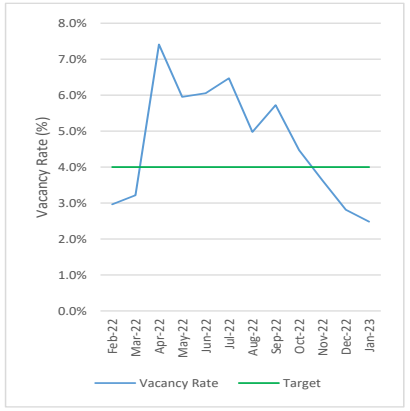
Breakthrough Goal| Reduction in Vacancy WTE

Trust Vacancy Position

WTE

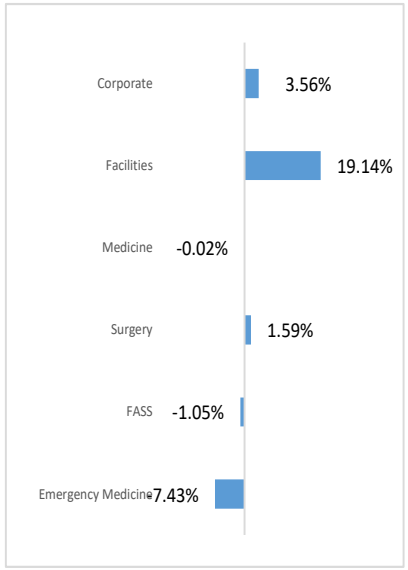


Vacancy Rate

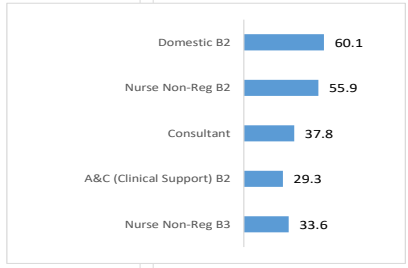


Current Vacancy WTE	133.3	Current Vacancy Rate	2.48%

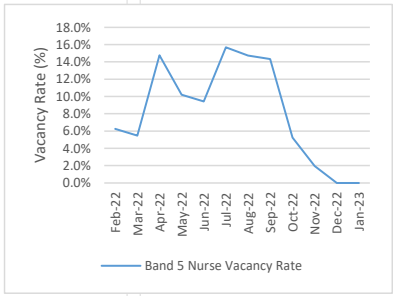
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

• Based on Unit 4 data the Trust now has a vacancy of 133.3.0 WTE, which is equivalent to 2.48%. This places the Trust on course to achieving the ambition of cutting vacancy to under 4% by the end of the Financial Year.

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

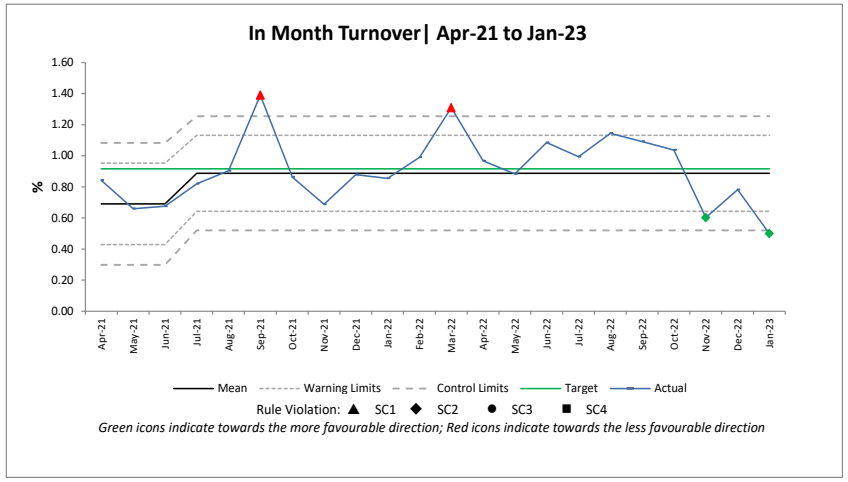
• Facilities continues to have the largest vacancy of the main Divisions, with this reflecting the vacancy associated with cleaning staff.
• Although Trust vacancy is trending down, a number of directorates have seen vacancy WTE increase since the start of the financial year. Exlcuding the COVID Directorate and directorates that remain over-established, the top 3 directorates for vacancy increases are Therapy Services, Older People's Unit and Human Resources.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Vacancies	Overall vacancy rates continue to fall, vacancies are now at the lowest rate since February 2022. This masks particular issues, such as the cleaning workforce.	The overall position on vacancies is well below target; the Operating Plan for 2023/24 will require workforce plans to address key shortages. Work is beginning to develop Divisional Workforce Plans, to be aggregated into an overall RUH Workforce Plan, for 2023/24, and with outline plans for the following four years. Improvement work in the Recruitment Team continues, to reduce time to hire.

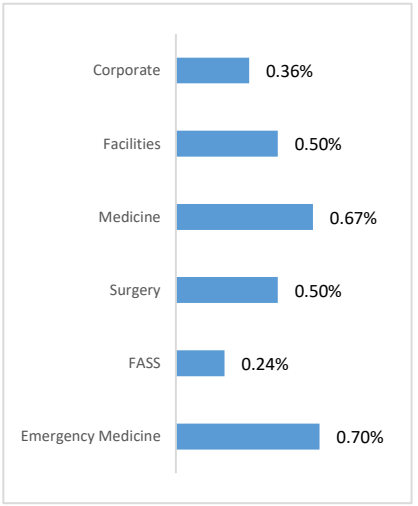
Key Standard| Turnover Rate

In Month Turnover - Trust

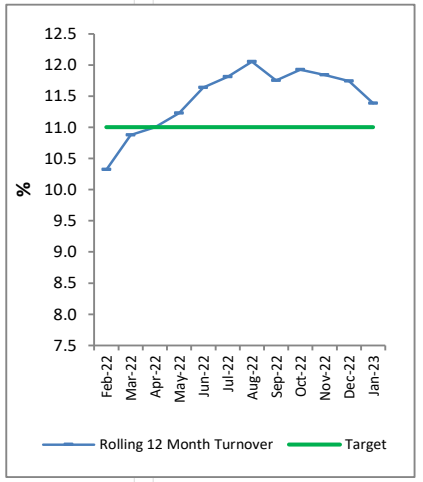


Turnover Rate	0.50%

In Month Divisional Turnover



Rolling 12 Months Turnover - Trust



Turnover Rate	11.39%

Is standard being delivered?

- As it stands, in month turnover in December was 0.50%. This is within the expected parameters as outlined by the SPC chart and below target.
- Rolling 12 month turnover remains fairly static on the position for last month at 11.39%.

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

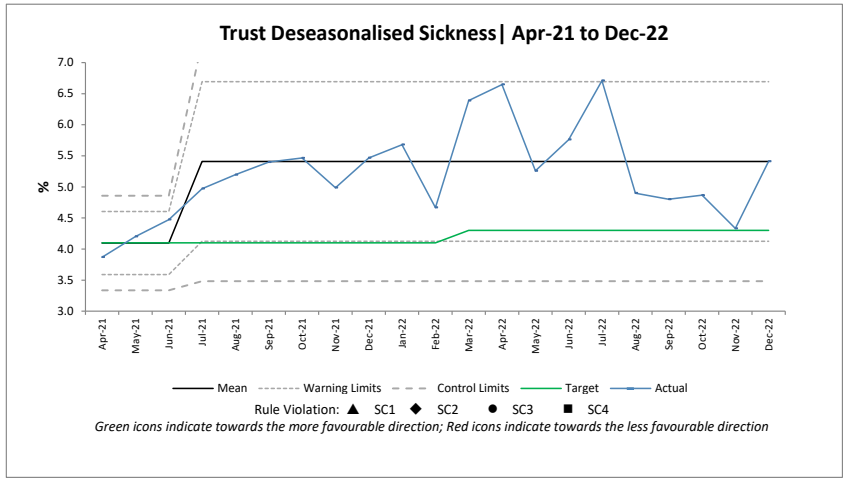
- Emergency Medicine had the highest in month turnover of the Divisions at 0.70%.
- At 14.15%, Facilities has the highest rolling 12 month turnover figure of the main divisions.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Staff Turnover / leavers	Overall turnover rates are near to target, with the exception of the Facilities Workforce (17%).	Further analysis is underway regarding reasons for leaving, by staff group and by Division. Work is being piloted in the Facilities Team to consider how to retain staff, supported by the Board decision to address the 'real living wage' for people employed on Agenda for Change Band Two.

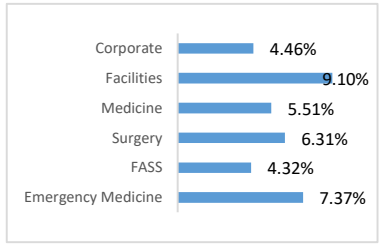
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

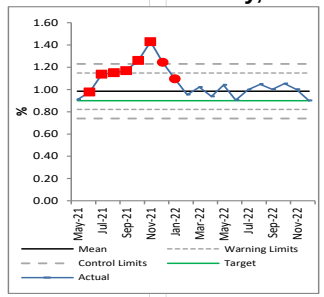


In Month Actual	In Month Deseasonalised	Rolling 12 Months
5.75%	£0.94m	5.43%

In Month Divisional Sickness Rates



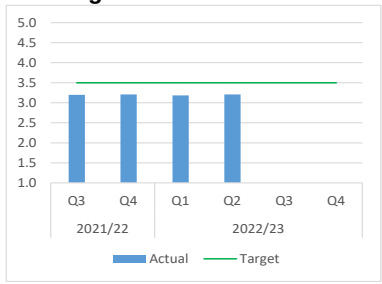
Anxiety, Stress & Depression - Trust



Absence Rate

0.90%

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	1	
Physical assault	-	1	-	-	1	1	1	
Slip, trip, fall same level	3	3	3	-	3	2	1	
Struck against	-	1	-	-	-	-	1	
Struck object	2	1	-	-	1	-	-	
Fell from height	-	-	1	-	-	-	-	
Another kind of accident	-	1	1	-	-	-	1	
Total	5	10	7	3	10	6	5	

Is standard being delivered?

• The sickness absence rate for November is 5.75%. This figure is above target, and is an increase on the position last month.

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

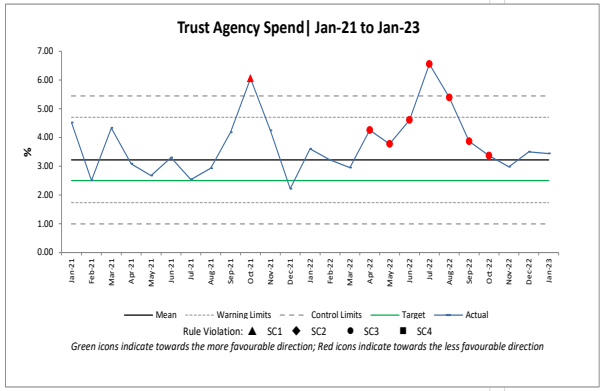
'• The covid absence rate continues to fall and now stands at 0.62%. At 3.99%, the non-covid absence has exceeded the 3.5-3.8% range where it had been for all months in the calendar year to date. • Anxiety,stress and depression absence rate has remained static at 1.0%, nonetheless with over 1500 WTE days lost in November this was the main cause of absence.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Absence	Overall absence rates continue to be above the 4.2% target	The vaccination programmes for COVID and flu have been mitigating the risks from these conditions. Preventative work is focused on anxiety and stress, with staff being encouraged to access support. Work is underway to develop a Wellbeing Centre at the RUH Our work on culture and addressing incivility is anticipated to have a positive impact on absence levels and will be evaluated.

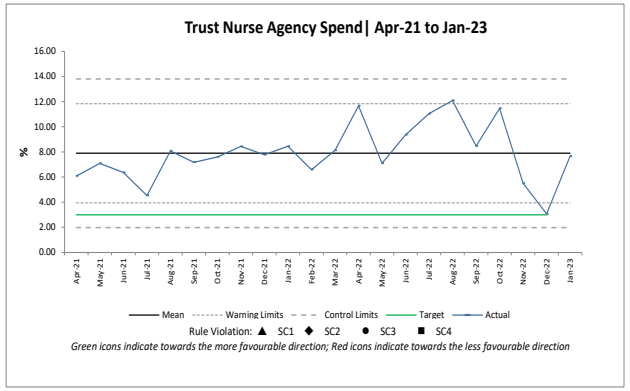
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill



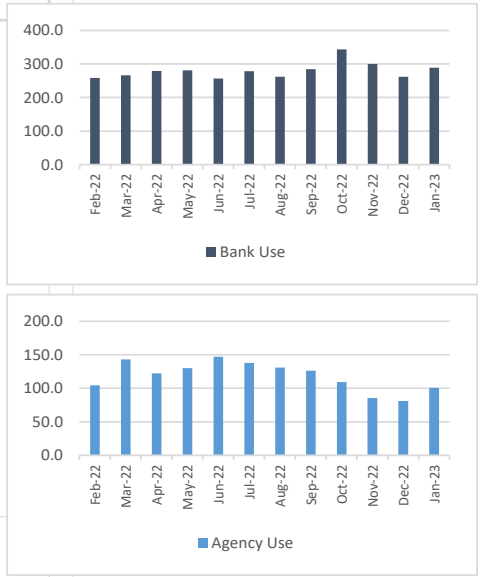
Proportion	3.44%

Nurse Agency Spend as Proportion of Total Registered Nursing Pay Bill



Proportion	7.65%

Bank & Agency Use – Staffing Solutions Data



Is standard being delivered?

- The overall agency spend was 3.44% of the total pay bill.
- Nurse agency spend is up considerably on last month at 7.65% of the nursing pay bill.

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

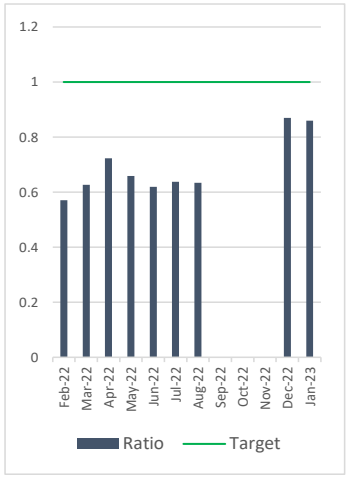
- The vast majority of agency spend was related to registered nursing.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Agency usage	The trend is for nurse agency spend is at target, however, overall agency saw the expected deterioration in December.	Agency usage is reduced primarily by filling vacancies and encouraging the use of the Staffing Solutions (Bank) workforce rather than filling gaps through agency. We have improved our approach to medical staffing by introducing a new supply route, through 'Locum's Nest'. Further work regarding how the Bank functions is underway.

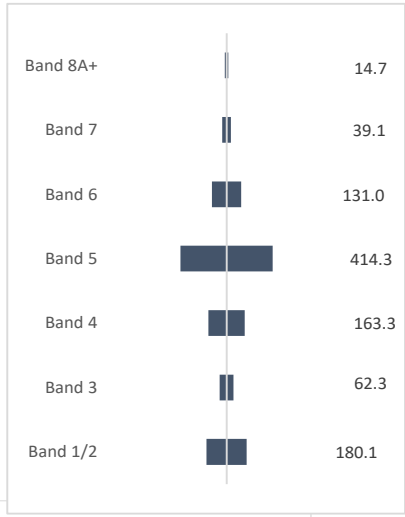
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill



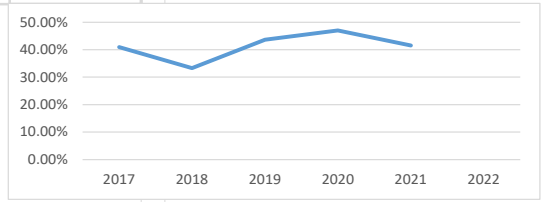
Proportion	0.86

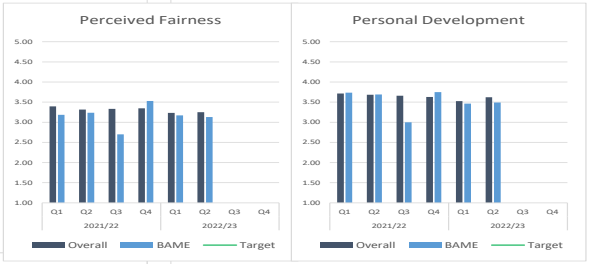
se Agency Spend as Proportion otal Registered Nursing Pay Bill



Proportion	

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

• Following the implantation of Trac, the last 2 available periods to report have both been below the target with the current ratio at 0.86. However this is an improvement on data from taken from NHS Jobs.

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

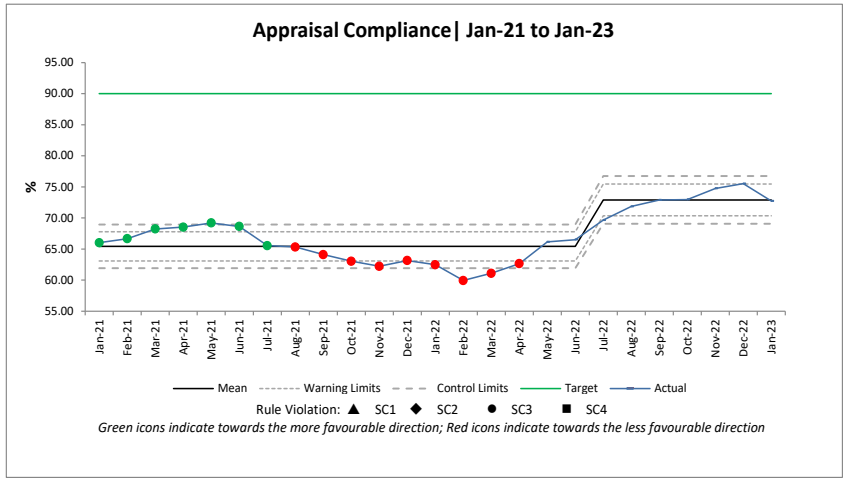
• Facilities is the highest contributor with a ratio above target at 1.17. Medicine is the poorest performing division with a ratio of only 0.59, which is considerably less than the other main divisions.

Countermeasure Summary

Countermeasure/Action	Owner

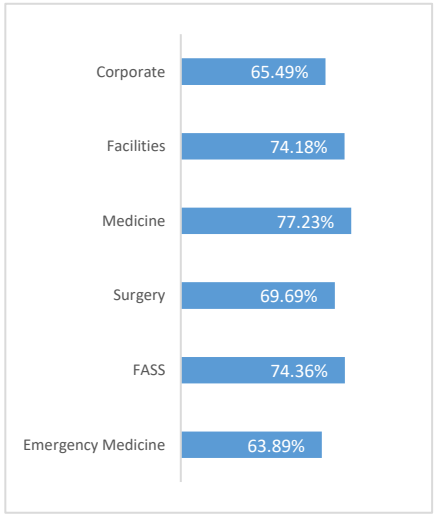
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	72.7%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff 72.3%

M&D Staff 77.4%

Consultants 92.8%

White 72.5%

BME 75.0%

Is standard being delivered?

• Appraisal compliance deteriorated from last months figure of 75.5% and now stands currently at 72.7%.

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

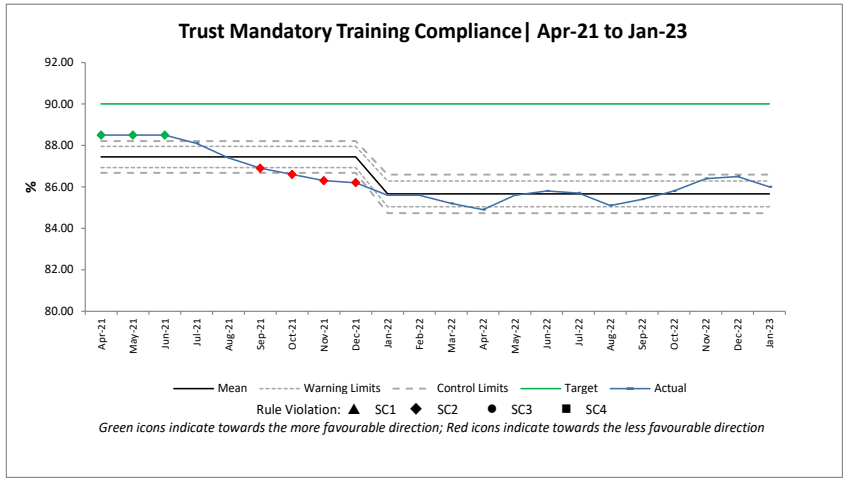
• Emergency Medicine (63.9%), followed by Corporate (65.5%) had the poorest compliance rates of the main Divisions.
• AfC compliance rate (72.3%) continues to fall short of Medical Staff (77.4%)

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Appraisal rates	This measure has improved slightly, but remains significantly below target.	Work is beginning to boost appraisal up-take, through providing improved appraisal systems, better feedback methods and by highlighting this requirement in Divisions and providing training. Some structural re-design work is planned to ensure appropriate 'span of control' (at or below 8 people to line manage) so that all staff have a clearly identified line manager, with sufficient time to provide regular supervision and appraisal.

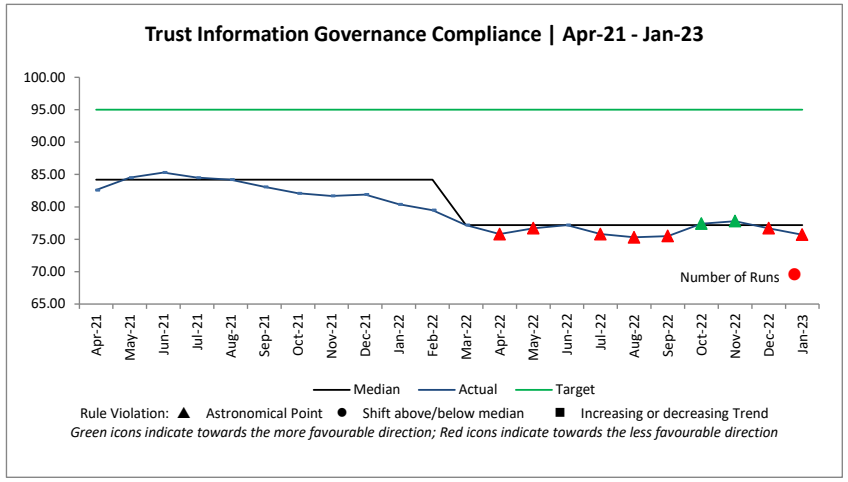
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



Compliance Rate	86.0%

Information Governance Training Compliance Rate - Trust



Compliance Rate	75.7%

Is standard being delivered?

• Overall mandatory training compliance (excluding bank) is fairly static at 86%.
• IG training compliance now stands at 75.7% well below its 95% target. Due to a continuous deterioration in IG compliance since Mar-22 the process has been re-based to reflect this poorer standard.

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

• As has been the case for some time, Facilities has the lowest compliance rates of the main Divisions for both overall mandatory training and IG training.

Countermeasure Summary

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
MaST training rates	This target has been adjusted to 85%.	Work is underway to streamline the MaST Programme, such that compliance is facilitated, both by placing a reduced training requirement upon staff and making learning materials more accessible, through the new Learning Management System (LMS)

The people we care for

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Operations Report

Month 10

The people we care for

The RUH, where you matter

Executive Summary: Performance

Royal United Hospitals Bath NHS
NHS Foundation Trust

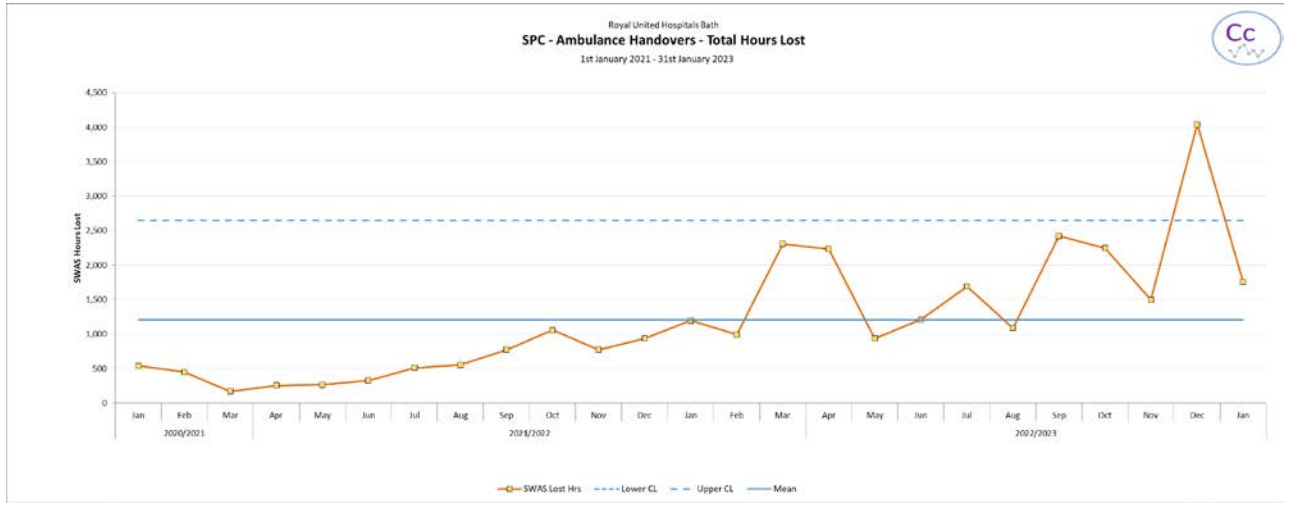
Strategic Goal		Performance Indicator	Target		2021/22						Trend	Movement From Previous Month
			Performing	Under Performing	Aug	Sep	Oct	Nov	Dec	Jan		
Trust Goals	People in our Community	Ambulance Handover Delays	>=39	<39	446	722	784	592	1007	476		
Breakthrough Objectives	People We Care For	4 Hour Performance (Total RUH Footprint, including MIU & Booked)	>=95%	<95%	65.2%	61.5%	60.6%	62.0%	60.1%	65.5%		
	People in our Community	Non Criteria to Reside	<=62	>62	135	129	155	130	141.9	141.6		
Key Standards	People We Care For	RTT - Incomplete Pathways in 18 weeks	>=92%	<92%	61.1%	59.4%	58.8%	59.2%	58.5%	60.2%		
		62 day urgent referral to treatment of all cancers	>=85%	<85%	62.7%	73.6%	68.4%	66.3%	68.0%	(LAG 1)		
		Diagnostic tests maximum wait of 6 weeks	<=1%	>1%	37.6%	40.8%	42.8%	41.9%	50.0%	49.3%		

Measures requiring focus and a countermeasure summary this month are;

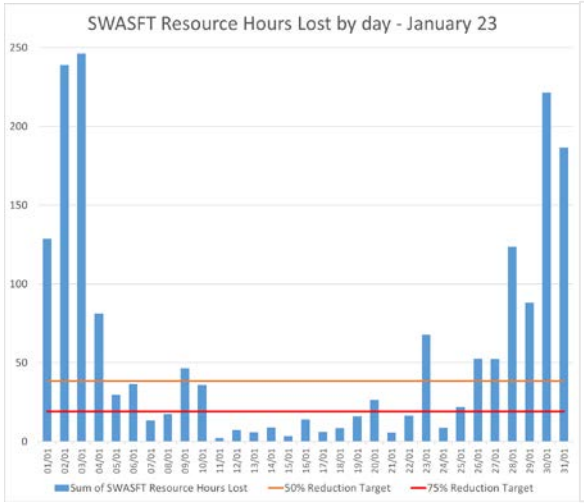
Measure	Change	Executive Summary
Ambulance Handover	↓	In January the Trust lost a total of 1,756 hours in ambulance handovers, an improvement on the previous month. The Trust still had significant challenges at the beginning of the month but saw improvements in both flow, and Ambulance handover delays during the middle of the month. This led to improvements in the ambulance handover position.
4 Hour Performance	↑	RUH 4 hour performance during January was 65.5%. This is a 5% improvement on December and the highest performance in the last 6 months. Flow challenges at the beginning and end of January had an impact on 4 hour performance. Additionally demand within Urgent Care remained very high, with demand still outstripping commissioned capacity.
Non Criteria to Reside (NC2R)	↓	During January the Trust had an average of 141.6 patients waiting who had no criteria to reside. This is a worsening position and still significantly above the system target of 74. The Trust is seeing reductions in the length of time patients are waiting to leave the hospital once they become fit for discharge with the average wait for pathway within BANES as pathway 1 has dropped from 18 days to 7 days, work is focused on further reducing this to 48 hours.
Referral to Treatment	↑	During January the Trust had no patients waiting longer than 104 weeks. The number of pts waiting over 78 weeks further decreased to 146. The biggest contribution to the decrease was from Gastro. The risk to 78 weeks remains being driven by Gastro, General Surgery and Cardiology.
Cancer 62 Days	↑	Performance in December for 62 improved slightly to 68%. Urology and Colorectal remained the largest contributors of breaches in month accounting for two thirds of total Trust breaches. Waiting times for diagnostic imaging and reporting remained a key factor in breaches, and LATP biopsy waiting times for prostate patients specifically.
Diagnostics	↓	January > 6 week performance was 49.3%, which is an improvement in performance when compared to previous month. Significant improvements into Ultra-Sound, MRI and echo.
Elective Recovery	↑	Trust delivered 106% in month against the 104% ERF, putting YTD at 106%. The Trust continues to perform well on day cases and outpatients. Inpatient activity remains lower but the Trust is aiming to start some orthopaedic operating at the RUH site in February.

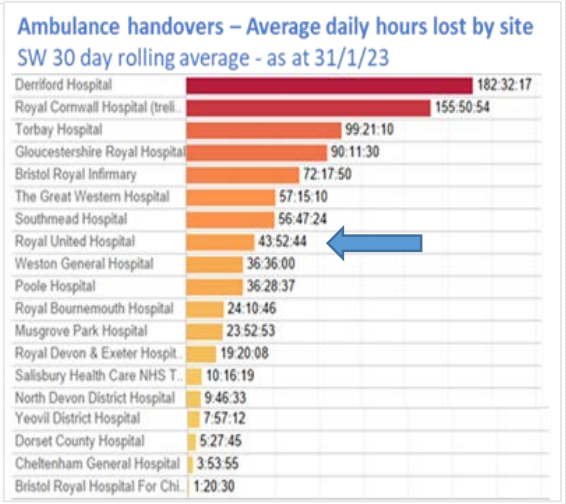
Trust Goal | Ambulance handover delays

Historic Data: hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

In January the Trust lost a total of 1,756 hours in ambulance handovers, a significant improvement in performance.

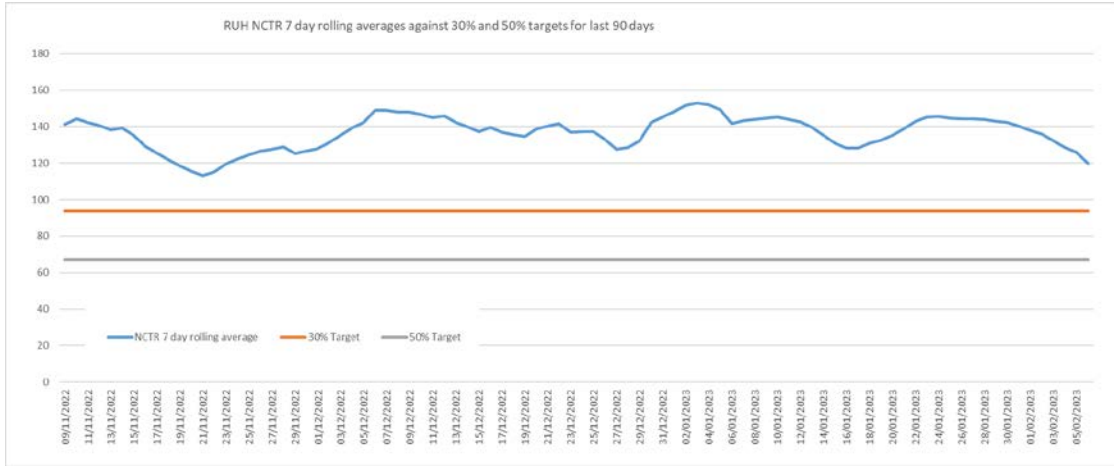
What's the top contributor for under/over achievement?

- During January the Trust started the month with 71 beds occupied with COVID but this dropped to an average of 37 during the month. The Trust also had an average of 141.6 NC2R pts, which is 0.5 better than December.
- As the graph in the top right demonstrates the Trust saw two periods of peak demand at either end of the month.
- The trust continued to use of ACA to support Trust position whilst also utilised its Fracture Clinic to support ambulance handover delays.
- During January the Trust also utilised up to 60 additional beds to try and support flow out of ED.

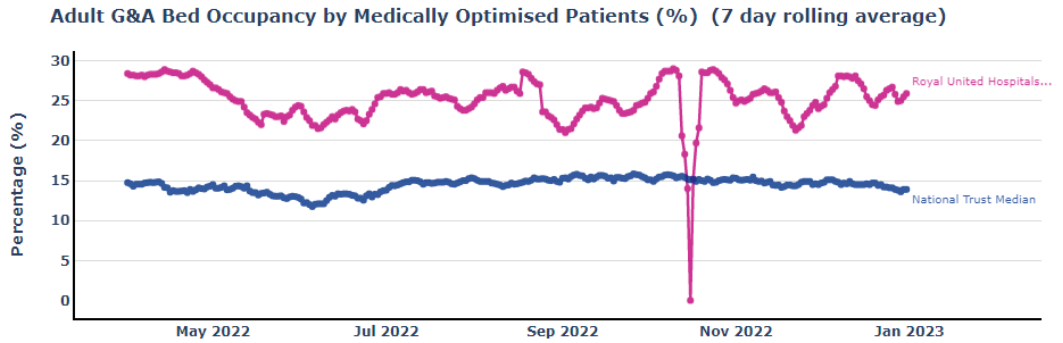
Countermeasures / Actions	Owner	Due Date
Utilise boarded beds to support maintaining flow	Prosser	Quarter 4
Reviewing the ACA model to identify potential different ways of managing and enhancing the offering	ED leadership team	In progress
Additional beds being opened within the RUH and within the community to support flow	Prosser	Quarter 4
Continue to drive improvements in NC2R position to release beds	Prosser	February 23

Breakthrough Goal | Non criteria to reside

Historic Data: as of 08/02/23



Supporting data



Is the standard being delivered?

During January, the Trust had an average of 141.6 patients waiting who had no criteria to reside this is 0.6 pts improvement. This remains above the system target and trajectory. Graph top right demonstrates the percentage of total beds occupied by NC2R patients. This demonstrates that the Trust has one of the most challenged position within the country. We have seen improvements in early February.

We are starting to see a reduction in the Length of time patients are waiting for the NC2R pts in BANES to be discharged with pathway 1 going from 18 to 7 days. This is a precursor to total waits going down.

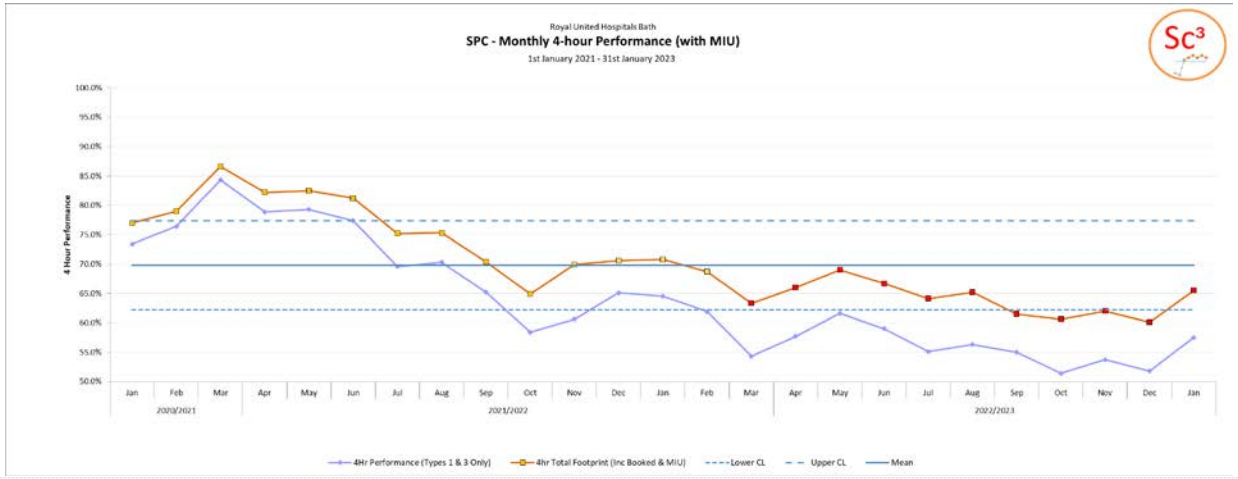
What's the top contributor for under/over achievement?

- The system opened additional capacity in November but not to the level within the initial plan as South Newton beds have not yet come online.
- The RUH has delivered an increase in both Hospital at Home and ART+ and is working on increasing both services capacity during Q4.
- Higher number of patients being discharged on a pathway 2 increasing demand for bedded care.

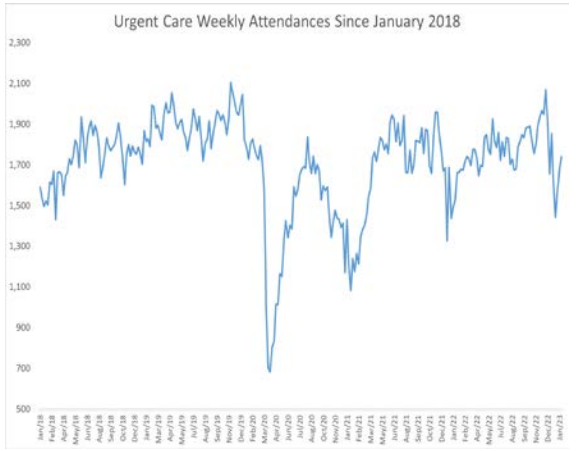
Countermeasures / Actions	Owner	Due Date
United Care BaNES and Council commissioned Domiciliary care to close current capacity gap. UCB to recover position.	Dolman-Sellars	Feb 22
Opening of south newton beds	WH&C	Jan - 23
Developing plans to expand ART to 40 pts and H@H to 35 pts in Q4. (H@H wont impact on NC2R but will support flow) and reduce time to discharge down to 48 hrs for pathway 1	Project Leads	Quarter 4

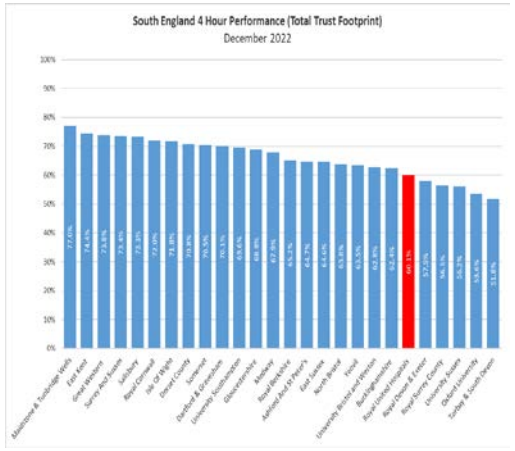
Key Standards | 4 hour Emergency Standard

Historic Data



Supporting data





Is the standard being delivered?

RUH 4 hour performance during January was 65.5% at Trust wide level and 57.5% within the RUH footprint. This is an improvement against performance seen over several months and the strongest performance for 6 months.

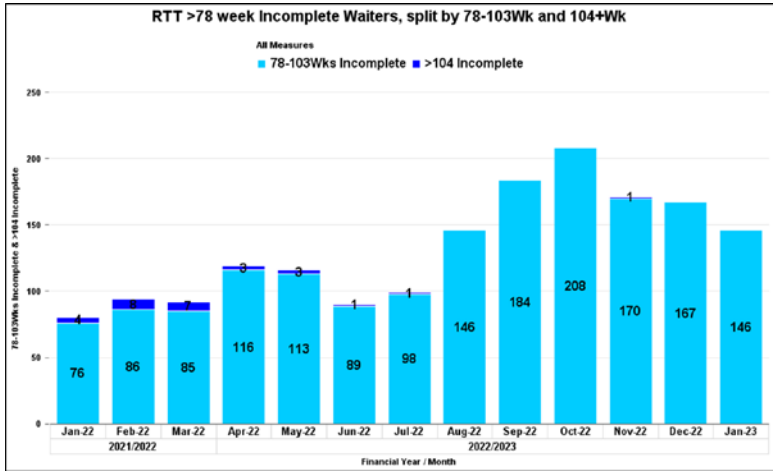
What's the top contributor for under/over achievement?

- The Trust bed occupancy has been peaking at 98.9% compared to a national average of 97% during peaks in January. This is limiting the Trusts ability to respond to the demand within ED.
- Demand levels in January slightly decreased, although have remained at average levels during 22/23 levels eg250 attendances per day.
- The Trust continues to see the impact of the flow challenges linked to high percentage of its bed base being to support Non Criteria to Reside patients. Flu and COVID as this continues to limit the bed availability for patients to be admitted into the hospital. This is delaying the discharge time for ED and leading to patients breaching the 4 hour clock.

Countermeasures / Actions	Owner	Due Date
Development of Medical staffing business case to support delivery of activity in 23/24	Forsyth, Prosser	In progress
Launching pilot for streaming within urgent care	Fouracre	Quarter 4
Work with AWP to progress their business continuity incident impacting on staffing and MH provision.	Prosser	Quarter 4
Continue to recruit to urgent care vacancies and medical staffing gaps	Laird, Fouracre	Feb 22

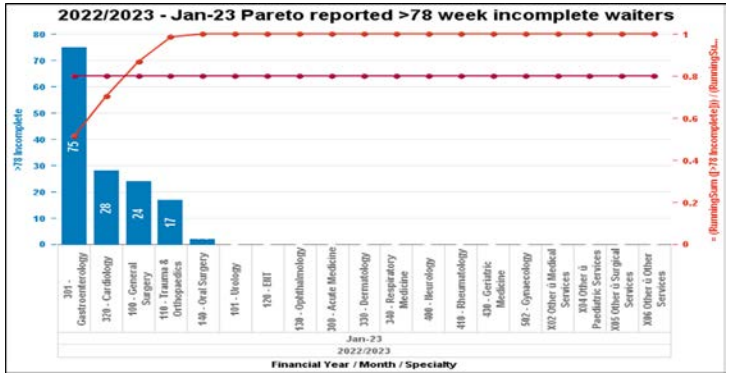
Key Standards | Referral to Treatment

Historic Data



Supporting data

Pareto 78+ (inc. 104+) by Specialty



Is the standard being delivered?

- In Jan the Trust had 146 patients waiting over 78 weeks, improvement on December 22.
- No patients waiting over 104 weeks .
- RTT performance was 60.2% in Jan, up from 58.5% in Dec

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

- Of the 146 Open 78+ Waits are in Gastro has 52%, Cardiology 19%, General Surgery 16% and T&O 12%.
- Cardiology, General Surgery and Oral Surgery 78+ Wait count has started to come down, meanwhile Gastro has increased from 57 to 75 in January
- Progress continues with the cohort of Trust Waits with the *potential* to be 78+ if not stopped before Mar'23. Jan ended with 389, down from 648 at the end of Dec. Oral Surgery made the greatest contribution to the overall reduction with –61

Countermeasures / Actions	Owner	Due Date
General Surgery insourcing agreed starting Jan 23 with theatre lists identified for Feb/Mar 23 -	S Roberts	Jan 23
Additional clinics being provided to reduce wait to first appointment	B Isaac	Ongoing
Cardiology recovery plan review	H Cox	Jan 23
Gastro locum in place and providing additional outpatient clinics.	R Weston	Ongoing
3 x per week 78 week risk meetings in place	J Dando	Ongoing

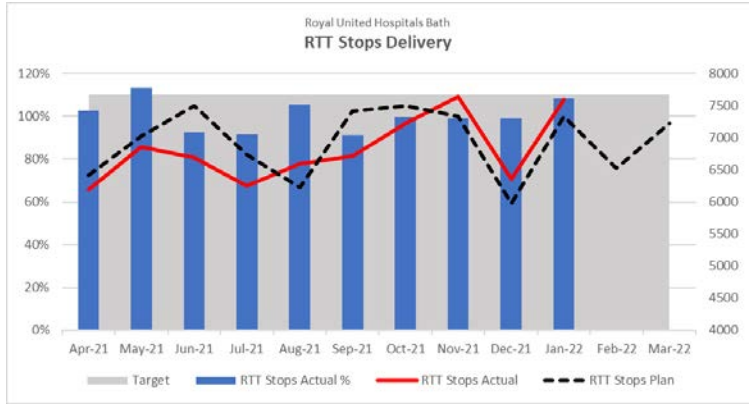
Key Standards | Elective Recovery

Historic Data

		M10	YTD
Division	Specialty	Perf %	Perf %
FASS	Day Cases	157%	108%
FASS	Elective	77%	111%
FASS	Elective XSBD	88%	121%
FASS	Follow up outpatient	125%	129%
FASS	New outpatient	114%	116%
FASS	Outpatient procedures	110%	129%
FASS	**Total**	**118%**	**118%**
Medicine	Day Cases	125%	122%
Medicine	Elective	129%	82%
Medicine	Elective XSBD	6%	72%
Medicine	Follow up outpatient	115%	119%
Medicine	New outpatient	108%	108%
Medicine	Outpatient procedures	101%	102%
Medicine	**Total**	**115%**	**114%**
Surgery	Day Cases	137%	103%
Surgery	Elective	51%	86%
Surgery	Elective XSBD	186%	263%
Surgery	Follow up outpatient	108%	94%
Surgery	New outpatient	96%	106%
Surgery	Outpatient procedures	105%	91%
Surgery	**Total**	**94%**	**96%**
RUH	**Total**	**106%**	**106%**

Supporting data

RTT Stops Delivery



Is the standard being delivered?

- RTT Stops delivery 108% against target of 110% in January
- Trust delivered 106% in month against the 104% ERF, putting YTD at 106%

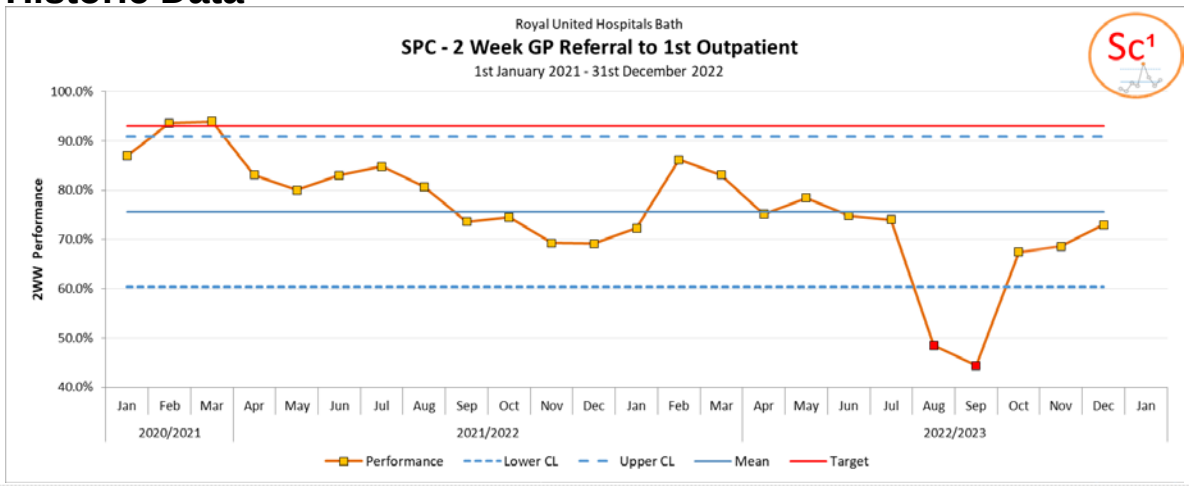
What's the top contributor for under/over achievement?

- Both IP and OP RTT stops high – 106% and 109% of 2019/20 respectively
- High Daycase delivery at 109%. Inpatients lower. Orthopaedic elective bed capacity remains closed
- Outpatient volumes remain high notably in Gastroenterology, Cardiology, Ophthalmology and Paeds
- OP procedures at 82%,which is an improvement on December
- MRI and CT above 120% target. Echoes at 119% and exceeded 1500 scans, which is their highest volume this year

Countermeasures / Actions	Owner	Due Date
Modular theatre at Sulis	S Sethi	Feb 23
ENT and Ophthalmology procedure recording recovery plan in place	S Roberts	On going
General Surgery in sourcing	S Roberts	Jan 23
Ophthalmology recovery plan – additional patients added to outpatient clinics and theatre lists	S Roberts	on going

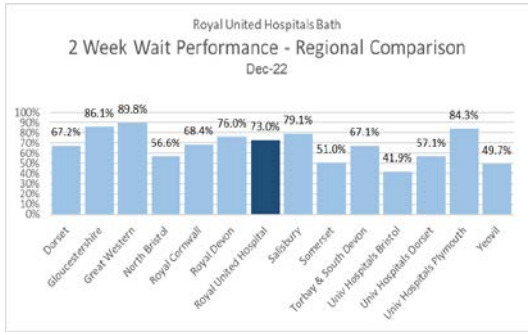
Key Standards | Cancer 2 week wait

Historic Data

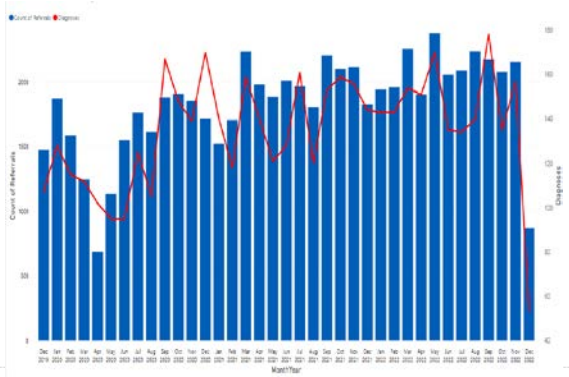


Supporting data

2 week wait Regional Comparison



2 week wait demand and diagnoses



Is the standard being delivered?

In December performance improved again to 73.0%.

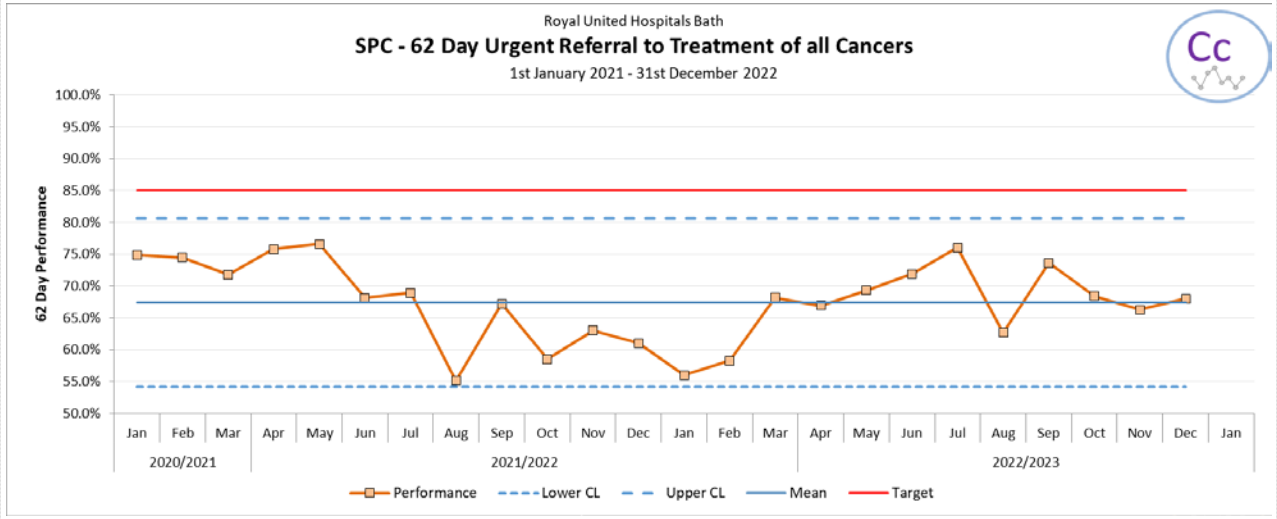
What's the top contributor for under/over achievement?

- Colorectal remained the biggest contributor of breaches but improved their performance from 21% in November to 49% in December.
- Most Colorectal breaches were due to long waiting times for first telephone or face to face outpatient appointments. These waiting times issues have now been resolved with most patients offered an appointment within one week. There were also breaches for patients undergoing endoscopy on *straight to test* pathways.
- Colorectal 2ww demand reduced in month, a common seasonal reduction.
- Urology breaches increased in month, predominantly for patients seen through the haematuria clinic. Performance has been impacted due to substantive consultant vacancies, alongside a considerable demand increased over the past year.
- Ability to increase clinic capacity impacted by strikes.

Countermeasures / Actions	Owner	Due Date
Colorectal – Revised 2ww referral form going live in January	M Bullock	January 23
Colorectal – Locum consultant remain in place – prioritisation of 2ww capacity	N Lepak	Ongoing
Urology – Two consultants appointed – start date April and May 23	J Dando	Completed
Urology – Review long term radiology capacity for haematuria clinics	J Dando	March 23
Urology - Additional flexi capacity being provided by WLI	J Dando	Ongoing

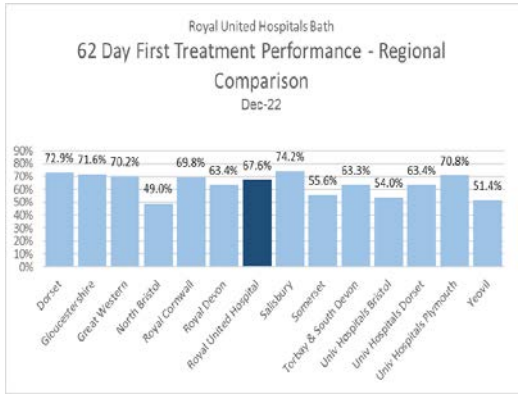
Key Standards | Cancer 62 days

Historic Data

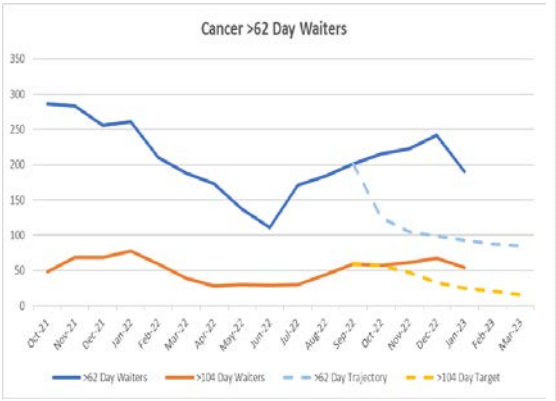


Supporting data

62 Day Regional Comparison



RUH 62 Day Backlog



Is the standard being delivered?

In December performance improved to 68%.

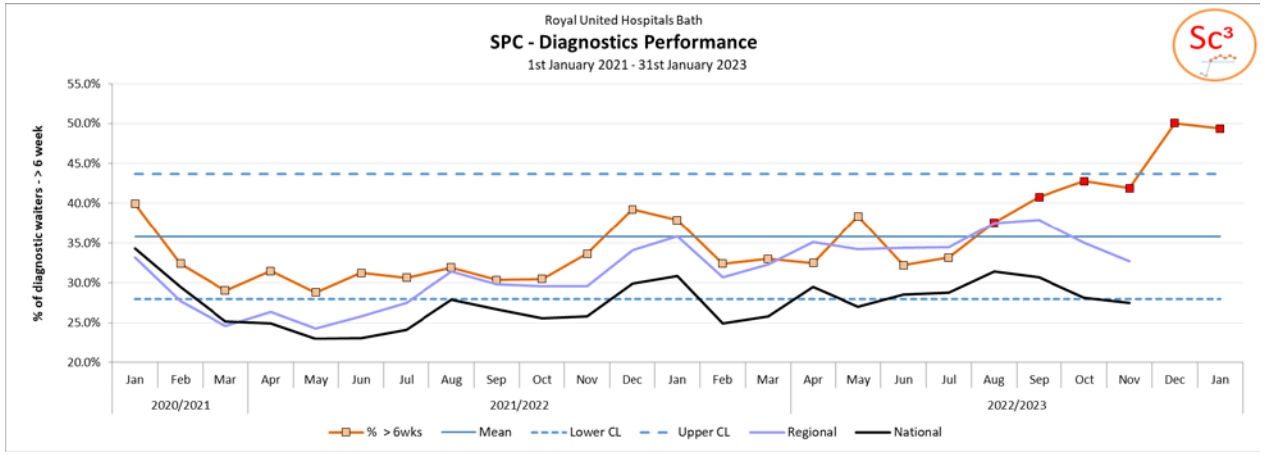
What's the top contributor for under/over achievement?

- Urology remained the top contributor of breaches. 70% of Urology breaches were for patients with prostate cancer. Delays with MRI reporting and LATP biopsies remained the most common reasons for breaches.
- Colorectal recorded the second largest amount of breaches but remained the most challenged tumour site recording performance of 23%. Waiting times for initial diagnostics are a consistent factor in the majority of breaches.
- The number of colorectal patients going straight to a diagnostic test has improved considerably in month to around 40-45% of all 2ww referrals.
- >62 day waiters improved considerably. Colorectal continue to account for over half of all patients over 62 days but the number has reduced dramatically in the past month as a result of the improvements made in the early diagnostic pathway.
- 62 day waiters may be at risk of increasing due to a focus on 78 week patients.

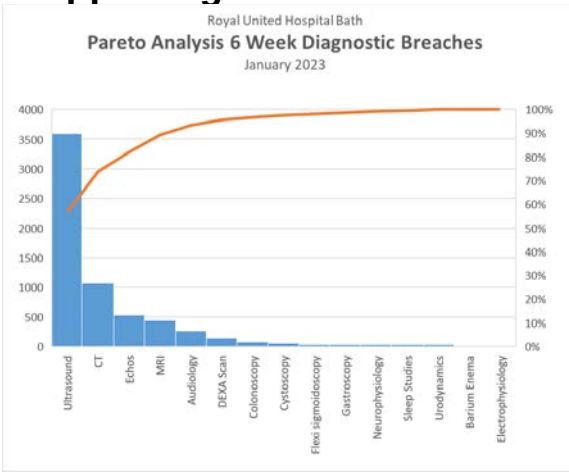
Countermeasures / Actions	Owner	Due Date
Urology – MRI scanning and reporting capacity alignment with PSA clinics	N Aguiar	Feb 23
Urology - Additional WLIs and bank providing LATP capacity.	J Dando	Ongoing
Colorectal – Increase GA endoscopy lists	B Colleypriest S Roberts	Feb 23
Colorectal – Backlog clearance plan for CTC reporting	N Aguiar	Complete
Colorectal – Consultant-led results review sessions planned for March	N Lepak	Mar 23

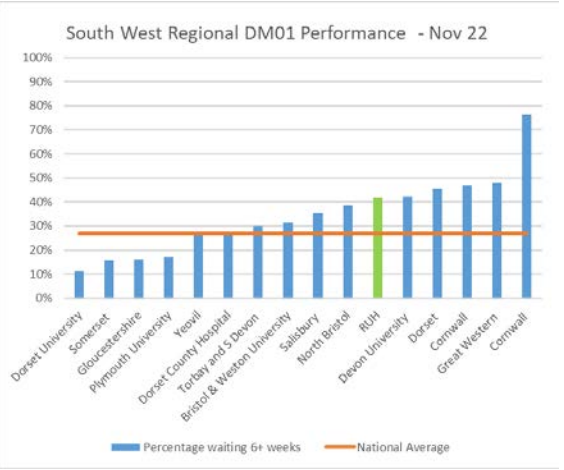
Key Standards | Diagnostics 6 weeks

Historic Data



Supporting data





Is the standard being delivered?

January > 6 week performance was 49.3%, which represents a 0.6% improvement when compared to previous month (-216 breaches).

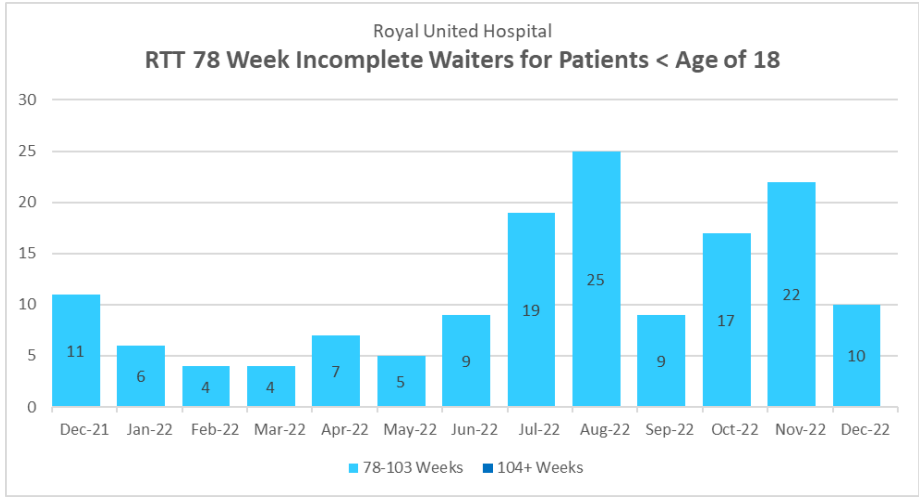
What's the top contributor for under/over achievement?

- Top contributors: Ultrasound, CT and Echocardiography.
- Improvement in performance driven by MRI (-125 breaches), USS (-123 breaches) and Echo (-161 breaches).
- Decline in performance in-month for CT, Audiology and Dexa.
- Reduction in the number of patients >52 weeks (1 breach reported – dated in February).
- Reduction in referrals waiting > 26 weeks.
- Increase in both clinically urgent (2WW) and >78 week requests reducing capacity for routine investigations. CT is the most impacted modality.

Countermeasures / Actions	Owner	Due Date
Modalities working with BIU (Sadie) on recovery trajectories and link with WLMDS	N Aguiar / S Pyecroft	Feb-23
Exploring options to accelerate USS recovery	N Aguiar	Feb-23
Service review commenced within Respiratory labs. 3rd Respiratory – works in progress	M Warner-Holt	In progress
Plan for administrative resources to support Echo booking.	M Beech / B Isaac	Feb-23
Audiology additional Room capacity and revised trajectory	A Bassadone / S Fox	Feb-23
Review and early action: • > 52 weeks referrals booking • > 26 weeks breaches review and booking	J Pegram /J Saddington / N Aguiar	Mar-23

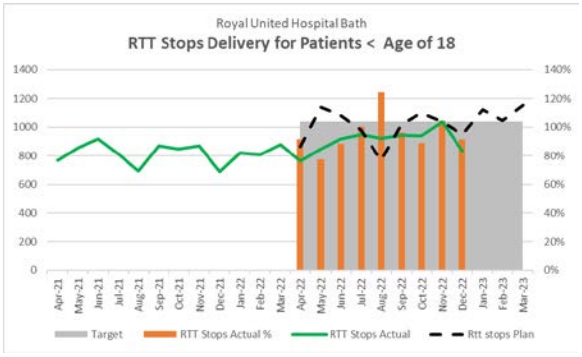
Key Standards | Paediatrics

Historic Data

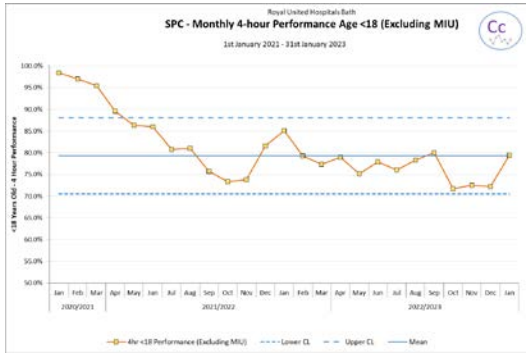


Supporting data

Stops v Plan



4 hr performance



Is the standard being delivered?

- RTT December reflected 5 paediatric patients over 78 weeks. This is a decrease of 5 patients from December position
- Cancer 2ww - There were no 2ww patients seen in December.
- Cancer Diagnostics – 50% One patient breached the 28 day standard due to waiting times for diagnostic imaging in the Breast Unit. The patient was non-cancer.

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

- Oral surgery make up 4 out or 5 to the paediatric waiting list over 78 weeks. All patients have confirmed TCIs.

Countermeasures / Actions	Owner	Due Date
New Day Surgery working group set up to optimise performance – increased dental booking to 8 cases per list	Goodwin	In progress
Additional theatre lists re-prioritised for paediatric oral surgery to support 78 week reduction trajectory	Gillett	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

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Quality Report

February 2023 (January 2022 data)

The RUH, where you matter

Executive Summary | Quality

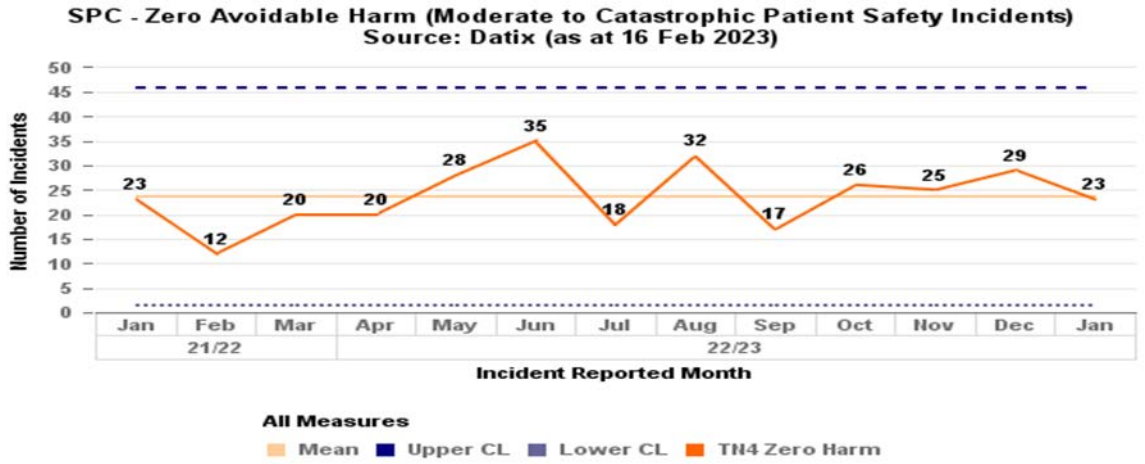
Strategic Goal		Performance Indicator	Description	Target		2021/22			2022/23										Trend
				Performing	Under Performing	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Trust Goals	People We Care For	Zero Avoidable Harm	Reported Patient Safety incidents resulting in significant harm (moderate to catastrophic), excl. rejected			23	12	20	20	28	35	18	32	17	26	25	29	23	
Breakthrough Objectives	People We Care For	Healthcare Associated Infections Excluding COVID, Norovirus & Flu	MRSA, MSSA, E coli, C diff (Healthcare Onset and Community Onset), Klebsiella spp, Pseudomonas aeruginosa	<=11	>11	19	21	26	20	18	13	15	21	23	21	37	17	25	
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	47	44	49	51	41	44	45	48	55	59	55	56	55	
		Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	5	3	2	2	3	2	1	3	1	3	3	4	2	
		Number of falls resulting in significant harm (Moderate to Catastrophic)		<=1	>=3	2	4	2	5	3	7	1	2	1	1	7	1	1	
		ED time to triage	Percentage of ED attendances triaged within 15 minutes			65.7%	57.0%	47.7%	48.1%	51.8%	50.2%	48.2%	54.7%	53.5%	56.1%	58.0%	52.9%	61.5%	
		Falls per 1000 bed days	Includes all falls			7.2	6.0	6.9	7.0	6.9	6.5	6.5	6.1	6.0	6.2	5.3	7.0	6.4	
		Medication Incidents per 1000 bed days	All Incidents			6.5	7.9	5.7	5.8	6.0	5.2	5.7	6.6	7.5	6.9	7.0	6.5	6.8	
		Number of Patients given medication by scanning device				0	0	0	0	0	0	0	0	0	0	0	0	0	
		Early Identification of Deteriorating Patient				17.7%	20.3%	20.3%	19.9%	18.0%	17.7%	19.4%	20.8%	21.0%	19.7%	21.9%	18.5%	22.8%	
		Number of COVID nosocomial infections				18	23	42	32	8	34	110	15	33	61	9	78	44	
		Number of Hospital Acquired Pressure Ulcers Category 2	Includes Medical Device Related	<=2	>2	2	4	3	0	5	5	7	1	1	4	1	3	3	
		Number of Hospital Acquired Pressure Ulcers Category 3 & 4	Includes Medical Device Related	0	>0	1	0	0	0	1	3	0	3	0	3	1	0	0	
		Infection Control - Influenza Outbreaks				0	0	0	0	1	0	0	0	0	0	0	3	0	
		Infection Control - Norovirus Outbreaks				0	0	0	0	0	3	0	0	2	0	0	1	0	
		Mixed Sex Accomodation Breaches					4	0	0	8	3	16	16	17	14	11	18	9	

Measures requiring focus and a countermeasure summary this month are;

Measure	Executive Summary
Healthcare Associated Infections	There were 25 Healthcare Associated Infections in January 2023. o There were 9 cases of *Clostrioides Difficile* with 58 cases so far for 2022/23 compared to a trajectory of 42 o There were 8 E coli infections for January 2023 compared to a monthly trajectory of 6.3 with 84 cases for 2022/23 compared to a trajectory of no more than 76 o There were 5 hospital associated Klebsiella infections reported during January 2023 with 28 infections for 2022/23 compared to a trajectory of no more than 26 o There were 3 hospital onset Methicillin-Susceptible Staphylococcus Aureus (MSSA) blood stream infection during January 2023.
Number of Hospital Acquired Pressure Ulcers Category 2	There were 3 Category 2 Pressure Ulcers in January 2023.
Mixed Sex Accommodation Breaches	There were 9 Mixed Sex Accommodation breaches for January 2023, all within Critical Care.

Trust Goal | Zero avoidable harm

Historic Data



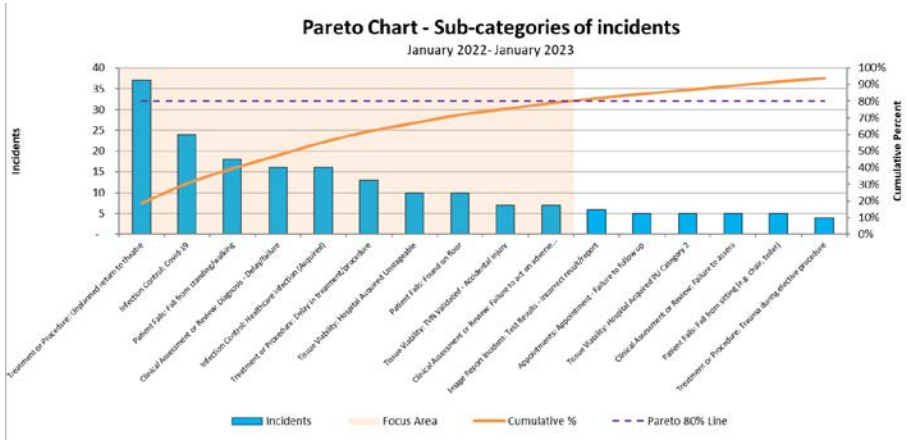
Is the standard being delivered?
In January 2023 there were 23 reported moderate to catastrophic incidents compared to a target of no more than 30 incidents.

What's the top contributor for under/over achievement?
The top contributors for incidents reported for January 2023 were: Infection Control (n=5), Treatment or Procedure (n=4), Clinical Assessment or Review (n=4), Image Report Incident (n=3).

For Infection Control, the top reported sub-category of incident was COVID-19 (n=3), followed by Healthcare Acquired Infection (n=2). For Treatment or Procedure, the top reported sub-category of incident in January was unplanned return to theatre (n=3). For Clinical Assessment or Review, there were 2 cases of Deep Vein Thrombosis or Pulmonary Embolism during hospital stay or within 60 days of hospital admission.

The most frequent types of reported incidents between December 2021 and December 2022 are unplanned returns to theatre (n=37), COVID-19 (n=24) and falls – from standing / walking (n=18).

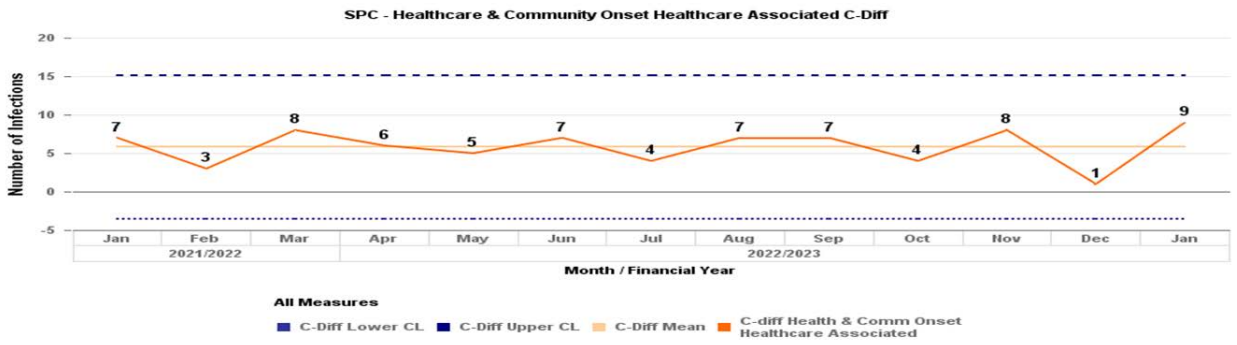
Supporting data



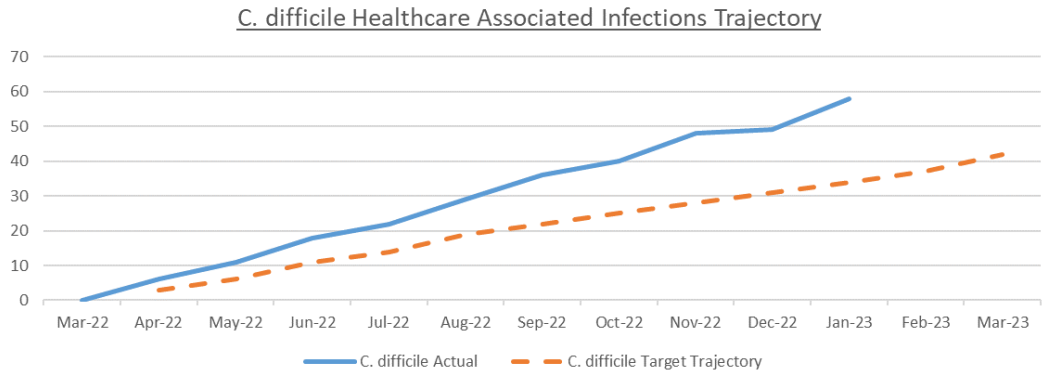
Countermeasures / Actions	Owner	Due Date
Patient Safety Programme (PSP) with 5 priorities monitored through PSSG.	Priority Leads	Oct-23
Refreshed A3 and Driver diagram developed by each PSP priority team.	Priority Leads	Mar-23
PSP priorities to be included in Divisional performance measures.	Improving Together Lead /Divisional triumvirates	Mar -23
Monthly meeting Divisional Governance and Patient Safety Lead to develop template report top contributing themes.	Divisional Governance Leads/Trust PS Lead / PS Nurses	Feb-23
PSIRF project group meeting monthly and starting Diagnostic and Discovery phase in line with national requirements.	Trust Patient Safety Lead	Apr-23

Breakthrough Objective | *Clostridioides Difficile*

Historic Data



Supporting data



Is the standard being delivered?
There were 9 cases of Clostridioides Difficile (CDI) reported during January, all of which were healthcare onset infections. 58 cases have been reported against the trajectory of 42 (trajectory has been breached).

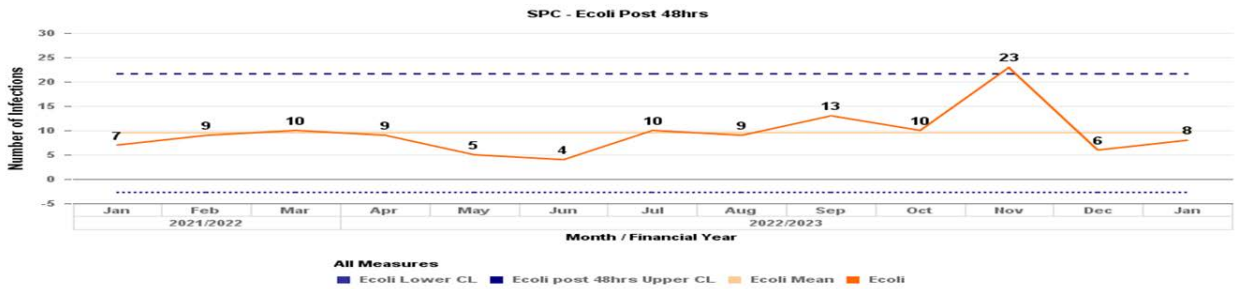
What's the top contributor for under/over achievement?
There was one period of increased incidence on Parry ward, which involved 2 patients being detected with CDI with 28 days.
Learning: Antimicrobial compliance met guidance. Delays in the completion of ward level RCAs. Hand washing technique at ward level was not consistently achieving the expected standard every time.

Trust	Rate (Dec 22)	Rate YTD
SW rate	**16.28**	**27.74**
RUH	**5.67**	**31.46**
GWH	5.57	21.42
SFT	14.42	20.35
Gloucester	30.91	34.13

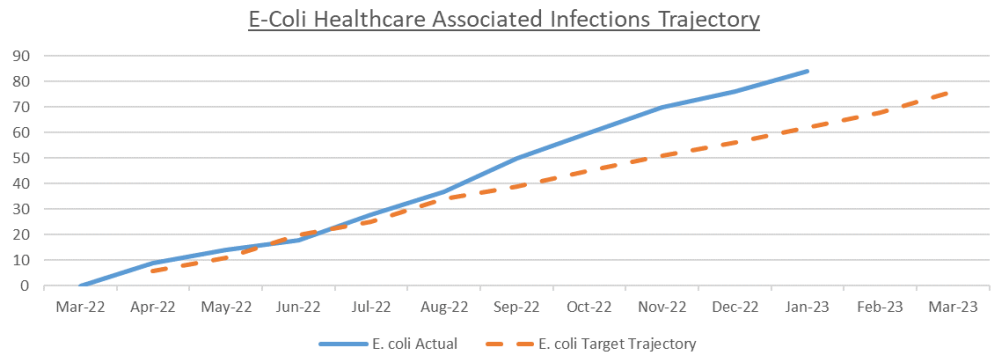
Countermeasures / Actions	Owner	Due Date
IPC team members to remain active members of the BSW HCAI reduction collaborative. 4 workshops scheduled to progress a system wide approach to addressing the issues.	IPC	Aug-23
Review of cleaning standards, staffing levels and effectiveness of the mop system.	Estates & Facilities / IPC	Mar-23
Focus on adherence to effective hand decontamination techniques.	IPC and ward leaders	Apr-23

Breakthrough Objective | E coli

Historic Data



Supporting data



Is the standard being delivered?

There were 8 healthcare associated E coli infections reported during January 2023. This is above the monthly trajectory of 6.3 cases per month, with the annual count to date being 84 against a trajectory of no more than 76 infections during 22/23. This trajectory is breached.

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

The 8 cases were associated to: Hepatobiliary (n=1), Gastrointestinal (n =1). Lower urinary tract infection (UTI) (n=3), UTI with catheter (n=1) and no root cause identified (n=2). A focus on hydration is being developed with BANES public health team and the Integrated Care Board (ICB) to prevent UTIs and improve access to correct treatment plans. This is a long term project and will take time to see any impact.

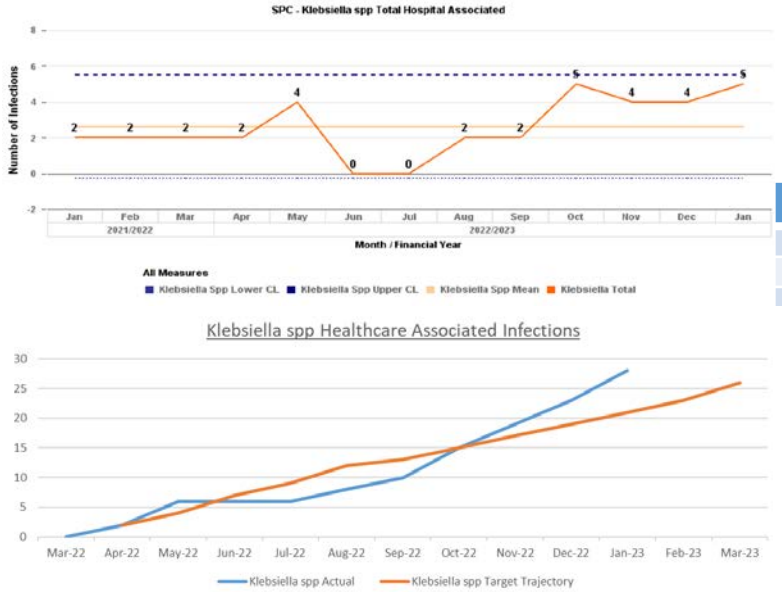
Benchmarking data:

Trust	Rate (Dec 22)	Rate YTD
SW rate	**29.3**	**33.82**
RUH	**34.02**	**49.29**
GWH	51.44	44.47
SFT	21.63	20.32
Gloucester	7.73	29.28

Countermeasures / Actions	Owner	Due Date
Hydration Improvement Group commenced – needs to link into the resources that are being developed with PH.	Matron / Quality Improvement Centre	May-23
Review of urinary catheter care practice and discharge processes as a preventive measure to infection developing- share learning with ICB.	Continence team/ IPC and matrons	May-23
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	Jan-23

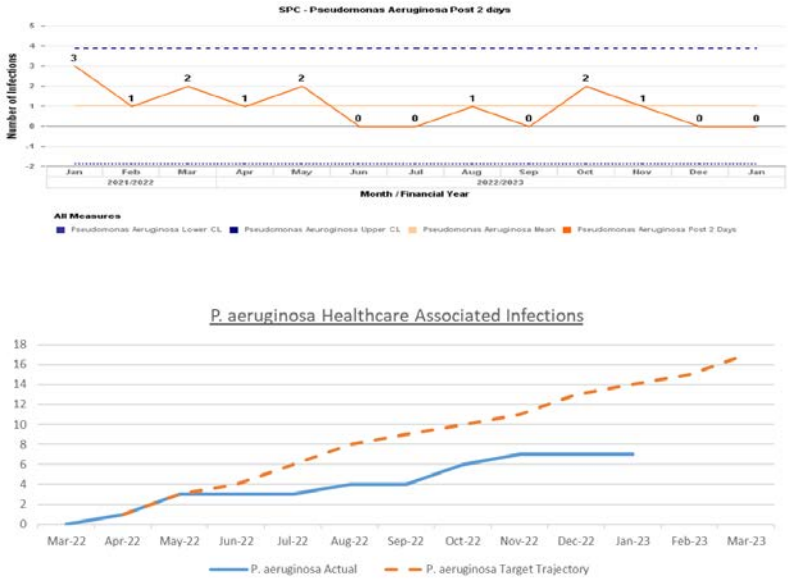
Breakthrough Objective | Klebsiella and Pseudomonas

Performance (Klebsiella)



Trust	Rate (Dec 22)	Rate YTD
SW rate	**10.09**	**11.26**
RUH	**22.68**	**14.93**
GWH	11.43	11.62
SFT	7.21	6.54
Gloucester	7.73	7.8

Performance (Pseudomonas)



Trust	Rate (Dec 22)	Rate YTD
SW rate	**3.91**	**5.28**
RUH	**0**	**5.1**
GWH	11.43	7.09
SFT	0	6.46
Gloucester	7.73	6.08

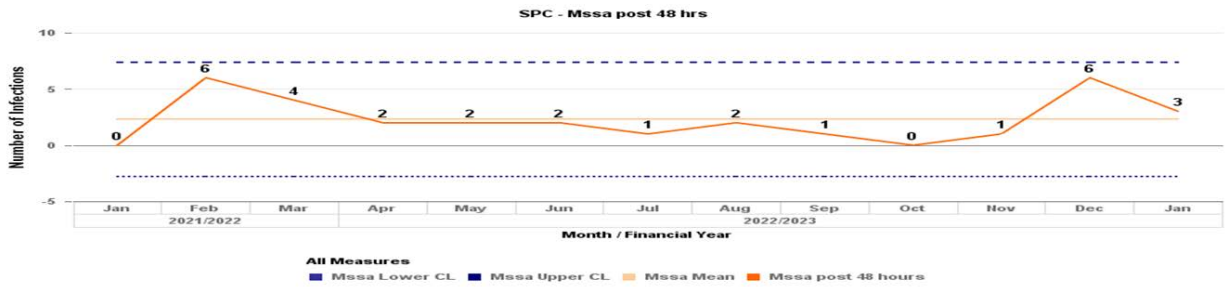
Is the standard being delivered?
There were 5 hospital associated Klebsiella infections reported during January 2023 with the annual count to date being 28 against the annual trajectory of no more than 26 infections during 22/23.
There were 0 Pseudomonas Aeruginosa reported during January with the annual count to date remaining 8 against the trajectory of 17 for 22/23.

What's the top contributor for under/over achievement?
The cases for Klebsiella were associated to: lower urinary tract infection with no catheter (n=1), LUTI with catheter (n=1), Hepatobiliary (n=1), Respiratory (n=1, unknown (n=1). There was no cases of Pseudomonas Aeruginosa.

Countermeasures / Actions	Owner	Due Date
Continue wider working with Public Health and the ICB collaborative to increase the messaging regarding adequate hydration for patients to reduce urinary tract infections (UTI). This is now an on going collaborative.	IPC and Trust Hydration Lead	Mar-23
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	Jan-23

Breakthrough Objective | MSSA

Historic Data



Supporting data

Trust	MSSA (Dec 22)	Rate YTD
SW rate	**16.93**	**17.1**
RUH	**39.69**	**14.05**
GWH	17.15	25.87
SFT	7.21	9.75
Gloucester	7.73	17.37

Is the standard being delivered?
There were 3 hospital onset Methicillin-Susceptible Staphylococcus Aureus (MSSA) blood stream infection during January 2023.
Endocarditis (n=2), line associated infection (n=1).

Review of the cannulation and venepuncture policy remains outstanding.

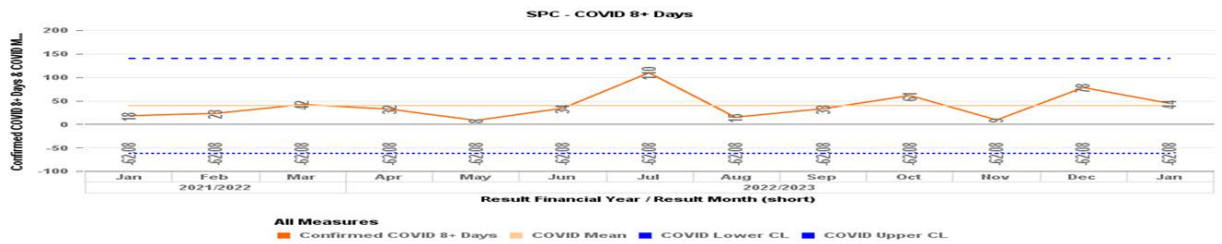
What's the top contributor for under/over achievement?
None of the 3 cases were linked to one specialist area, and there were no obvious steps omitted that could have prevented these cases occurring.

*The cannula trial was not successful and is on hold until a suitable replacement product comes to market.

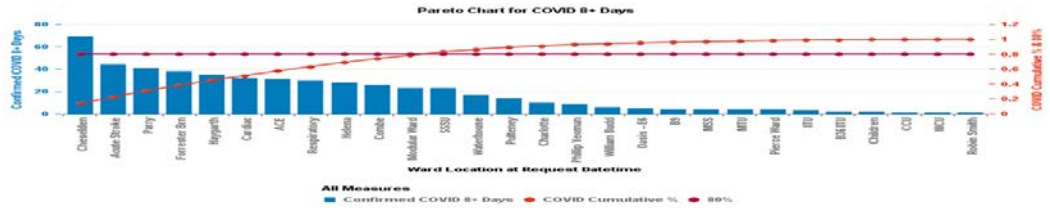
Countermeasures / Actions	Owner	Due Date
Procurement are trialling a new cannula with staff, if successful the company can provide a comprehensive training and support package to staff.	Procurement	Mar-23
Review the policy for the insertion and management of lines, taking into account the Practice versus Guidelines assessment of cannulation and PVC care/maintenance.	Training Department / Matrons	Jan-23

Breakthrough Objective | Confirmed COVID-19

Historic Data



Supporting data



Is the standard being delivered?
There was 137 COVID positive cases detected during January. 44 of these cases were confirmed as COVID-19 8+ days infections.

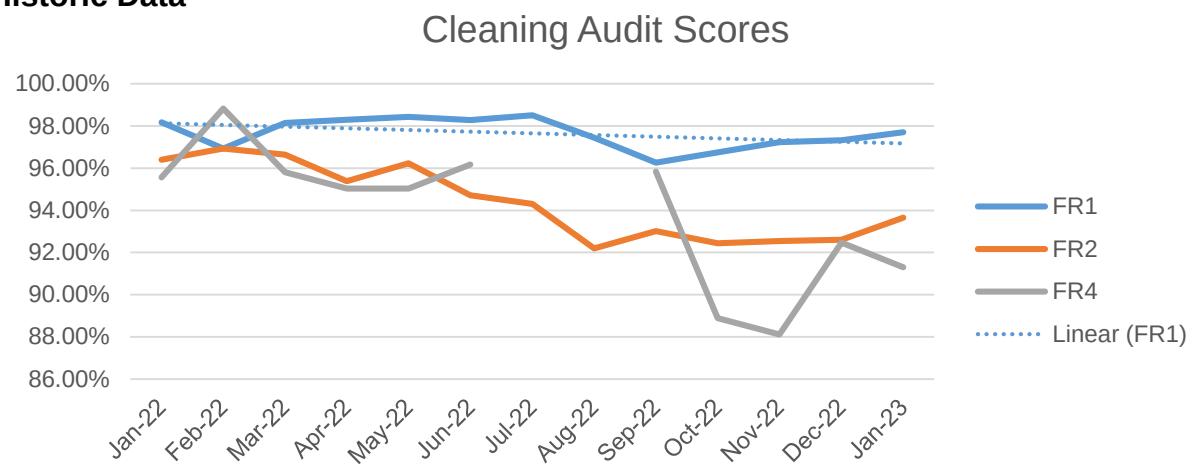
What's the top contributor for under/over achievement?
There were 2 mortalities associated to a nosocomial COVID-19 infection. Both cases have COVID-19 recorded on part 1 of the death certificate.

The BANES COVID-19 rate decreased to 18.63 in January 2023 from 112.79 per 100.000 during December.

Countermeasures / Actions	Owner	Due Date
COVID contact bays being maintained with exposure testing on day 3 to released beds earlier.	IPC	NA
Review of asymptomatic COVID-19 testing as funding is withdrawn to labs, which includes contact screening.	IPC and Microbiology	Apr-23
Review the RCA template for COVID-19 mortality to focus on omissions or gaps in care that may lead to a Serious Incident.	Clinical risk and IPC	Mar-23

Breakthrough Objective | Cleaning

Historic Data



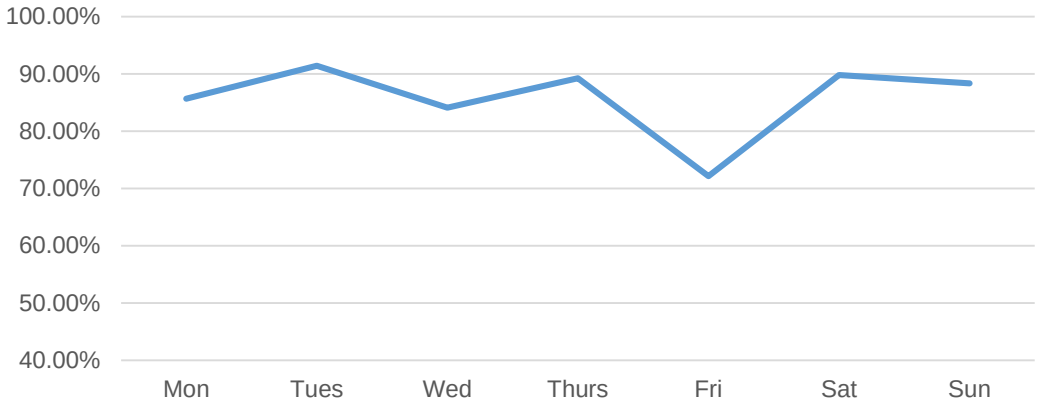
Is the standard being delivered?

Functional Risk (FR) 1 – 97.71% (target 98%) – Audits are conducted weekly
FR2 (wards) – 93.65% (target 85%) – Audits are conducted monthly

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

- Staffing gaps
  - Recruitment – 29.79 WTE vacancies (13.68%)
  - Unfilled hours - Shift fill rate 85.47%
  - Agency usage – 22.02% of shifts filled by agency staff.
- Staff training:
  - A training room has set up for new starters, which will provide a new style of induction before going to a live environment.
  - The supervisor role is key to supporting staff and ensuring they adhere to the training standards and schedules.

Supporting data



Countermeasures / Actions	Owner	Due Date
Cleaning standards group commenced and is meet monthly until cleaning standards are able to be maintained.	Estates and facilities	Completed
Detailed action plans for 1 star clinical areas.	Facilities	Completed
Improved management of temporary staffing.	Facilities	Completed
Recruitment in vacancies.	Facilities	Mar-23
Staff training to follow new cleaning schedules which incorporate required cleaning frequencies.	Facilities	Feb-23

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

Historic Data

Is the standard being delivered?
Overall, there is a trend of increased incident reporting with 55 incidents reported per 1,000 bed days in January.

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

The top reported patient safety incidents are Admission (n=192), followed by Patient falls (n=118) and Medication (n=86). The majority of the admission incidents are for excessive trolley waits in Medicine and Surgery Divisions (n=158).

Supporting data

Countermeasures / Actions	Owner	Due Date
PSIRF driver diagram completed.	Trust PS Lead/ PSIRF project Lead	Feb -23
PSIRF Subgroup established to map roles and analyse existing patient safety roles.	Deputy Chief Nurse/ Divisional Directors of Nursing	Mar-23
PSIRF Subgroup established to review current process and future PSIRF process.	Trust PS Lead/ Risk Lead/Assurance Lead	Mar-23
Complete PSIRF stakeholder mapping to assign level of interest and influence for key staff involved in PSIRF implementation.	Assurance Lead/Risk Management Lead	Feb-23
Development of a communication plan.	Trust Coms Lead/ PM PRIRF	Mar- 23

Tracker Measures | Serious incidents with overdue actions

Historic Data

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

What's the top contributor for under/over achievement?
There are 2 Serious Incidents with overdue actions in Surgery Division that remain open. All overdue actions continue to be followed up with the leads for each action.

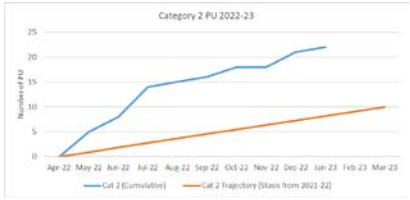
Supporting data

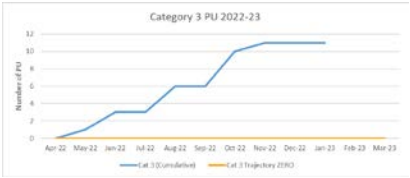
Datix ID	Category of SI	Division	Action details	Due date
100237	Patient Falls	Surgical Division	Updating of internal transfer policy with acknowledgement of need to: Review of internal transfer process and sharing of policy with the clinical site team.	31/12/2022
105915	Clinical Assessment or Review	Surgical Division	Duty of Candour and sharing with the patient: Feedback investigation report and action plan to the patient in person in line with their wishes	15/12/2022

Countermeasures / Actions	Owner	Due Date
Monthly report produced for each Division summarising any overdue actions and these are followed up with the leads for each action.	Head of Quality Assurance	Monthly update
Report of SI actions due for completion over the following month (to prompt more timely and proactive review of SI actions) has been trialled in Family & Specialist Services – to roll out to all Divisions.	Head of Quality Assurance	Mar-23

Tracker Measures | Pressure Ulcers

Historic Data





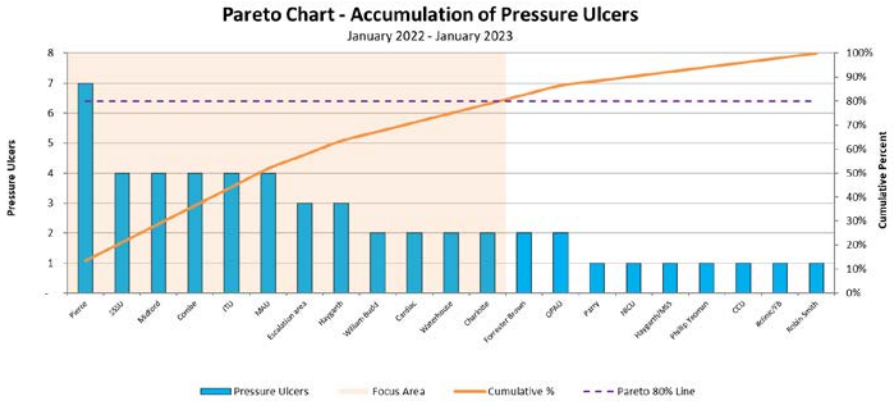
Is the standard being delivered?

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.
The Trust is over trajectory for all categories with the exception of category 4.
There was one category 2 pressure ulcer on Coronary Care Unit where the patient had full capacity but was declining care, their first PU in 10 years. NICU reported a medical device related PU on an extreme pre-term baby with no lapses in care and William Budd reported pressure damage due to poorly fitting anti-embolic stockings.

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

The top contributors for total number of pressure ulcers are: Pierce and Critical Care.
Key themes are patient non-concordance and lack of skin checking under stockings.

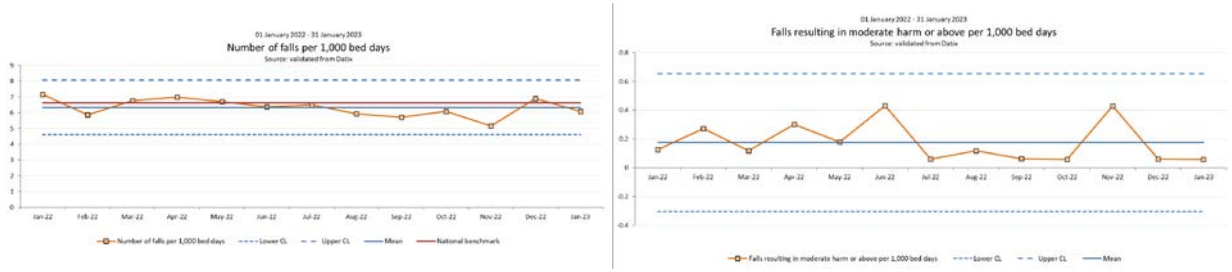
Supporting data



Countermeasures / Actions	Owner	Due Date
Awareness of the correct process for requirement, measurement and care of a patient with anti embolic stockings.	TVNs	Mar-23
Refresh awareness of the non-concordance with pressure ulcer care protocol.	TVNs	Mar-23

Tracker Measures | Falls

Historic Data

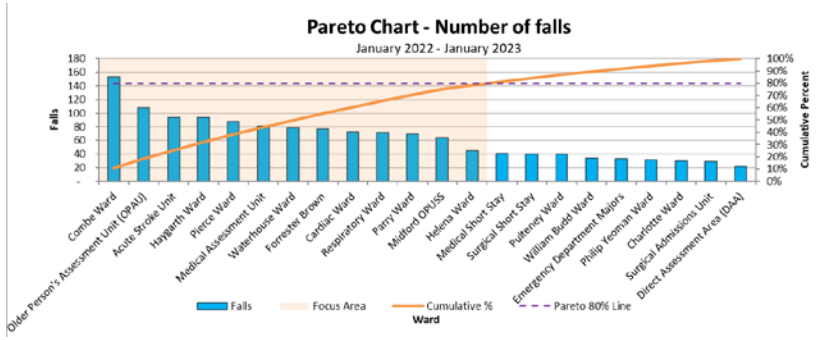


Is the standard being delivered?

There was one fall resulting in moderate harm in January, against a target of 3 per month: this was for Pulteney ward. This incident is being investigated as part of the falls serious harm process and part of the weekly tracker measures linking falls data with safer staffing analysis.

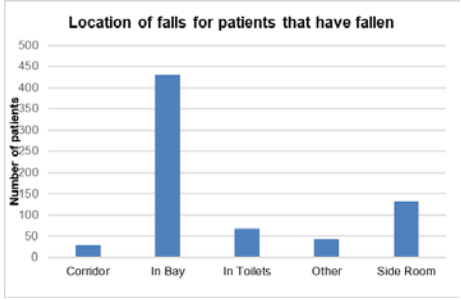
What's the top contributor for under/over achievement?

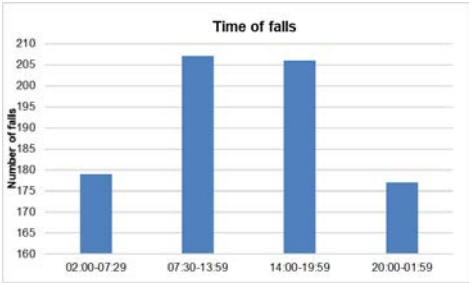
The pareto chart shows the top contributors to falls. The Quality Improvement Team provide targeted support for the wards with high numbers of falls.



Supporting data

Analysis of trustwide data from datix over last 6 months identifies :
61% of falls occur in bays and 54% occur between the hours of 07.30 and 19.59

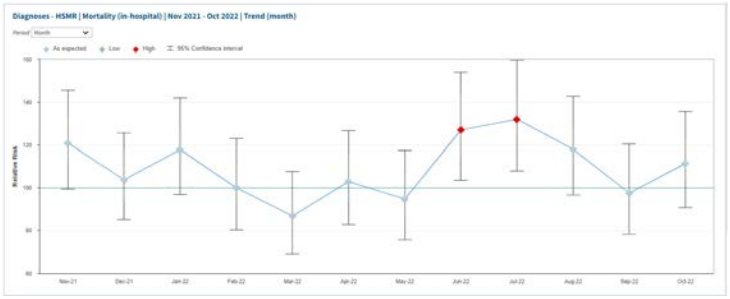




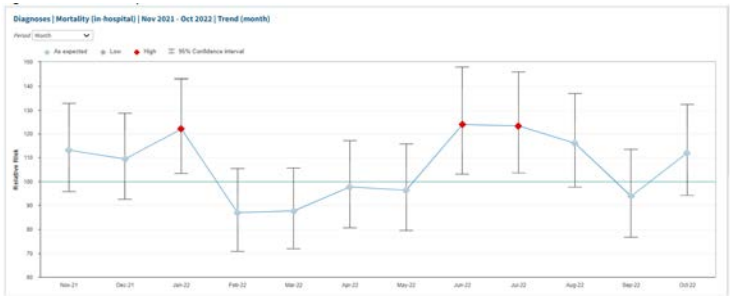
Countermeasures / Actions	Owner	Due Date
Working group continues for 'Stop the Socks' campaign.	QI Falls Lead	Ongoing
Weekly tracker measures linking falls data with safer staffing analysis.	Senior Nurse QI	Ongoing
Reconditioning games - total of 8 gold medals awarded to Midford, Cheseldon, Oasis and Combe.	QI Falls Lead	Ongoing until April 2023
Refresh of the Falls A3 completed.	Senior Nurse QI & Falls lead	Completed
PDSA on OPAU advice checklist for carers/relatives of personal belongings to support the safety of patients (e.g. footwear, clothing).	QI Falls Lead	Feb-23
Stop the socks campaign – secured funding for slippers to PDSA on OPAU.	QI Falls Lead	Feb-23
Review of the current falls elearning programme – consider elearning for healthcare as alternative.	QI Falls Lead	Mar-23
Changes to the recording of Lying and Standing Blood pressure on Millennium launch Feb 2023.	Senior Nurse QI	Feb-23

Quality | Mortality

Historic Data



HSMR

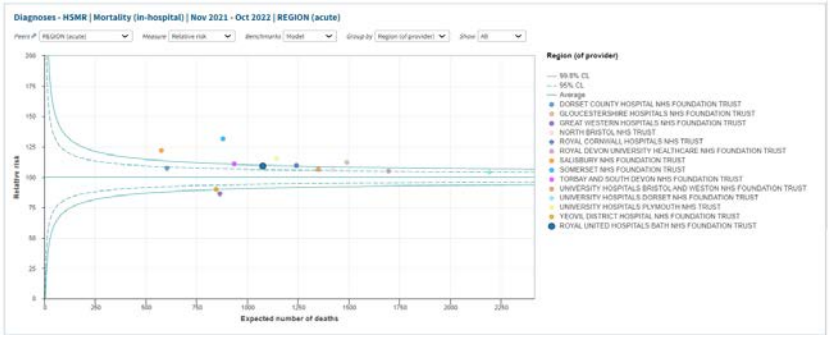


SMR

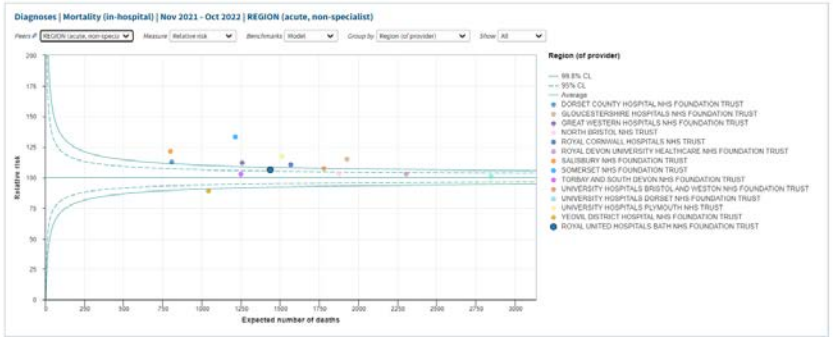
Is the standard being delivered?
The Trust is statistically significantly higher than expected for Hospitalised Standardised Mortality Rate (HSMR) (108.9) and SMR (106.6) for the rolling 12 month period to October 2022.

What's the top contributor for under/over achievement?
A backlog in coding is impacting the mortality ratios. The figures for October are likely to change due to the large number of unclassified diagnosis groups. The Trust is one of seven in the region with an HSMR that is statistically significantly higher than expected. Both the weekday and weekend HSMR are statistically significantly higher than expected but weekend performance is not statistically significantly worse than weekday performance.
Standardised Mortality Ratio (SMR): National and regional trends are most likely related to the COVID-19 pandemic & potentially connected issues such as workforce pressures and changes in patient behaviours (generally due to delays). The Trust is

Supporting data



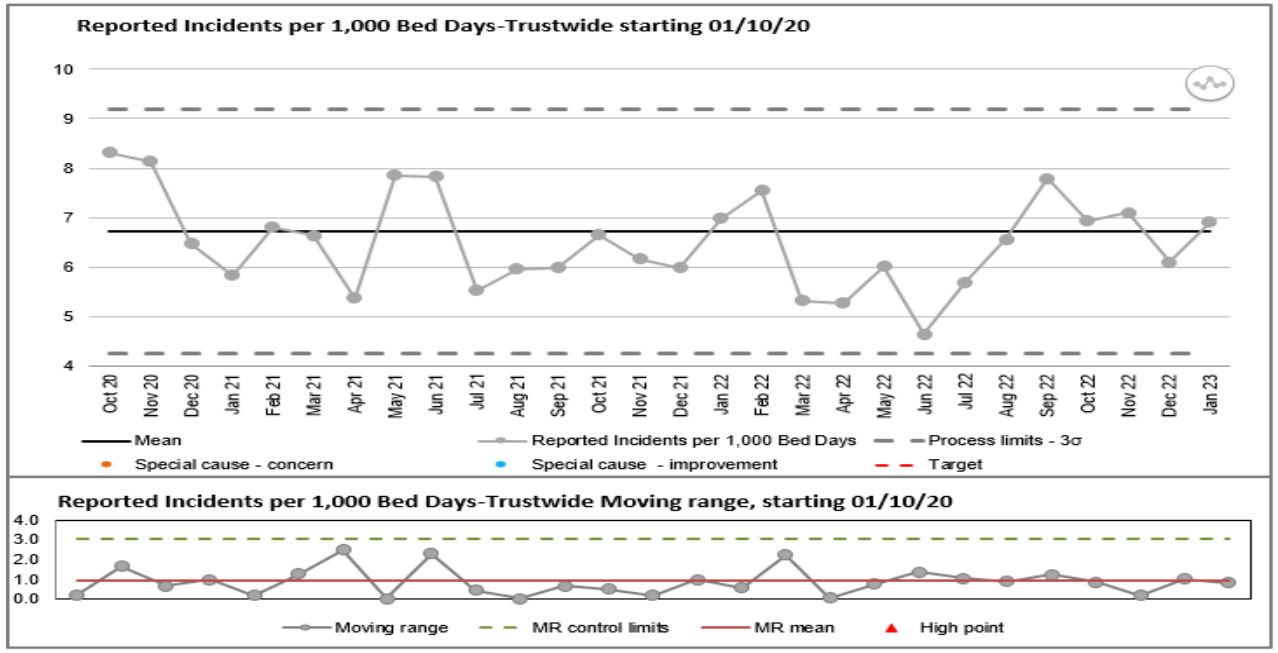
HSMR

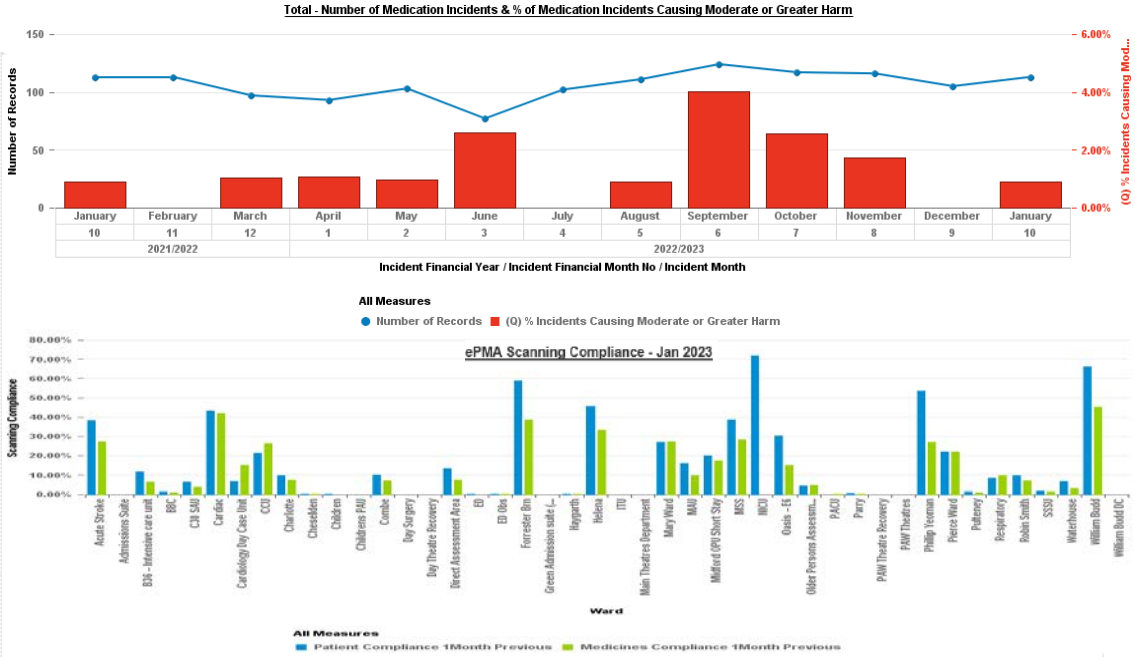


SMR

Countermeasures / Actions	Owner	Due Date
Review of deaths from Sepsis and AKI over the weekend and weekdays highlighted that there was no difference in pathway survivors, but those that died entered the organisation in extremis	Trust Patient Safety Lead	Completed
Review of data and run a case mix comparison against regional and national peers, looking at age, method of admission, diagnosis, morbidities, and frailties.	Senior Consultant, Telstra Health	Feb-22
Conduct postcode weekend analysis to analyse the HSMR situation in terms of weekdays	Senior Business Analyst	Feb-22

Quality | Medicines Safety





Is the standard being delivered?

- Barcode scanning: 100% patient + medicine scanning would prevent >1,000 medication errors/month.
- All front line staff should receive adequate training to supply or administer high risk or critical medicines: insulin / antibiotics / oxygen.
- Process for escalation of medicines-related mod-severe harm incidents agreed with Divisional Patient Safety Leads has been embedded.

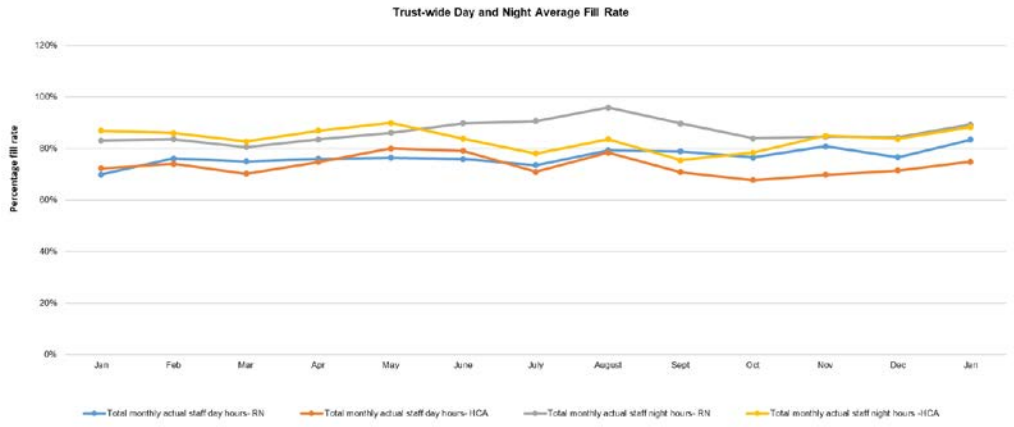
What's the top contributor for under/over achievement?

- Medication incidents: for information only – reported incidents/1,000 bed days reported incidents within normal variation. No action required.
- Barcode Scanning: Medicines compliance 14.8%. William Budd top contributor (45.4%), Mary ward is the most improved ward (16.1% to 27.1%).

Countermeasures / Actions	Owner	Due Date
Onc/Haem SI investigation has been finalised and alert added to ARIA e-prescribing system	F&SS Patient Safety Lead	N/A
SACT safety group to be set up	Director of Pharmacy & Medicines Optimisation	May-23
Review of Medical Gas Designated Nursing Officer training	DivDoNs/Pharmacy	Dec-23
Lack of secure medicine storage in escalation areas to be addressed	DivDoNs	April-23

Quality | Safer Staffing

Historic Data



Is the standard being delivered?

Compared to the 90% target, in January 2023:

- The percentage fill rate for registered nurses was 83% for day hours and 89% for night hours.
- The percentage fill rate for HCAs was 75% for day hours and 88% for night hours.

What's 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, fill rate and increased sickness during January. This has included ward outbreaks and reduced flexibility of staff movement.
- Review of shifts requiring temporary staffing fill and the allocation of workforce.
- Surgical Short Stay are working to dependency and occupancy. Night capacity has reduced to max 8 patients.
- Changes in December to Philip Yeoman as non–elective and additional staff required.
- New establishment delivers an increase to night RN numbers to increase RN to patient ratio.

Supporting data: 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	74%	75%	82%	78%
Cardiac Ward	83%	87%	92%	87%
Charlotte Ward	62%	100%	74%	107%
Cheselden Ward	74%	60%	100%	97%
Children's Ward	87%	35%	104%	43%
Combe Ward	82%	74%	76%	105%
Coronary Care Unit	92%	71%	100%	94%
Emergency Department	81%	75%	90%	86%
Forrester Brown Ward	72%	68%	82%	95%
Haygarth Ward	86%	64%	103%	100%
Helena Ward	104%	85%	101%	110%
ITU	85%	78%	118%	58%
MAU	70%	85%	75%	120%
Medical Short Stay	122%	81%	134%	100%
Midford OPUSS	76%	71%	101%	75%
NICU	74%	85%	84%	84%
OPAU	94%	84%	95%	93%
Parry Ward	105%	85%	86%	100%
PAW Mary / BBC	91%	68%	96%	98%
Philip Yeoman Ward	75%	72%	81%	78%
Pierce Ward	90%	81%	98%	97%
Pulteney Ward	64%	87%	83%	85%
Respiratory Ward	73%	64%	73%	91%
Robin Smith Ward	71%	78%	77%	77%
SAU	79%	76%	85%	92%
Surgical Short Stay	77%	72%	64%	51%
Waterhouse Ward	96%	51%	86%	86%
William Budd Ward	98%	85%	60%	90%

Countermeasures / Actions	Owner	Due Date
Review patient assessment for those requiring a mental health specialist nurse/enhanced care, Matrix for mental health at printers and PDSA undertaken and at the printers.	DDoN - Medicine	Feb-23
Develop a business case for an Enhanced Care Team, submitted to business planning and awaiting outcome.	Vulnerable Adult Lead	Complete
E-Roster work continues and is being well received. Work was paused for both half term and the industrial action but despite this remains on target.	Workforce Utilization & Safe Staffing Lead	Nov-22 (project ongoing)
Develop a dedicated support program for Internationally Educated Nurses (IEN) following NMC registration, recruitment is underway, with new Clinical Practice Educators appointed. Work to detail the content of the support program is underway.	IR Lead & ADON for workforce	TBC
Review of temporary staffing process and reduction in high cost agency. Process in place for all agency via DDON in place. Risk of increased agency usage due to escalation and strike planning. Roster reviews commenced.	CNO & DDON	Complete (ongoing monitoring)

Update on safeguarding actions following unannounced CQC inspection of Medical care

Safeguarding Training

Subject	Compliance (at 14 Feb 23)	Target
Safeguarding Adults Level 2	81.6%	90%
Safeguarding Adults Level 3	64.2%	90%

Safeguarding Adults Training:

Levels 2:

- Safeguarding level 2 training – face to face from February 2023.
- Compliance has decreased slightly from 81.9% in December 2022 to 81.6% in February 2023

Level 3:

- All staff requiring training have been booked on to future training sessions.
- Compliance has decreased slightly from 66.1% in December 2022 to 64.2% in February 2023

Monthly Senior Sister, Charge Nurse / Matron inspection

Section	Compliance (Jan-23)
Ward Environment	95%
Information Governance	88%
Notices / display of information	89%
Sharps and resus checks	93%
Medicines	87%
Infection Prevention and Control	96%
Vulnerable patients	80%

Safeguarding audits (results from monthly Matron inspection)

Audit standard	Compliance (Jan-23)
ReSPECT / TEP form completed.	85%
Mental capacity assessment for TEP / ReSPECT decisions completed.	76%
Where the patient lacks capacity to consent to serious medical treatment and / or change of accommodation / discharge plans, the MCA forms have been completed.	67%
Where a MCA form has been completed, a best interest decision form has been completed.	74%
Where the patient has been unable to consent to remain in hospital, the Deprivation of Liberty Safeguards (DoLS) authorisation has been completed.	83%

The inspections ensure issues are identified and resolved or escalated by the Senior Sister, Charge Nurse/Matron in real time. Variance in percentage scores is expected with improvement using Improving Together methodology.

Executive Summary | Patient Experience

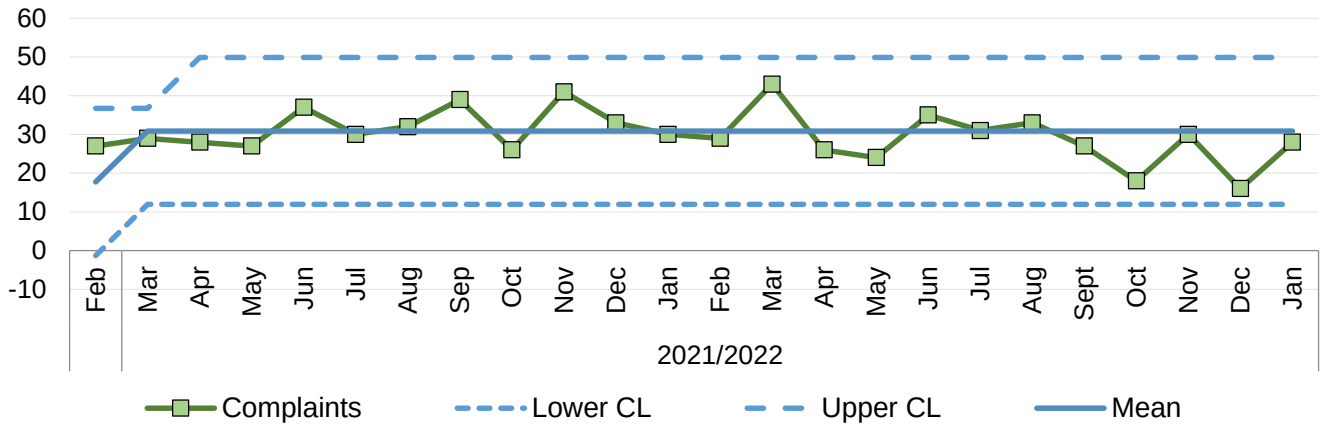
Strategic Goal		Performance Indicator	Description	Target		2021/22			2022/23										Trend
				Performing	Under Performing	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	
Trust Goals	People We Care For	Number of Formal Complaints		<30	>=30	29	32	44	28	28	34	33	39	30	18	31	16	28	
Tracker Measures	People We Care For	Overall Patient Experience (FFT)	Proportion responding 'good' or 'very good'	>=95%	<95%	98.2%	96.6%	95.7%	96.4%	94.5%	93.7%	95.7%	97.1%	96.5%	95.2%	96.3%	93.9%	95.8%	
		% of Complaints responded to within target		>=90%	<90%	42.3%	44.4%	52.4%	61.1%	69.4%	82.4%	52.4%	60.9%	57.9%	64.5%	76.0%	77.3%	52.6%	
		Number of re-opened complaints		<=3	>3	2	3	4	3	3	3	2	2	1	6	2	3	2	
		PALS Response Time	% of Responses within 2 days			-	-	-	79.6%	80.5%	64.0%	72.0%	65.0%	62.0%	61.0%	62.0%	66.0%	60.0%	
		Number of Compliments				44	15	18	15	15	92	36	31	58	10	47	24	43	
		Number of Family Liaison Service Contacts				72200.0%	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 January. Overall, 53% of complaints closed during January met the required timescale of 35 working days (10/19). This metric has deteriorated this month primarily due to the focussed work completed by the Family and Specialist Services Division to address the backlog in their complaint responses. The numbers of re-opened complaints remains stable. The reasons for exceptions in this measure are: Focused work in Family and Specialist Services Division to address backlog in responses, this means that all of the responses did not meet the 35 day working target Delays in the final review process for 2 cases.
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 days. With PALS contacts in excess of 400 every month, enquiries responded to within 2 working days remains at just over 60%. The numbers of PALS contacts in January was 373. The reasons for the timeframe exceptions are mostly due to: Workload of clinicians causing delays in responding The volume, complexity and logging of cases A review of the team resources and benchmarking with other Trusts has been completed. Two PALS and Complaints Officers have joined the team. 70% of PALS enquiries were responded to within 5 working days. 60% of PALS enquiries were responded to within 2 working days.

Trust Goal | Patient complaints

Historic Data



Response Rate	Medicine	Surgery	F&SS	Corporate
Completed within timescale	83% (5/6)	83% (5/6)	0% (0/6)	0% (0/1)

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

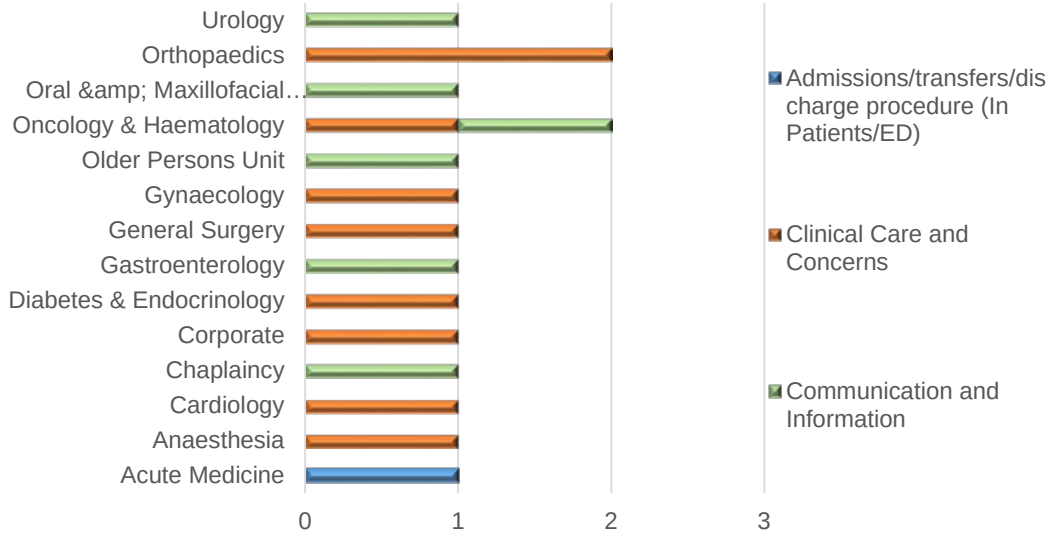
Is the standard being delivered?
The Trust received 28 formal complaints in January 2023. This is 2 less than January 2022 and 3 less than the mean average for the rolling 24 months.

Underperforming >=34, Performing <30.

What's the top contributor for under/over achievement?
Clinical Care and Concerns accounted for 68% (n=19) of complaints. Orthopaedics (n=4), Oncology & Haematology (n=3) and General Surgery (n=3) accounted for 53% of Clinical Care complaints. The complaints related to inappropriate care/treatment, coordination if medical treatment, wrong diagnosis and privacy and dignity.

53% of complaints closed during January met the required timescale of 35 working days (17/22). This is a deterioration from last month (77%)

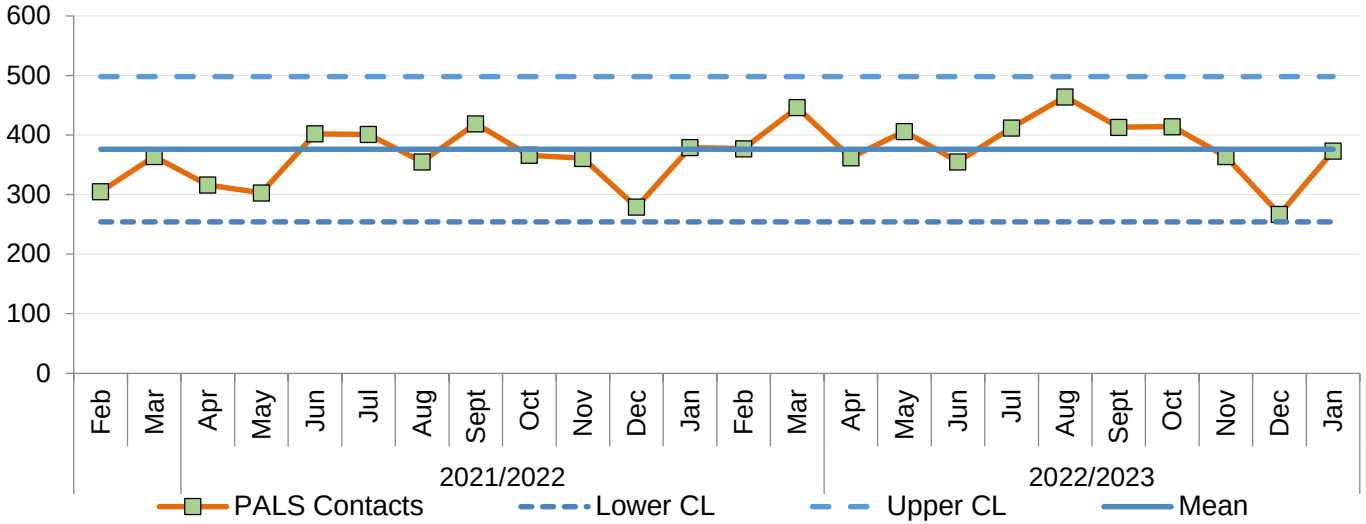
Supporting data



Countermeasures / Actions	Owner	Due Date
Continue to support the Family and Specialist Services Division work to address complaints backlog.	Patient Safety Lead	Ongoing
PALS outreach service commenced – 70 patients seen in first week and feedback provided to ward Sister/Charge Nurse. Plan for 6 ward visits per week	Complaints Lead	Ongoing
Plans for single point of access for patient support and complaints/concerns continue.	Complaints Lead	1 April 2023

Tracker Measure | PALS

Historic Data



Is the standard being delivered?

Situation report: There were 373 contacts with PALS in January 2023.

KPI: Performance against 48hr standard resolution timeframe 60% of cases were resolved in 48 hours or less; a further 12% were resolved in 6 days and 12% between 7-14 days. 16% of the complex cases took more than 14 days.

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

Appointments (n=51). The highest number of enquiries related to the length of time patients were waiting for new and follow up appointments 56% (n=29). Hotspot areas for the month were Children's (n=4) and Orthopaedic (n=3) Outpatients.

Communication and information (n=38). The highest number of contacts concerned inappropriate/inaccurate/incomplete correspondence 16% (n=6). These were spread across different departments/wards.

Clinical care and concerns (n=31). The highest number of contacts were around inappropriate care and treatment 19% (n=6). These were spread across different departments/wards.

Supporting data

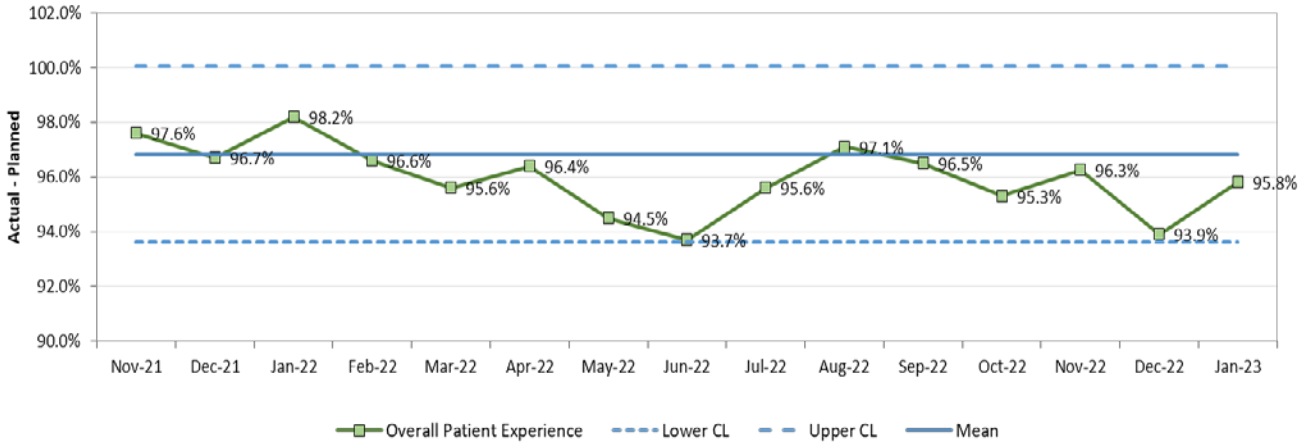
- 100 Required resolution (37%)
- 130 Requested advice or information (49%)
- 13 Compliments (5%)
- 24 Provided feedback (9%)
- 28 Clinical Care and Concerns
- 21 Communication and information
- 19 Appointments

Countermeasures / Actions	Owner	Due Date
Cardiology outpatients are undertaking a review of PALS contacts to support with service improvements around communication of test results and appointment wait times.	Cardiology Specialty Managers	March 2023
Family Liaison Facilitators have been successfully recruited to post. This will help support wards with communication between patients and their family/carers, with a focus on ED, MAU and OPAU.	Interim Divisional Director of Nursing Medicine	February 2023

Patient | Friends and Family Test

Historic Performance

Royal United Hospital
1st November 2021 - 31st January 2023
SPC Overall Patient Experience
Source: eQuest (as 9th February 2023)



Is standard being delivered?

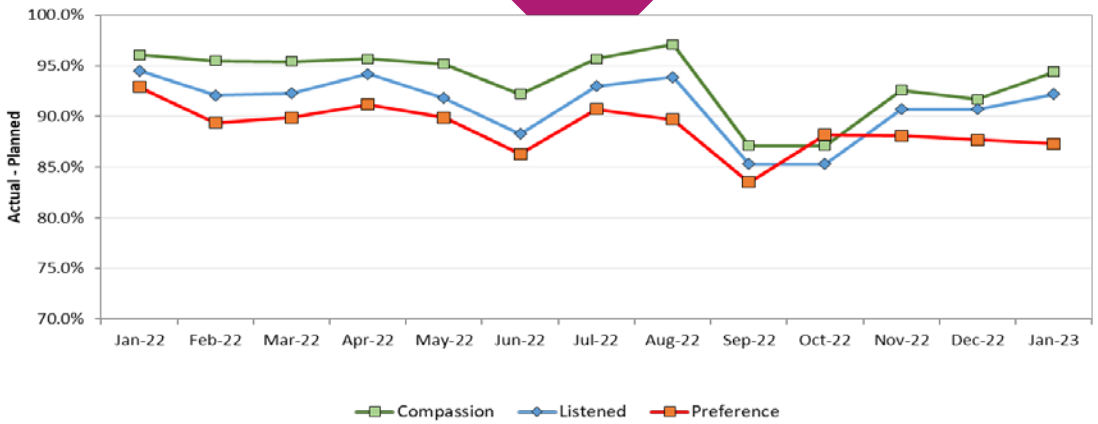
The proportion of patients across the Trust that responded positively (very good or good) about their overall experience this month was 95.8%. Above the 95% target on the scorecard. This is broken down by Division in the chart below.

What is the top contributor for under/over-achievement of the standard?
The number of responses using FFT across the Trust is low. The Patient Experience Team are working to identify an electronic solution to increase FFT responses.

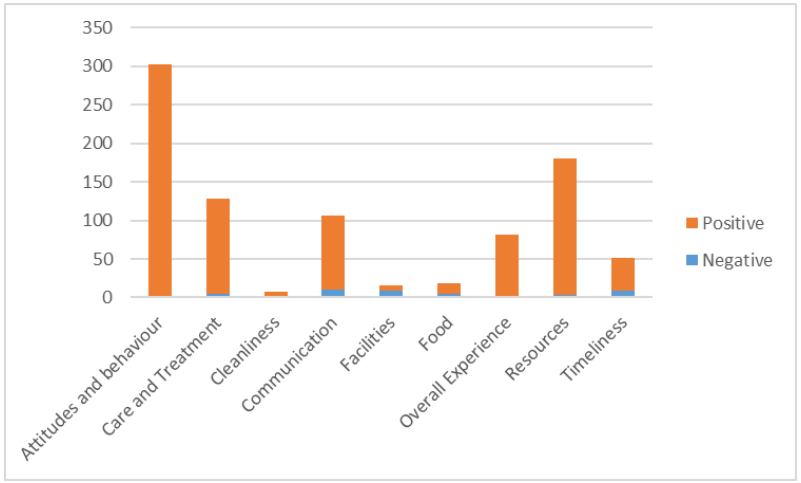
FFT responses September 2022	'Overall how was your experience of our service?'			
	Medicine Division	Surgery Division	F&SS	Corporate (ED)
Very good/ good	93.7% (389) ↓	98.8% (166) ↑	99.3% (144) ↑	77.7% (7) ↑
Poor/ very poor	2.9% (12)	1.2% (2)	0.7% (1)	22.3% (2)
Neither good nor poor	3.4% (14)	0% (0)	0% (0)	0% (0)

Royal United Hospitals Bath

% Treated with Compassion, Listened to, and Staff Considered their Preferences, Needs and Values



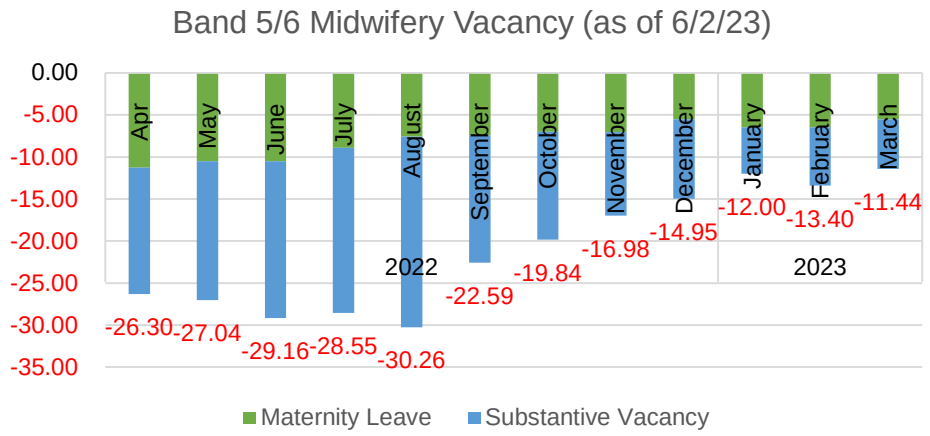
Themes - Patient experience comments collected via FFT in January 2023:



As in December 2022, January 2023 FFT Positive feedback – top three themes are:
Attitudes and behaviour of staff (n=302), Resources (Staff) (n=177) and Care and Treatment (n=124).
In January 2023 FFT Negative feedback – top three themes are:
Communication (n=10), Facilities (n=9) and Timeliness (n=9).

Maternity | Workforce

Historic Data



Is the standard being delivered?

- 1 to 1 care in labour was achieved at all times.
- Supernumerary Labour Ward coordinator status not maintained on 2 occasions. Not involving labour or 1-2-1 care. No harm.
- The Midwife to birth ratio is improving.
- There is a -12 WTE midwifery workforce gap including maternity leave.

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

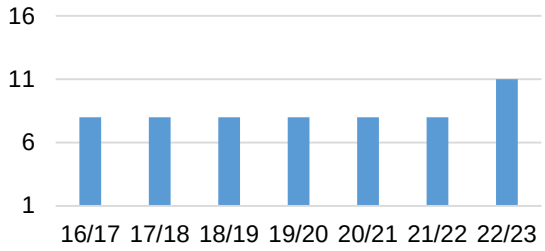
- Vacancy rate.
- Maternity leave.
- Challenges in recruiting midwives.
- Challenges with retaining midwives.
- Sickness.
- Accuracy of data capture for fill rates (MSW day rate).

Supporting data

Average Shift Fill Rates

		Nov 22	Dec 22	Jan 23
Midwives	Day	88.5%	82.0%	90.4%
	Night	93.2%	92.5%	95.9%
MCA/MSWs	Day	58.2%	51.8%	66.5%
	Night	81.8%	72.6%	98.5%

Total number of obstetric consultants (WTE)



Countermeasures / Actions	Owner	Due Date
Bid to recruit 8 International Midwives approved. Six new international midwives recruited this month. Due to commence in staged approach from April 2023 onwards.	DOM	Complete
Repeat BirthRate+ assessment commenced.	DOM	Complete
2 x WTE locum posts covering maternity leave have now been extended for 12 months to allow for future business planning.	Clinical Director Maternity	Complete
Moving from 60hrs to 98hrs consultant presence as per Royal College of Obstetrics and Gynaecology (RCOG) recommendations.	Clinical Director Maternity	Complete
Change from 1:8 to 1:11 staffing model. This will allow for: Change in evening ward round time to 8.30pm. Splitting the on-call daytime rota between Obstetrics and Gynaecology in daytime as per Ockenden recommendations.	Clinical Director Maternity	Complete
Continuing work with NHSI to establish the longer term workforce plan for acute/community sites & continuity of carer. Awaiting BirthRate + report.	DOM	Feb-23
Working with BSW Academy to widen routes into Midwifery. Five funded MSc nursing conversion places available.	DOM	Complete
First international midwife recruited.	DOM	Complete
Completion of obstetric workforce review.	Clinical Director Maternity	Complete

Maternity | Workforce

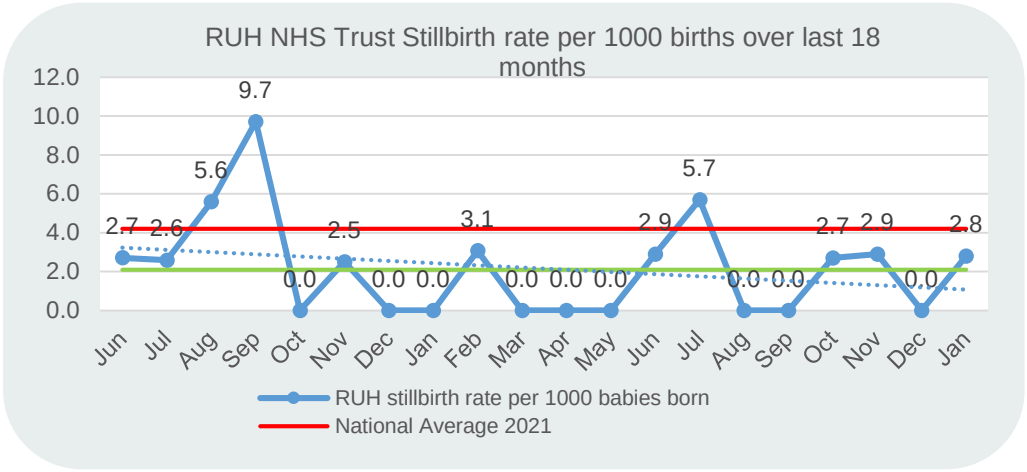
	Target	Threshold			Nov 22	Dec 22	Jan 23	SPC	Comment
		Green	Amber	Red					
Midwife to birth ratio	1:27	<1:28		>1:30	1:31	1:30	1:33	F	Linked to vacancy – see figure including bank
Midwife to birth ratio (including bank)	1:27	<1:28		>1:30	1:26	1:27	1:30	?	Reviewing deteriorating ratio vs. improving shift fill rates
Labour ward coordinator not supernumerary episodes	0	0		>1	0	2	0	?	
1:1 care not provided	0	0		>1	0	0	0	P	
Confidence factor in BirthRate+ recording	60%	>60%		<50%	70%	70%	67%	?	Percentage of possible episodes for which data was recorded
Consultant presence on BBC (hours/week)	98	>97			60	60	98	H F	Meeting RCOG recommendation from Jan 23
Daily multidisciplinary team ward round	90%	>90%		<80%	100%	100%	77%	?	Second ward round taking place on night shift from Jan 23
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0	L P	

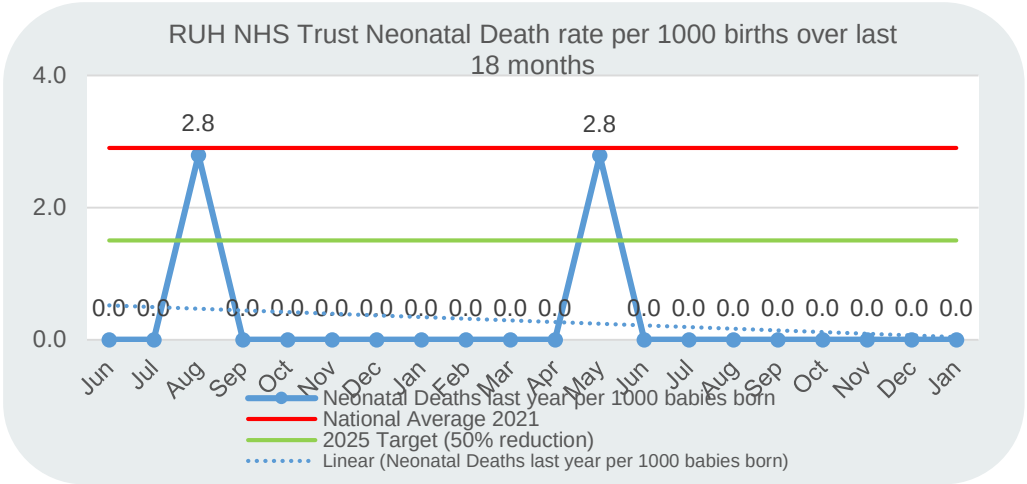
What is SPC?
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation to guide appropriate action. A recommendation of the East Kent Report, is that measures are analysed and presented using SPC to identify the 'signals among noise'.

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

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

Maternity | Perinatal Deaths





- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT) tool since 2018. PMRT reporting is Safety Standard 1 of the NHSR Maternity Incentive Scheme year 4. A quarterly update paper is shared with the Board of Directors.
- Postmortem resumed routine service from 12 weeks in November 22 (except specific clinical indications)
- 1 perinatal death reported in January – 24 week stillbirth - unknown cause. Will be reviewed at PMRT.

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

Perinatal Case ID	Issue Text	Action plan text	Implementation text	Person responsible	Target date	Completed
81978/1	Cabergoline was not given to suppress lactation.	Pathway to be updated including Lactation and Loss SOP.	Bereavement Care Pathway to be updated and disseminated.	Bereavement Midwife	30/11/22	Yes
82268/1	Reduced fetal movement leaflet was not provided in mother's first language.	Reminder sent on how to access Reduced Fetal Movement leaflet in different languages.	Reminder sent to all staff on how to access Reduced Fetal Movements leaflet in different languages.	Patient Safety team	30/09/22	Yes

Maternity | Serious Incidents

New Cases for January 2023

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
11302	30/01/2023	Moderate harm (risk level under review)	Maternal re-admission with wound de-hiscence requiring surgical repair.	Currently awaiting maternal notes to return to undertake an MDT review and validate level of harm.	N/A	N/A

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
111552	12/12/2022	Moderate harm – maternal admission to ITU	Maternal Admission to ITU.	On-going RCA	N/A	2022/27044
108198	16/09/2022	Moderate harm	Management of a suspected eclamptic fit.	On-going RCA	N/A	2022/21155
109848	26/10/2022	Major Harm	Neonatal seizures and subsequent HIE following an Impacted fetal head and uterine rupture at lower segment caesarean section.	Ongoing RCA	N/A	2022/25209
103325	12/04/2022	Unavoidable Death	Maternal death following a diagnosis of cerebral venous sinus thrombosis.	Ongoing RCA due at SI panel 16/02/2023	N/A	2022/8613

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

Maternity | Health Care Safety Investigation Branch (HSIB)

Case Cluster Q1 of 2022 review and feedback

From 22 March 2022 to 14 May 2022 (within a six week period) there were seven referrals to HSIB for investigation. Due to this increased number of cases over a short period of time the Southwest Regional HSIB investigators held an internal round table meeting to discuss these cases to try to identify any common themes. HSIB investigated all cases referred to them over a three month period until the end of August 2022. This included all babies that had a normal MRI scan after they had been cooled.

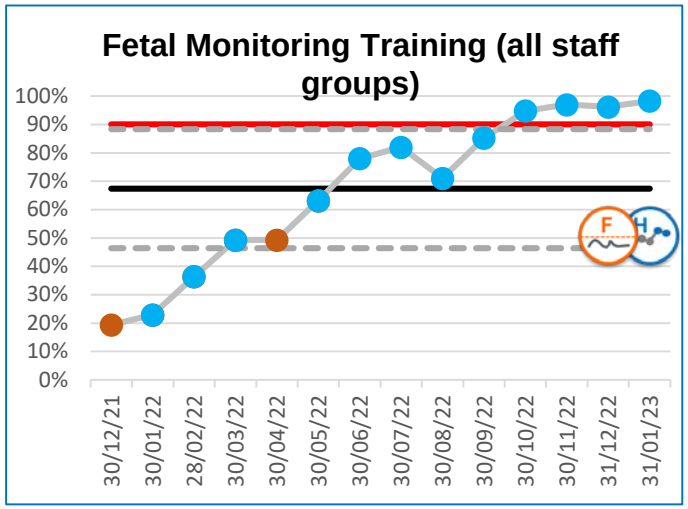
HSIB Case Cluster Findings

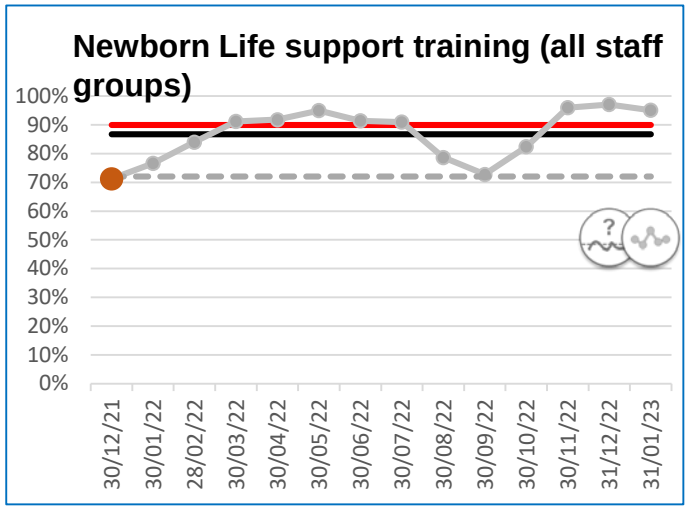
- No clear themes across all cases.
- No safety recommendations in 2/4 cases that progressed.
- Communication was a theme in 2/7 recommendations, and 5/15 findings.
- HSIB confirmed their investigation found no evidence of systemic safety concerns or any underlying issues that require further escalation.
- HSIB considers it would be beneficial for the Trust to focus on communication recommendations.

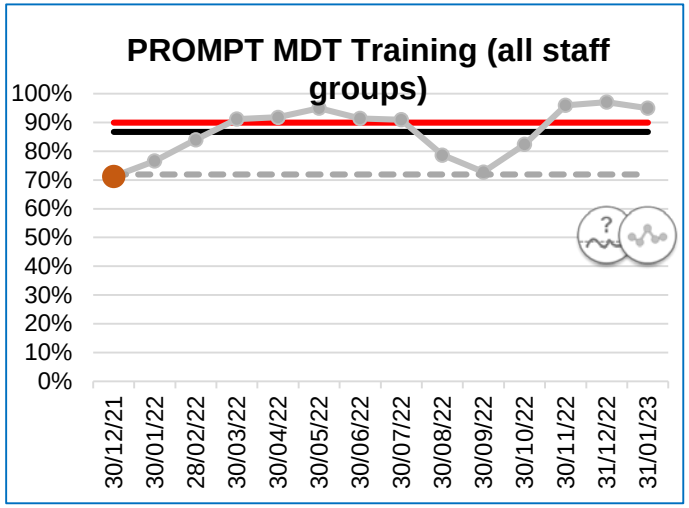
HSIB Ongoing Maternity and Neonatal Reviews

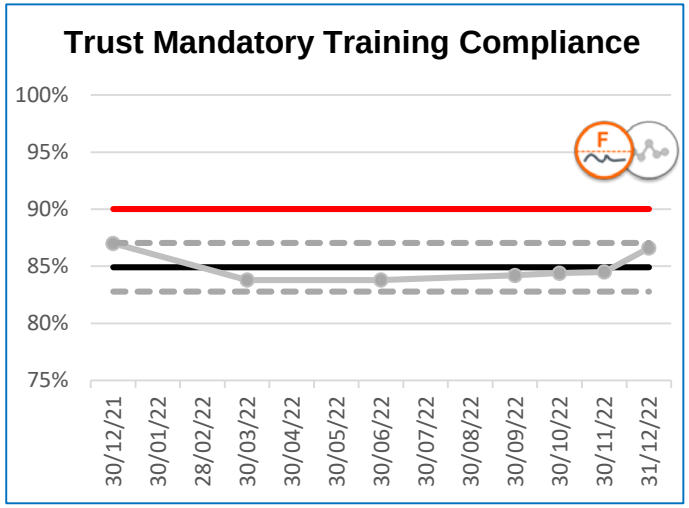
Case Ref (Datix)	Date	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
107283	18/08/22	Therapeutic cooling following birth	First draft of report received and returned to HSIB factual accuracy assessment. No safety recommendations made to Trust.	MI-01255	2022/18296
108058	13/09/22	Therapeutic Cooling following shoulder dystocia at birth-Normal MRI post cooling proceeding at parental request.	Ongoing HSIB review.	MI-014673	2022/21156
110141	02/11/22	Intrapartum stillbirth following Propess administration during an Induction of Labour	Ongoing HSIB review.	MI-017511	2022/25202

Maternity | Well-led: Training









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

Countermeasures/actions:
Additional training dates secured for period of peak staffing changes (doctor change over/midwifery pins/new starters). These will run in Sept, Oct and Nov 2023. Long-term plans to introduce additional dates in Feb and March but no room capacity for 2023.
PROMPT train the trainer – 22 March to develop faculty and improve standard of training for MDT teams.
Bespoke refresher skills sessions available for community staff: Skills drills and newborn life support ahead of community births being fully reinstated. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs).
Additional skills sessions available to newly qualified staff and senior students.

Risks:
Consultant compliance for Jan/Feb – due to staff returning from maternity leave we will see consultant compliance drop. Linked in with Obstetric Lead to ensure staff are supported to book on their return to maintain full compliance.
The use of our own compliance tracker as opposed to using ESR data – ESR still reflects theatre teams which impacts on our compliance. Linking in with ESR and Theatres to find a resolution to this for transparency and information sharing.

Maternity | Effective

Maternity Incentive Scheme – Year 4		
SA1	Submission to PMRT	Amended MIS year 4 published October 2022. Revised reporting period 5/5/22 - 2/2/23 Triumvirate review of all evidence completed to support full compliance with all ten MIS safety actions 23/11/22 Board presentation 11/1/23 ICB and Safety Champions review of all evidence completed to support full compliance 23/2/23 **Final submission to NHS Resolution formally declaring full compliance 26/1/23** Deadline 2/2/23
SA2	Digital and data Quality	
SA3	TC and ATAIN	
SA4	Clinical workforce	
SA5	Midwifery workforce	
SA6	SBLv2	
SA7	Feedback and MVPP	
SA8	Training	
SA9	Assurance to Board	
SA10	HSIB and NHS EN Scheme	

Ockenden Initial Report		
IEA1	Enhanced Safety	
IEA2	Listening to Women and Families	
IEA3	Staff Training and Working Together	Q21 – 90% MDT Training **– now complete** Q22 - Consultant ward rounds **– now complete**
IEA4	Managing Complex Pregnancy	
IEA5	Risk Assessment in Pregnancy	Q30 - Risk Assessment **– non-compliant** • Compliant for routine antenatal appointments. • Risk to compliance for ward attendance/DAU/MW USS. • Digital option being explored regionally to improve the capture at other contact points. • Differences to interpretation of IEA at regional partner Trusts. • MDT working group set up to review standards and standardise approach.
IEA6	Monitoring Fetal Wellbeing	
IEA7	Informed Consent	
	Workforce Planning	Q45 – Clinical Workforce Planning **– now complete**
	Guidelines	

Fully Compliant

Working Towards

Non-Compliant

The people in our community

The RUH, where you matter

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 10

The people in our community

The RUH, where you matter

Finance Director Focus

RUH Position
The Trust is £3.9 million worse than plan at the end of January which is a deterioration in the month of £0.2m.
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 increased and a reduction in expenditure has been seen in agency spend; discretionary spend; and additional capacity. Progress is being made on these schemes and the run rate has reduced.

Elective Recovery
The elective recovery position is performing well with 106% of 19/20 levels being delivered. 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 have been spent to maintain the safety of the site over winter and non-recurrent funding has been confirmed to cover these costs. The financial plan is expected to deliver with the implementation of the recovery plan and the identification of mitigations for £2.0 m of outstanding financial risks.

BSW
The BSW system are managing a number of financial risks relating to the operational pressures across the system but are continuing to forecast achievement of the financial breakeven position at the end of the financial year. A total of £6 million of risks (including the £2m net risk for the RUH) are being managed across the system.

2023/2024 Planning
National planning guidance has been received setting out the planning assumptions for 2023/2024. Financial plans for 2023/2024 are being developed and it will be a significant challenge to achieve the national expectation of a break even position.

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	Oct-22	Nov-22	Dec-22	Jan-23
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	£(2,170)k	£(2,702)k	£(3,652)k	£(3,894)k
	Forecast delivery of Group financial plan	Forecast variance from year to date plan	<=0	>0	£0	£0	£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	£(16.42)m	£(17.90)m	£(19.74)m	£(20.96)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	£5.392m	£7.163m	£9.544m	£11.111m
	Delivery of QIPP against plan	Performance against plan	<=100%	>100%	48.0%	61.0%	115.0%	137.6%	116.0%	96.0%	96.0%	104.0%	101.7%	110.4%	99.8%
	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%	3.4%	3.0%	3.6%	3.4%
	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%	3.1%	3.0%	3.6%	3.2%
	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	156	130	142	142
	No COVID admissions	Average number of beds occupied by COVID patients	<=30	>30	64	35	19	28	72	26	24	50	16	40	36
	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%	5.60%	3.40%	2.90%	3.50%
	Net impact of high cost drugs and devices	Total expenditure and income against plan for high cost drugs and devices (YTD)	<=0	>0	£0	£230k	£514k	£1.126m	£1.060m	£1.638m	£1.611m	£1.542m	£1.906m	£1.585m	£1.595m
	Increase productivity	Implied productivity based on financial and operational performance (Quarterly)	>=3%	3%	-20%	-15%	-22%	-22%	-23%	-23%	-23%	-23%	-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%	96%	111%	105%	106%
	Non elective activity	Performance against planned levels of activity (Value Based)	>= 100%	< 100%	n/a	92.0%	102%	103%	107%	108%	114%	109%	111%	113%	110%
	Delivery of capital programme	Variance from year to date planned capital expenditure (exc IFRS16 from M7)	+ or - 1%	><1%	n/a	13.6%	15.0%	17.4%	7.5%	16.4%	14.1%	19.0%	14.4%	15.4%	12.9%
	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+ or - 1%	><1%	n/a	0	0	0	0	0	0	0	1%	1%	1%
	Delivery of planned cash balance	Variance from year to date planned cash balance (exc system alignment funding received from M7)	+ or - 10%	><10%	n/a	(8.8%)	(6.4%)	(7.3%)	12.5%	30.2%	8.6%	17.9%	10.7%	(4.8%)	(20.2%)

Executive Summary

- The RUH is £3.9m adverse to plan with a deficit of £21.0 m against a plan of £17.1m. The number of non-criteria to reside patients has remained high with an average of 142 and continues to create operational pressures. Agency usage as a proportion of total pay costs is 3.6% and therefore above the 3% target. The year to date elective recovery performance is 106% of 2019/20 levels which is above the target of 104%. A fixed level of funding has been confirmed to the end of the financial year as the claw back rule has been removed across all commissioners.

- The Trust is managing risks through the finance recovery plan totalling £6.00m (£4.00m in the RUH and £2.00m at Sulis). The key schemes continue with actions being taken and improvements have been seen in nurse agency usage and the identification of QIPP schemes. There remains £2.0million of risks to be managed this financial year.

- £11.1 m of savings have been delivered year to date against a plan of £11.1m of which £6.1m were non-recurrent. This is broken down into under-recovery of £2.2m against transformation programmes, £0.3m over-recovery against divisional programmes and an additional £1.9m non-recurrent savings. The full £14.8m target has now got identified plans. £3.7m of the QIPP savings are due to be delivered in the last two months of the year.

- Pay for the RUH is over plan in month by £1.4m (£15.9m year to date). All the clinical divisions have overspent this month, partly as a result of Bank Holiday cover and the creation of additional capacity to respond to emergency demand.

- Capital expenditure was £33.6 million at Month 10 which was £8.7 million less than planned however this includes IFRS16. Excluding IFRS16 the position is £4.1 million less than planned

- The closing cash balance for the Group was £40.6 million which is £13.9 million higher than the plan sent to NHSE/I.

True North | Breakeven position

Statement of Comprehensive Income	Total							
	202210			YTD			FY	
Period to 202210	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Forecast £'000
Commissioner Income (NHSE/CCG)	32,794	34,484	1,690	326,543	336,976	10,433	392,045	404,602
Other Patient Care Income	1,900	1,862	(38)	18,140	21,595	3,455	21,808	25,932
Other Operating Income	2,478	4,562	2,083	24,476	32,772	8,297	37,577	45,716
Income Total	37,172	40,908	3,736	369,160	391,344	22,184	451,430	476,250
Pay	(23,969)	(25,488)	(1,519)	(242,316)	(259,798)	(17,482)	(290,261)	(310,769)
Non Pay	(11,828)	(13,033)	(1,205)	(120,635)	(128,208)	(7,572)	(144,362)	(149,159)
Depreciation	(1,798)	(1,720)	78	(17,775)	(17,203)	572	(21,372)	(21,685)
Impairment	0	(309)	(309)	0	0	0	0	0
Expenditure Total	(37,594)	(40,550)	(2,955)	(380,727)	(405,209)	(24,483)	(455,995)	(481,613)
Operating Surplus/(Deficit)	(422)	358	780	(11,567)	(13,866)	(2,299)	(4,565)	(5,363)
Other Finance Charges	(600)	(499)	101	(5,962)	(5,754)	208	(7,163)	(7,265)
Finance Charges	(600)	(499)	101	(5,962)	(5,754)	208	(7,163)	(7,265)
Surplus/(Deficit)	(1,022)	(141)	881	(17,529)	(19,620)	(2,091)	(11,728)	(12,628)

Adjusted Financial Performance								
Add back all I&E impairments/ (reversals)	0	309	309	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	(1,022)	167	1,189	(17,529)	(19,620)	(2,091)	(11,728)	(12,628)
Retain impact of DEL I&E (impairments)/ reversals	0	(309)	(309)	0	0	0	0	0
Remove capital donations/grants I&E impact	46	(1,076)	(1,122)	466	(1,337)	(1,803)	(7,572)	(6,672)
DEL Impairment Adjustment	0	0	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) including PSF as per accounts	(976)	(1,218)	(242)	(17,063)	(20,957)	(3,894)	(19,300)	(19,300)
Adjusted financial performance surplus/(deficit)	**(976)**	**(1,218)**	**(242)**	**(17,063)**	**(20,957)**	**(3,894)**	**(19,300)**	**(19,300)**

System Adjustment	0	1,608	1,608	0	16,083	16,083	0	19,300
Adjusted financial performance for the purposes of system achievement	**(976)**	**391**	**1,367**	**(17,063)**	**(4,874)**	**12,189**	**(19,300)**	**(0)**

Tracker Measure | Sustainability Savings

2022.23 SAVINGS PLANS

	Internal Annual Plan	YTD Plan	YTD actual	YTD variance	Forecast Outturn	Forecast Variance to Plan	Recurrent	Non-Recurrent (NR)
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Transformation Schemes								
Outpatient Productivity	158	126	0	126	0	158	0	0
Home First	0	0	0	0	0	0	0	0
Medicines Management	779	1,287	131	1,155	254	525	131	0
Agency and Recruitment - Nursing	1,461	1,230	256	974	354	1,106	256	0
Agency and Recruitment - Medical	500	389	0	389	0	500	0	0
Theatre Efficiency	383	382	0	382	0	383	0	0
ICU Capacity	1,300	929	3,392	(2,463)	4,592	(3,292)	1,592	1,800
ICU Transformation Target	1,500	900	0	900	0	1,500	0	0
Investment Review - TIG	934	876	776	100	934	0	776	0
Elective Recovery (Orthopaedics)	200	133	0	133	0	200	0	0
Cleaning / Catering Income	275	240	229	11	275	0	0	229
Portering	75	65	0	65	0	75	0	0
Sulis Transformational Target	500	389	0	389	0	500	0	0
Workforce Processes	0	0	0	0	0	0	0	0
To be identified	149	12	0	12	0	149	0	0
Sub Total Transformation	8,214	6,957	4,784	2,174	6,409	1,805	2,755	2,029
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Divisional / Sulis QIPP								
Surgery	1,420	815	1,569	(753)	2,027	(607)	719	850
Medicine	1,678	677	1,075	(398)	1,129	549	183	893
Emergency Medicine	249	0	137	(137)	195	54	0	137
FaSS	775	531	643	(112)	767	8	643	0
ERM	325	252	246	6	295	30	139	107
Corporate	639	203	208	(5)	239	400	166	42
Sulis	500	389	22	367	22	478	22	0
Procurement stretch target	0	458	0	458	0	0	0	0
COVID	1,000	854	556	298	637	363	305	251
Sub Total Divisional	6,586	4,179	4,456	(277)	5,310	1,276	2,176	2,280
ERF Efficiency	0	0	0	0	0	0	0	0
Divisional Recovery Efficiencies	0	0	0	0	850	(850)	0	0
Non Recurrent slippage	0	0	1,871	(1,871)	2,231	(2,231)	0	1,871
Total QIPP	14,800	11,136	11,111	25	14,800	0	4,930	6,181

Countermeasure /Action – Completed	Owner
Budget have been reviewed and non-recurrent savings identified by the Divisions. Additional savings have been identified within Ophthalmology in Surgery due to a cheaper drug now being used	Project Leads

Countermeasure /Action – Future Actions	Owner
Schemes to support targets are being worked up with Finance and Project Leads as part of the budget setting programme for 2023/24	Project Leads / Finance

Tracker Measure | Sustainability – Capital (RUH and SULIS)

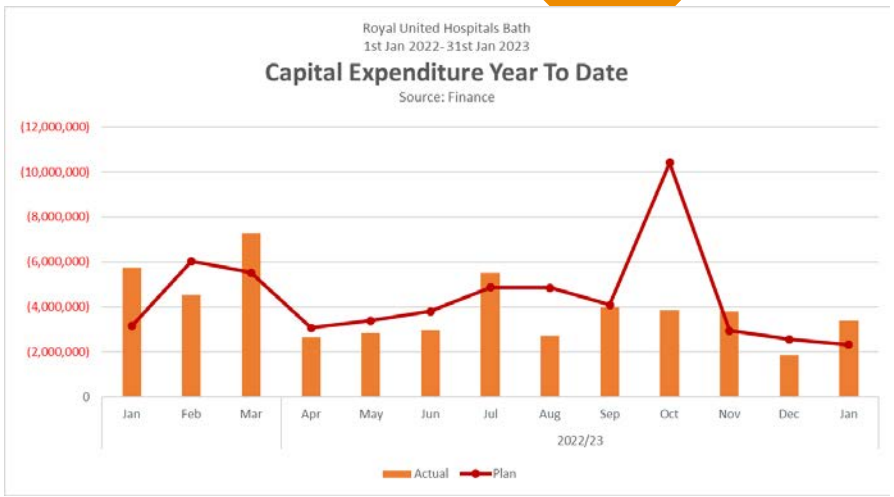
Capital Programme

Capital Position as at 31st January 2023	Annual Plan	Forecast	Year to Date Plan	Year to Date Actuals	Year to Date Variance
	£000s	£000s	£000s	£000s	£000s
Internally Funded schemes	(12,795)	(13,295)	(10,631)	(8,204)	2,427
IFRS 16 Lease Schemes	(6,236)	(6,236)	(6,236)	(1,653)	4,583
IFRS 16 Leases for Regional Orthopedic Centre	0	(39,652)	0	0	0
External Funded (PDC & Donated):					
Cancer Centre PDC	(22,530)	(22,530)	(21,765)	(20,624)	1,141
Regional Orthopaedic Centre PDC	(823)	(823)	(823)	(770)	53
Digital PDC	(1,214)	(1,214)	(108)	(113)	(5)
Other PDC	(185)	(185)	(85)	0	85
CPOA Ward Project (PDC)	(1,600)	(1,600)	0	(173)	(173)
Donated	(7,531)	(3,899)	(2,670)	(2,053)	617
Total	**(52,914)**	**(89,434)**	**(42,318)**	**(33,590)**	**8,728**

Is standard being delivered? No
What is the top contributor for under/over-achievement?

Trust funded programme is £7.0m under plan to date.

External funded schemes The forecast outturn will utilise the full PDC funding available this year.



Countermeasures completed last month

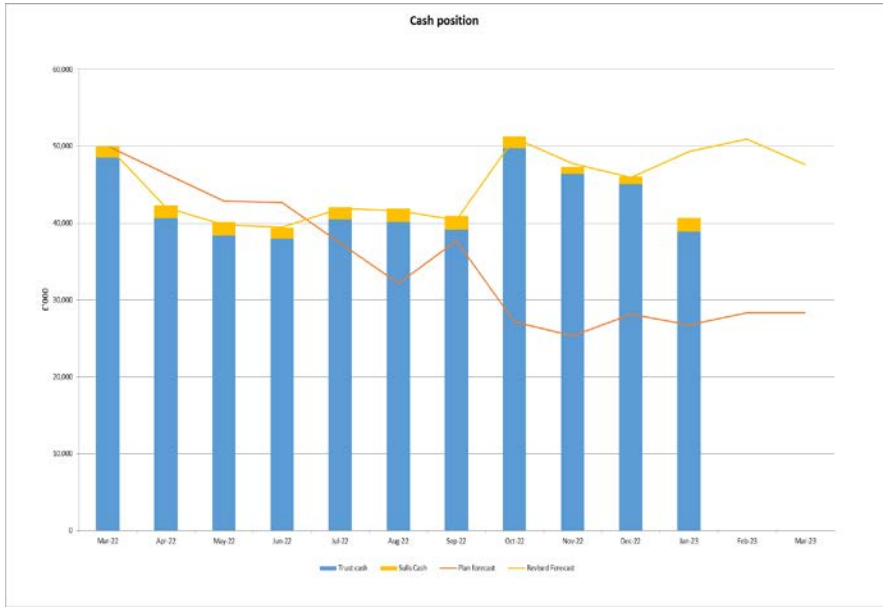
Countermeasure /Action	Owner
Cost Pressure on Sulis MRI & CT project to be confirmed	Head of Capital Projects

Countermeasures for the month ahead

Countermeasure /Action	Owner
CPMG to continue to monitor delivery of projects and schemes as approach year end	Head of Financial Services
Capital cover for IFRS16 leases to be determined with region	Deputy Director of Finance & Head of Financial Services

Tracker Measure | Sustainability – Cash (RUH and SULIS)

Group Cashflow statement against Month 12



Cashflow statement	
	£'000
Operating Surplus/(deficit)	2,218
Depreciation & Amortisation	17,202
Income recognised in respect of capital donations (cash and	(2,053)
Impairments	0
Working Capital movement	(11,322)
Provisions	(119)
Cashflow from/(used in) operations	**5,926**
Capital Expenditure	(33,239)
Cash receipts from asset sales	0
Donated cash for capital assets	2,053
Interest received	705
Cashflow before financing	**(30,481)**
Public dividend capital received	21,557
Movement in loans from the DHSC	(312)
Capital element of finance lease rental payments	(2,304)
Interest on loans	(112)
Interest element of finance lease	(309)
PDC dividend (paid)/refunded	(3,510)
Net cash generated from/(used in) financing activities	**15,010**
Increase/(decrease) in cash and cash equivalents	**(9,545)**
Opening Cash balance	**49,989**
Closing cash balance	**40,445**

Is standard being delivered for cash? No
The closing cash balance is £40.6 million which is £13.9 million higher than the planned NHSI return submitted for 2022-23.

Countermeasures completed last month

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

Countermeasures for the month ahead

Countermeasure /Action	Owner
Update 2023-24 cash forecast in line with draft plan	Financial Accountant

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

	31/12/2022 Actual £'000	31/01/2023 Actual £'000	Mv't in month £'000
Non current assets			
Intangible assets	6,653	6,561	(92)
Property, Plant & Equipment	267,213	269,388	2,175
Right of use assets - leased assets for lesse	28,576	28,144	(432)
Trade and other receivables	2,739	2,179	(560)
Non current assets total	**305,181**	**306,273**	**1,091**
Current Assets			
Inventories	6,805	6,962	157
Trade and other receivables	24,988	23,813	(1,175)
Cash and cash equivalents	46,112	40,445	(5,667)
Current Assets total	**77,905**	**71,221**	**(6,684)**
Current Liabilities			
Trade and other payables	(59,744)	(53,426)	6,320
Other liabilities	(15,929)	(13,344)	2,584
Provisions	(192)	(239)	(47)
Borrowings	(5,038)	(5,061)	(23)
Current Liabilities total	**(80,903)**	**(72,070)**	**8,833**
Total assets less current liabilities	**302,183**	**305,423**	**3,240**
Non current liabilities			
Provisions	(1,856)	(1,669)	187
Borrowings	(31,874)	(31,366)	507
TOTAL ASSETS EMPLOYED	**268,453**	**272,388**	**3,934**
Financed by:			
Public Dividend Capital	226,432	228,900	2,468
Other reserves	0	(0)	(0)
Income and Expenditure Reserve	2,115	3,582	1,467
Revaluation reserve	39,906	39,906	0
Total Equity	**268,453**	**272,387**	**3,934**

The Group Balance Sheet (RUH and Sulis)

Month 10 against month 9 movement:

- Capital has increased in line with reported capital spend less depreciation.
- Cash has decreased between months.