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| **Report to:** | **Public Board of Directors** | **Agenda item:** | **10** |
| **Date of Meeting:** | **4 September 2024** | | |
| **Title of Report:** | **Integrated Performance Report** | | |
| **Status:** | **For noting** | | |
| **Board Sponsor:** | **Paran Govender, Chief Operating Officer**<br>**Jon Lund, Interim Chief Financial Officer**<br>**Alfredo Thompson, Chief People Officer**<br>**Toni Lynch, Chief Nursing Officer** | | |
| **Author:** | **Tom Williams, Head of Financial Management**<br>**Rob Eliot, Lead for Quality Assurance**<br>**Matt Foxon, Associate Director for People** | | |
| **Appendices** | **Appendix 1: Integrated Performance Report**<br>**Appendix 2: Trust Scorecard** | | |

## 1. Executive Summary of the Report

The report provides an overview of the Trust Operational and Financial Performance for the period up to and covering July 2024, 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.

**Performance**

**Ambulance Handover**

In July, the Trust lost a total of 1532 hours in ambulance handovers, which was down from the previous month (2199). The percentage of Ambulances handed over within 30 minutes increased for July to 49.08% compared to the previous month (43.9%) against the national standard of 95%. Through the BSW Ambulance handover improvement group, there is an action to review the handover process with SWASFT to align across BSW aiming to streamline processes and improve quality standards including patients being seen within 15 minutes of arrival. During June, an immediate change took place with the external green light remaining on outside ED allowing crews to bring patients straight into the department upon arrival for the ED team to undertake a rapid triage. The % of patients triaged within 15mins in Majors improved from 46.60% in May, to 65.51% June and 69.18% July.

**4-Hour Performance**

The RUH 4-hour performance in July was 71.5%, missing the trajectory of 73.0%. Attendances in July were 8,656, which was an increase on June. Non-admitted performance was 73.43% (plan 84.2%). There are 6 WTE UTC staffing gaps (vacancy, maternity leave and long-term sickness) requiring 100 shifts per month on average to cover the service, which are filled to 70%, affecting performance delivery in the UTC. Admitted performance was 40.46.% (plan 46.8%) which was affected by not having a consistent medical rota to support rapid assessment delaying onward referral to specialties; Trust occupancy was 93.6% (versus trajectory 92%), occupancy of patients without a criteria to reside was over trajectory of 55, ward discharges occurring after midday (21.7% before midday) and an average of 46.6 beds were affected by IPC restrictions per day in July. Improvement in performance

will be supported by the delivery of the UEC improvement plan, specifically the integrated front door workstream for non-admitted 4-hour performance and the In Hospital workstream, which will support the 4-hour admitted pathway recovery.

**Non-Criteria to Reside (NC2R)**
During July, the Trust had an average of 88 patients waiting who had no criteria to reside, this was a reduction of 3.2 on the previous month. Some localities saw a decrease in average numbers of NC2R. BANES and Wiltshire had seen small improvements, but a significant increase was seen with Somerset patients. Discussions with all providers and ICB regarding NC2R are ongoing.

**Referral to Treatment**
In July, the Trust had 2 patients waiting over 78 weeks and 36 patients waiting over 65 weeks. The longest waiters are in General Surgery, Gastroenterology, Trauma & Orthopaedics and ENT. There are detailed plans to address this.

**Cancer**
In June, 62 Day performance was maintained above target at 71.6%, slightly ahead of trajectory (71.4%). Urology remained the top contributor of breaches and performance saw a deterioration from May. Haematuria and prostate post-MDT OPA waiting times, pre-op/AA clinic and theatre capacity remained the main causes for the breaches. Lung performance declined again, impacted by surgical waiting times in UHBW and legacy of PET/EBUS equipment breakdowns. Performance was expected to improve from July with improved surgical waiting times in UHBW, but diagnoses are increasing following Targeted Lung Health Checks. Colorectal performance improved in month to above 50% for first time in two years. Gastro OPA and diagnostic waiting times remained a challenge in the pathway.

**Diagnostics**
The national operational standard for diagnostics is 95% to be delivered within 6 weeks (DMO1) by the end of March 2025. In July 2024, 64.42% of patients received their diagnostic within 6-weeks, a deterioration of 0.36% when compared to previous months and not in line with the revised trajectory for June of 72.47%. The number of patients waiting > 6 weeks for a diagnostics test decreased by 45 in July 24, to a total of 4176 by month end. Performance affected by the cumulative impact of increased demand for Radiology modalities in July 24 (+11%). Within total demand, urgent/suspected cancer cohort continues to increase above plan and is impacting directly on available capacity for routine DM01 referrals, despite overall increased activity levels in month. The diagnostic modalities of MRI, USS, CT, Sleep Studies and Echo remain the top contributors to adverse performance. Additional capacity came online in July 24, with additional CT and MRI mobile capacity and increased capacity at Sulis CDC in line with the revised trajectory (Aug trajectory 72.27%). Sulis-CDC delivered in July; CT 551, MRI 470, US 172, Endoscopy 157 and Cardiology 73 investigations.

**Elective Recovery**
M4 saw performance against 19/20 (119%) remain positive despite Industrial Action, at the start of the month. There continued to be challenges in Theatre Staffing, which resulted in cancellations of theatre lists impacting activity. As a trust, we under-

delivered against 24/25 Plan in M4, at 99%, translating in an overall in month income position -£107k. The Trust has delivered financial performance year-to-date of 112% of 19/20 and 105% of our M4 24/25 plan, in ERF. This has delivered a surplus of £1.3mln year-to-date, with Day Case and Outpatient New attendances being the significant contributors to this position.

**Finance**

**BSW Integrated Care System**

- The organisations in the BSW Integrated Care System must collaborate to develop Revenue and Capital Financial Plans with a view to achieving breakeven against allocations each year. The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to it's pre-pandemic levels.
- The BSW System has developed a financial plan with a £30.0m deficit for the year, of which the RUH is £5.3m deficit. This plan has been accepted by NHS England and non-recurrent revenue support funding is to be provided during the year. NHS England have amended NHS business rule this year and delivery of the plan means this funding will not be repayable in future years.
- At Month 4 the Integrated Care System is at a deficit position of £21.2m, which is £7.1m adverse to plan (see slide for further details)

**RUH Group Financial Plan**

- The RUH deficit plan of £5.3m is underpinned by £22.7m of non-recurrent revenue financial support from commissioners and £6.3m of NHSE funding for revenue consequences of new capital investment
- The financial plan for the year requires full delivery of a £36.6m Savings Programme, which has been phased to recognise progressive reduction in costs and increases in income over the year. Delivery of this plan is supported by an Improvement programme with 3 workstreams focussing on (1) Clinical Operational Productivity (2) Paybill Reduction and (3) Cost Control and Commercial Income
- Achieving the financial plan is an RUH Breakthrough Objective for 2024/25
- The consequence of not achieving the financial plan are significant. Deficits will need to be repaid in future periods, there will be less revenue investment for strategic investment priorities, there will be less capital funding, there will be less autonomy for ICS, Trust, Divisions, and Budget Holders, and increase regulatory scrutiny & intervention

**Revenue Financial Performance – Month 4**

- At Month 4. the Group is at a deficit position of £6.6 million, which is £0.6 million adverse to plan
- Savings of £7.9m have been delivered to date (21.6% of annual target in 33.3% of the financial year), including £5.1m of pay savings against budget, and the benefit of Elective Recovery Fund income and operating margin of 48%. The Pay Savings include the release of £0.9m of the Annual Leave Provision, bringing forward benefit anticipated in Month 6.

**Risks and Actions required**

The Trust has undertaken a high-level forecast at the end of Month 4. This clarifies a

path to deliver the Operational Plan that requires the following management actions:

- Sustain current I&E and Savings delivery, this would deliver a base case forecast I&E deficit of £19.8m, which would be £14.5m adverse to plan
- £4.2m Increasing Elective Recovery Fund income through Theatre and Outpatient productivity, and improved clinical coding
- £4.3m Further delivery of all Pay bill savings through controls, improved rostering and service redesign, reducing worked wte by 195.8wte from current levels
- £3.1m Delivery of Non-Pay & Commercial Income Savings

**Capital and Balance Sheet Position – Month 4**

- Total capital expenditure is £4.5m at Month 4, which is £11.3m behind plan due to delays in both the SEOC and EPR programmes
- The closing cash balance for the Group was £29.7m which is 38.7% higher than the plan due to the capital delays set out above, but £4.8m lower than 31st March due to I&E deficit and settlement of liabilities accrued at year end.

**Workforce**

The RUH establishment in July 2024 (M4) was 5699 whole time equivalents (WTE), (increasing from 5639 WTE in June 2024).

- The staff-in-post in July 2024 was 5549 WTE, a slight reduction compared to M3.
- The M4 Vacancy rate (2.64%) has increased compared to M3.
- Agency spend as a proportion of the total pay bill increased from 0.27% (M3) to 1.02% (M4) still significantly within the local target of 3.5% and the national target of 3.2%.
- Nurse Agency spend as a proportion of the Registered Nursing pay bill increased to 0.60% in M4.
- Rolling turnover slightly increased to 8.47% (from 8.39% in M3) a continued positive variance against a target of 11.00%.
- Rolling sickness in June 24 was 4.54% (from 4.39% in May 24)
- The target percentage figure for Appraisal completion is 90%; Appraisal has decreased slightly to 79.85%.
- Mandatory Training compliance continues to be narrowly above target at 90.03%.

A key focus throughout 2024/25 will be the delivery of the programmes within the People Plan. In Q3 work will begin to refresh the RUH People Plan to ensure it meets the upcoming challenges and priorities.

The immediate priorities within our People Agenda will be to continue our work around pay efficiencies, improve how we manage sickness absence and achieve a 90% appraisal uptake.

**Actions are being taken to improve support to the RUH workforce and workforce performance:**

**People Plan Programme 1 – Foundations**

We continue to develop the People Hub, which is our 'one stop shop' in the People

Directorate for managing HR and medical workforce queries.

The Halo HR portal development is progressing well, working alongside colleagues in IT. Halo will enable a:

- Case management solution
- Self-service functionality

The People team will be trained on the Halo case management system in September 2024. We expect self-service via Halo to be available in Q3 of 2024/25, this will include chat box functionality. The delivery of the Halo system will enable a full launch of our People Hub, enabling improved workflows and efficiencies for our users.

**People Plan Programme 4- Diverse and Inclusive**
Addressing abuse and violence, we have launched two new interventions to support everyone to speak up when colleagues experience or see unacceptable behaviour, and to get the support they need.

The three-step Violence Prevention and Reduction Policy addresses unacceptable behaviour from patients and the public, and the Report + Support platform is for unacceptable behaviour from colleagues.

These are just two ways of reporting concerns about behaviour – this can include bullying, abuse, harassment, discrimination and violence.

Other projects seek to improve the experiences of colleagues by providing safe and inclusive working environments. Core approaches include our renewed breakthrough objective to reduce discrimination (focussing on disability and long-term conditions), building and energising our staff networks, our network of inclusion champions and independent advisors, and delivering tailored programmes of intervention to increase inclusive working practices.

**People Plan Programme 9 – Talent Acquisition**
A central Vacancy Control and Agency Reduction Panel continues to support having the right people, in the right posts against our workforce plans. The new controls and scrutiny are a fundamental element of the financial recovery plans.

This quarter we'll also be launching our employer value proposition to showcase all that the RUH has to offer to current, potential and future employees supporting attraction, engagement and retention. Employee Value Proposition will provide a new look and feel to support our vision of staff recommending us a place to work. Expected go live from September 2024.

**People Plan Programme 10 – Temporary Staffing**
This programme drives improvement on the three nationally reported measures: price cap compliance, framework provision and our total spend on agency as a percentage of our total pay bill.

Total agency spend in July 24 was 1.02% of the total pay bill, which is under the current national target of 3.2%. Bank usage increased slightly in July 24.

The key actions taking place to support temporary staffing reductions are:

- South West Agency rate card for Medical & Dental goes live 1st September for new bookings. A longer lead in time for existing locums to reach rate card no later than March 2025.
- AfC Bank rates changing to align with system partners approach of paying to grade supporting collaborative work. This new way of working also supports the movement from overtime to bank.
- Locally Agreed Bank rates under review to consider impact of standing down or stepping down rates to create equity and transparency in our approach.
- Divisional workforce data tracked prospectively (and retrospectively) and shared with divisional teams to support management of spend.
- SW Regional Agency Rate card for Nursing live from 1st July reaching NHS price cap compliance.

**Quality**

**Pressure Ulcer**

The RUH benchmarks with the local ICB with both 1,000 bed day data and numbers of pressure ulcers. The RUH for June 2024 is 0.3/1,000 bed days with 2 category 2 pressure ulcers. GWH is 1.86/1,000 bed days with 31 category 2 pressure ulcers. Salisbury is 2.52/1,000 bed days with 29 category 2 pressure ulcers.
The RUH has been 5 years category 4 pressure ulcer free. GWH has had 5 and Salisbury has had 2 since 2022.

There was one category 3 pressure ulcer and one category 3 device related pressure ulcer against a threshold of zero in June 2024. Analysis of RUH figures show that the top contributor is inadequate skin assessment and escalation to senior staff.

**Falls**

In June there were 2 reported falls that resulted in moderate harm, both were hip fractures. The falls occurred on older persons wards, where all patients are at risk of falls as they are over 65 years old. An investigation into the occurrence of the falls is now being completed and will be presented to the falls review panel to agree if there are actions for learning. Any actions formulated are then included in the falls work plan to ensure improvement work is planned and completed.

**Infection Prevention and Control Update**

There were 4 cases of Clostridioides difficile infection reported during June (3 HOHA and 1 COHA). The analysis demonstrates all the patients were over the age of 62. All of the cases are attributed to medicine. There were 5 cases of E. coli infection reported during June with 1 case associated to FASS and 4 to Medicine.
The frailty and complexity of patients often means that they have an increased vulnerability to infections whilst in Hospital, despite the care and prudent prescribing in place to prevent this occurring. Our antibiotic consumption and usage is one of the best in the region. Cleaning standards is often the first concern when trying to prevent infections. There has been a focus on recruiting into the team, retraining all

staff and providing leadership the cleaning team to improve the overall service provided

**Patient Support and Complaints**
The majority of patient feedback is positive. In June the Trust received 1.3 complaints per 10,000 patient contacts. This compares to 1.2 in May and 1.1 in April.
The number of reopened complaints is a simple measure of quality. The number of complaints reopened each month remains low with the majority of contacts satisfied with the outcome/response. The top contributors for both concerns and formal complaints were Orthopaedics and Gastroenterology.

**Maternity Update**

- Small drop in % staff meeting acuity on bath birthing centre, corroborated with a slight increase in the Midwife to Birth Ratio of 1:27, including usage of bank staffing this was reduced to 1:25, slightly above the recommended target of 1:24.
- Drop in budget vs actual midwifery staffing due to increase of maternity leave and slight increase in turnover rate from 4 to 6%, successfully recruited into vacancies, anticipated that new starters will improve position in October 24.
- On going work with health roster team to removed unused tiles to improve shift fill rates- anticipated accurate data from September rota
- Neonatal staffing slight decrease in staffing meeting British Association of Perinatal Medicine (BAPM) standards to 82%. This was attributable to a period of high acuity in the middle of the month with 3 ITU admissions and 4 HDU admissions.
- No episodes of non-maintenance of 1:1 care in labour, or supernumerary status of the labour ward co-ordinator
- Currently undertaking review of the staffing ‘red flag’ triggers to align to the NICE safe staffing paper of 2015 and Local Maternity and Neonatal System (LMNS).
- Access to ‘summaries’ function of Birth Rate + acuity tool for Mary Ward (inpatient antenatal and Postnatal care) enabled this month following a period of ‘down-time’ due to a system update. Data entry commenced in January 2024, June compliance of ‘staffing meets acuity’ is recorded as 33%. New tool format, further training and validation required to ensure effective acuity scoring in place, % does not feel reflective of acuity/staffing within the clinical area
- 1 Neonatal death following presentation with placental abruption, chose not to resuscitate after counselling. The death has been reported to MBRRACE and will receive a full PMRT review.
- No stillbirths in the month, in view of the increased 12 month rolling average for stillbirth currently conducting case cohort review to ensure no commonalities or underlying themes between the cases.
- 2 new MNSI referrals in the month of June, no immediate concerns identified
- One ‘in month’ insights commonality identified regarding the information available for women and families on the Trust website. This feedback was seen within Maternity and Neonatal Voices Partnership and a PALS contact, service collaborating with the Trust wide project to re-design and improve the accessibility of the maternity and neonatal pages.

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

| 3. | Legal / Regulatory Implications |
|---|---|
| Trust Single Oversight Framework. | |

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

| 5. | Resources Implications (Financial / staffing) |
|---|---|
| Operational and financial risks as set out in the paper. | |

| 6. | Equality and Diversity |
|---|---|
| NA | |

| 7. | References to previous reports |
|---|---|
| Standing agenda item. | |

| 8. | Freedom of Information |
|---|---|
| Private | |

| 9. | Sustainability |
|---|---|
| None identified. | |

| 10. | Digital |
|---|---|
| None identified. | |

Royal United Hospitals Bath
NHS Foundation Trust

# Integrated Performance Report

August 2024 (July data)

The RUH, where you matter

# Trust Priorities 2024/25

Royal United Hospitals Bath NHS Foundation Trust

## The people we care for

## The people we work with

## The people in our community

## Trust goals

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

## Breakthrough goals 24/25

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

**Discrimination**
*% of staff reporting they have experienced discrimination at work*

**Making best use of available resources**
*Delivery of financial plan*

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

## Trust-wide projects

- **Patient Safety Programme -** Quality Management System, Patient Safety Incident Response Framework, Paperless Inpatients
- **Atrium Redesign**
- **Patient Experience Programme** - DrDoctor Patient Platform, Website
- **Clinical Estate -** One ICU, Maternity DAU, Dyson Cancer Centre Benefits Realisation
- **Community Services Tender**
- **Elective & Cancer -** Community Diagnostic Centre & Sulis Elective Orthopaedic Centre

- **Foundations Programme** – Basics Matter & People Hub
- **Workforce Plan**
- **Employee Experience & Engagement –** Joy at Work, Employee Recognition
- **Restorative, Just & Learning Culture**
- **Equality, Diversity & Inclusion Programme** – Positive Action & Dignity at Work
- **Leadership Development Programme**

- **Health Inequalities Programme** – Preventative services, Anchor Plan
- **Estate Decarbonisation**
- **Financial Improvement Programme** – Clinical productivity, Pay Bill, Income and cost controls
- **Single EPR**
- **Acute Hospital Alliance reset** – Clinical and Corporate Services

# Business Rules

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

# The people we care for

The RUH, where you matter

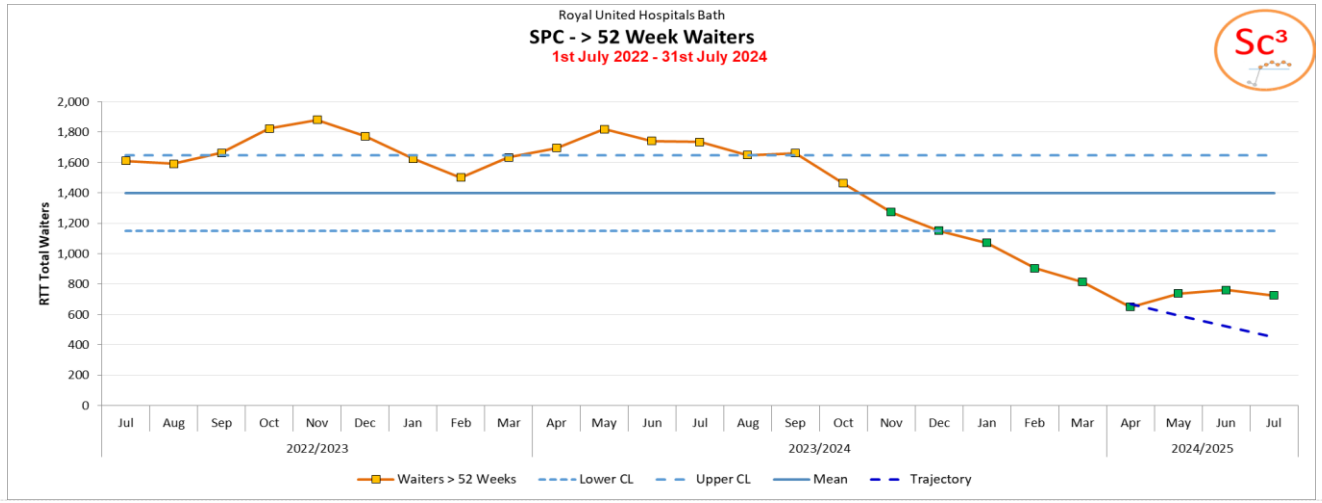
# Executive Summary: Performance

| Measure | Change | Executive Summary |
|---|---|---|
| Ambulance Handover | ↓ | In July, the Trust lost a total of **1532** hours in ambulance handovers, a reduction from the previous month (2199). The percentage of Ambulances handed over within 30 minutes increased for July to **49.08%** compared to previous month (43.9%) against the national standard of 95%. Through the BSW Ambulance handover improvement group, there is an action to review the handover process with SWASFT to align across BSW aiming to streamline processes and improve quality standards including patients seen within 15 minutes of arrival. During June, an immediate change took place with the external green light remaining on outside ED allowing crews to bring patients straight into the department upon arrival, ED team will undertake a rapid triage. The % of patients triaged within 15mins in Majors improved from 46.60% in May to 65.51% June and 69.18% July. The UEC improvement plan will support flow out of ED, which will increase the number of patients handed over within 30 minutes. The recent SWAST Ambulance Handover Perfect Week has identified system-wide actions. Work continues with SWASFT as the hours lost relate to SWASFT processes, which include leaving the Combe Park site freeing capacity for the next ambulance arrival. |
| 4 Hour Performance | ↓ | RUH 4-hour performance in July was **71.5%** and **63.4%** on the RUH footprint (unmapped), static from the previous month, however missing the trajectory of **73.0**% unmapped. Attendances during July were 8,656, an increase from June. Non-admitted performance 73.43% (plan 84.2%). There are 6 wte UTC staffing gaps (vacancy, maternity leave and long-term sickness) requiring 100 shifts per month on average to cover the service, which are filled to 70%, affecting performance delivery in UTC. Admitted performance was 40.46.% (plan 46.8%). Admitted performance was affected by not having a consistent medical rota to support rapid assessment delaying onward referral to specialties; trust occupancy 93.6% (trajectory 92%), occupancy of patients without a criteria to reside over trajectory of 55, ward discharges occurring after midday (21.7% before midday) and an average of 46.6 beds affected by IPC restrictions per day in July. Improvement in performance will be supported by the delivery of the UEC improvement plan, specifically the integrated front door workstream for non-admitted 4- hour performance and the In Hospital workstream, which will support the 4-hour admitted pathway recovery. |
| Non-Criteria to Reside (NC2R) | ↓ | During July, the Trust had an average of **88** patients waiting who had no criteria to reside, which is a reduction by 3.2 than the previous month. Some localities saw a decrease in average numbers of NCTR,. BANES and Wiltshire had small improvements, but a more significant increase seen with Somerset patients. Ongoing discussions with all providers and ICB re NCTR. |
| Referral to Treatment | ↓ | In July, the Trust had **2** patients waiting over 78 weeks and **36** patients waiting over 65 weeks. The longest waiters are in General Surgery, Gastroenterology, Trauma & Orthopaedics and ENT. There are detailed plans to address and with risk. |
| Cancer 62 Days | ↑ | In June, 62 Day performance was maintained above target at **71.6%,** slightly ahead of trajectory **(71.4%)**. Urology remained the top contributor of breaches and performance deteriorated from May. Haematuria and prostate post-MDT OPA waiting times, pre-op/AA clinic and theatre capacity remans the main causes for breaches. Lung performance declined again, impacted by surgical waiting times in UHBW and legacy of PET/EBUS equipment breakdowns. Performance expected to improve from July with improved surgical waiting times in UHBW but diagnoses increasing following Targeted Lung Health Check. Colorectal performance improved in month to above 50% for first time in two years. Gastro OPA and diagnostic waiting times remain a challenge in the pathway. |
| Diagnostics | ↑ | The national operational standard for diagnostics is 95% to be delivered within 6 weeks (DMO1) by the end of March 2025. **In July 2024, 64.42% of patients received their diagnostic within 6-weeks, a deterioration of 0.36% when compared to previous month and not in line with the revised trajectory for June of 72.47%.** The number of patients waiting > 6 weeks for a diagnostics test decreased by 45 in July 24, to a total of 4176 by month end. Performance affected by the cumulative impact of increased demand for Radiology modalities in July 24 (+11%). Within total demand, urgent/suspected cancer cohort continues to increase above plan and impacting directly on available capacity for routine DM01 referrals, despite overall increased activity levels in month. The diagnostic modalities of MRI, USS, CT, Sleep Studies and Echo remain the top contributors to adverse performance. Additional capacity came online in July 24, with additional CT and MRI mobile capacity and increased capacity at Sulis CDC in line with the revised trajectory (Aug trajectory 72.27%). Sulis-CDC delivered in July; CT 551, MRI 470, US 172, Endoscopy 157 and Cardiology 73 investigations. |
| Elective Recovery | ↑ | M4 saw a strong performance against 19/20 (**119%**) despite Industrial Action, at the start of the month. Challenges in theatres around staffing resulted in cancellations of some theatre sessions which impactied activity. As a trust, we under-delivered against 24/25 plan in M4, at **99%.** The Trust has delivered financial performance year-to-date of 122% of 19/20 and 104% of our M4 24/25 ERF plan. This has delivered a surplus of £1.3mln year-to-date, with Day Case and Outpatient New attendances being the significant contributors |

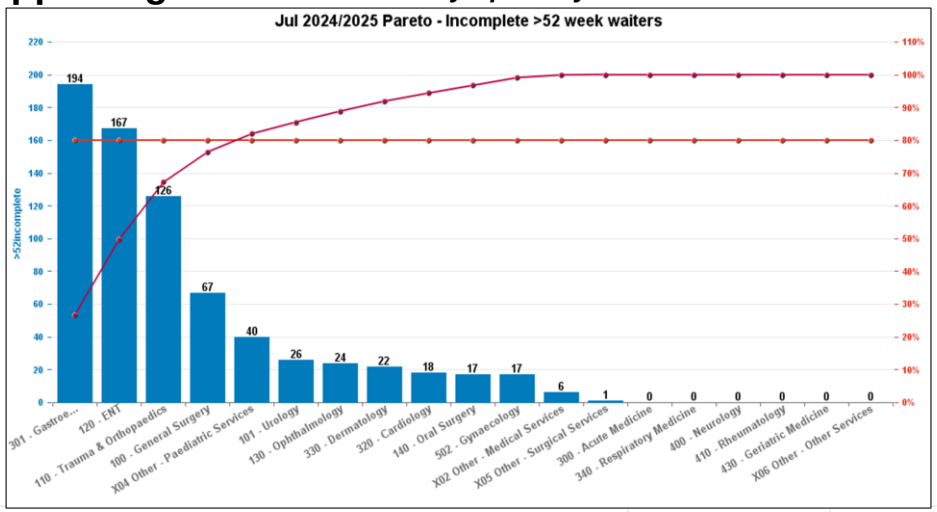
# Trust Goal | Referral to Treatment

**Performance target**; No patients waiting greater than 52 weeks by March 25

## Historic Data




## Supporting data - *Pareto 52+ by Specialty*




## Is the standard being delivered?

- In July 24, the Trust had 725 patients waiting > 52 weeks, a decrease of 5% from June.
- For waiters **> 65 weeks**, the Trust also saw a decrease in July from 56 to 36 patients.
- There were 2 patients waiting **> 78 weeks** at the end of July (these were in Dermatology)
- RTT performance was 65.5% in July.
- For waiters over 52 weeks, the three largest specialties combined represent over two thirds of the waiters. These are Gastroenterology, ENT and Trauma & Orthopaedics.
- ENT saw a big spike in June but have now improved their >52-week position from 220 patients to 167, bringing them back to the same position as at the end of May.
- After five consecutive months of improvement, in July Gastro's position worsened from 170 to 194 patients waiting >52 weeks.
- T&O experienced a second consecutive decrease in >52-week waiters this month, from 154 to 126.

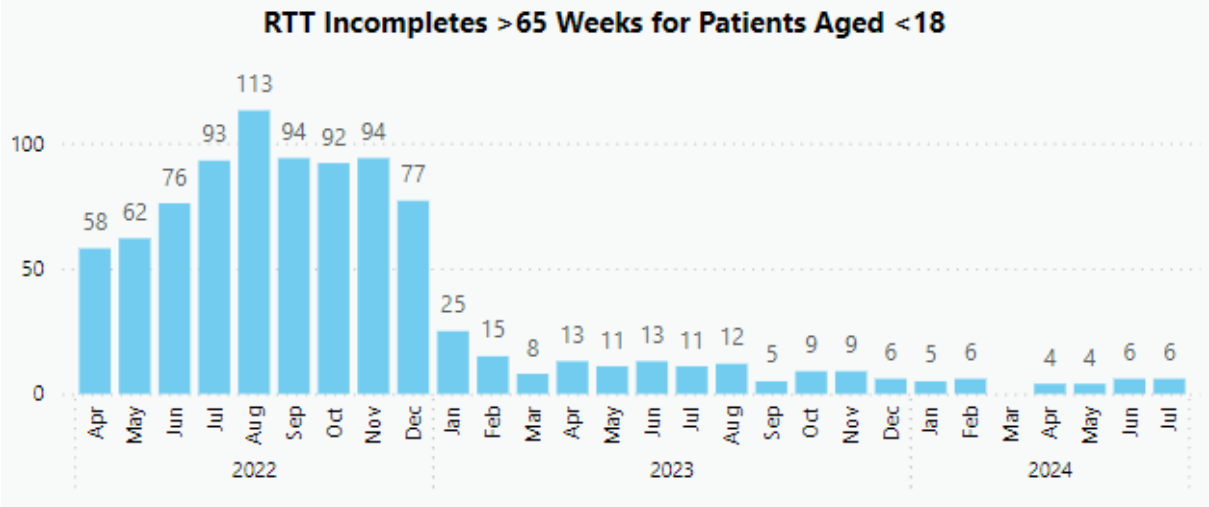
## What's the top contributor for under/over achievement?

- T&O continue to be challenged with long waiting spinal and paediatric patients. Joint working with Sulis to support the longest waiting Spinal patients continues. Paediatric T&O continues to be a challenge – additional capacity at registrar level will be available from late August/early September.
- ENT continue to work with Sulis to treat the longest waiting routine adult patients
- Gastro continue to experience long waits to first appointment with numbers increasing in July

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Development of robust pathways for routine patients in pressured specialties e.g. spine and ENT, being developed with Sulis to provide additional capacity to support performance | Roberts | Q1&2 24/25 |
| Continue 3 x weekly long waiter PTLs for "challenged" specialties to meet 65 weeks by end of Sept 24 – currently Gastro, T&O, Gen Surg, ENT | Dando | End of Q3 24/25 |
| Continued focus on utilising BSW system wide capacity to support focused effort on reducing waiting list | Roberts/ Macgregor | Ongoing |
| Validation "deep dive" into challenged specialties to obtain learning for specialties and drive process improvements | Dando | Ongoing |

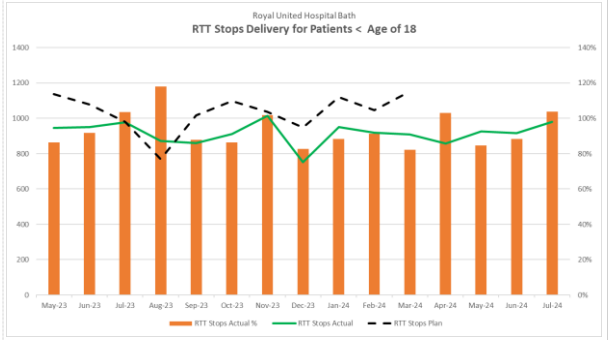
# Trust Goal | Paediatrics

## Historic Data

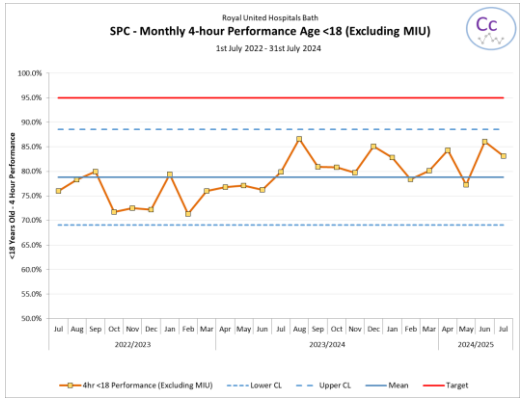



## Supporting data

***Stops v Plan***




***4 hr performance***




## Is the standard being delivered?

- RTT non-compliant – In June we reported 1 patient <age of 18 waiting **>78 weeks** under Dermatology and a further 5 patients waiting over 65 weeks (4 Trauma and Orthopaedics and 1 ENT).

- Cancer 28 Day Diagnosis non-compliant – 0% (5 breaches). All were for patients awaiting dermatology appointments. All delayed due to first appointment waiting time extending beyond 28 days. Waiting time impacted due to department having 2.8 WTE consultant vacancies and unable to recruit. Insourcing for appointments commenced end of July. Waiting time now circa. 20 days. All cases confirmed non-cancer.

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

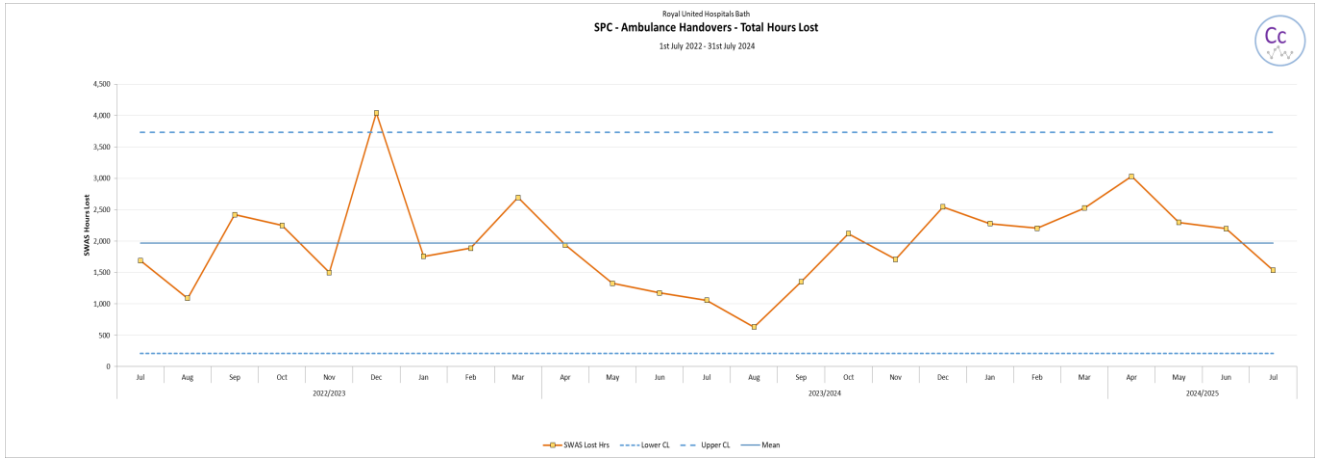
Paediatric Orthopaedic capacity remains challenged – a business case for an additional surgeon has been developed and is awaiting approval. Additional capacity will be provided at registrar level from late August/early September 24.

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Business case for additional Paediatric Orthopaedic Consultant going through ICB and regional external approval process | S Roberts | End of Aug 24 |
| CED/PAU - working together to improve 4hrs<br>- FirstNet screen installation and improved comms<br>- Ambulatory paeds pilot – date tbc (increase PAU capacity) | Gilby / Potter/Goodwin | In progress |
| CAMHS pathway – new low risk pathway to expedite CAMHS discharge process. Awaiting sign off by consultant psychiatrist. | Goodwin | In progress |

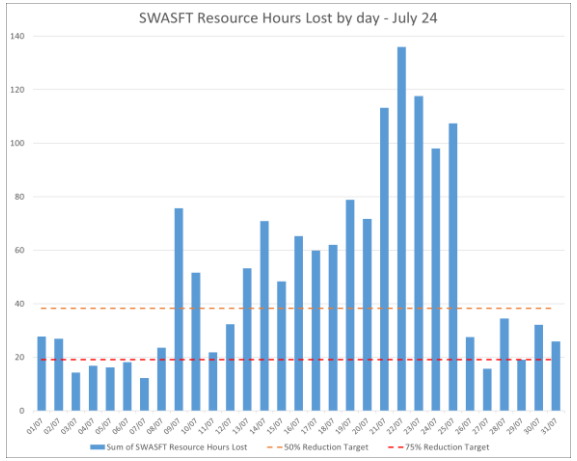
# Key standards | Ambulance handover delays

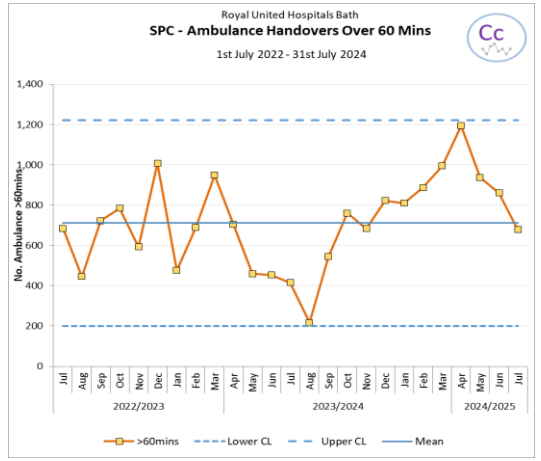
**Performance target:** lose no more than 500 hours per month

## Historic Data: Hours lost to Ambulance handover




## Supporting data




**Is the standard being delivered?**

In July, the Trust lost a total of **1532** hours in ambulance handovers, a reduction from the previous month (2199). The percentage of Ambulances handed over within 30 minutes increased for July to 49.08% compared to previous month (43.9%) against the national standard of 95%. Through the BSW Ambulance handover improvement group, there is an action to review the handover process with SWASFT to align across BSW aiming to streamline processes and improve quality standards including patients seen within 15 minutes of arrival. During June, an immediate change took place with the external green light remaining on outside ED allowing crews to bring patients straight into the department upon arrival, ED team will undertake a rapid triage. The % of patients triaged within 15mins in Majors improved from 46.60% in May to 65.51% June and 69.18% July. The UEC improvement plan will support flow out of ED, which will increase the number of patients handed over within 30 minutes. The recent SWAST Ambulance Handover Perfect Week has identified system-wide actions. Work continues with SWASFT as the hours lost relate to SWASFT processes, which include leaving the Combe Park site freeing capacity for the next ambulance arrival.

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

The Trust improved the number of hours lost (albeit still below trajectory to achieve 95% target) and improved the percentage of handovers completed within 30 minutes in July. Attendances to ED & UC increased in July compared to the previous month by 157 patients (8657 vs 8500). The Trust saw ongoing flow pressure with bed occupancy (above trajectory at 93.6%), nC2R over trajectory, IPC restrictions due to Covid and Norovirus, which led to periods of not offloading. The overall performance was also contributed by:

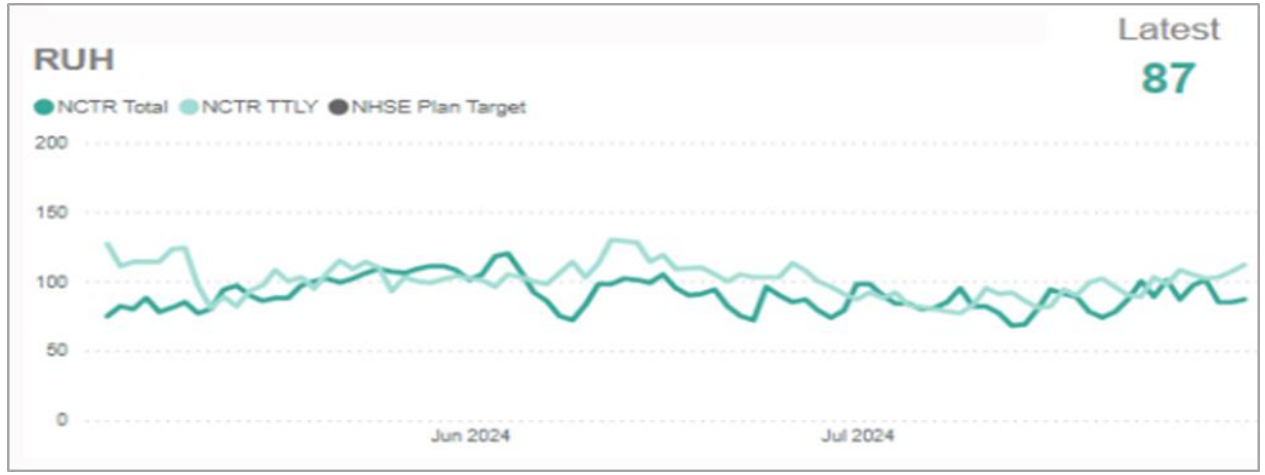
- X-CAD continues to only be utilised in ED, which is leading to data errors particularly when cohorting patients. This creates challenges with validating ambulance handover delays when a patient is placed into a Cohort Area. Daily validation is ongoing but manual validation will not override X-CAD recorded time.
- Days when SDEC Units full so expected patients arrive in ED & UC contributing to overcrowding.
- Challenges with flow out of the ED resulting in increased LoS in Pitstop and Ambulance Cohort areas

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| RAT working Group recommenced. SOP for Pitstop / RAT drafted, awaiting sign off my Deputy MD, then launch and embed monitoring impact. Trial of a second SpR overnight to be able to undertake overnight RAT | M. Price / C. Forsyth / F. Maggs | 31.08.24 |
| Internal escalation and role cards launched in July. Site Team to work with David A around actions and response to ED's escalation position. | D. Allison / A. West | 31.08.24 |
| ED Reset Week. PDSA some different ways of working including repurposing green Resus to a larger RAT and repurposing ED Obs Unit into a 24hr Fit to Sit. | ED Tri / D. Allison | w/c 16.09.2024 |
| Review Fit to Sit protocol and maximise with patients arriving by ambulance. Trial undertaken during Ambulance Perfect Week. It has been identified if patients being brought in by SWAST crew on a chair this will increase the number of patients going to Fit to Sit. Embed throughout August | M. Price & C. Irwin-Porter | 31.08.24 |

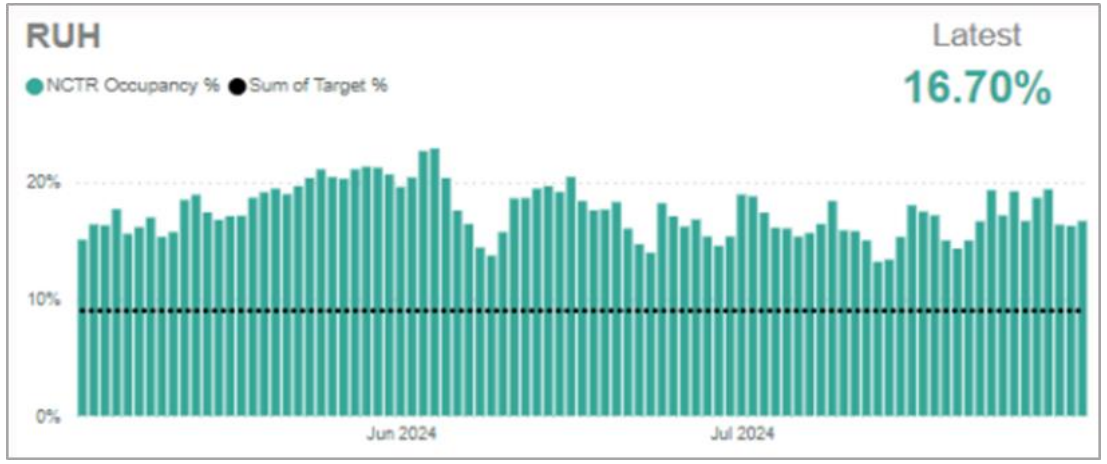
# Is this a key standard?| Non criteria to reside

**Performance target**; agreed with commissioners for no more than 55 patients waiting who don't have criteria to reside

## Historic Data: as of 01/08/24




## Supporting data




## Is the standard being delivered?

During July the Trust had an average of 88.1 patients waiting who had no criteria to reside, which is 3.2 lower than previous month. This remains above the system refreshed target of 55

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

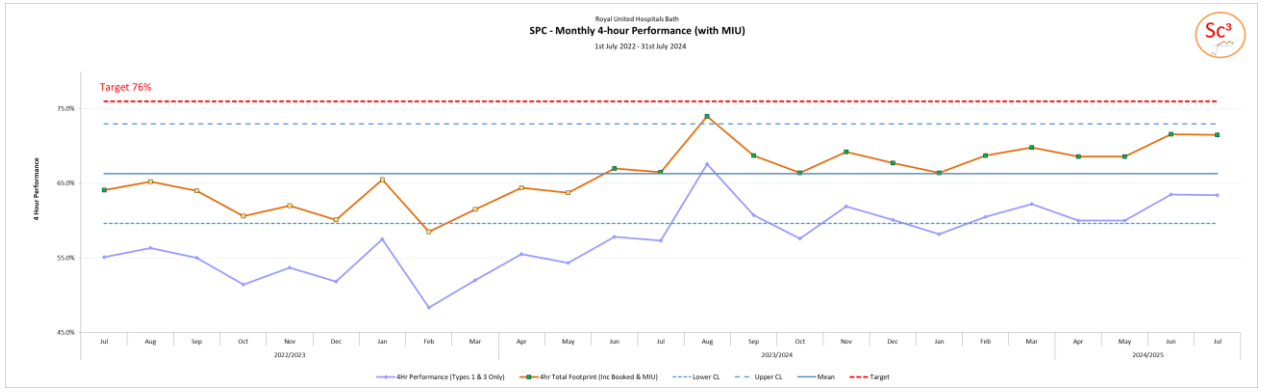
- Top right graph shows the daily percentage of beds occupied at the RUH by NCTR patients
- Reduction in Bedded capacity waits for NCTR have reduced
- Banes have seen an increase in NCTR for P1 patients due to a change in process – process being reviewed
- Ward 4 processes are now streamlines to reduce cancelled discharges however TTAs remain an issue the team are working through

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Recovery plan and measures in place to support Wiltshire system | Crockett | On going |
| Home is Best focus on admission avoidance with system colleagues | Allison | Q1 23/24 |
| Review process for accepting NCTR repatriations back to the RUH | West | June 24 |
| Implementation of electronic whiteboards to streamline discharge planning | Allison | Q2 |
| | | |

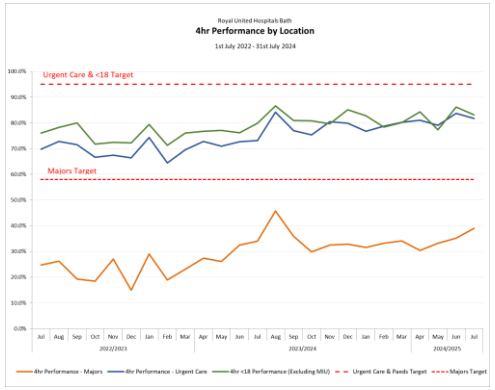
# Key Standard | 4-hour Emergency Standard

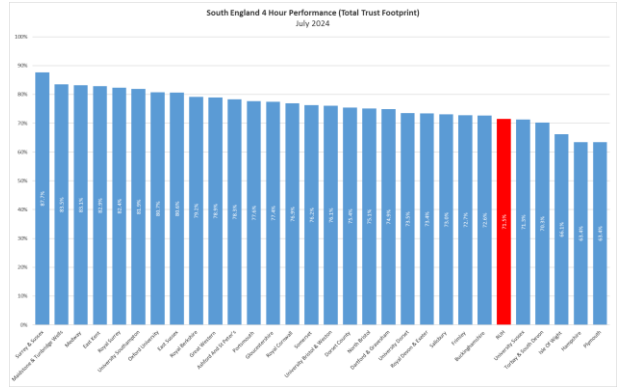
**Performance target**; 76% of patients discharged or admitted from ED within 4 hours

## Historic Data:




## Supporting data




**Is the standard being delivered?**

RUH 4-hour performance in July was **71.5%** and **63.4%** on the RUH footprint (unmapped), static from the previous month, however missing the trajectory of **73.0**% unmapped. Attendances during July were 8,656, an increase from June. Non-admitted performance 73.43% (plan 84.2%). There are 6 wte UTC staffing gaps (vacancy, maternity leave and long-term sickness) requiring 100 shifts per month on average to cover the service, which are filled to 70%, affecting performance delivery in UTC. Admitted performance was 40.46.% (plan 46.8%). Admitted performance was affected by not having a consistent medical rota to support rapid assessment delaying onward referral to specialties; trust occupancy 93.6% (trajectory 92%), occupancy of patients without a criteria to reside over trajectory of 55, ward discharges occurring after midday (21.7% before midday) and an average of 46.6 beds affected by IPC restrictions per day in July. Improvement in performance will be supported by the delivery of the UEC improvement plan, specifically the integrated front door workstream for non-admitted 4- hour performance and the In Hospital workstream, which will support the 4-hour admitted pathway recovery.

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

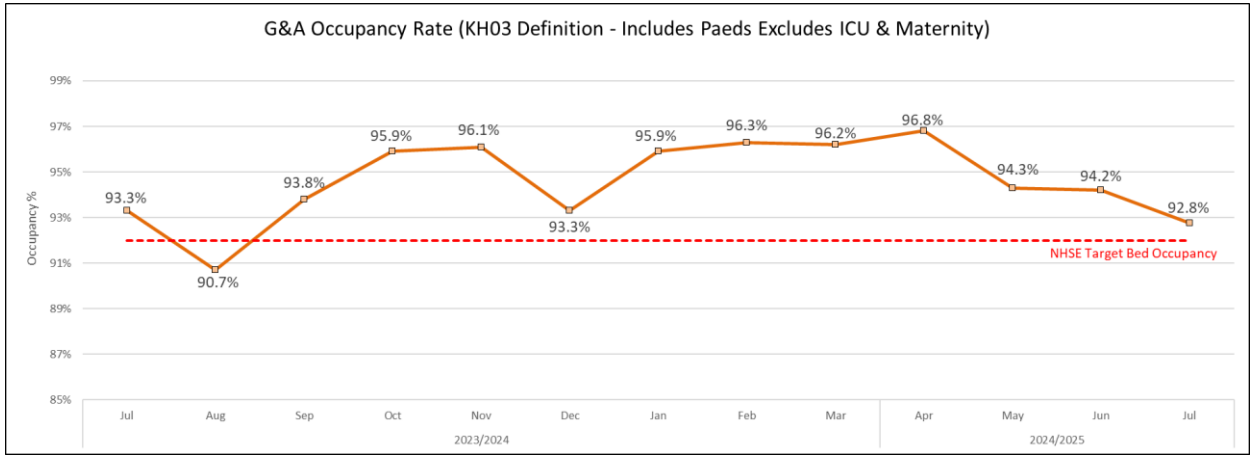
- Improvement in handover times (43.9% within 30mins) and the number of overall lost ambulance hours from 2199 to 1532 in July.
- IPC restrictions impacted on patient flow out of the ED (average of 46.6 beds per day throughout July affected)
- Majors saw a slight dip in performance from the previous month to 39.05% (June 41.8%) as well as Urgent Care to 81.74% (June 83.7%) in their 4hr performance.
- Time to Initial Assessment performance improved further (July 56.31% vs June 55.0%) with Majors particularly improving by 3.67%.
- Non-criteria to reside numbers remain over trajectory.
- Ongoing long waits for mental health patients to be seen by Mental Health Liaison / AWP, particularly overnight, and in addition long waits for MH beds.
- Live clinical validation commenced in July which has been positively received. Extra administrative validation continues with an increase in performance being gained.
- UEC Improvement Plan; Integrated Front Door workstream and In Hospital workstream.
- Practitioner In charge role in urgent care worked well and as a key workstream in the UEC PIP there are actions to review staffing matched to service demand including embedding the role of practitioner in charge during peak times of arrivals.

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Real-time clinical validation went live in July – this needs to be embedded during August. This will ensure that breach recording is more accurate with improved breach reason. This should also reduce the requirement for retrospective validation. | ED Triumvirate | 31.08.2024 |
| Internal escalation and role cards launched in July. Site team to work with David A around actions and response to ED's escalation position. | D. Allison / A. West | 31.08.24 |
| Review and change roster in urgent care to accommodate staff ratio to service needs. Roster change will be from 1st September as new rota will consist of 4 shift types (11 currently) which will be weighted to match demands on the service resulting in patients being seen within target. | T. Thorn / J. Lloyd-Rees | 02.09.2024 |
| Define urgent care exclusion criteria. This will support the practitioners in streaming patients back to primary care or to other services supporting the right patient, right service methodology. This includes updating the Urgent Care Directory of Services in line with GWH and the national specification. | T. Thorn / D. Allison | 01.10.2024 |
| ED reset week. PDSA some different ways of working including repurposing green resus to a larger RAT and repurposing ED Obs Unit into a 24hr Fit to Sit. | ED Tri / D. Allison | w/c 16.09.2024 |

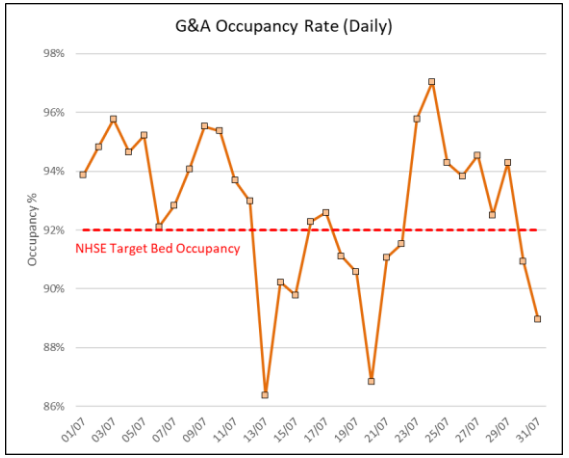
# Key Standards | Bed Occupancy

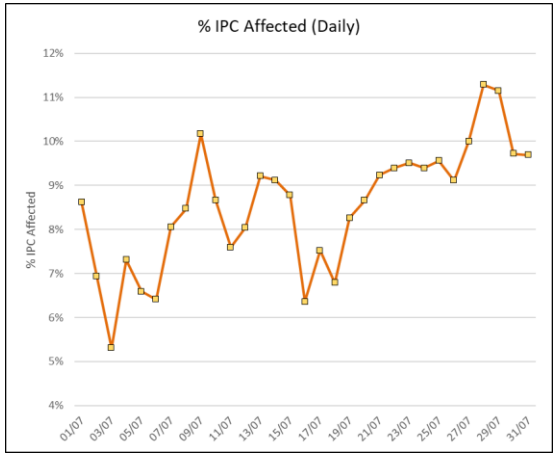
**Performance target**; Bed occupancy should be no greater than 92%

## Historic Data




## Supporting data




## Is the standard being delivered?

NHS England target as described in the Urgent and Emergency Care Recovery Plan indicates that bed occupancy should be 92%. For July, the Trust's bed occupancy was 92.8%.

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

- SDEC in July of 33.6% - pathways continue to be improved
- Non-elective LOS reduced to 3.7 (0.3)
- Pre midday discharges saw a reduction to 19.96 of all discharges this reduced by 2.64%
- 19.5% of discharges utilised the discharge lounge in May which is a reduction of 1.6%

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Embedding of Discharge lounge SOP to increase utilisation and compliance | West | Q1 24/25 |
| Continued Improvement work on pre-midday discharges and utilisation of discharge lounge | Divisions | Q1 24/25 |
| Launching review of board rounds and comparing against the Royal College of Physicians guide on modern ward rounds | Medicine | Q1 24/25 |
| Relocation of Discharge Lounge to main block to increase utilisation (avoids weather dependent transfers) | Allison | Q2 24/25 |

# Key Standards | Elective Recovery

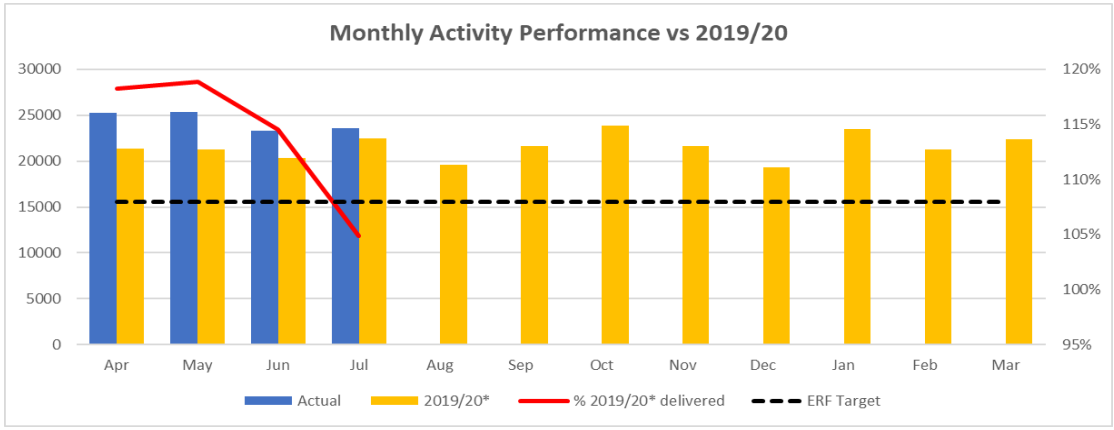
**Performance target**; Deliver 109% of elective activity compared to 2019/20

## ERF Performance

| | Vs 19-20 | | | | | Vs 24-25 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Division** | **Month 1** | **Month 2** | **Month 3** | **Month 4** | **YTD** | **Month 1** | **Month 2** | **Month 3** | **Month 4** | **YTD** |
| FASS | 150% | 149% | 149% | 151% | 150% | 110% | 108% | 149% | 109% | 110% |
| Medicine | 135% | 126% | 130% | 118% | 127% | 99% | 101% | 101% | 89% | 97% |
| Surgery | 122% | 110% | 103% | 110% | 111% | 114% | 106% | 101% | 101% | 106% |
| **Total** | **130%** | **121%** | **118%** | **119%** | **122%** | **109%** | **105%** | **104%** | **99%** | **104%** |

## Supporting data

**ERF Activity Delivery**




The biggest contributors to this performance in month over 2019/20 in each Division are as follows:

Surgery

- T&O ENT, General Surgery and Urology continue to be the main contributors to the Surgery performance.
- ENT income is a £223k YTD over 19-20 plan; this is driven by the DC baseline decreasing and a higher volume of OP attendance;
- T&O continues to be over 19-20 with activity slowly increasing each month – YTD performance of £589k in-month £112k
- Urology is performance is £275 YTD over plan, which is mostly all day-case activity and an increase in new outpatients

Medicine

- Gastro, Cardiology and Rheumatology adults continue to be the biggest contributors towards Medicines performance
- Gastro overall performance is £579k YTD. This is mostly in day-cases and new outpatients. Activity has increased but the average tariff has reduced which suggest we are seeing more patients of a lower complexity. This also includes a improvement of £30k for Months 1 and 2 due to the coding of activity
- Dermatology in-month position is £241k is mostly day cases offset by a reduction in OP procedures and is an improvement compared to last month. However, CINAPSIS activity continues to be very low and is offsetting the benefit
- We have now moved to reporting on an actuals basis for physio (therapies) previously reported as a block and Cardiology appointments previously reported under non-chargeables.

FASS

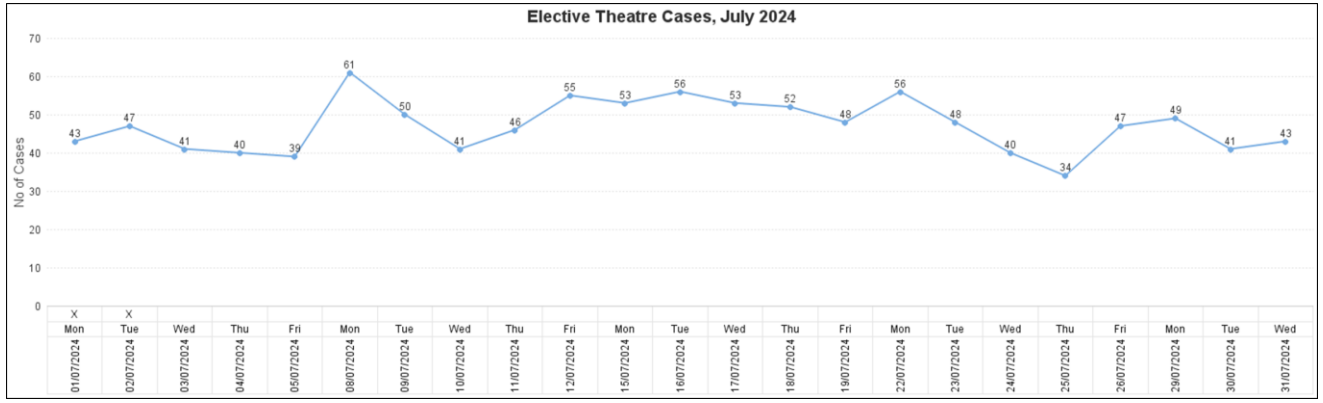
## Is the standard being delivered?

24/25 has started well with the strong position for M1, M2, although there had been industrial action in M3. M4 saw performance against 19/20 (119%) remained positive despite Industrial Action, at the start of the month. There continued to be challenges in Theatre Staffing, which resulted in cancellations of theatre lists impacting activity. As a trust, we under-delivered against 24/25 Plan in M4, at 99%, translating in an overall in month income position -£107k. The Trust has delivered financial performance year-to-date of 112% of 19/20 and 105% of our M4 24/25 plan, in ERF. This has delivered a surplus of £1.3mln year-to-date, with Day Case and Outpatient New attendances being the significant contributors to this position.

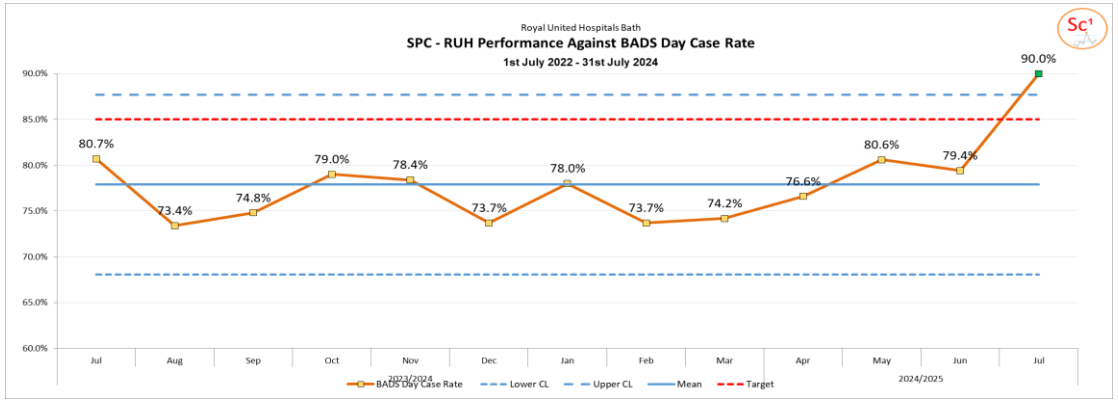
| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Transformation workstreams focused on supporting increased activity within Theatres and Outpatients. Extending to endoscopy/ Cath labs | Divisions | Through Q1-Q3 24/25 |
| Clinic Templates are being reviewed. In some | Divisions/ | Q2-3 24/25 |

# Key Standards | Productivity

## Historic Data:




## Supporting data




## Is the standard being delivered?

- The RUH aims to book to 85% of lists available minutes (to allow for turnaround time), in July theatres were booked to 81.2% an improvement from June at 79.5%; the capped utilisation was 73.2% (target 85%) a small drop from 74.3% in June.
- The British Association of Day case Rates (BADs) increased to 90.0% (unvalidated), surpassing the 85% National Target.

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

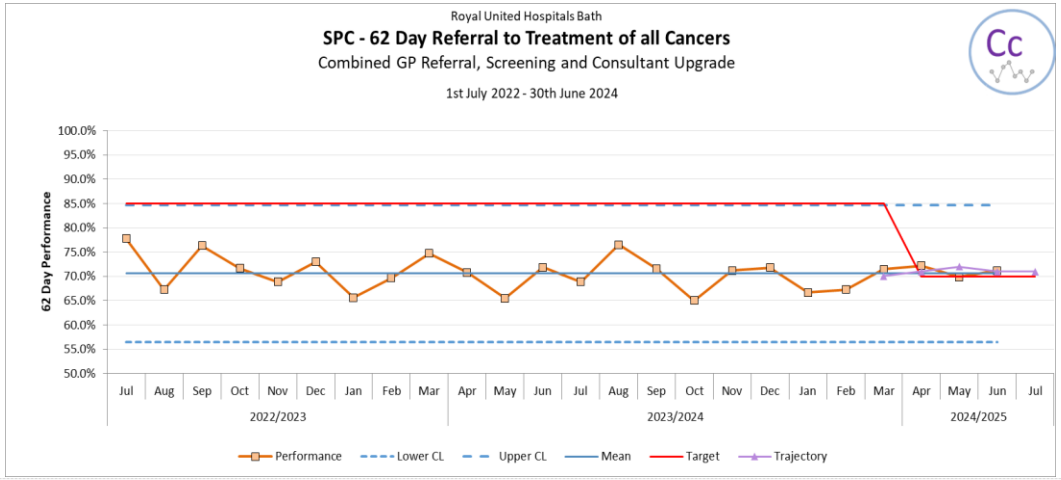
- In July, Theatre cancellations continued to be driven by a spike in sickness in Anaesthetics and Theatre Staff.
- The cancellation on the day were 32, a reduction from June (35), the number of cancellations due to list overruns remained the same in July. The number of lists finishing late increases slightly in July from June, however we ran 50 more lists than the previous month.
- The Improvement Team continue to support theatre efficiency projects with focus on elective bookings and wider theatre efficiency measures, including late starts, turnaround time.
- The total number of High-Volume Low Complexity (HVLC) case complete in July (52) increased from June (29), some specialities over-delivered against their targets for 'additional cases' on lists, including ENT, T&O and General Surgery . YTD we have delivered an additional 154 cases within the

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Theatre productivity workstream has been re-launched – additional cases by specialty agreed for 24/25. Monitored through monthly divisional ERF review. | S Roberts | Q1-Q4 24/25 |
| BADs day case recovery action plan been implemented and will continue through 24/25 focusing on reaching 90% | R Edwards | Q1-Q4 24/25 **Note July BADs %** |
| Review/refresh of booking and procedure times to ensure lists booked more accurately . | D Robinson | Q4 24/25 |
| Development of speciality specific productivity dashboard to become breakthrough objective for each speciality | S Williams | Q1 24/25 |
| Planning for theatres 'perfect' week in September, focusing on capped utilisation | J Price/A Dougherty | Q3 24/25 |

# Key Standards | Cancer 62 days

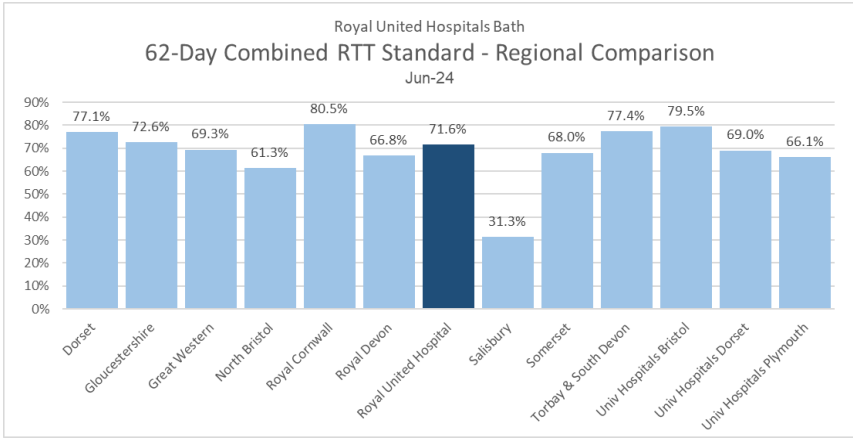
**Performance target**; 70% of patients treated within 62 days of referral on a cancer pathway

## Historic Data




## Supporting data

***Regional 62 Day Combined RTT Comparison***




## Is the standard being delivered?

June performance remained above target at 71.6%, slightly ahead of trajectory (71.4%).

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

**62 Day Treated:**

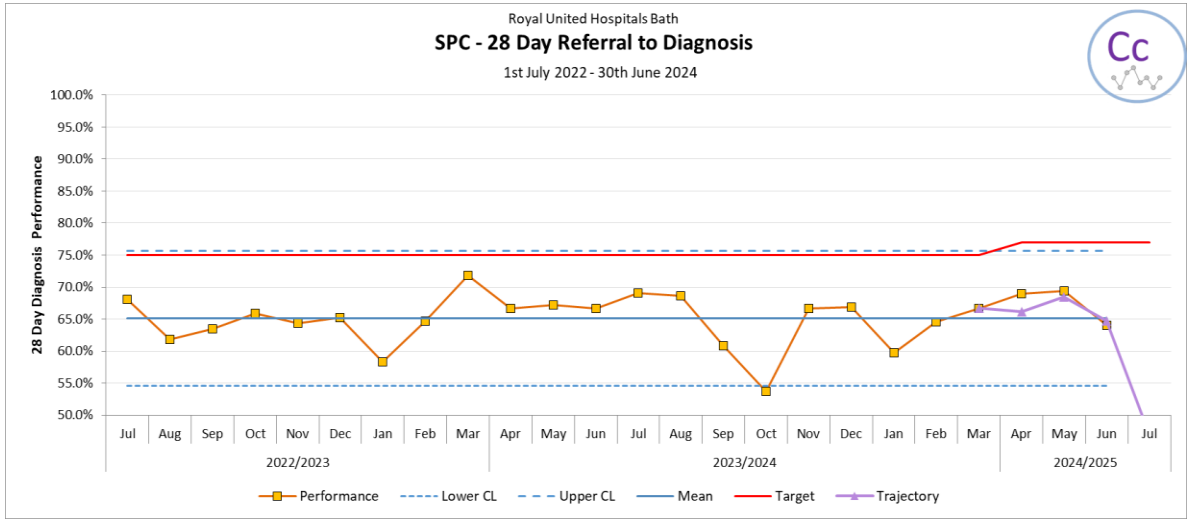
- Urology performance deteriorated for the second month in a row to 56.1% (May 67.4%).
- Haematuria and prostate post-MDT OPA waiting times resulted in increased breaches.
- LATP waiting times above timed pathway target. Lower uptake in WLIs from nursing staff.
- Pre-op/AA clinics and theatre capacity remained a factor in breaches.
- Bone scan waiting times for prostate patients causing pathway delays. Increased usage due to PSMA national shortage of capacity.
- Lung performance deteriorated in month to 52.8% (May 58.8%) with the primary challenge being surgical waiting times at UHBW. Additional capacity has helped this resolve with improved performance expected from July.
- Increase in diagnoses implementation of the Targeted Lung Health Check (TLHC) programme impacting Respiratory and Oncology OPA waiting times.
- Legacy of EBUS and PET investigation delays resulted in increased breaches as patients attended for treatment. Both resolved with waiting times reducing.
- Colorectal performance improved to 53.8% (May 31.3%). Surgical waiting for non-specialist procedures remains low.
- Gastro OPA and diagnostic waiting times remain a common factor in breaches.

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Urology - Substantive consultant recruited | J Prosser | October 2024 |
| Endoscopy – Increased recovery space works complete | R Wilson | August 2024 |
| Pre-op – Review of pre-op booking practices and capacity utilisation | J Schram | September 2024 |
| Anaesthetics – Daily drop-in pre-op clinics being implemented, posts recruited | R Leslie | Autumn 2024 |
| Colorectal – Imaging and histology results going directly to requesting non-medical practitioner | N Lepak | August 2024 |
| Skin – WLIs for minor ops to manage increased referrals from insourcing clinics | G Lewis | August 2024 |
| Lung – Plan for capacity increase to manage impact of TLHC | M Warner-Holt | September 2024 |

# Key Standards | Cancer 28 days

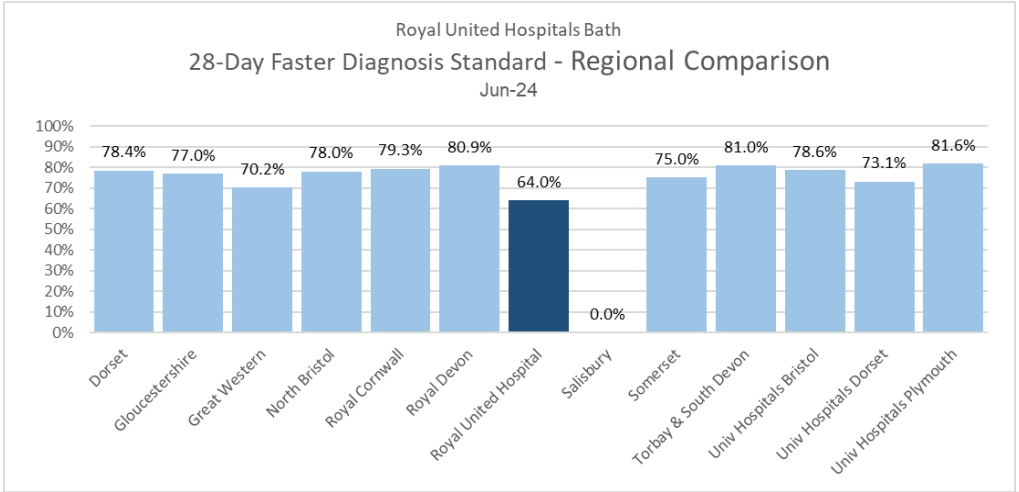
**Performance target**; 77% of patients given their diagnosis within 28 days of referral

## Historic Data




## Supporting data

***28 Day FDS Regional Comparison***




## Is the standard being delivered?

- June performance deteriorated to 64.0%. RUH remains in NHSE tier 2.

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

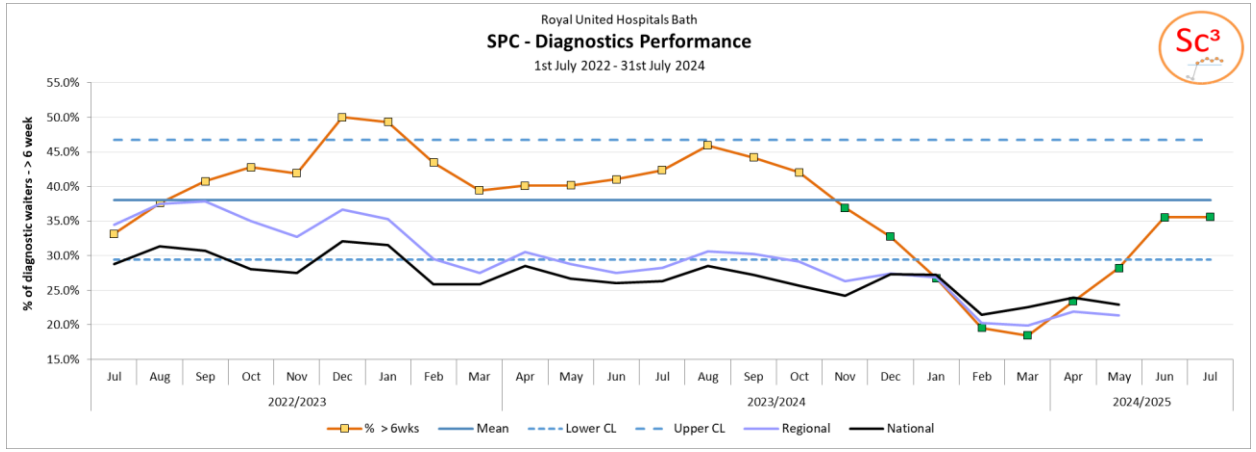
- Top contributor for FDS was colorectal with performance remaining challenged at 31.7%.
- Diagnostic waiting time remains above timed pathway. Endoscopy at 18 days but capacity at Sulis is supporting the position. Complex endoscopy waiting times impacted due to consultant vacancy.
- Imaging demand high, mitigated partly by mobile capacity.
- Gastro appointment waiting time at 28 days. Locum covering existing consultant vacancies.
- Skin performance main contributor to deterioration in performance in month due to first appointment waiting time.
- 2.8 WTE consultant vacancies. Insourcing in place; waiting time reduced to 18 days (08/08).
- Urology first appointment waiting time for haematuria above 28 days, impacted by reduced staff uptake of WLIs.
- Histology waiting times remain challenged due to consultant vacancies/national shortage of posts. Locum in place and recruitment packages being offered in future job adverts.
- Successful pilot of Breast one-stop clinic in August. Full implementation in September.

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Endoscopy – Additional consultant training for complex endoscopy | R Wilson<br>J Saunders | 2025 |
| Colorectal – CTC Radiographer training | N Aguiar | October 2024 |
| Skin – Insourcing for first appointment commenced from w/c 22/07. | G Lewis | July 2024 |
| Urology – Cease non-urgent haematuria appointments – re-provide at Sulis | J Prosser | August 2024 |
| Breast – One-stop clinic implementation | H Wheeler | September 2024 |

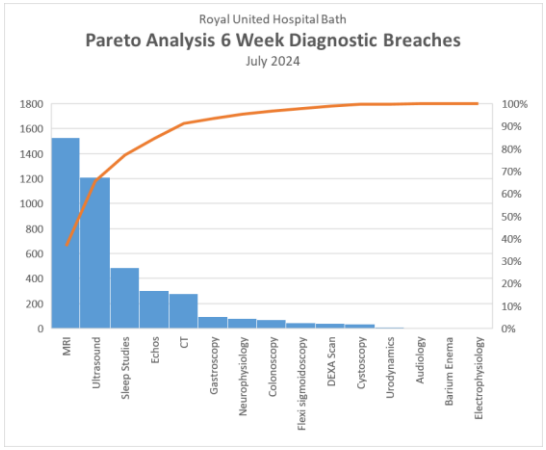
# Key Standards | Diagnostics 6 weeks

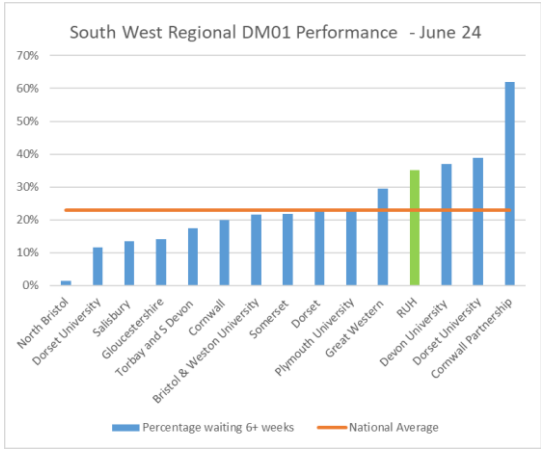
**Performance target**; No more than 5% of patients waiting over 6 weeks for their diagnostic test

## Historic Data




## Supporting data




## Is the standard being delivered?

July 2024, **64.42%** of patients received their diagnostic within the 6-week target against an in-month target of 70.24% and year-end target of 95.0%. The number of patients waiting > 6 weeks increased by **0.36% (+ 367 breaches).** The total waiting list decrease by 45 patients compared to June.

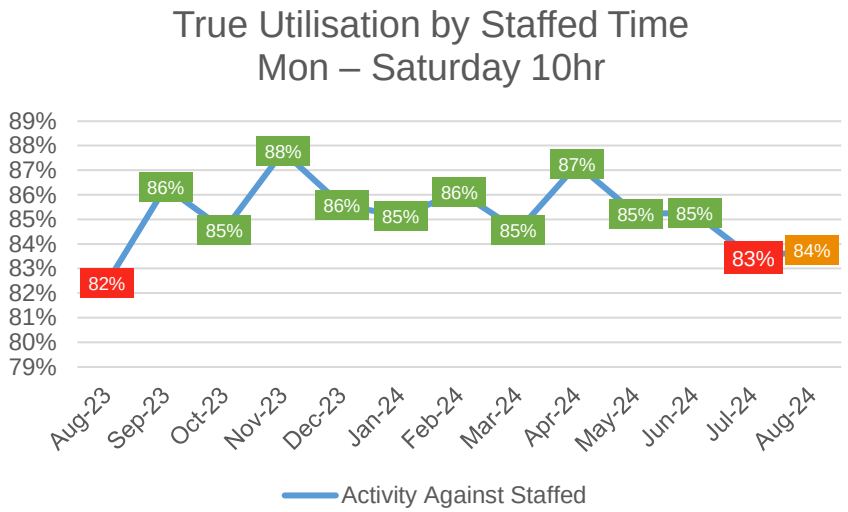
MRI, CT, Sleep Studies and USS remain the top contributors for overall performance. Performance affected by an increase in demand for overall diagnostics, with a noted increase in suspected cancer referrals which impact directly on the available capacity for DM01 activity. Additional capacity has come online for July 24, with additional CT and MRI mobile capacity and increased capacity at Sulis CDC in line with June revised trajectory – positive impact predicted from August 24 (-2% breaches). Sulis-CDC delivered in June CT 551, MRI 470, US 172, Endoscopy 157 and Cardiology 73 investigations.

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

- Top contributors: MRI, USS, CT, Sleep Studies and Echo.
- Cumulative impact of increased demand for Radiology modalities in June 24 (+11%) into July position. Within total demand, urgent/suspected cancer cohort increasing above plan and impacting directly on available capacity for routine DM01 referrals, despite increased activity levels in month.
- Sleep Studies position remains unchanged until whole service transfers to Sulis CDC in October 24 (revised target date).

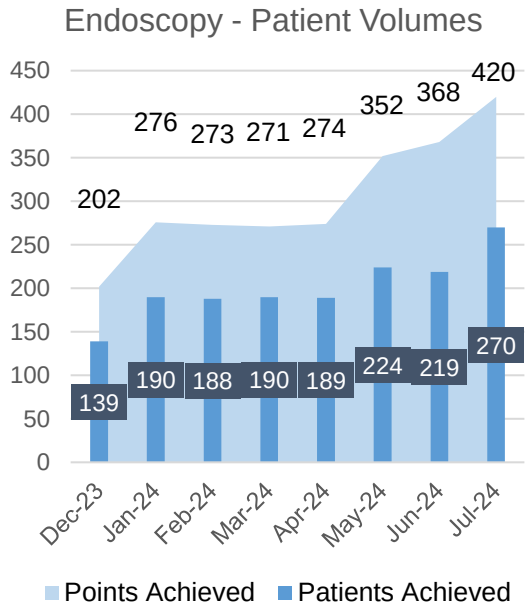
| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Sustain and increase radiology activity at Sulis CDC (additional 150 CT/MRI diagnostics) - monitored weekly. Review of plans for direct access to CDC for GP's and CDC reporting DM01 for activity delivered. | NA / TB / MC | Ongoing |
| MRI/CT increased capacity - additional mobile Unit days and explore additional weekend work (staff dependant). Additional mobile unit days x2 delivering circa 150 MRI and 200 CT per month. | NA | July-24 |
| Increased Echocardiography activity at Sulis CDC from July 2024. Predicted additional 20 diagnostics per week which would improve DM01 performance by 5%. | MB / BI | July-24 |
| Increased Endoscopy capacity at GWH for surveillance colonoscopy (up to 8 additional lists until September 2024) - up to 40 colonoscopies per week. | RW / JE | July-24 |
| Plan for overdue surveillance endoscopy: add to active DM01 list. Links with Medilogik go-live. Predicted impact of circa 1000 additional breaches added to DM01 active list by end of | RW / JE | September-24 |

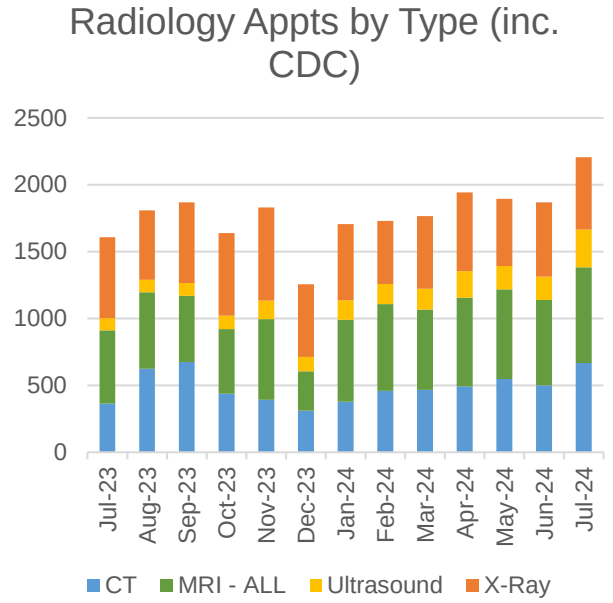
# Key Standards | Sulis Hospital




RTT: **71% - ↓ 3%**

| Weeks | PT QTY |
|---|---|
| 78+ | 2 |
| 65+ | 5 |
| 31-65 | 310 |
| 19-30 | 651 |
| 0-18 | 2044 |




**Is the standard being delivered?**

- **Theatre** uptake slightly down. Summer period always hits consultant availability.
- High utilisation of theatres vs lower patient pipeline has meant patient waitlist has dramatically decreased. This causes impact to patient selection and utilisation of lists.
- **Endoscopy** session up-take was static at 89%. Activity levels increased along with this capacity increase. Activity volume of JAG points 420 (270 patients). This is 88% utilisation against staffed capacity.
- **Radiology** volumes increased 22% MoM. Radiology volumes of CDC Programme up against plan.
- **Ultrasound/MRI/CT** activity was overperformed against plan. XRAY volumes continue to underperform due to aging equipment. New mitigation in place September.
- Sulis **RTT position** at 71%. Long waits have appeared due to EPR system error. Mitigation in place. September target on track.

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

- Main highlights are Endoscopy session up-take to 90% with activity utilisation at 88%.
    - NM: August session up-take limited due to consultant holidays. Will impact performance
- Decreasing pipeline for elective surgical activity is of concern. Engaging with GIRFT team to explore Devon, Somerset and Gloucester wait lists.

| Countermeasures / Actions | Owner | Due Date |
|---|---|---|
| Engagement meetings with GIRFT elective groups to increase patient pipeline at Sulis Hospital | Milner | August |
| Review clinical model for Endoscopy – Review SLA with consortium of Gastroenterologists to enable sustainable staff capacity. | Milner | September |
| Commence CDC services for Sleep Studies and Respiratory at Sulis Hospital Bath | Milner/ MacGregor | September |
| Commence start of temporary XRAY room and capital project for lower ground floor XRAY upgrade. | Milner | September |

Royal United Hospitals Bath
NHS Foundation Trust

# Finance Report

Month 4

The people in our community

The RUH, where you matter

# Summary

**BSW Integrated Care System**

- The organisations in the BSW Integrated Care System must collaborate to develop Revenue and Capital Financial Plans with a view to achieving breakeven against allocations each year. The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to it's pre-pandemic levels.
- The BSW System has developed a financial plan with a £30.0m deficit for the year, of which the RUH is £5.3m deficit. This plan has been accepted by NHS England and non-recurrent revenue support funding is to be provided during the year. NHS England have amended NHS business rule this year and delivery of the plan means this funding will not be repayable in future years.
- At Month 4 the Integrated Care System is at a deficit position of £21.2m, which is £7.1m adverse to plan (see slide 11 for further details)

**RUH Group Financial Plan**

- The RUH deficit plan of £5.3m is underpinned by £22.7m of non-recurrent revenue financial support from commissioners and £6.3m of NHSE funding for revenue consequences of new capital investment
- The financial plan for the year requires full delivery of a £36.6m Savings Programme, which has been phased to recognise progressive reduction in costs and increases in income over the year. Delivery of this plan is supported by an Improvement programme with 3 workstreams focussing on (1) Clinical Operational Productivity (2) Paybill Reduction and (3) Cost Control and Commercial Income
- Achieving the financial plan is an RUH Breakthrough Objective for 2024/25
- The consequence of not achieving the financial plan are significant. Deficits will need to be repaid in future periods, there will be less revenue investment for strategic investment priorities, there will be less capital funding, there will be less autonomy for ICS, Trust, Divisions, and Budget Holders, and increase regulatory scrutiny & intervention

**Revenue Financial Performance – Month 4**

- At Month 4. the Group is at a deficit position of £6.6 million, which is £0.6 million adverse to plan
- Savings of £7.9m have been delivered to date (21.6% of annual target in 33.3% of the financial year), including £5.1m of pay savings against budget, and the benefit of Elective Recovery Fund income and operating margin of 48%. The Pay Savings include the release of £0.9m of the Annual Leave Provision, bringing forward benefit anticipated in Month 6.

**Risks and Actions required**

The Trust has undertaken a high-level forecast at the end of Month 4. This clarifies a path to deliver the Operational Plan that requires the following management actions:

- Sustain current I&E and Savings delivery, this would deliver a base case forecast I&E deficit of £19.8m, which would be £14.5m adverse to plan
- £4.2m Increasing Elective Recovery Fund income through Theatre and Outpatient productivity, and improved clinical coding
- £4.3m Further delivery of all Pay bill savings through controls, improved rostering and service redesign, reducing worked wte by 195.8wte from current levels
- £3.1m Delivery of Non-Pay & Commercial Income Savings

**Capital and Balance Sheet Position – Month 4**

- Total capital expenditure is £4.5m at Month 4, which is £11.3m behind plan due to delays in both the SEOC and EPR programmes
- The closing cash balance for the Group was £29.7m which is 38.7% higher than the plan due to the capital delays set out above, but £4.8m lower than 31st March due to I&E deficit and settlement of liabilities accrued at year end.

# Executive Scorecard

| | Performance Indicator | Description | Target: Performing | Target: Under Performing | Baseline | Actual 2024/25: Apr-24 | May-24 | Jun-24 | Jul-24 |
|---|---|---|---|---|---|---|---|---|---|
| Sustainability Tracker Metrics | Delivery of Group financial plan | Variance from year to date plan | <=0 | >0 | £0 | £0m | (£0.08m) | (£1.50m) | (£0.61m) |
| | Forecast delivery of Group financial plan | Forecast variance from year to date plan | <=0 | >0 | (£5.30m) | £0m | £0m | £0m | £0m |
| | Group delivery of Plan | Total year to date financial performance | <=0 | >0 | (£5.30m) | (£2.26m) | (£4.06m) | (£6.50m) | (£6.59m) |
| | Delivery of QIPP | Total QIPP delivery | N/A | N/A | £36.6m | £1.8m | £3.1m | £5.5m | £7.9m |
| | Delivery of QIPP against plan | Performance against plan | <=100% | >100% | 100.0% | 100.0% | 98.0% | 96.1% | 99.2% |
| | Reduction in agency expenditure | Agency costs as a % of total pay costs | <= 3% | > 3% | 3.0% | 1.2% | 1.2% | 0.3% | 1.0% |
| | Sickness against plan | Actual levels of sickness against average pre-pandemic levels | <= 4.1% | > 4.1% | 4.5% | 4.5% | 4.5% | 4.4% | 4.8% |
| | Reducing no criteria to reside patients | No criteria to reside to reduce by 40% from December 2021 | <= 90 | > 90 | 80 | 73 | 103 | 73 | 73 |
| | Reducing staff vacancies | Total contracted vacancies reported each month | <=7.4% | >7.4% | 4.0% | 4.9% | 1.7% | 0.9% | 2.6% |
| | Net impact of high cost drugs and devices | Total expenditure and income against plan for high cost drugs and devices | <=0 | >0 | £0 | £0 | (£0.4m) | (£0.4m) | (£0.4m) |
| | Increase productivity | Implied productivity based on financial and operational performance (Quarterly) | >=3% | 3% | -20% | -23% | -23% | -23% | -23% |
| | Elective recovery | In Month Performance against planned levels of activity (Value based) | >= 100% | < 100% | n/a | 109% | 104% | 103% | 99% |
| | Non elective activity | In Month Performance against planned levels of activity (Value Based) | <= 102% | > 102% | n/a | 119.0% | 142.0% | 116.0% | 120.0% |
| | Delivery of capital programme | Variance from year to date planned capital expenditure (Internally Funded Schemes) | -5% | <5% | n/a | 67.3% | 51.9% | 69.7% | 65.7% |
| | Forecast delivery of capital programme | Forecast variance from annual planned capital expenditure | + or - 5% | ><5% | n/a | 0 | 0 | 0 | 0 |
| | Delivery of planned cash balance | Variance from year to date planned cash balance | - 10% | <10% | n/a | 8.8% | 25.6% | 24.50% | 38.7% |

# True North | Breakeven position

| Statement of Comprehensive Income Period to 202404 | RUH 202404 Budget £'000 | RUH 202404 Actual £'000 | RUH 202404 Variance £'000 | RUH YTD Budget £'000 | RUH YTD Actual £'000 | RUH YTD Variance £'000 | Sulis 202404 Budget £'000 | Sulis 202404 Actual £'000 | Sulis 202404 Variance £'000 | Sulis YTD Budget £'000 | Sulis YTD Actual £'000 | Sulis YTD Variance £'000 | Group Adjustment 202404 Actual £'000 | Group Adjustment YTD Actual £'000 | Total Group Position 202404 Budget £'000 | Total Group Position 202404 Actual £'000 | Total Group Position 202404 Variance £'000 | Total Group Position YTD Budget £'000 | Total Group Position YTD Actual £'000 | Total Group Position YTD Variance £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Commissioner Income (NHSE/CCG) | 38,197 | 37,869 | (328) | 152,789 | 151,865 | (924) | 2,681 | 2,471 | (210) | 9,165 | 8,948 | (217) | 0 | 0 | 40,878 | 40,340 | (538) | 161,954 | 160,813 | (1,141) |
| Other Patient Care Income | 575 | 767 | 192 | 2,298 | 2,802 | 504 | 1,338 | 1,331 | (7) | 5,725 | 4,956 | (770) | 0 | 0 | 1,913 | 2,098 | 185 | 8,024 | 7,758 | (266) |
| Other Operating Income | 3,904 | 3,926 | 22 | 15,349 | 13,801 | (1,547) | 12 | 133 | 121 | 48 | 234 | 186 | (197) | (788) | 3,719 | 3,863 | 143 | 14,609 | 13,248 | (1,362) |
| **Income Total** | 42,676 | 42,563 | (113) | 170,436 | 168,468 | (1,968) | 4,031 | 3,935 | (96) | 14,939 | 14,138 | (801) | (197) | (788) | 46,510 | 46,301 | (209) | 184,587 | 181,819 | (2,769) |
| Pay | (27,597) | (27,288) | 309 | (111,010) | (110,909) | 102 | (2,024) | (1,812) | 212 | (7,917) | (7,386) | 531 | 0 | 0 | (29,621) | (29,099) | 522 | (118,927) | (118,295) | 632 |
| Non Pay | (12,373) | (13,143) | (770) | (50,893) | (53,596) | (2,703) | (1,422) | (1,436) | (14) | (5,497) | (5,243) | 254 | 0 | 0 | (13,796) | (14,579) | (783) | (56,391) | (58,839) | (2,449) |
| Depreciation | (2,019) | (2,019) | 0 | (8,077) | (8,077) | 0 | (245) | (239) | 7 | (981) | (951) | 30 | 145 | 580 | (2,120) | (2,113) | 7 | (8,478) | (8,448) | 30 |
| Impairment | (578) | 0 | 578 | (2,314) | 0 | 2,314 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (578) | 0 | 578 | (2,314) | 0 | 2,314 |
| **Expenditure Total** | (42,568) | (42,450) | 118 | (172,294) | (172,581) | (287) | (3,691) | (3,486) | 205 | (14,395) | (13,581) | 815 | 145 | 580 | (46,115) | (45,791) | 323 | (186,109) | (185,582) | 527 |
| **Operating Surplus/(Deficit)** | 108 | 113 | 5 | (1,858) | (4,113) | (2,255) | 340 | 449 | 109 | 543 | 557 | 14 | (52) | (207) | 395 | 509 | 114 | (1,522) | (3,763) | (2,241) |
| Other Finance Charges | (938) | (764) | 174 | (3,752) | (2,958) | 793 | (54) | (44) | 10 | (221) | (181) | 39 | 33 | 134 | (959) | (776) | 183 | (3,839) | (3,006) | 833 |
| Other Gains/Losses | 0 | 16 | 16 | 0 | 19 | 19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 16 | 16 | 0 | 19 | 19 |
| **Finance Charges** | (938) | (749) | 189 | (3,752) | (2,939) | 812 | (54) | (44) | 10 | (221) | (181) | 39 | 33 | 134 | (959) | (760) | 199 | (3,839) | (2,987) | 852 |
| **Surplus/(Deficit)** | (830) | (636) | 194 | (5,610) | (7,052) | (1,443) | 286 | 404 | 119 | 323 | 376 | 53 | (19) | (74) | (564) | (251) | 313 | (5,361) | (6,750) | (1,390) |

| Adjusted Financial Performance | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Add back all I&E impairments/ (reversals) | 578 | 0 | (578) | 2,314 | 0 | (2,314) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 578 | 0 | (578) | 2,314 | 0 | (2,314) |
| Remove capital donations/grants I&E impact | (1,140) | 17 | 1,157 | (2,940) | 157 | 3,097 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1,140) | 17 | 1,157 | (2,940) | 157 | 3,097 |
| **Adjusted financial performance surplus/(deficit)** | **(1,392)** | **(619)** | **773** | **(6,236)** | **(6,896)** | **(659)** | **286** | **404** | **119** | **323** | **376** | **53** | **(19)** | **(74)** | **(1,126)** | **(234)** | **891** | **(5,987)** | **(6,593)** | **(606)** |

Note. The 24/25 Financial Plan is underpinned by £22.7m of non-recurrent revenue financial support from commissioners (£1,891k per month); and £6.3m of funding from NHSE to support revenue costs of strategic capital investment.

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

# Tracker Measure | Sustainability – Capital (RUH and SULIS)

## Capital Programme

| Capital Position as at 31st July 2024 | Annual Plan | Forecast @ M4 | Year to Date | | |
|---|---|---|---|---|---|
| | | | Plan | Actuals | Variance |
| | £000s | £000s | £000s | £000s | £000s |
| Internally Funded schemes | (13,559) | (13,561) | (3,640) | (2,272) | 1,368 |
| IFRS 16 Lease Schemes | (3,700) | (3,700) | 0 | (119) | (119) |
| Disposals - NBV write off - Internally Funded | | 2 | | 2 | 2 |
| Disposals - NBV write off-Lease | | | | | 0 |
| **External Funded (PDC & Donated):** | | | | | |
| SEOC PDC | (20,010) | (18,138) | (7,552) | (1,286) | 6,266 |
| BSW EPR PDC | (2,793) | (2,794) | (2,186) | (92) | 2,094 |
| Digital Diagnostic PDC | (213) | (213) | 0 | 0 | 0 |
| Community Diagnostic Centre PDC | (3,193) | (2,065) | (349) | (283) | 66 |
| Cancer Centre PDC | (422) | (422) | (416) | (255) | 161 |
| UEC PDC | (1,400) | (1,400) | 0 | 0 | 0 |
| Salix Decarbonisation Grant | (10,819) | (10,819) | (1,481) | (159) | 1,322 |
| Donated | (2,580) | (2,949) | (227) | (83) | 144 |
| **Total** | **(58,689)** | **(56,059)** | **(15,851)** | **(4,547)** | **11,304** |


**Is standard being delivered?** No

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

The SEOC and BSW EPR schemes are both behind plan.

**Trust funded programme**. The largest underspends remain against the BSW EPR scheme (Trust funded element) and the single ITU scheme. The late signing of the BSW EPR business case in March means that the Trust has not achieved the plan profile from the business case, this will need to be reviewed and managed in year. The single ITU scheme will catch up in the coming month and is due to complete in October/November.
Other schemes behind plan are the Fire risk reduction and Sulis specific schemes.

**External funded schemes**. The largest underspend is against the Sulis Elective Orthopaedic Centre (SEOC) scheme, this is due to delays in the planning permission and a large downpayment on equipment made in March to the main contractor. The first valuation for works in this year has been received and is expected to come back to plan in the coming months.
The procurement process for the Decarbonisation scheme has yet to be completed in full.

**Countermeasures completed last month**

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

**Countermeasures for the month ahead**

| Countermeasure /Action | Owner |
|---|---|
| CPMG to continue to monitor delivery of projects and schemes | Head of Financial Services |

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

| | 31/03/2024 Actual £'000 | 31/07/2024 Actual £'000 | Movement from March 24 £'000 |
|---|---|---|---|
| **Non current assets** | | | |
| Intangible assets | 7,105 | 6,259 | (846) |
| Property, Plant & Equipment | 301,392 | 300,049 | (1,343) |
| Right of use assets - leased assets for lessee | 51,035 | 49,325 | (1,710) |
| Trade and other receivables | 1,861 | 1,981 | 120 |
| **Non current assets total** | **361,393** | **357,614** | **(3,779)** |
| | | | |
| **Current Assets** | | | |
| Inventories | 8,284 | 8,870 | 586 |
| Trade and other receivables | 29,887 | 27,862 | (2,024) |
| Cash and cash equivalents | 34,531 | 29,718 | (4,813) |
| **Current Assets total** | **72,702** | **66,450** | **(6,252)** |
| | | | |
| **Current Liabilities** | | | |
| Trade and other payables | (54,354) | (49,483) | 4,870 |
| Other liabilities | (13,298) | (15,425) | (2,127) |
| Provisions | (475) | (430) | 45 |
| Borrowings | (3,070) | (3,076) | (6) |
| **Current Liabilities total** | **(71,197)** | **(68,414)** | **2,783** |
| | | | |
| **Total assets less current liabilities** | **362,897** | **355,650** | **(7,247)** |
| | | | |
| **Non current liabilities** | | | |
| Provisions | (1,370) | (1,370) | 0 |
| Borrowings | (54,128) | (53,205) | 923 |
| | | | |
| **TOTAL ASSETS EMPLOYED** | **307,399** | **301,074** | **(6,326)** |
| | | | |
| **Financed by:** | | | |
| Public Dividend Capital | 253,535 | 253,956 | 421 |
| Income and Expenditure Reserve | 12,303 | 5,556 | (6,747) |
| Revaluation reserve | 41,562 | 41,562 | 0 |
| | | | |
| **Total Equity** | **307,399** | **301,074** | **(6,326)** |

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

**Month 4 against 31/03/24:**

- Non-current assets have decreased. The actual position reflects spend related to capital expenditure, which is currently behind plan as detailed in the capital slide, less depreciation.
- Trust inventories have increased, the drivers of this relate to drug and theatre stock.
- Trust receivables have decreased. This is net of increases in prepayments for expenses paid in advance of use, and income earned which has not yet been paid and decreases in amount owed from NHS bodies.
- Trust payables have decreased. This is net of increases in the Public Dividend Capital dividend and capital payables offset by decreases in expenditure.
- Trust other liabilities have increased. Key movements relate to income received in relation to CPD and education funding.

# QIPP | Financial Progress

## Deliver by Month 4 by Improvement Programme Theme

| | Year to Date Plan | Year to date Actuals | Variance |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| 1_Clinical Operation Trans | £1,975 | £792 | -£1,183 |
| 2_Pay Bill reduction | £4,078 | £4,232 | £155 |
| 3_Cost Control/Comm Income | £1,910 | £2,007 | £97 |
| **Total** | **£7,962** | **£7,031** | **-£931** |
| Annual Leave Accrual Release | £0 | £868 | £868 |
| **Total (inc A/L Release)** | **£7,962** | **£7,899** | **-£63** |

## Deliver by Month 4 by Division

| DIVISION | PAY | NON-PAY | INCOME | TOTAL |
|---|---|---|---|---|
| CORPORATE | £566 | £102 | £0 | £668 |
| ED | £188 | £0 | £2 | £190 |
| ESTATES & FACILITIES | £952 | £106 | £37 | £1,096 |
| FASS | £517 | £76 | £182 | £775 |
| MEDICINE | £685 | £379 | £119 | £1,183 |
| SULIS | £0 | £3 | £114 | £117 |
| SURGERY | £1,328 | £422 | £514 | £2,264 |
| INCOME | £0 | £89 | £650 | £739 |
| Total | £4,236 | £1,177 | £1,618 | £7,031 |
| Annual Leave Accrual | £868 | £0 | £0 | £868 |
| Total (inc A/L Release) | £5,104 | £1,177 | £1,618 | £7,899 |

**Summary**

QIPP in month 4 delivered £7.9m against a £8.0m plan. The release of accrued annual leave is earlier than planned and without this there would be a savings shortfall of £0.9m against plan

This was achieved predominantly due to:

- Clinical Income - Theatres productivity
- Clinical Income - Coding initiatives
- Pay bill – Controls - Vacancy Gap savings and the benefits of enhanced pay controls
- Pay bill – service redesign - RMNs from Enhanced Care Initiative
- Pay bill - Release of annual leave accrual
- Procurement and Medicine Optimisation savings
- Sulis

At end of July there is a forecast, through plans and opportunities, to deliver £34.0 million. However, the programme and approvals continues at pace and currently only £2.6 million is unidentified.

Royal United Hospitals Bath
NHS Foundation Trust

# Workforce Report

August 2024 (July 2024 data)

The RUH, where you matter

# Executive Summary I

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

| | | | | Last 12 Months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Performance Indicator | Performing | Outside Tolerance | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 |
| Key Standard | Trust Vacancy WTE (Unit 4) | | | 252.5 | 225.0 | 133.9 | 176.8 | 104.5 | 91.8 | 56.2 | 80.4 | 290.2 | 94.7 | 50.1 | 150.5 |
| Contextual Information | Trust Establishment WTE (Unit 4) | | | 5659.5 | 5694.5 | 5671.4 | 5693.8 | 5689.9 | 5690.5 | 5700.2 | 5699.4 | 5888.3 | 5693.9 | 5639.3 | 5699.8 |
| Contextual Information | Substantive WTE (Unit 4) | | | 5407.0 | 5469.4 | 5537.5 | 5517.0 | 5585.4 | 5598.7 | 5643.9 | 5619.0 | 5598.1 | 5598.6 | 5589.2 | 5549.3 |
| Key Standard | Vacancy Rate | <=4.00% | >4.50% | 4.46% | 3.95% | 2.36% | 3.11% | 1.84% | 1.61% | 0.99% | 1.41% | 4.93% | 1.66% | 0.89% | 2.64% |
| Contextual Information | Total Pay Bill (exc R&D) | | | | | | | | | | | £27.5M | £27.2M | £27.3m | £26.7m |
| Key Standard | In Month Turnover | <=0.92% | >1.00% | 1.01% | 0.94% | 0.63% | 0.52% | 0.49% | 0.53% | 0.51% | 0.80% | 0.66% | 0.92% | 0.69% | 0.63% |
| Key Standard | Rolling 12 Month Turnover | <=11.00% | >12.00% | 10.21% | 9.94% | 9.35% | 9.24% | 8.98% | 8.78% | 8.52% | 8.40% | 8.12% | 8.45% | 8.39% | 8.47% |
| Contextual Information | Leavers Inside 1st Year WTE (Permanent Contract Held, All Reasons) | | | 11.3 | 6.9 | 4.8 | 4.9 | 3.2 | 3.3 | 3.6 | 6.0 | 12.8 | 11.4 | 7.5 | 5.3 |
| Contextual Information | Bank Use (Staffing Solutions Data) | | | 219.9 | 234.4 | 255.0 | 241.2 | 196.2 | 204.5 | 193.6 | 183.3 | 189.2 | 199.1 | 197.3 | 207.5 |
| Contextual Information | Agency Use (Staffing Solutions Data) | | | 84.3 | 77.6 | 63.3 | 43.7 | 28.5 | 20.8 | 18.8 | 20.8 | 19.8 | 17.2 | 17.1 | 13.3 |
| Key Standard | Agency Spend as Proportion of Total Pay Bill | <=2.50% | >3.50% | 2.27% | 3.27% | 2.14% | 2.47% | 2.13% | 0.33% | 2.22% | 1.05% | 1.14% | 1.13% | 0.27% | 1.02% |
| Contextual Information | Agency Spend | | | £636k | £874k | £590k | £683k | £588k | £87k | £600k | £446k | £315k | £310k | £73k | £277k |
| Contextual Information | % of agency usage that are off framework | | | 13.63% | Not Avail | 16.86% | 2.88% | 1.13% | 1.58% | 0.54% | 3.62% | 1.26% | 4.89% | 9.15% | 5.93% |
| Contextual Information | % agency shifts that are above price cap | | | 83.70% | Not Avail | 73.74% | 94.51% | 81.9% | 76.9% | 81.4% | 82.9% | 95.6% | 88.5% | 76.8% | 55,67% |
| Key Standard | Nurse Agency Spend as Proportion of Registered Nursing Pay Bill | <=3.00% | >4.00% | 2.76% | 4.81% | 3.73% | 3.73% | 3.62% | 0.85% | 2.16% | 1.57% | 1.62% | 1.71% | -1.71% | 0.60% |
| Key Standard | In Month Sickness Rate (Actual) - Reported 1 month behind | <=3.93% | >4.43% | 4.24% | 3.93% | 4.53% | 4.40% | 4.66% | 4.92% | 4.83% | 4.57% | 4.43% | 4.39% | 4.84% | |
| Contextual Information | In Month Sickness - Estimated Cost (£m) | | | £691k | £655k | £794k | £736k | £807k | £860k | £812k | £791k | £758k | £784k | £851k | |
| Key Standard | Rolling 12 Month Sickness Rate - Reported 1 month behind | <=4.30% | >4.80% | 4.66% | 4.63% | 4.59% | 4.56% | 4.46% | 4.45% | 4.47% | 4.47% | 4.48% | 4.49% | 4.54% | |
| Tracker | Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind | <=0.9% | >1.0% | 1.14% | 1.15% | 1.18% | 1.22% | 1.22% | 1.19% | 1.20% | 1.22% | 1.20% | 1.17% | 1.19% | |
| Contextual Information | In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind | <=0.9% | >1.0% | 1.18% | 1.08% | 1.24% | 1.30% | 1.22% | 1.13% | 1.25% | 1.17% | 1.12% | 1.15% | 1.31% | |

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

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

| Measure | Commentary | Actions being taken to manage / mitigate the workforce risks |
|---|---|---|
| Vacancy Rate | Vacancy rates may increase as we take the necessary steps to right-size our workforce and slow down the recruitment pipeline where feasibly safe to do so. | Trust led Vacancy Control and Agency Reductional Panel continues to support right-sizing our workforce against our workforce plans. The controls are supporting the Trust financial recovery plans. |
| Sickness Absence | Sickness absence was un-seasonally high in June at 4.84%, with Anxiety, Stress and Depression and Cold and Flu contributing reasons. | Focus on absence management across all Divisions via improvement programmes.<br>A simplified guide on managing attendance has been published for line managers.<br>New model of EAP being evaluated for impact. |

# Executive Summary II

| | Performance Indicator | Performing | Outside Tolerance | Last 12 Months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 |
| Tracker | Global Majority likelihood of being appointed from shortlisting - comparative ratio to 1 White (WRES 2) - Rolling 3 months | 0.8 - 1.25 | <0.8 or > 1.25 | 0.62 | 0.58 | 0.62 | 0.64 | 0.70 | 0.67 | 0.64 | 0.56 | 0.56 | 0.63 | 0.64 | 0.59 |
| Contextual Information | % of Band 6/7 who are from Global Majority Background (WTE) | | | 13.78% | 14.20% | 14.57% | 14.87% | 14.86% | 15.18% | 15.09% | 15.34% | 15.33% | 15.32% | 15.39% | 15.46% |
| Contextual Information | % of Band8A+ who are from Global Majority Background (WTE) | | | 5.50% | 5.41% | 5.11% | 5.88% | 6.20% | 6.17% | 6.14% | 6.53% | 6.54% | 6.45% | 6.42% | 6.15% |

| | Performance Indicator | Latest Month Target | Outside Tolerance | Last 12 Months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 |
| Key Standard | Appraisal Compliance Rate | >=90.00% | <85.00% | 73.41% | 71.94% | 71.44% | 72.67% | 74.84% | 75.82% | 77.04% | 77.05% | 77.66% | 77.65% | 78.83% | 78.51% |
| Contextual Information | Global Majority Appraisal Compliance Rate | >=90.00% | <85.00% | 72.73% | 69.63% | 67.63% | 69.76% | 71.82% | 73.02% | 75.69% | 76.79% | 76.95% | 78.23% | 80.97% | 79.85% |
| Key Standard | Mandatory Training Compliance (exc Bank) | >=85.00% | <80.00% | 89.54% | 89.01% | 89.37% | 89.37% | 89.82% | 90.29% | 90.84% | 90.40% | 90.32% | 90.03% | 90.04% | 88.78% |
| Key Standard | IG Training Compliance (exc Bank) | <=95.00% | >100.00% | 86.05% | 86.20% | 85.72% | 86.18% | 86.79% | 87.62% | 88.40% | 87.72% | 88.51% | 86.61% | 85.92% | 85.28% |
| Key Standard | Safeguarding Adults Level 1 Compliance (exc Bank) | >=90.0% | <85.0% | 92.08% | 91.41% | 91.81% | 91.62% | 92.10% | 92.44% | 92.81% | 92.43% | 92.79% | 92.84% | 92.93% | 92.63% |
| Key Standard | Safeguarding Adults Level 2 Compliance (exc Bank) | >=90.0% | <85.0% | 91.69% | 90.74% | 90.99% | 90.68% | 91.31% | 91.02% | 91.84% | 91.34% | 91.69% | 91.84% | 92.08% | 92.03% |
| Key Standard | Safeguarding Adults Level 3 Compliance (exc Bank) | >=90.0% | <85.0% | 92.92% | 93.58% | 92.59% | 96.26% | 94.55% | 93.75% | 89.47% | 93.21% | 30.43% | 36.01% | 37.97% | 42.16% |
| Key Standard | Safeguarding Children Level 1 Compliance (exc Bank) | >=90.0% | <85.0% | 91.93% | 91.44% | 91.81% | 91.82% | 92.23% | 92.64% | 92.88% | 92.22% | 92.55% | 92.30% | 92.11% | 91.73% |
| Key Standard | Safeguarding Children Level 2 Compliance (exc Bank) | >=90.0% | <85.0% | 91.96% | 91.26% | 91.14% | 90.97% | 91.61% | 91.74% | 92.46% | 91.57% | 9187.00% | 91.51% | 91.28% | 91.21% |
| Key Standard | Safeguarding Children Level 3 Compliance (exc Bank) | >=90.0% | <85.0% | 89.85% | 91.26% | 90.88% | 91.48% | 91.24% | 91.97% | 90.95% | 91.20% | 91.32% | 90.41% | 88.14% | 87.29% |

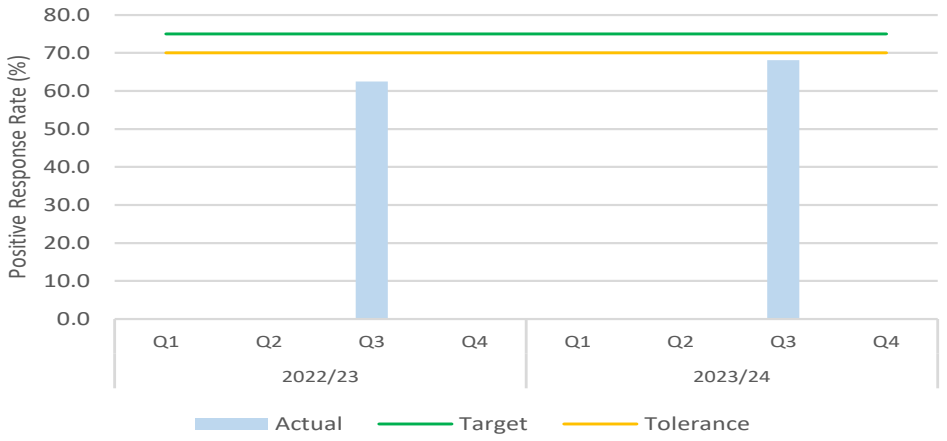
** Training data based on Learning Together from Jun-23; Appraisal and Training information re-stated due to new reporting methodology

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

| Measure | Commentary | Actions being taken to manage / mitigate the workforce risks |
|---|---|---|
| Appraisal | Compliance rates are slowly improving but remain over 10 percentage points below target. | Capacity for colleagues to choose their own appraiser will go live in September 2024<br>DPPs focussing work within Division in hotspots such as Gastro and ED. |
| Mandatory Training compliance | Compliance rates have decreased, which is partially attributable to changes affecting the Prevent subjects. | Ongoing focus on improving compliance following changes to requirements. |

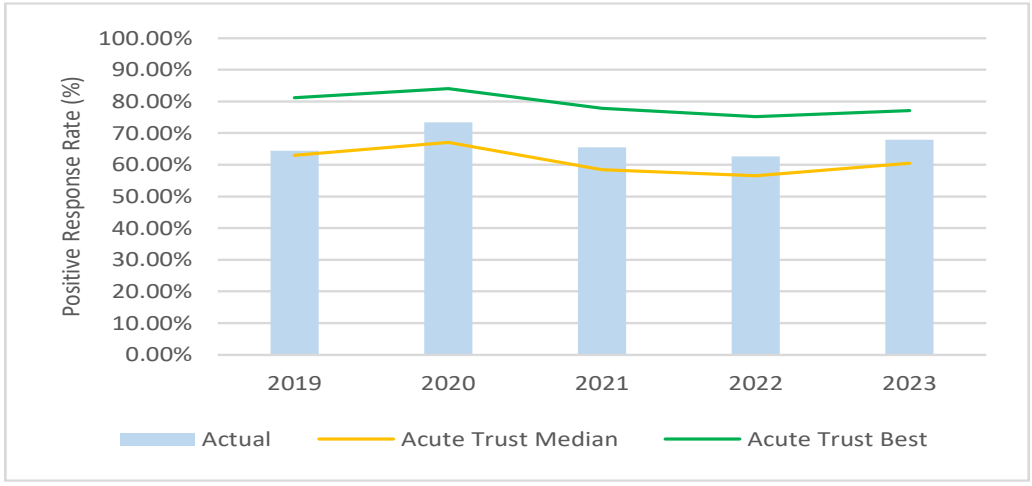
# Trust Goal | Staff Recommend the Trust as a Place to Work

**Making a Difference Survey Result**




| Latest Survey | 68.1% |
|---|---|

**National Survey Results**




| Latest Survey | 67.9% |
|---|---|

**Is standard being delivered?**

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

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

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

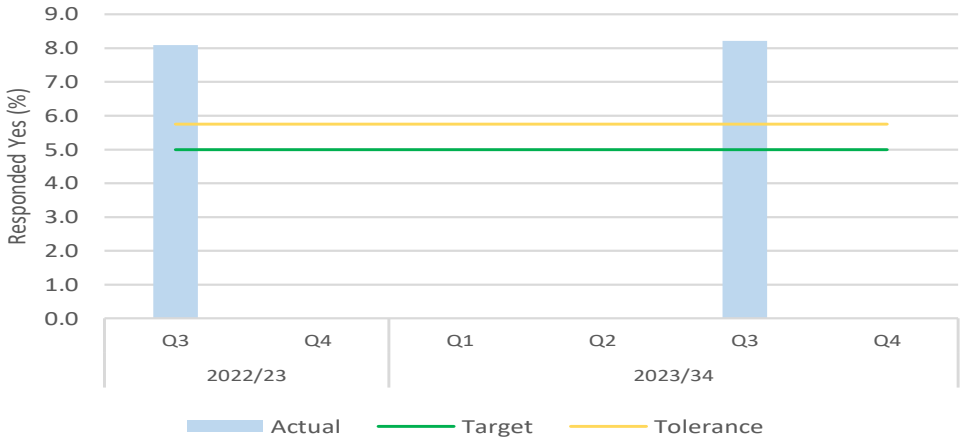
**Countermeasure Summary**

| Countermeasure/Action | Owner |
|---|---|
| Central workstreams continue to prioritise this measure, with projects including;<br>• IHI Framework for Joy in Work<br>• Exploring new, easy to use team development options for struggling areas<br>• EDI projects to increase engagement and provide safe, inclusive working environments.<br>• Change team interventions Division People Partners working through actions plans at Divisional and Specialty level.<br>• Basics Matter programme identified priorities from staff survey to inform the content of the workstreams. | People Team<br>for Culture<br>Divisional<br>People Partners/<br>Divisional<br>Leadership<br>Teams<br>Basics<br>Matter Team |

# Breakthrough Goal |

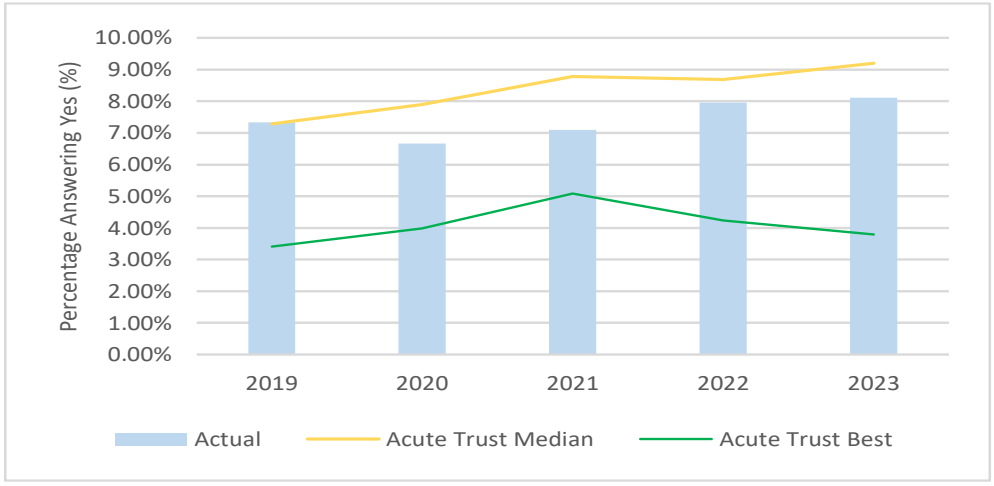
## Reduce Proportion of Staff Reporting Experiencing Discrimination from Line Managers/ Colleagues

**Making a Difference Survey Result**




| | |
|---|---|
| Latest Survey | 8.22% |

**National Survey Results**




| | |
|---|---|
| Latest Survey | 8.11% |

**Is standard being delivered?**

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

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

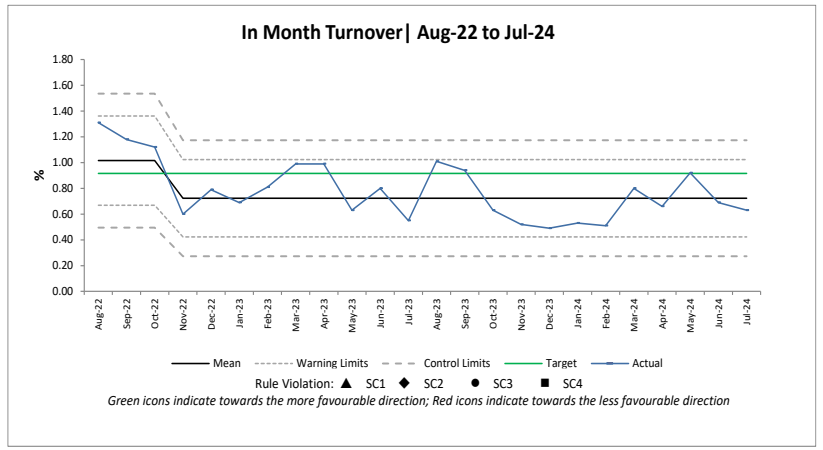
- Emergency Medicine had the lowest proportion of staff reporting that they had not experienced discrimination from a manager or colleague at 85.9%.

**Countermeasure Summary**

| Countermeasure/Action | Owner |
|---|---|
| • Targeted team development interventions (in collaboration with HR) to address identified issues, including emergency medicine, theatres and cleaning.<br>• Introduction of Report and Support in August 2024, to be linked with RUH People Hub – therefore better, swifter support to areas most affected by discrimination.<br>• Violence Management and Reduction Policy launched august 2024<br>• Refreshed breakthrough objective – 2024/25 focus on Disability and Long-Term Conditions, and embedding work on race (esp. Anti-Racist Statement) | People Hub / DPPs People Team for Culture |

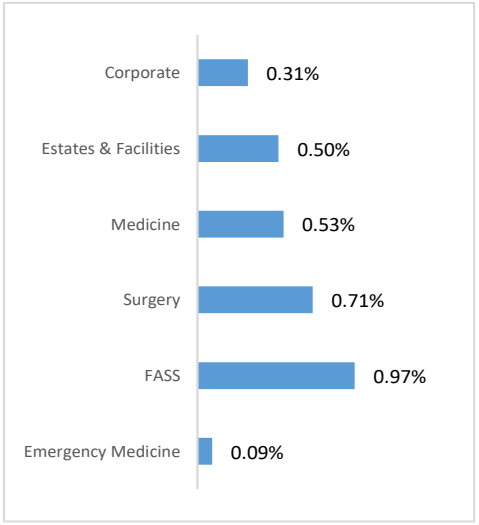
# Key Standard| Turnover Rate

## In Month Turnover - Trust

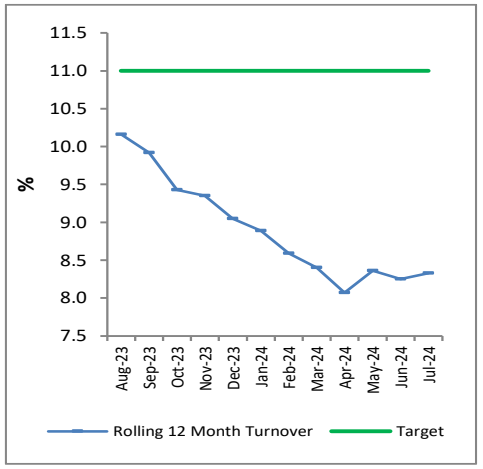



| Turnover Rate | 0.63% |
|---|---|

## In Month Divisional Turnover



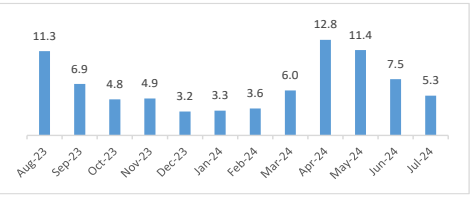

## Rolling 12 Months Turnover - Trust



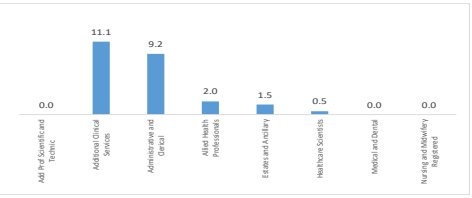

| Turnover Rate | 8.47% |
|---|---|

## Leavers Inside 1st Year (Permanent Contract)

Trust Trend




Staff Group - Last 3 Months




**Is standard being delivered?**

- Both the in-month and rolling 12-month turnover rates are below target at 0.63% and 8.47% respectively.
- The turnover rate is not causing concerns at present.

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

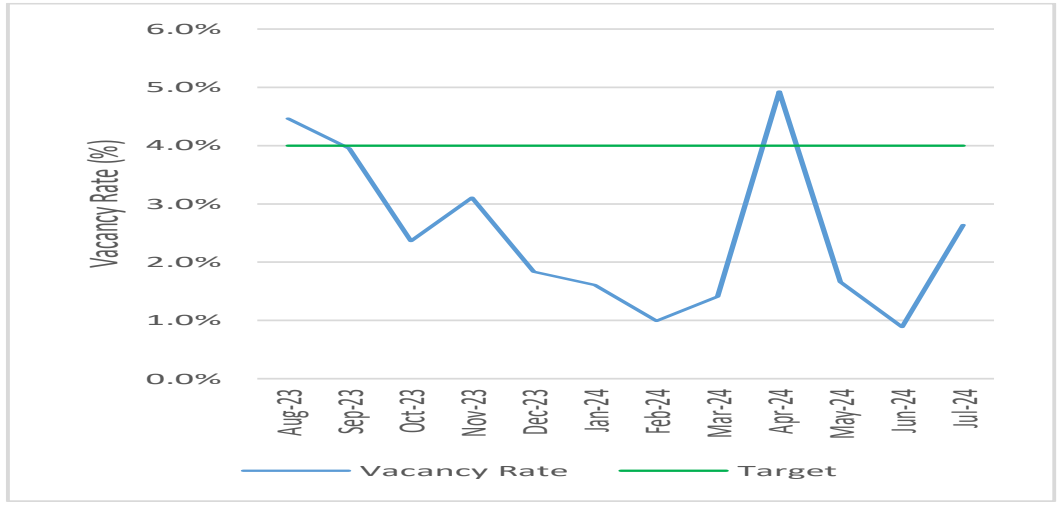
- All main Divisions have a 12-month turnover rate below 10% and thus below target.

**Countermeasure Summary**

| Countermeasure/Action | Owner |
|---|---|
| • A combination of the 11 People Programmes contribute to reducing turnover, including Foundations, Health and Well Being and Leadership. | Associate Directors for People |

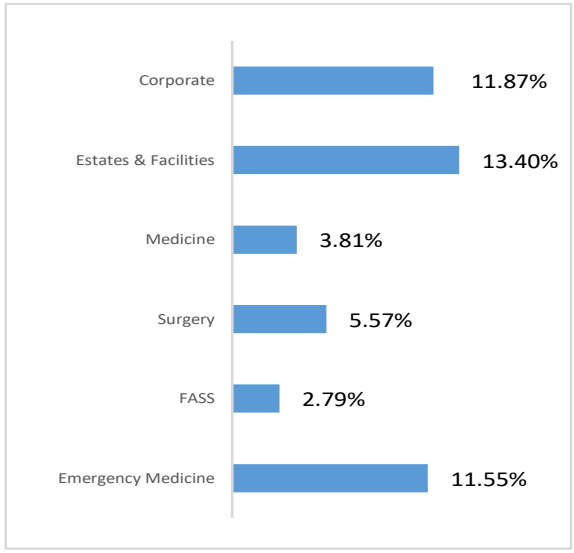
# Key Standard| Vacancy Rate

### Vacancy Rate - Trust

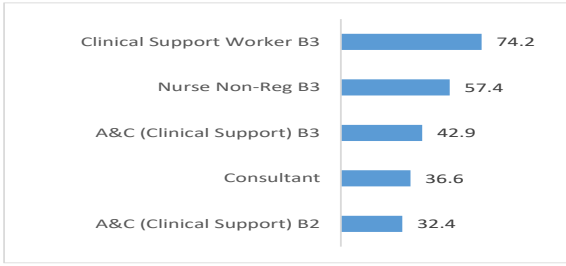



| | |
|---|---|
| Vacancy Rate | 2.64% |

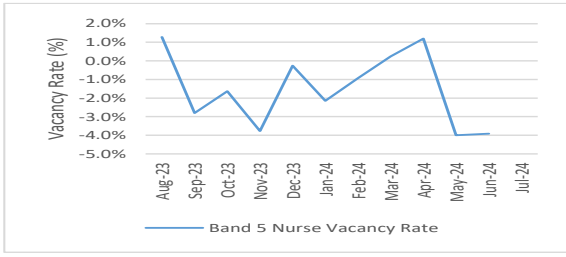
### Divisional Vacancy Rates




### Top 5 Roles by Vacancy Rate




### B5 Nurse Vacancy Rate




### Is standard being delivered?

The vacancy rate taken from Unit 4 data remains below our target position with 150.5 WTE or 2.64% vacancy rate demonstrating we're attracting and retaining talent as turnover also remains below our internal target.

Band 5 Nurse vacancy rate remains in a positive position supporting the reduction and reliance in temporary staffing in general nursing areas.

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

Divisional vacancy rates may increase as we take the necessary steps to right-size our workforce and slow down the recruitment pipeline where feasibly safe to do so.

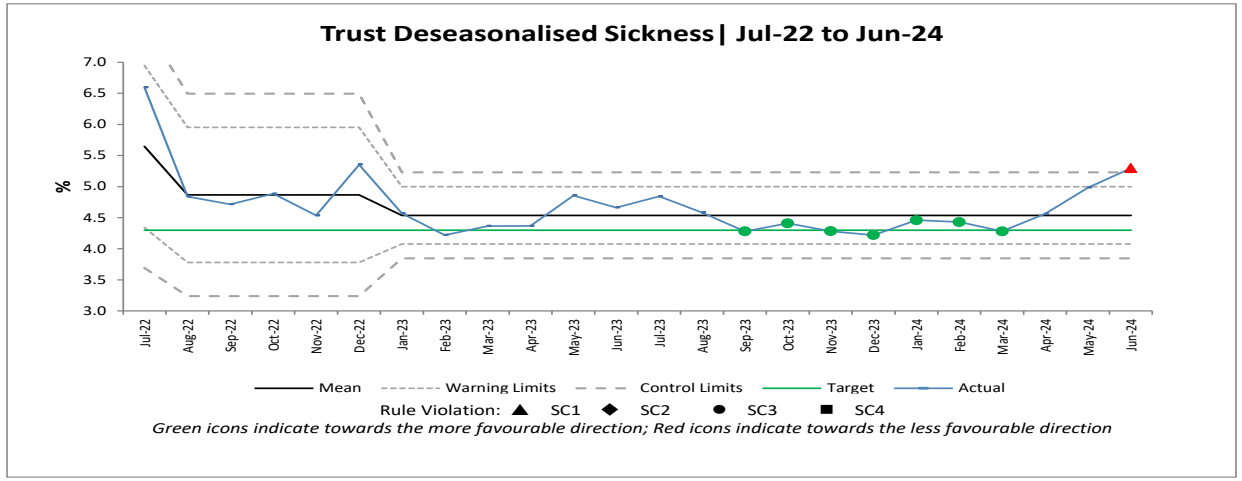
Estates and Facilities has the highest vacancy rate at 13.40% which we expect to see significantly reduce in the coming weeks following a successful recruitment campaign which will also significantly reduce their reliance on bank.

### Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| Trust led Vacancy Control and Agency Reductional Panel continues to support right-sizing our workforce against our workforce plans. The new controls are supporting the Trust financial recovery plans. | Executive Team |
| Employee Value Proposition assets being created for recruitment with the new look and feel to support our vision of staff recommending us a place to work. Live from September 2024. | Head of Comms |
| International Recruitment cohorts becoming eligible for Indefinite Leave to Remain. Options of support being explored to retain the diverse talent. | Associate Director of People & Culture |

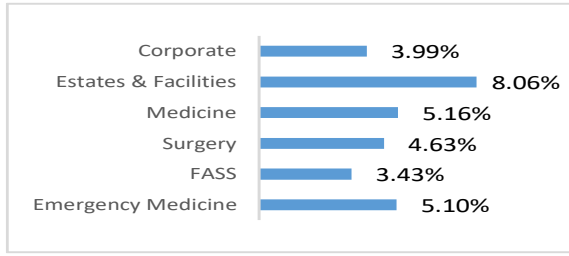
# Key Standard| Sickness Absence Rate

## Deseasonalised Sickness Absence Rate - Trust

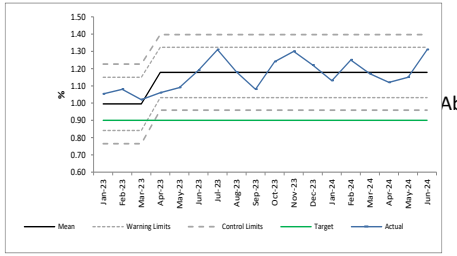



| In Month Actual | 4.84% | In Month Deseasonalised | 5.30% | Rolling 12 Months | 4.54% |
|---|---|---|---|---|---|

## In Month Divisional Sickness Rates

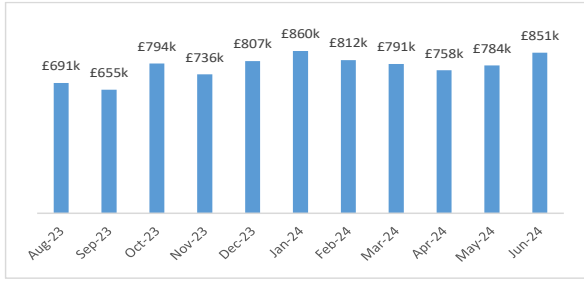



## Anxiety, Stress & Depression - Trust



Absence Rate 1.31%

## Estimated Absence Cost




## RIDDOR Reporting - Employees

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

## Is standard being delivered?

- The sickness absence rate in June was 4.84%, which is notably high for the season and well above target.
- The rolling 12 month figure is also above target, having increased to 4.54%.

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

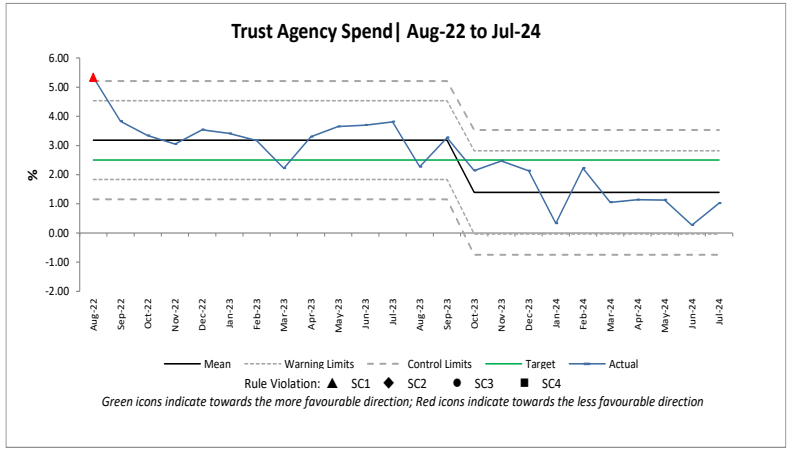
- 2191.6 WTE days were lost in June due to Anxiety, Stress and Depression - equivalent to an absence rate of 1.31%. Although the absence rate has increased on the previous month, the number of distinct employees off has fallen. As one would therefore expect, a greater proportion (approx. two-thirds) is long-term absence.
- 11% of absence pertained to Cold and Flu (890.7 WTE days lost, 246 distinct employees absent). This is on a slight downward trend, but the significance of this is evident when compared to 2019 figures (pre-Covid). Cold and Flu accounted for only 4.29% in June 2019, with the current figure more comparable with historic winter levels (January 2019 - 11.57%).

## Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| • Project ongoing to review sickness trigger notifications to managers and align this with real time data in allocate.<br>• Integration of sickness management into HALO case management system<br>• Education work aimed at improving quality of OH referrals<br>• Staff Physio service now bookable through OH and all cases reviewed to make sure those off sick with conditions that would benefit from physio are receiving it. | Divisional People Partners/ Nursing Improvement Group/People Hub Lead |

# Key Standard| Agency Spend & Bank

### Agency Spend as Proportion of Total Pay Bill

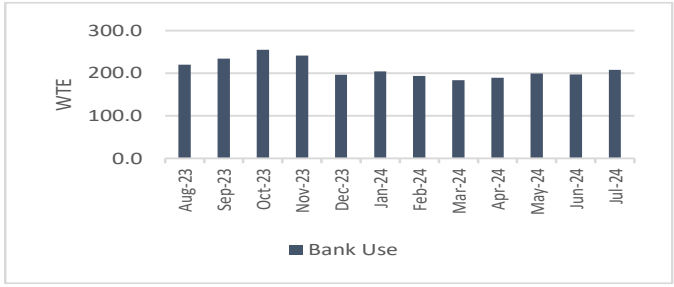


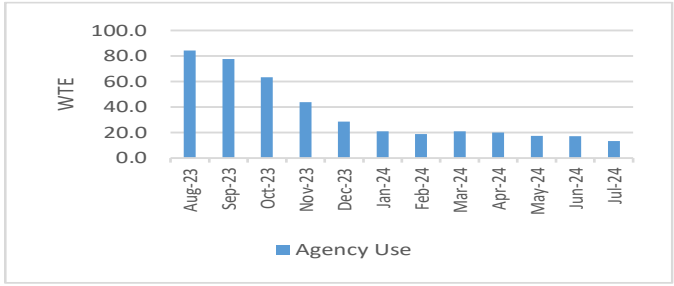

| | |
|---|---|
| Proportion | 1.02% |

### Agency Spend Breakdown

| | In Month | FYTD |
|---|---|---|
| Consultants | £192,328 | £590,059 |
| Junior Medical Staff | £0 | £9,467 |
| Non Medical - Non-Clinical Staff | £33,368 | £172,729 |
| Registered Nurses & Midwives | £50,925 | £203,282 |
| ST&T - Allied Health Professionals | £0 | £0 |
| ST&T - Health Care Scientists | £0 | £0 |
| ST&T - Other | £0 | £0 |

### Bank & Agency Use – Staffing Solutions Data




**Is standard being delivered?**

- Total agency spend recorded in July was £227k, which equates to 1.02% of the total pay bill supporting us to remain below the national target of 3.2%.
- Nurse agency spend was also below target at 0.6%. A supporting factor is July is the first month whereby price cap compliance is in place for nursing due to the implementation of our new PSL.
- Off-framework usage decreased from 9.15% in M3 to 5.93% in July. This is largely due to a non-framework consultant which we're actively exploring exit plans to increase compliance.

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

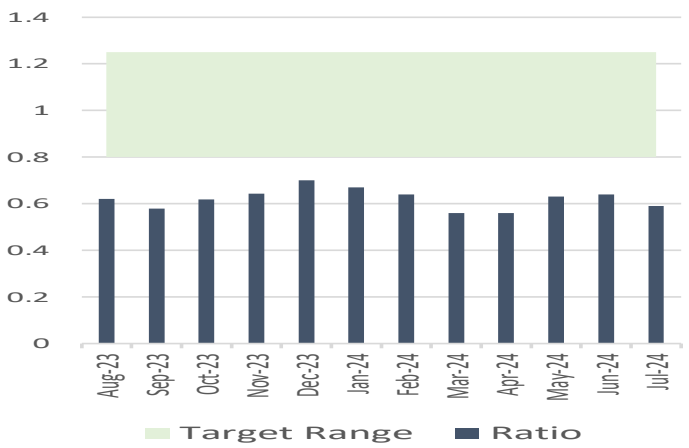
- Medical and Dental remain the highest in month and FYTD spend on agency provision. In July 69.5% of the total spend was on Agency Consultants with Oncology, Cellular Pathology and MAU the top contributors.
- 18.4% of agency spend was on Registered Nursing with the Enhanced Care Team being the top contributor whilst we actively recruit to reduce our reliance on agency provision
- Price cap compliance increased in July to 55.67% of shifts being above cap in comparison to 76.8% of all shifts in June being above cap.

**Countermeasure Summary**

| Countermeasure/Action | Owner |
|---|---|
| South West Agency rate card for Medical & Dental goes live 1st September for new bookings. A longer flight path in place for existing locums to reach rate card no later than March 2025 | Associate Director for Talent & Capacity |
| AfC Bank rates changing to align with system partners approach of paying to grade supporting collaborative work. This new way of working also supports the movement from overtime to bank. | Associate Director for Talent & Capacity |
| Locally Agreed Bank rates under review to consider impact of standing down or stepping down rates to create equity and transparency in our approach. | Associate Director for Talent & Capacity |
| Divisional workforce data tracked prospectively (and retrospectively) and shared with divisional teams to support management of spend | Head of Workforce Planning |
| SW Regional Agency Rate card for Nursing live from 1st July reaching NHS price cap compliance. | Associate Director for Talent & Capacity |

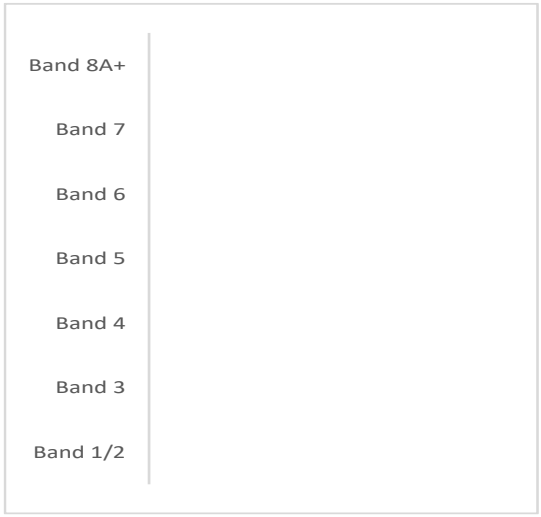
# Tracker| Global Majority Likelihood of Appointment

**Likelihood of being appointed from shortlisting**

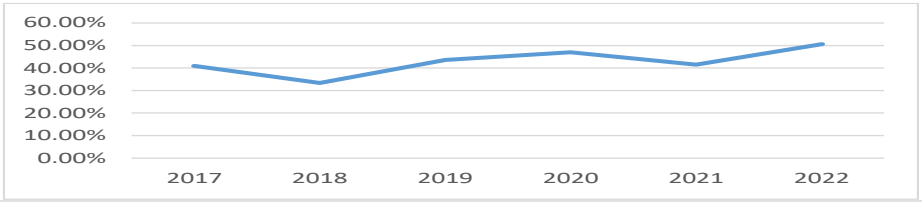



| Ratio for every 1 White | 0.59 |
|---|---|

**Global Majority by AfC Band - WTE**




**Global Majority Positive Response Rate: Organisation Provides Equal Opportunities for Career Progression and Promotion**




**Selected Quarterly Survey Themes**


**Is standard being delivered?**

- Based on Trac data, the ratio of the likelihood of appointment from shortlisting comparing Global Majority to White candidates Is 0.59 - below the targeted two-fifths range(0.8-1.25).

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

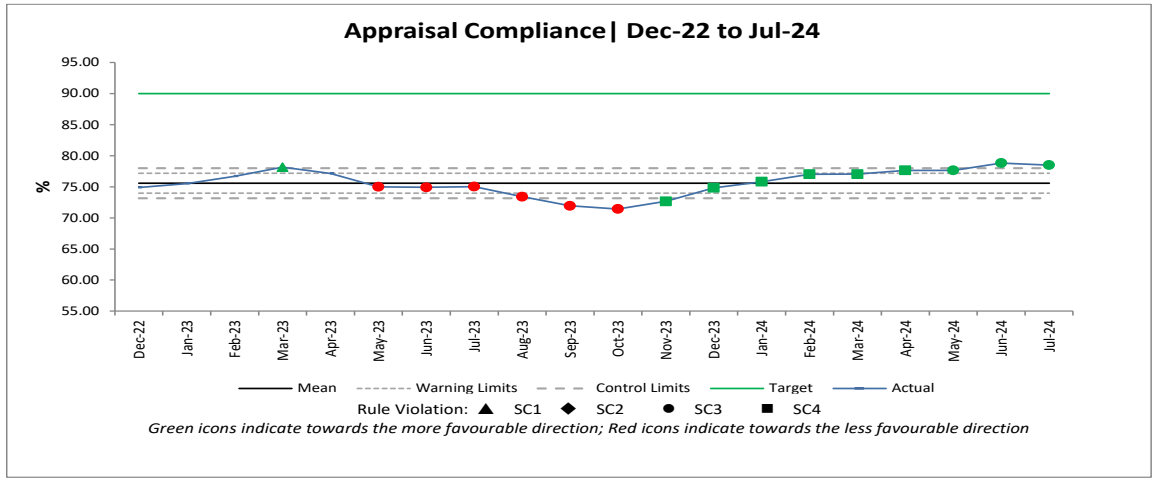
- Candidate distribution across vacancies is masked by the aggregation and this has a significant impact in determining the overall figure.

**Countermeasure Summary**

| Countermeasure/Action | Owner |
|---|---|
| Projects related to People Plan Programme 4: EDI contribute to improving this metric. These include:<br><br>- Positive action programme – Routes to Success (Oct 24)<br>- Independent Advisors (Oct 24)<br>- Inclusion Champions network<br>- Staff Network collaboration (REACH Network)<br>- EDI team-based and learning interventions<br>- Work following launch of anti-racist statement | Associate Director for People (Culture Change)<br>DPPs<br>Divisional Directors of Nursing and Operations |

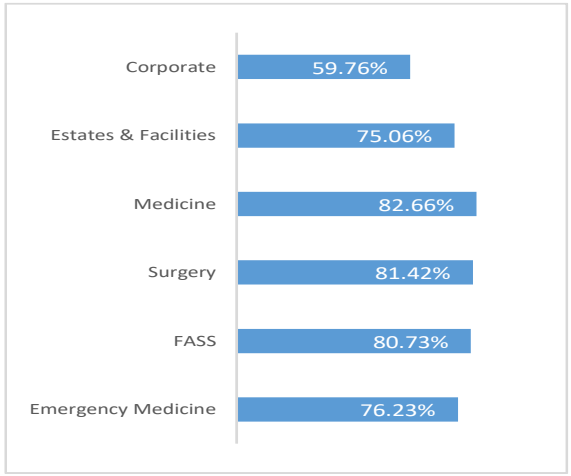
# Key Standard| Appraisal Compliance

## Appraisal Compliance - Trust




| | |
|---|---|
| Compliance Rate | 78.5% |

## Divisional Appraisal Compliance




## Selected Group Compliance Rates

| | |
|---|---|
| AfC Staff | 78.8% |
| M&D Staff | 75.9% |
| Consultants | 84.0% |
| White | 78.2% |
| BME | 79.9% |

## Is standard being delivered?

Appraisal compliance has marginally fallen to 78.51% and continues to be below the targeted 90%.

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

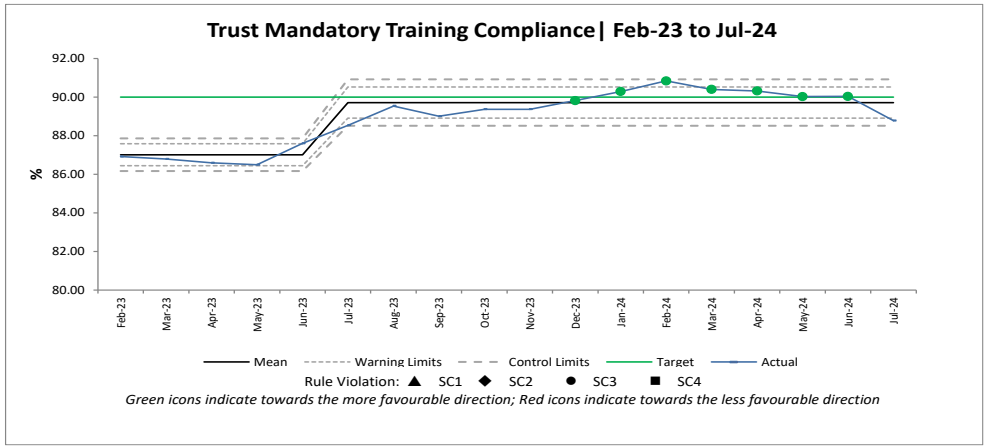
Corporate Division has the poorest compliance at 59.76% and has improved less than 2 percentage points since March.
Medicine, Surgery and FASS are all above the tolerance level, but their trends currently don't suggest they will kick on towards the 90% target.

## Countermeasure Summary

| Countermeasure/Action | Owner |
|---|---|
| • Deputy People Partner's continue to work closely with Divisions regarding appraisal compliance. | Deputy People Partner's |
| • Medicine focus on hotspots such as ED and Gastro improving uptake by 5%. | Deputy People Partner's |
| • System changes are being made in September 24 enabling appraisees to change their appraiser on the Learning Management System | Associate Director for People |

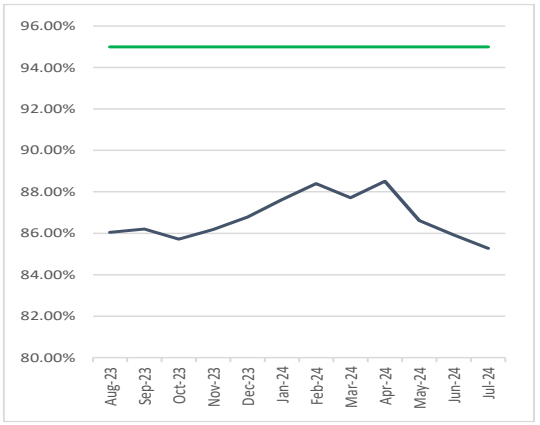
# Key Standard| Mandatory Training Compliance

## Mandatory Training Compliance Rate - Trust



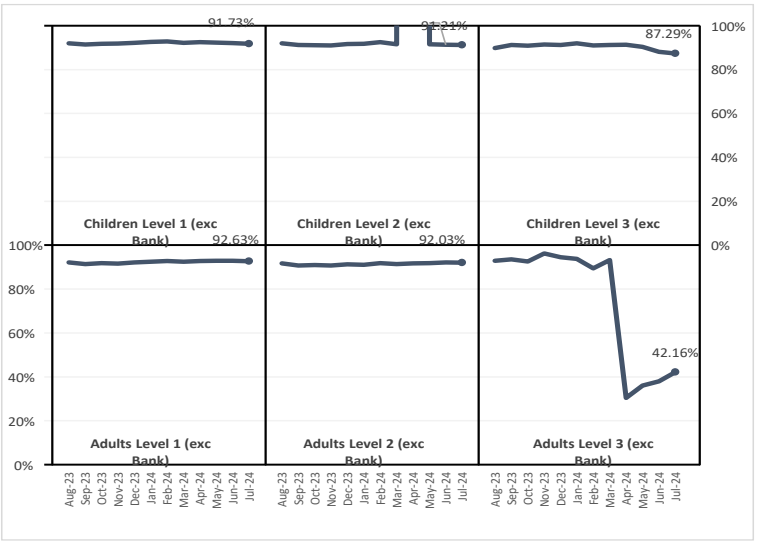

| Compliance Rate | 88.8% |
|---|---|

## Information Governance Training Compliance Rate - Trust




| Compliance Rate | 85.3% |
|---|---|

## Safeguarding Training Compliance Rates - Trust




**Is standard being delivered?**

Although Mandatory Training compliance has fallen to 88.78%, it remains above target.

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

The drop in compliance can partly be explained by changes to requirements related to Prevent training.
As a result of the change, Prevent WRAP 2 joins Information Governance, Safeguarding Adults L3 and the Resuscitation subjects in being red against their respective target.
Emergency Medicine's compliance has fallen below the tolerance level, with Estates and Facilities marginally above it.

**Countermeasure Summary**

| Countermeasure/Action | Owner |
|---|---|
| Continued to be pushed through Divisional PRM structure. | Deputy People Partner's |

NHS
Royal United Hospitals Bath
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# Quality Report

August 2024 (June 2024 data)

The RUH, where you matter

# Executive Summary | Quality

Trust Integrated Balanced Scorecard - June 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

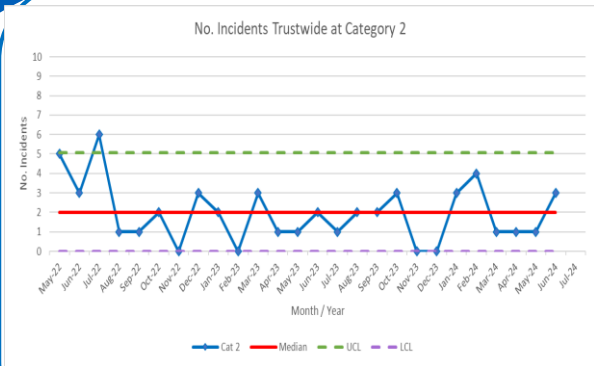
| Strategic Goal | | Performance Indicator | Description | Target | | 2023/2024 | | | | | | | | | | 2024/2025 | | | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Performing | Under Performing | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | |
| Trust Goals | People we care for | Connecting with you - helping you feel safe, understood and always welcome | Reported Patient Safety incidents resulting in significant harm (moderate to catastrophic), excl. rejected | | | 17 | 21 | 25 | 25 | 26 | 26 | 13 | 23 | 18 | 16 | 18 | 20 | 8 | |
| 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 | 56 | 50 | 50 | 51 | 54 | 55 | 49 | 52 | 50 | 45 | 45 | 43 | 23 | |
| | | Serious Incidents with Overdue Actions | All non-rejected serious incidents reported on Datix with incomplete actions at month end. | <5 | >=5 | 4 | 3 | 2 | 2 | 3 | 6 | 2 | 2 | 3 | 3 | 1 | 0 | 1 | |
| | | Number of falls resulting in significant harm (Moderate to Catastrophic) | | <=1 | >=3 | 0 | 3 | 1 | 4 | 3 | 1 | 0 | 5 | 0 | 1 | 3 | 3 | 2 | |
| | | ED time to triage | Percentage of ED attendances triaged within 15 minutes | | | 52.1% | 55.6% | 65.9% | 58.8% | 50.3% | 52.6% | 54.1% | 53.1% | 48.8% | 49.2% | 47.1% | 44.7% | 55.0% | |
| | | Falls per 1000 bed days | Includes all falls | | | 6.6 | 6.5 | 7.2 | 6.6 | 7.1 | 8.4 | 7.4 | 7.1 | 7.0 | 6.8 | 5.1 | 6.4 | 7.2 | |
| | | Medication Incidents per 1000 bed days | All Incidents | | | 6.2 | 7.6 | 7.2 | 7.8 | 8.4 | 8.9 | 6.4 | 7.4 | 7.3 | 7.2 | 8.5 | 6.0 | 6.7 | |
| | | Number of Patients given medication by scanning device | | | | 22.9% | 24.3% | 27.5% | 29.5% | 30.1% | 33.0% | 35.7% | 39.5% | 40.6% | 41.2% | 42.1% | 46.3% | 46.6% | |
| | | Early Identification of Deteriorating Patient | | | | 19.7% | 18.1% | 20.1% | 20.3% | 22.2% | 25.6% | 22.8% | 25.3% | 26.0% | 23.2% | 23.1% | 27.6% | 25.6% | |
| | | Hospital acquired infections | | | | 16 | 24 | 16 | 11 | 13 | 15 | 15 | 22 | 29 | 22 | 23 | 23 | 12 | |
| | | Number of COVID nosocomial infections | | | | 8 | 14 | 7 | 20 | 52 | 13 | 15 | 44 | 22 | 12 | 37 | 9 | 13 | |
| | | Hospital Associated Infections including Flu, COVID-19 and Norovirus | | | | 24 | 40 | 23 | 31 | 68 | 28 | 34 | 66 | 53 | 36 | 60 | 32 | 26 | |
| | | Number of Hospital Acquired Pressure Ulcers Category 2 | Includes Medical Device Related | <=2 | >2 | 3 | 1 | 4 | 4 | 4 | 2 | 2 | 5 | 4 | 1 | 1 | 1 | 3 | |
| | | Number of Hospital Acquired Pressure Ulcers Category 3 & 4 | Includes Medical Device Related | <=0 | >0 | 0 | 1 | 9 | 1 | 3 | 3 | 0 | 0 | 2 | 0 | 1 | 1 | 2 | |

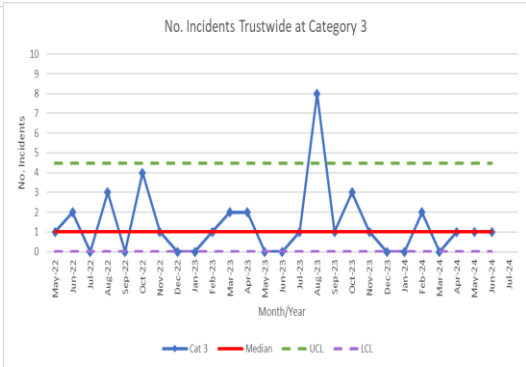
**Measures requiring focus and a countermeasure summary this month are:**

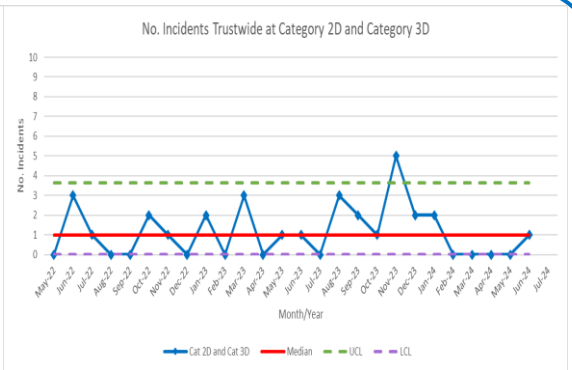
| | Executive Summary |
|---|---|
| Patient safety incidents – rate per 1,000 bed days | The reporting rate presented for June 2024 is inaccurate due to changes in how the type of incidents (events) are reported on Datix following the implementation of the Learning from Patient Safety Events (LFPSE) mandatory fields on Datix. This is being addressed with the Business Intelligence Unit. There were 44 patient safety incidents per 1000 bed days in June 2024. |
| Number of Hospital Acquired Pressure Ulcers Category 2, 3 and 4 | There were 3 x Category 2 and 2 x Category 3 Pressure Ulcers reported in June 2024. |

# Pressure Ulcers

Breakthrough Objective




## We are driving this measure because…

Pressure ulcers are estimated to cost the NHS £1.4 Million a day. Maintaining a low incidence of pressure ulcers is a Trust breakthrough objective.

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

## Understanding the performance

The RUH benchmark performance against the other Acute Trusts across the ICS with both the number of pressure ulcers per 1,000 bed day and the overall numbers of pressure ulcers by category.

For June 2024 the RUH reported 0.3 category 2 pressure ulcers per 1,000 bed days (2 pressure ulcers). GWH reported 1.86 per 1,000 bed days and Salisbury at 2.52 per 1,000 bed days.

Analysis of RUH figures show that the top contributors relate to skin assessment and escalation to specialist staff.

## Actions (SMART)

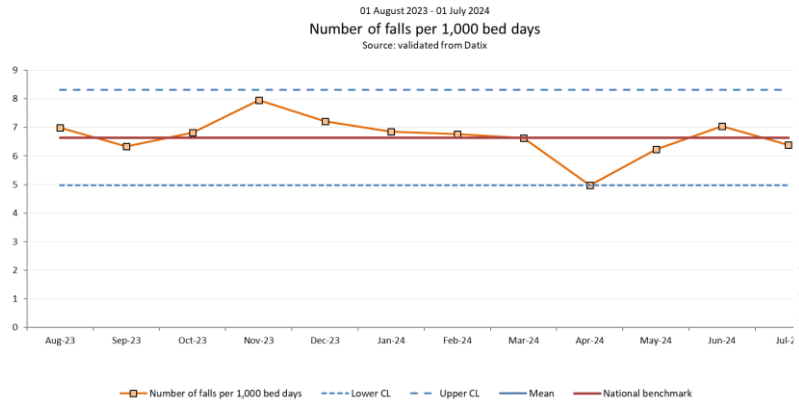
- The Tissue Viability Improvement Group continues to monitor all harms related to pressure ulcers of category 2 and above and medical device to identify trends and opportunities for learning.
- An A3 has been completed with the aim of reducing medical device related pressure ulcers by 50% in 6 months of the new year. This has been achieved to date.
- A Tissue Viability Ambassadors Day is being held on the 27th September 2024 with a focus on skin assessments and escalation

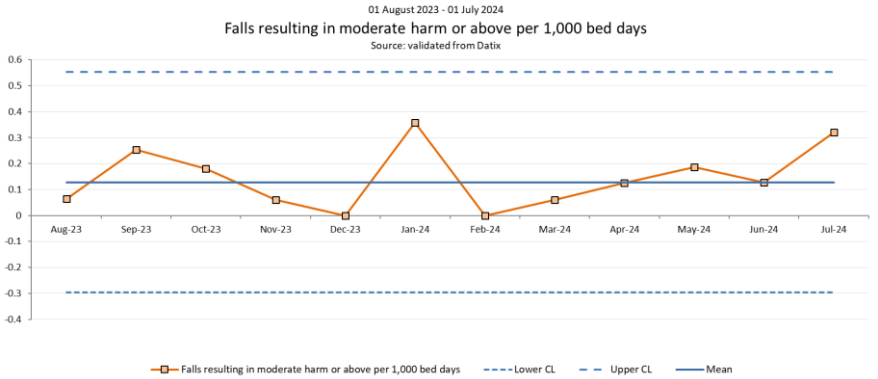
## Risks and Mitigations

1. The roll out of paperless inpatients in August requires training for staff and will be a new way of working. There is a risk that this will affect timely documentation and reporting during the implementation phase. This is being robustly monitored and support is being provided.

# Falls (Patient Safety Priority)

Breakthrough Objective




## We are driving this measure because…

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

## Understanding the performance

Analysis identifies that 98% of inpatients do not fall in our care. Pareto analysis identifies the 4 top contributing inpatient areas are within the older persons specialty. The frailty and complexity of patients on older persons wards does lead to an increased vulnerability to falling whilst in Hospital.

Analysis reveals that the top contributing factors are:
1. Orthostatic hypotension - NICE guidance advises all inpatients at risk of falls have a lying and standing blood pressure recorded as part of a multifactorial risk assessment.
2.Enhanced observation levels are recorded on all patients daily – this is to assess and identify patients who require *Enhanced care.

## Actions (SMART)

1. The Falls Prevention Improvement Group continue to drive quality improvement projects in 4 wards on lying and standing blood pressure compliance to achieve:

- A reduction in the number of falls in the 4 wards by 10% by April 2025
- 50% of patients in the 4 wards have a lying and standing blood pressure recorded on admission by December 2024

2. Enhanced care and support team (Trust-wide) recruitment. This is ongoing and sits outside of the Falls Prevention Improvement Group work but the falls prevention lead is a member of the working group.

## Risks and Mitigations

1. The roll out of paperless inpatients in August requires training for staff and will be a new way of working. There is a risk this may limit the time required to train staff on lying to standing blood pressure assessments. The Falls Prevention Improvement Group mitigation is to pause training for August and start in September 2024.

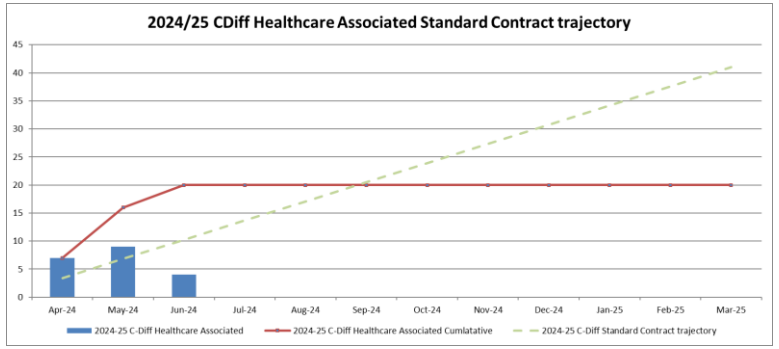
2. There is a risk that the enhanced care team recruitment may not fill all available posts. The impact is that the number of trained staff in enhanced care may not be able to provide the level of care required to help reduce the risk of a complex patient falling.

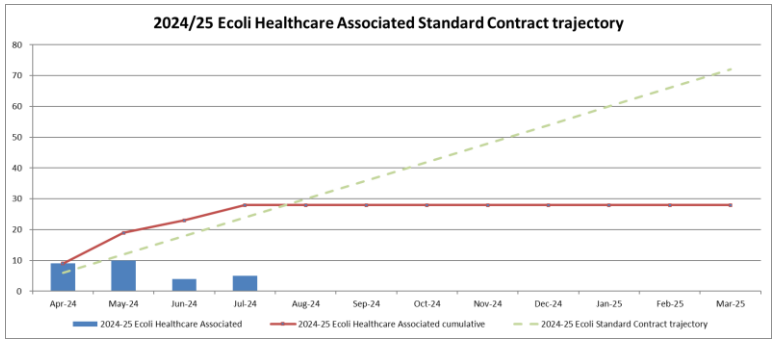
**The RUH, where you matter**

* Enhanced care is an approach to caring for patients who require either intermittent or continuous supervision to keep them safe.

# Infection Prevention and Control (Patient Safety Priority)

Breakthrough Objective




## We are driving this measure because…

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

## Understanding the performance

There were 4 cases of Clostridioides difficile infection reported during June (3 HOHA and 1 COHA). There were 5 cases of E. coli infection reported during June.

An increase in frailty and complexity of patients can lead to an increased vulnerability to infections whilst in hospital. Antibiotic prescribing is a contributing factor, although the Trust antibiotic usage is one of the best in the region.

Cleaning standards are vital to the prevention of infections. There has been a successful focus on recruitment in the facilities team.

## Actions (SMART)

The Infection Prevention Team will be driving quality improvement projects on:

1. Patient hand hygiene – to increase patient hand hygiene pre and post meals initially within the Older Person's Short Stay Unit by 30% within 3 months.
2. Implementing a hydration project in elderly care wards in collaboration with the nutrition and hydration improvement group at the RUH - to increase and maintain patients fluid intake
3. To develop and launch a PPE App - to empower clinical staff to select the correct PPE 100% of the time by December 2025.

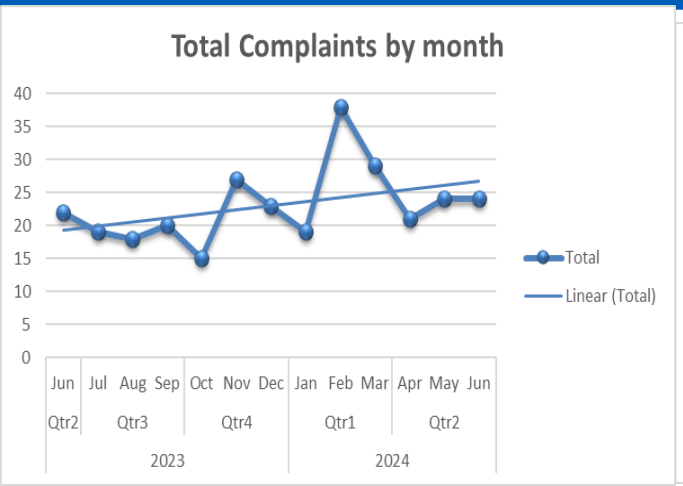
## Risks and Mitigations

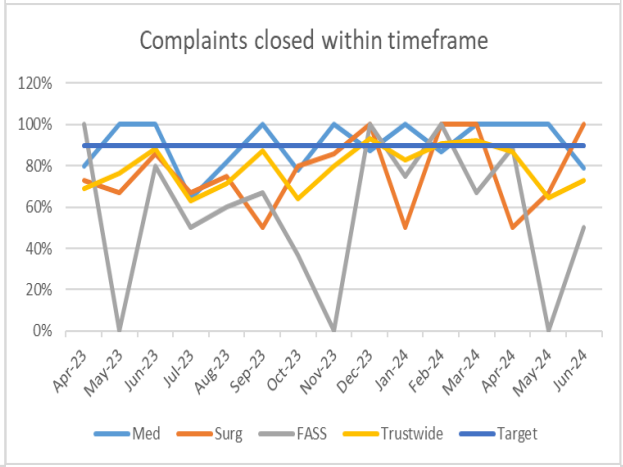
1. New and emerging infections such as Avian flu (H5N1) and high consequence infectious disease (HCID) on the Horizon, which includes Clade I mpox virus (MPXV). This is being mitigated by published SOPs and HCID PPE training being delivered.
2. Single room capacity is currently 18.76% for acute adult care alongside an aging estate. This is being mitigated by active IPC oversight regarding case managemen and the ward refurbishment plan with estates.

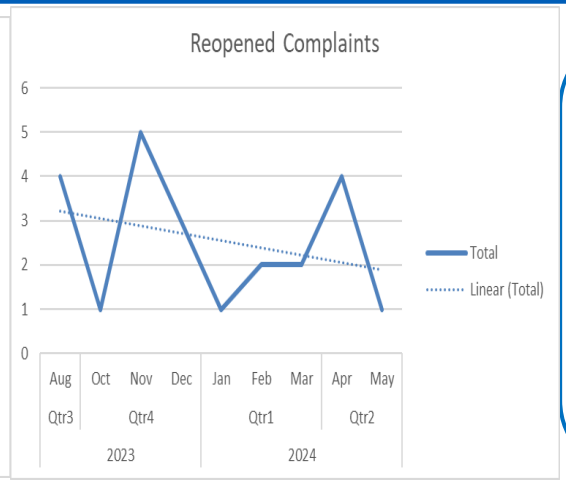
**The RUH, where you matter**

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

# Patient Support and Complaints




## We are driving this measure because…

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

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

## Understanding the performance

Most of the patient feedback received is positive. In June the Trust received 1.3 complaints per 10,000 patient contacts. This compares to 1.2 in May and 1.1 in April.

The number of reopened complaints is an important measure regarding the quality of our response. The number of complaints reopened each month remains low with most contacts satisfied with the response and outcome.

A key driver for the Trust is to maximise the early resolution of complaints and concerns by responding within 14 days. In June we achieved early resolution in 77% of cases.

**The RUH, where you matter**

| Month | June 2024 |
|---|---|
| % Complaints/concerns resolved with early resolution (14 days) | **77%** (target 75%) |

## Actions (SMART)

- Head of Patient Support and Complaints working closely with clinical divisions to support sustained improvements in complaint response times and embedding early resolution.
- Patient Experience workplan has been implemented and drives the year 1 improvement work from the Patient Experience Strategy. This is monitored by the Patient Experience Committee.

## Risks and Mitigations

1. There is an opportunity to empower and increase the confidence of patient facing staff to address and resolve complaints and concerns in real time. Focused learning is being developed to empower frontline staff.
2. The learning from patient feedback needs to be embedded across the Trust to ensure sustained quality improvement. This is a key element of the Patient Experience Strategy and focussed work has commenced in year 1.

Royal United Hospitals Bath
NHS Foundation Trust

# Perinatal Quality Surveillance


RUH Maternity

**The RUH, where you matter**

# Safe – Maternity& Neonatal Workforce

| | Target | Threshold G | Threshold A | Threshold R | Apr 24 | May 24 | Jun 24 | SPC | Comment |
|---|---|---|---|---|---|---|---|---|---|
| Midwife to birth ratio | 1:24 | <1:24 | | >1:26 | 1:25 | 1:27 | 1:27 | | |
| Midwife to birth ratio (including bank) | 1:24 | <1:24 | | >1:26 | 1:23 | 1:24 | 1:25 | | |
| Consultant presence on BBC (hours/week) | 98 | >97 | | | 98 | 98 | 98 | | Meeting RCOG recommendation from Jan 23 |
| Consultant non-attendance when clinically indicated (in line with RCOG guidance) | 0 | 0 | | >1 | 0 | 0 | 0 | | |
| Daily multidisciplinary team ward round | 90% | >90% | | <80 % | 97% | 90% | 100% | | Data capture issue recognised in response to digital transition. Please see countermeasures |
| Band 5/6 Midwifery Vacancy rate (inclusive of Maternity leave) WTEs | 7.0 WTE | ≤7.0 | | >10 | 4.90 | 7.0 | lag | | |
| Neonatal Nurse QIS rate | 70% | ≥70% | | ≤60 % | 63% | 63% | 65.5% | | On going training in place to increase compliance |
| Neonatal staffing meeting BAPM standards | 100% | >90 | | <80 % | 96% | | 82% | | High acuity mid month – 3 x ITU, 4 x HDU |
| Maternity 12 Month Turnover rate | ≤5% | ≤5% | | ≥7% | 4.60 % | 6.37% | lag | | |
| Neonatal Unit 12 month Turnover rate | ≤5% | ≤5% | | ≤7% | 7.60 % | 7.45% | lag | | |
| Percentage of TC shifts with staff dedicated to TC care only | | >90% | | <80 % | 100 % | 100% | 98% | | |

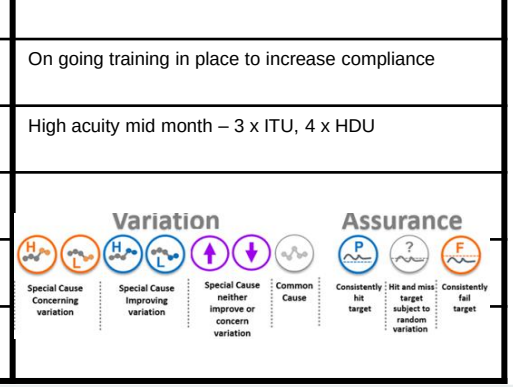



Table 1.

**Is the standard of care being delivered?**
- No episode of consultant non attendance
- Midwife to birth ratio target not met in June 24

**What are the top contributors for under/over-achievement?**
- Reversion to paper-based data capture for MDT ward round
- Roster reviews ongoing with Allocate to remove excess shift tiles impacting on shift fill rates.
- Staff turnover rate in the NNU due to family re-locations

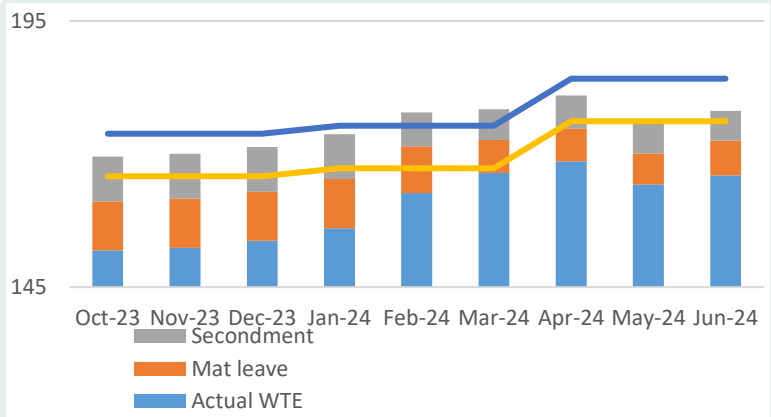



Table 2. Band 5/6 Midwifery Vacancy rate and staffing pipeline projections

| Countermeasure /Action (completed last month) | Owner |
|---|---|
| Data capture problem identified since transition to digital audit tool for MDT ward round. Transition back to paper audit tool from April 24, resulting in increased compliance more reflective of 'work as done' | Clinical audit midwife/ BBC Lead Midwife |
| Anticipated increase in QIS compliance as staff complete their training | Consultant neonatal nurse |
| Continued work with HR and finance to ensure pipeline position is accurate and externally funded posts are visible to explain ESR variation | Acute Matron |

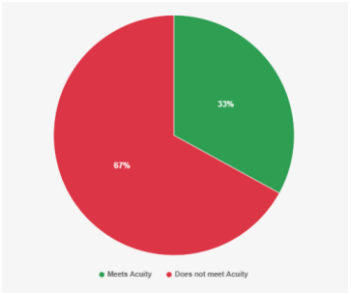
| Countermeasure /Action (planned this month) | Owner |
|---|---|
| Continuing work to establish workforce plan for acute/community sites, continuity of carer and strengthening out of hours model. | DOM |
| Fill rate % - inaccuracies due to significant number of unused tiles, working with health roster team, anticipated improvement in Oct/Nov rota | Acute Matron/Heath roster team |

**Average Shift Fill Rates**

| | | | Apr 24 | May 24 | Jun 24 |
|---|---|---|---|---|---|
| Maternity | Midwives | Day | 92% | 92% | 96% |
| | | Night | 97% | 93% | 92% |
| | MCA/MSWs | Day | 56% | 54% | 64% |
| | | Night | 47% | 45% | 54% |
| Neonates | Registered nurses | Day | 62% | 67% | 80% |
| | | Night | 91% | 82% | 94% |
| | Nursing support staffing | Day | 62% | 48% | 29% |
| | | Night | 53% | 81% | 63% |

# Safe – Maternity& Neonatal Acuity Jun 24

| | Target | Threshold G | Threshold A | Threshold R | Apr 24 | May 24 | Jun 24 | SPC | Comment |
|---|---|---|---|---|---|---|---|---|---|
| Percentage of 'staff meets Acuity' BBC ( intrapartum care) | 100% | >90% | | <70% | 79% | 74% | 70% | | Please see countermeasures |
| Percentage of 'staff meets Acuity' Mary Ward ( inpatient care) | 100% | >90% | | <70% | 37% | 41% | 33% | | New tool format, further training and validation needed to ensure effective acuity scoring in place, % does not feel reflective of acuity/staffing within the clinical area |
| Confidence factor in BirthRate+ recording BBC | 60% | >60% | | <50% | 87.22 | 87.63 | 89.44 | | Percentage of possible episodes for which data recorded. |
| Confidence factor in BirthRate+ recording Mary Ward | 60% | >60% | | <50% | 81.67 | 88.71 | 80.8 | | Percentage of possible episodes for which data recorded. |
| Maternity Absence rate | 4.5% | <4% | | >5% | 5.7% | 5.16% | lag | | |
| Neonatal Unit Absence rate | 4.5% | <4 % | | >5% | 4.54% | 4.59% | lag | | |
| 1:1 care not provided in labour | 0 | 0 | | >1 | 0 | 0 | 0 | | |
| Labour ward coordinator not supernumerary episodes | 0 | 0 | | >1 | 0 | 0 | 0 | | |
| Number of red flags on Birth Rate + (NICE 2015 and RUH specific) | No target | | | | 38 | 65 | 136 | | A midwifery 'red flag' event is a warning indicator that something may be wrong with midwifery staffing , 12 NICE Red flags all other red flags were RUH locally set red flags |
| Birth outside of BAPM L2 place of birth standards | 0 | 0 | | 1 | 0 | 0 | 0 | | |
| Number of days in LNU outside of BAPM guidance | 0 | 0 | | >2 | 0 | 0 | | | |




ble 2 Acuity vs staffing Mary Ward June 2024

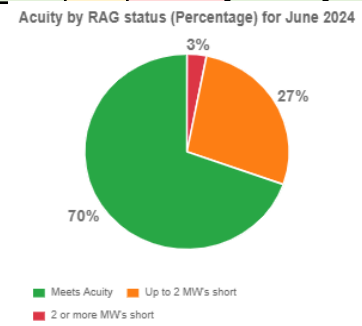



Table 3. Acuity by RAG for BBC June 2024

**Is the standard of care being delivered?**

- No episodes of supernumerary Labour Ward coordinator status not maintained
- No episodes where 1-1 care in labour not provided.
- RUH Red flags triggered pertained to delays to IOL
- Mary ward

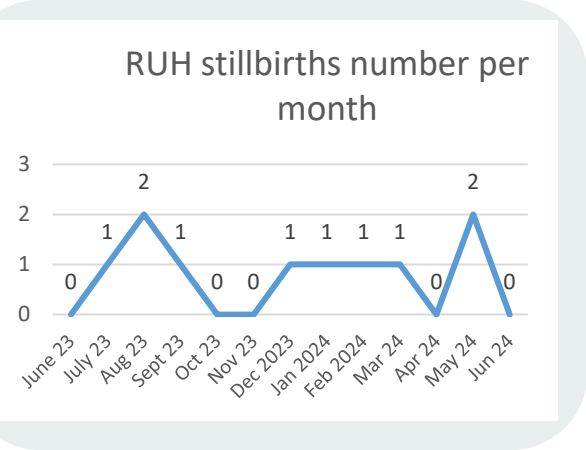
**What are the top contributors for under/over-achievement?**

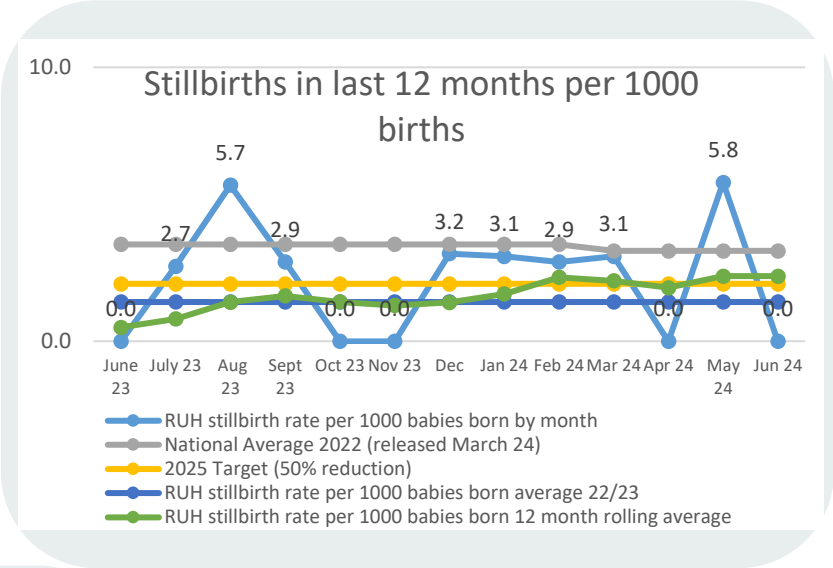
- Recruitment continues in response to BRA+ report recommendations
- Identification of disparity of red flag data

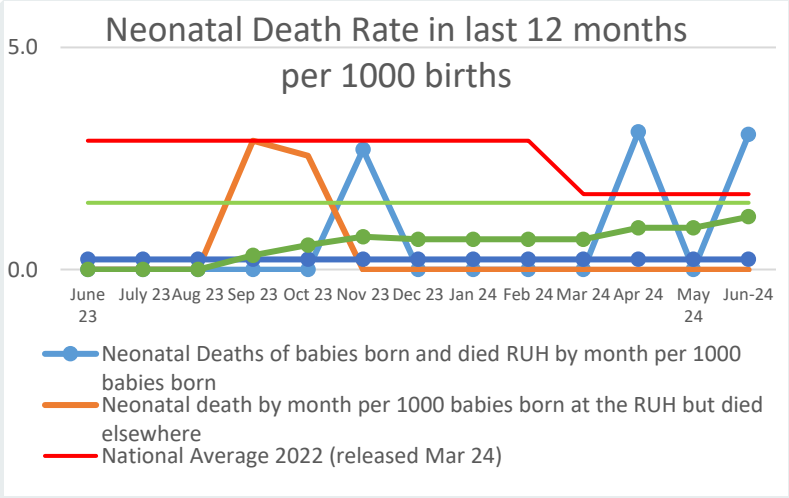
| Countermeasure /Action (completed last month) | Owner |
|---|---|
| Commencement of recruitment into increased midwifery establishment as outlined within the Maternity Business case aligned to the Birth Rate + report of 2023 | DOM |
| Review of current 'Red Flag' Birth Rate + Acuity triggers to ensure system wide, regional and national alignment. Meeting took place on the 17th of May with Birth Rate + team to align the RUH BirthRate+ portal | Quality and Patient Safety Lead / Acute Services Matron |
| Return of Summaries function for inpatient area 'Mary Ward' providing antenatal and postnatal care. | |

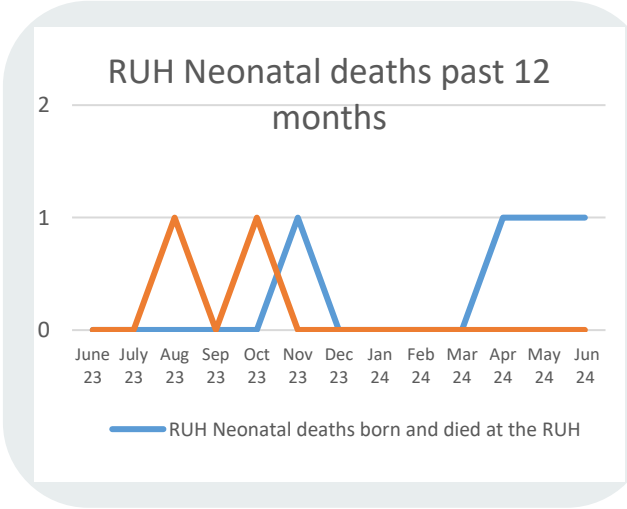
| Countermeasure /Action (planned this month) | Owner |
|---|---|
| Recruitment to current vacancies in LNU | Lead Senior Sister |
| To complete the BirthRate+ guidance tool to ensure ability for national benchmarking (NICE 2015 'safe staffing red flags') and local proactive KPI measures . LMNS to review and agree red flag presentation of data | Quality and Patient Safety Lead / Acute Services |
| To review red flag data capture for the new Maternity Triage service aligned to NICE 2015 | |
| Validate summaries compliance for Mary ward, identified new toll format required further training to ensure accuracy | Matron Acute Services Matron |

# Safe- Perinatal Mortality Review Tool (PMRT)




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.

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

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

From January of 2023 the internally reported neonatal death rate is representative of babies born at the RUH but died elsewhere, this is to accurately reflect MBRRACE perinatal mortality rates representative of the crude MBRRACE stats. Therefore the overall neonatal death rate for the RUH appears greater than previously reported rates , this is an anticipated position due to a change in internal reporting criteria as above.

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

During June of 2024 there was 1 Neonatal death of a 22 week infant following maternal  presentation with a placental abruption, the family were counselled regarding resuscitation at 22 weeks gestation prior to birth and chose not to resuscitate. The death has been reported to MBRRACE and will receive a full PMRT review.

There were 0 stillbirths during the month of June

Data collection has begun for the case cohort review of stillbirths in 2024 to ensure no additional commonalities, learning or causation can be found.

# Incidents

## New Cases for Jun 24

| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions | MNSI Reference | SI? Reference |
|---|---|---|---|---|---|---|
| 130582 | 01/07/2024 | Unexpected death | Placental abruption at 22 weeks of pregnancy and neonatal death | Will receive a full PMRT review | | |
| 129960 | 10/06/2024 | Moderate harm | Transfer of neonate to tertiary level NICU for active therapeutic cooling- normal MRI post cooling | Referral to MNSI, DOC commenced<br>Rapid Review undertaken | MI-037554 | |
| 130511 | 29/6/2024 | Moderate harm | Transfer of neonate to tertiary level NICU for active therapeutic cooling | Referral to MNSI, DOC commenced<br>Rapid review undertaken | MI-037619 | |
| 130232 | 18/06/2024 | Moderate harm | Term baby born with undiagnosed brain tumour | DOC commenced<br>Awaiting return of AN/PN notes for rapid review<br>Sought external FMU consultant opinion. | | |

## Ongoing Maternity and Neonatal Reviews

| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions | MNSI Reference | SI? Reference |
|---|---|---|---|---|---|---|
| 125436 | 25/1/2024 | Unexpected death | Term Intrapartum stillbirth - Birth Before Arrival | MDT review – no immediate concerns identified<br>For full PMRT review, Case referred to MNSI, DOC commenced | **MI-036771** | |
| 125988 | 09/02/2024 | Unexpected death | Term stillbirth | DOC commenced PMRT review | | |
| 126853 | 4/03/2024 | Unexpected death/ Moderate Harm | Placental abruption - Intra-uterine death | DOC commenced by on call obstetric consultant<br>MDT review commenced – decision for local Patient Safety Incident Investigation (PSII) with terms of reference regarding review of holistic assessment of mother and baby with the use of computerised CTG monitoring | | |
| 127900 | 04/04/2024 | Unexpected Death | Neonatal death following elective caesarean birth | DOC commenced by on call consultant<br>Referred to Maternity Independent Advocacy service<br>Will receive full PMRT | Discussed- did not meet criteria | |
| 129283 | 17/05/2024 | Unexpected death | 32+4 stillbirth | DOC commenced PMRT review | | |
| 128985 | 09/05/2024 | Unexpected death | 36 stillbirth | DOC commenced PMRT review | | |

## Closed Cases Jun 24

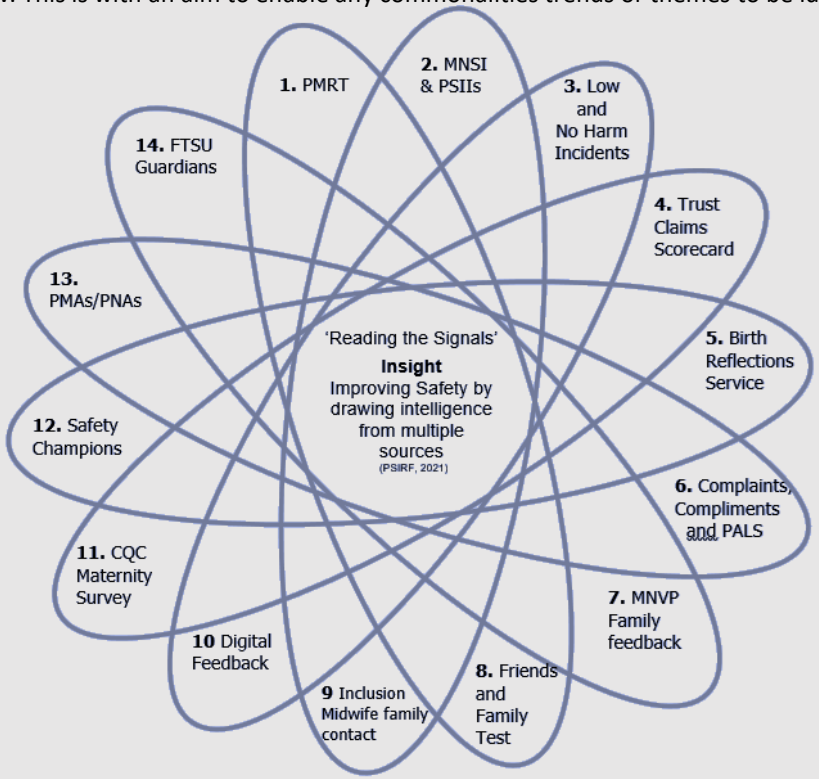
| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions | HSIB Reference | SI? Reference |
|---|---|---|---|---|---|---|
| 124381 | 26/12/23 | Unexpected death | Term stillbirth | DOC commenced PMRT review | | |

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

# Responsive

## Family Feedback 'Insights' Triangulation Group 24

The Maternity and Neonatal 'Insights' Family Feedback triangulation group meet every month to discuss the 'in month' feedback which has been received across the service via the various sources listed below. This is with an aim to enable any commonalities trends or themes to be identified.




## Safety Champions Staff Feedback

**Key points raised**

- Decision to remove paid breaks – staff disgruntled and considering hours reductions, timing of announcement and consultation left mixed emotions after positive staff survey and CQC inspection results.
- Issues raised with bank pay
- Concerns raised regarding Maternity Support Worker (MSW) establishment gaps due to turn over and job satisfaction
- Recent period of high acuity in June- great teamwork, matrons provided email of praise a token of thanks to staff which was greatly appreciated
- Birth options clinic discussed and the benefits this is bringing. Staff spoke highly of the consultant running this service.

**Next steps**

- Deputy Chief nurse to explore some of the concerns raised regarding bank work payments
- Education Lead midwife working with Wiltshire college and Lead Maternity Support worker to develop 'T levels' and access routes into midwifery to improve progression opportunities for MSWs

## Maternity and Neonatal Voices Partnership (MNVP)

pieces of service feedback received across various sources including in person conversations, birth workers, and in June 24 attendance at local twins and multiples group.

- **Key points raised**
- rapid progress in labour felt not listened to –birth in 2023
- Did not receive orientation to Mary Ward – birth march 2023
- Automatic MASH referrals generated in response to previous CSC involvement no current involvement
- Single parents by choice did not feel supported to attend classes alone or with birth partner as website information felt very heavily partnership focused.

## Compliments & Complaints

| | | | |
|---|---|---|---|
| **Formal Compliments** | **3** | **PALS Contacts** | **5** |
| **Online Compliments** | **--** | **Formal Complaints** | **0** |

- 1 commonality identified within PALS contacts regarding communication – 1 pertaining to perineal injuries and wound care, 1 pertaining to the booking of a caesarean birth and 1 pertaining to difficulty in obtaining ward visiting information ahead of birth.

## Jun 24 Themes

1 theme was identified in the month of June within MNVP feedback and PALS contact regarding the website information accessibility and content- 1 pertaining to ward visiting and information and 1 regarding antenatal education class advertisement

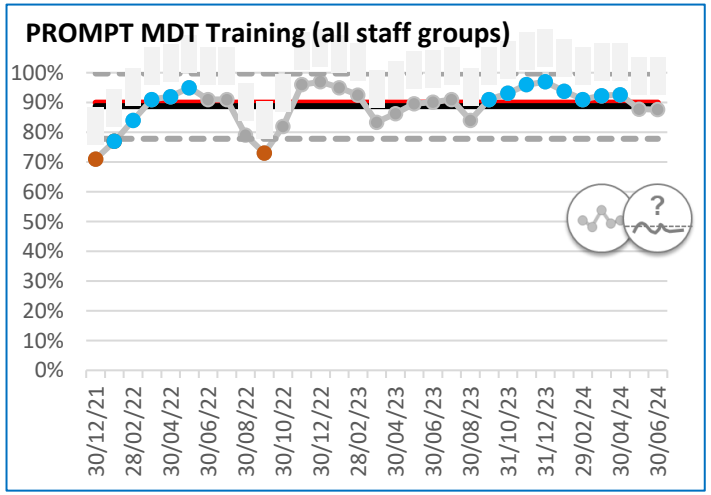
**Next steps:**

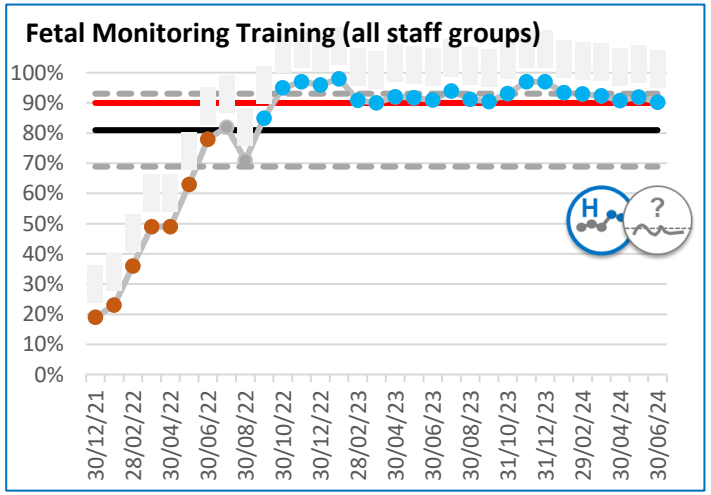
## Friends & Family Survey

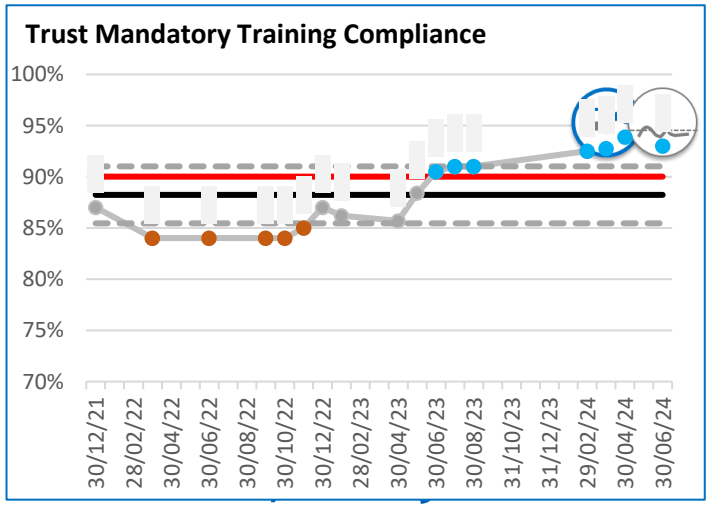
**Key Achievements:**

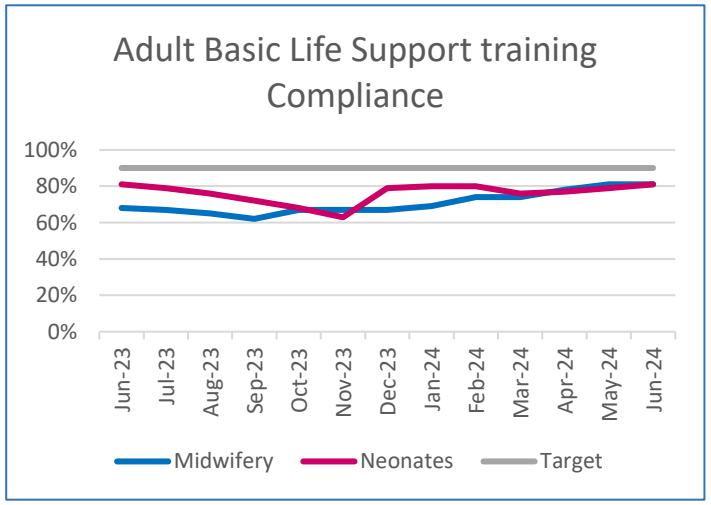
**Identified Areas of Improvements: - AWIAING data-**

# Well-led – Training




**Training**

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

**Countermeasures/action:**

- Bespoke refresher skills sessions available for community staff : Skills drills and newborn life support with dates booked for the next year. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs).
- Additional skills sessions available to newly qualified staff and senior students facilitated by the Retention and Education team.
- Risk assessment for the risk register completed for mandatory training room bookings.
- PROMPT Faculty proposal completed decision to utilise CSF to reduce using establishment hours
- Agreement for ABLS to become managed in specialty moving forwards as part of the PROMPT programme.

**Risks:**

- The use of our own compliance tracker as opposed to using ESR data – ESR still reflects theatre teams which impacts on our compliance. Linking in with ESR and Theatres to find a resolution to this for transparency and information sharing.
- Booking of training rooms availability – currently provided with rooms however 11/15 on a Friday presenting a risk to flexible availability to staff. **Risk 2681 (9)**
- ABLS compliance Risk Assessment completed for risk register
- Drop in compliance in June for PROMPT to 88% (less than target of 90%)
- Summer annual leave impact on training facilitation and availability
- New MIS Y6 standard for all anaesthetists who contribute to the on-call rota to be accounted for in PROMPT compliance, increased as on previous years however currently in progress no concerns foreseen at current.

# Compliance to National Guidance

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

**Ockenden 2022**

| IEA | Blue | Green | Amber | Red | Total Actions | % of Compliance |
|---|---|---|---|---|---|---|
| 1- Workforce Planning and sustainability | 12 | 0 | 5 | 0 | 17 | 70.6 |
| 2- Safe Staffing | 8 | 1 | 1 | 0 | 12 | 66.7 |
| 3- Escalation and Accountability | 5 | 1 | 1 | 0 | 7 | 71.4 |
| 4- Clinical Governance Leadership | 14 | 1 | 1 | 0 | 16 | 87.5 |
| 5- Incident investigation and complaints | 7 | 2 | 0 | 0 | 9 | 77.8 |
| 6- Learning from maternal deaths | 4 | 0 | 0 | 0 | 4 | 100.0 |
| 7- Multidisciplinary Training | 11 | 5 | 1 | 0 | 17 | 64.7 |
| 8- Complex Antenatal Care | 5 | 0 | 0 | 0 | 6 | 83.3 |
| 9- Pre-term Birth | 3 | 2 | 0 | 0 | 5 | 60.0 |
| 10- Labour and Birth | 7 | 1 | 1 | 0 | 11 | 63.6 |
| 11- Obstetric Anaesthesia | 4 | 2 | 0 | 0 | 6 | 66.7 |
| 12- Postnatal Care | 1 | 1 | 2 | 0 | 4 | 25.0 |
| 13- Bereavement Care | 8 | 1 | 0 | 0 | 9 | 88.9 |
| 14- Neonatal Care | 7 | 3 | 0 | 0 | 9 | 77.8 |
| 15- Supporting Families | 3 | 1 | 0 | 0 | 4 | 75.0 |
| **Total** | **99** | **21** | **12** | **0** | **130** | 76.2 |

**Maternity Incentive Scheme (CNST) Year 6**

- **Key Achievements:**
- Continued 100% compliance with PMRT- 1 administration error on PMRT during Feb 24 discussed with MIS – evidence in place to demonstrate 100% compliance
- DOC/MNSI/ENS referrals remain 100%
- Increase in Consultant workforce in place from July 2024
- Continued non requirement for use of Locum obstetricians
- Planning and agreements in place with LMNS to progress/demonstrate compliance with SA6.
- Q1 SBLv3 evidence submission completed

**Next Steps for Progressions:**

- Bi monthly Quad leadership meets at safety champions
- Bi-monthly culture slide to continue in safety champions PQST
- MSDS submission data for July 24
- Finalisation of LMNS MNVP work plan
- Training compliance across all staff groups fluctuates per month however overall compliance remains strong- continued work towards improving medical compliance – small numbers resulting in large impact on overall compliance.

**Ockenden and RUH NHSE Action plans of 2022**

Percentage of compliance only attributed to those actions within the action plan which have been completed and evidence for assurance can be obtained if required (Blue)
Green - work on target for completion, developing assurance processes
Amber- work in progress however continued work required no assurance of compliance at present
Red – current non compliance no work in progress currently

**Next Steps for Progressions:**

RUH Maternity Improvement plan collating Local and National improvement drivers for cohesive presentation of Quality Improvement progress within Maternity and Neonates. This encompasses Ockenden 2022 and the 3 year delivery plan.

- Succession planning strategy
- Mentorship for band 7s and 8s
- Specialist workforce gap Analysis
- Manual Audit of maternal readmissions to assess timeliness of consultant review ( target <14 hours)

## Trust Integrated Balanced Scorecard - July 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

| Strategic Goal | | Goal Description | Performance Indicator | Measure description | Target | | Baseline | 2023/2024 | | | 2024/2025 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Performing | Under Performing | | Jan | Feb | Mar | Apr | May | Jun | Jul |
| People Group Goals (5yr ambition, annual measure) | People we care for | Together we will support you, as when you need us most | To achieve 'much better than expected' score and best in class for our region | Annual CQC IP survey | 8.5 | 7.8 | 8.2 | - | - | - | - | - | - | - |
| | People we work with | Together we will create the conditions to perform at our best | % Recommend RUH as a place to work | | >=70% | <62% | 62% | - | 59.0% | - | - | 53.0% | - | 50.1% |
| | People in our community | Together we will create one of the healthiest places to live | RUH Social Impact Score? | | | | | - | - | - | - | - | - | - |
| Trust Goals (monthly or quarterly measure) | People we care for | Connecting with you - helping you feel safe, understood and always welcome | Reported Patient Safety incidents resulting in significant harm (moderate to catastrophic), excl. rejected | | | | | 23 | 18 | 16 | 17 | 20 | 8 | - |
| | | Consistently delivering the highest quality healthcare and outcomes | Number of patients over 65 weeks | Ensure no patient waits over 65 weeks for treatment by December 2023 | Target is 0 by March - trajectory being agreed during business planning | | | 256 | 193 | 39 | 33 | 41 | 56 | 36 |
| | | Communicating well, listening and active on what matters to you | % of positive responses to friends and family test | | | | | 93.9% | 94.0% | 93.6% | 93.9% | 93.7% | 93.2% | 94.7% |
| | People we work with | Demonstrating our shared values with kindness, civility and respect | % Recommend RUH as a place to work | | >=70% | <62% | 62% | - | 59.0% | - | - | 53.0% | - | 50.1% |
| | | Taking care of and investing in teams, training and facilities | % staff say the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age | | | | | - | 57.1% | - | - | 57.0% | - | 50.1% |
| | People in our community | Working with partners to make the most of our shared resources and plan wisely for future needs | Delivery of Breakeven Position | Variance from Plan YTD (£'000) | >=0 | <0 | | -5545 | -6130 | 1665 | 527 | 192 | -1086 | -817 |
| | | Taking positive action to reduce health inequalities | Equity of access to the RUH for all | | | | | - | - | - | - | - | - | - |
| | | Creating a community that promotes the wellbeing of our people and enviornment | Carbon emission reduction | Monthly proxy measure - % carbon footprint reduction of electricity & gas, against 20/21 carbon footprint | <=0% | >0% | | - | - | - | - | - | - | - |
| Breakthrough Goals | People we work with | | % staff reporting they have personally experienced discrimination at work from manager, team leader or other colleagues | | | | | - | 13.7% | - | - | 14.0% | - | 16.7% |
| | | | We improve together | % of teams that are regularly holding Improvement Huddles (out of 122 frontline teams) | >90% | <90% | 39% | 69.0% | - | - | 57.0% | - | - | 72.0% |
| | People we care for | | Why not home, why not today | | | | | - | - | - | - | - | - | - |
| | People in our community | | Delivery of financial plan' | Delivery of Group financial plan | Variance from year to date plan | <=0 | >0 | (£5.03m) | (£6.70m) | £0.01m | £0m | (£0.08m) | (£1.50m) | (£0.61m) |

## Key Standards

| Strategic Goal | | | Description | Performance Indicator | | Target | | Baseline | 2023/2024 | | | 2024/2025 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Performing | Under Performing | | Jan | Feb | Mar | Apr | May | Jun | Jul |
| Key Standards | People in our community | | | Deliver 109% of 19/20 Elective Activity | | >=109% | <109% | | 112.0% | 114.0% | 115.0% | 130.0% | 125.0% | 122.0% | 122.0% |
| | People we care for | | Improve safety of patients needing unplanned care across the RUH from arrival at ED to discharge | % treated and admitted or discharged within four hours | To ensure 76% of patients can be treated within 4 hours of arrival at ED | >=76% | <76% | | 66.4% | 68.7% | 69.8% | 68.6% | 68.6% | 71.6% | 71.5% |
| | | L | C Diff Total Healthcare Associated (Hospital & Community) tolerance = 59 | Clostridium Difficile Hospital Onset, Healthcare Associated | | | | - | 6 | 9 | 6 | 2 | 8 | 3 | 7 |
| | | SOF | RTT - Incomplete Pathways in 18 weeks | RTT - Incomplete Pathways in 18 weeks | | >=92% | <92% | 87.1% | 60.4% | 62.3% | 63.6% | 65.4% | 66.4% | 66.2% | 65.5% |
| | | NT | 31 day diagnosis to first treatment for all cancers | 31 day diagnosis to first treatment for all cancers | | >=96% | <96% | - | - | - | - | - | - | - | - |
| | | NT | 31 day second or subsequent treatment - drug treatments | 31 day second or subsequent treatment - drug treatments | | >=98% | <98% | - | - | - | - | - | - | - | - |
| | | NT | 31 day second or subsequent cancer treatment - radiotherapy treatments | 31 day second or subsequent cancer treatment - radiotherapy treatments | | >=94% | <94% | - | - | - | - | - | - | - | - |
| | | NT | 2 week GP referral to 1st outpatient | 2 week GP referral to 1st outpatient | | >=93% | <93% | - | - | - | - | - | - | - | - |
| | | NT | 2 week GP referral to 1st outpatient breast symptoms | 2 week GP referral to 1st outpatient - breast symptoms | | >=93% | <93% | - | - | - | - | - | - | - | - |
| | | NT | 28 day referral to informed of diagnosis of all cancers | 28 day referral to informed of diagnosis of all cancers | | >=70% | <70% | - | 59.7% | 64.6% | 66.7% | 69.0% | 69.4% | 64.0% | (LAG 1) |
| | | NT | Combined 31 Day Cancer Targets | Combined 31 day cancer targets for first treatment, subsequent surgery, subsequent drug, subsequent radiotherapy and subsequent other treatments; excludes subsequent active monitoring and subsequent palliative care) | | >=96% | <96% | | 90.8% | 94.4% | 95.8% | 91.6% | 95.0% | 90.6% | (LAG 1) |
| | | SOF | Combined 62 Day Cancer Targets | Combined 62 day cancer targets for GP referral, screening and consultant upgrade | | >=75% | <75% | | 66.5% | 67.3% | 71.5% | 72.2% | 70.1% | 71.2% | (LAG 1) |
| | | SOF | 62 day referral to treatment from screening | 62 day referral to treatment from screening | | >=90% | <90% | | - | - | - | - | - | - | - |
| | | SOF | 62 day urgent referral to treatment of all cancers | 62 day urgent referral to treatment of all cancers | | >=85% | <85% | | - | - | - | - | - | - | - |
| | | SOF | Diagnostic tests maximum wait of 6 weeks | Diagnostic tests maximum wait of 6 weeks | | <=1% | >1% | | 26.8% | 19.6% | 18.5% | 23.4% | 28.2% | 35.5% | 35.6% |

# Trust Integrated Balanced Scorecard - July 2024

Royal United Hospitals Bath NHS
NHS Foundation Trust

| Strategic Goal | | | Performance Indicator | Description | Target | | 2023/2024 | | | | 2024/2025 | | | | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Performing | Under Performing | Baseline | Jan | Feb | Mar | Apr | May | Jun | Jul | |
| Tracker Measures | People we care for | IT | % of complaints responded to within agreed timescales with complainant | | >=90% | <90% | - | 82.6% | 90.9% | 92.3% | 86.7% | 64.5% | 73.1% | 73.1% | |
| | | | Number of complaints received | | <30 | >=30 | | 21 | 39 | 34 | 25 | 25 | 24 | 38 | |
| | | IT | Number of reopened complaints each month | | <=3 | >3 | - | 3 | 5 | 2 | 1 | 3 | 2 | 8 | |
| | | | Total PSCT cases acknowledged within 2 working days | | >90% | <90% | - | - | - | - | 100.0% | 98.0% | 99.0% | 100.0% | |
| | | | Complaints acknowledged within 2 working days (target 90%) | | | | | | | | | | | | |
| | | | Number of cases referred to the PHSO | | | | | | | | | | | | |
| | | | % of concerns resolved by early resolution (target 75%) | | | | | | | | | | | | |
| | | IT | 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 | - | 52 | 50 | 45 | 45 | 43 | 23 | - | |
| | | IT | Serious Incidents with Overdue Actions | All non-rejected serious incidents reported on Datix with incomplete actions at month end. | <5 | >=5 | - | 2 | 3 | 3 | 1 | 0 | 0 | 4 | |
| | | IT | Number of falls resulting in significant harm (Moderate to Catastrophic) | | <=1 | >=3 | - | 5 | 0 | 1 | 2 | 3 | 2 | 4 | |
| | | IT | ED time to triage | Percentage of ED attendances triaged within 15 minutes | | | - | 53.1% | 48.8% | 49.2% | 47.1% | 44.7% | 55.0% | 56.3% | |
| | | IT | Falls per 1000 bed days | Includes all falls | | | - | 7.1 | 7.0 | 6.8 | 5.1 | 6.4 | 7.2 | 6.4 | |
| | | IT | Medication Incidents per 1000 bed days | All Incidents | | | - | 7.4 | 7.3 | 7.2 | 8.5 | 6.0 | 6.7 | 6.8 | |
| | | IT | Number of Patients given medication by scanning device | | | | | 39.5% | 40.6% | 41.2% | 42.1% | 46.3% | 46.6% | 45.9% | |
| | | | Early Identification of Deteriorating Patient | | | | | 25.3% | 26.0% | 23.2% | 23.1% | 27.6% | 25.6% | 25.9% | |
| | | | COVID 8+ Days | | | | | 45 | 21 | 12 | 37 | 9 | 13 | 34 | |
| | | IT | Same Day Emergency Care (SDEC) | Non-elective adult admissions with 0 day LOS, Medicine only. | >=30% | <30% | - | 32.5% | 32.7% | 33.0% | 35.4% | 34.0% | 33.2% | 34.5% | |
| | | | Ambulance Handover Delays | minutes (below 39 is upper quartile) | | | | 810 | 887 | 995 | 1194 | 938 | 860 | 679 | |
| | | IT | Time from arrival in ED to decision to admit | Percentage of majors attendances with DTA within 3 hours of arrival. Excludes non-admitted patients with DTA. | >=80% | <80% | - | 52.7% | 52.8% | 48.0% | 51.7% | 49.9% | 53.4% | 52.1% | |
| | | IT | Time from decision to admit in ED to admission | Percentage of majors patients admitted via ED that are admitted within 1 hour of DTA. Excludes non-admitted patients with DTA. | >=50% | <50% | - | 24.8% | 26.0% | 25.8% | 22.7% | 24.5% | 23.7% | 29.2% | |
| | | | % with Discharge Summaries Completed within 24 Hours | | | | | 84.2% | 84.2% | 84.7% | 84.3% | 83.9% | 83.7% | 83.7% | |
| | | | Non Criteria to Reside (Average per day) | | | | | 81.9 | 80.7 | 86.2 | 88.0 | 92.8 | 93.3 | 86.9 | |
| | | | HSMR - Total | | | | | 99.8 | 100.4 | 99.5 | 97.6 | 99.0 | (LAG 2) | (LAG 2) | |
| | | | HSMR -Weekday | | | | | 100.4 | 101.5 | 99.7 | 97.4 | 98.5 | (LAG 2) | (LAG 2) | |
| | | | HSMR -Weekend | | | | | 97.7 | 96.9 | 99.0 | 98.4 | 100.7 | (LAG 2) | (LAG 2) | |
| | People we work with | IT | Turnover - Rolling 12 months | Voluntary turnover only | <=11% | >12% | | 8.8% | 8.6% | 8.4% | 8.1% | 8.5% | 8.4% | 8.5% | |
| | | IT | Vacancy Rate | | <=4% | >5% | | 1.6% | 1.0% | 1.4% | 5.6% | 5.2% | 4.8% | 6.1% | |
| | | IT | Sickness Rate | Rolling 12 months | <=3.5% | >4.5% | | 4.9% | 4.8% | 4.6% | 4.4% | 4.4% | 4.8% | (LAG 1) | |
| | | IT | Mandatory Training Compliance | | >=90% | <80% | | 90.3% | 90.8% | 90.4% | 90.3% | 90.0% | 90.0% | 88.8% | |
| | | | % Staff with annual appraisal | | >=80% | <80% | | 75.8 | 77.0 | 77.1 | 77.7 | 77.7 | 78.9 | 78.5 | |
| | People in our community | | Health Inequalities 1 | % Difference in DNA rates between IMD1-2 and IMD 9-10 | | | | 4.0% | 5.4% | 4.2% | 4.1% | 3.6% | 3.1% | 3.5% | |
| | | | Health Inequalities 2 | % Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD9-10 | | | | 7.9% | 0.7% | 13.5% | 5.1% | 4.8% | 12.4% | 3.1% | |
| | | IT | Sustainable Development Assessment Tool (SDAT) Score | Overarching measurement across all sustainability areas | >=44% | <44% | - | - | - | - | - | - | - | - | |
| | | IT | Delivery of Financial Control Total - Variance from Revised Plan (£'000) | Under/Overspent, YTD | <=0 | >0 | - | -6438 | -6807 | 3986 | 308 | 526 | -537 | -185 | |
| | | IT | Forecast Delivery of Financial Control Total at end of financial year | | <=0 | >0 | - | - | - | - | - | - | - | - | |
| | | IT | Delivery of Recurrent Finance Improvement Programme (£'000) | Variance from year to date planned recurrent QIPP | >=0 | <0 | - | - | - | - | - | - | - | - | |
| | | IT | Forecast Delivery of Recurrent Finance Improvement Programme at end of financial year | Forecast variance from annual planned recurrent QIPP | | | - | - | - | - | - | - | - | - | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | IT | Reduction in Agency Expenditure | Agency costs as a % of total pay costs | < 19/20 % | > 19/20 % | - | 2.7% | 2.7% | 2.5% | 1.2% | 1.2% | 0.9% | 0.9% |  |
| | | | % activity delivered off site (virtual and community) | | | | | 22.7% | 21.8% | 22.1% | 22.1% | 22.3% | 21.8% | 21.3% |  |

| Strategic Goal | | | Performance Indicator | Description | Target: Performing | Target: Under Performing | Baseline | 2023/2024: Jan | 2023/2024: Feb | 2023/2024: Mar | 2024/2025: Apr | 2024/2025: May | 2024/2025: Jun | 2024/2025: Jul | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Other Measures | People We Work With | | Total monthly fill rate, day hours, RN | Average per ward | >=90% | <90% | | 79.9% | 75.0% | 82.3% | 84.4% | 86.3% | 85.9% | 87.7% | |
| | | | Total monthly fill rate, day hours, HCA | Average per ward | >=90% | <90% | | 75.1% | 78.4% | 77.3% | 77.3% | 84.2% | 84.7% | 84.1% | |
| | | | Total monthly fill rate, night hours, RN | Average per ward | >=90% | <90% | | 92.7% | 92.0% | 93.5% | 93.4% | 93.1% | 94.7% | 95.9% | |
| | | | Total monthly fill rate, night hours, HCA | Average per ward | >=90% | <90% | | 83.8% | 85.6% | 85.4% | 87.9% | 88.8% | 92.5% | 92.5% | |
| | | | Information Governance Training Compliance | | >=80% | <80% | | 87.6% | 88.4% | 87.7% | 88.5% | 86.8% | 85.9% | 85.3% | |
| | People we care for | NR | Serious Incidents (NRLS) reporting (TBC) | | | | | 3 | 1 | 1 | - | - | - | - | |
| | | NR | Hip fractures operated on within 36 hours | | >=80% | <=70% | | 66.7% | 53.2% | 46.9% | 66.0% | 39.6% | 69.2% | 51.4% | |
| | | NR | Time to Initial Assessment - 95th Percentile | | | | | 104 | 102 | 106 | 154 | 120 | 79 | 42 | |
| | | NR | % of mothers booked within 12 completed weeks | | >=90% | <=85% | | 84.7% | 88.6% | 87.6% | 86.3% | 86.3% | 84.7% | 82.1% | |
| | | NR | % Women identified as smokers referred to specialist stop smoking service | | >=90% | <=80% | | 100.0% | 96.6% | 93.1% | 89.3% | 94.7% | 100.0% | 96.0% | |
| | | NR | Midwife to Birth Ratio | | <=1:27 | >1:32 | | 1:27 | 1:29 | 1:27 | 1:27 | 1:29 | 1:28 | 1:28 | |
| | | NT | TIA Treated within 24 hours | | >=60% | <=55% | | 44.2% | 41.7% | 21.2% | 19.0% | 20.8% | 49.0% | 28.3% | |
| | | NT | 12 Hour Breaches | | 0 | >0 | | 21 | 24 | 16 | 39 | 4 | 19 | 5 | |
| | | LC | Number of medical outliers - median | | <=25 | >=30 | | 9 | 16 | 11 | 10.5 | 6 | 3 | 4 | |
| | | L | Readmissions - Total | | <=10.5% | >12.5% | | 7.4% | 7.6% | 7.9% | 7.9% | 8.1% | 8.0% | 9.3% | |
| | | L | Discharges by Midday (excluding Maternity) | Includes transfers to the Discharge Hub | >=45% | <45% | | 22.6% | 21.9% | 22.6% | 23.3% | 22.5% | 22.5% | 23.7% | |
| | | NT | Number of 52 Week Waiters Incomplete Pathways | | | | | 1072 | 905 | 813 | 650 | 737 | 760 | 725 | |
| | | L | GP Direct Admits to SAU | | >=168 | <168 | | 237 | 243 | 249 | 218 | 259 | 212 | 259 | |
| | | L | GP Direct Admits to MAU (including DAA) | | >=84 | <84 | | 328 | 269 | 353 | 289 | 305 | 286 | 329 | |
| | | NR | Bed occupancy (Adult) | | <=93% | >97% | | 96.6% | 96.9% | 96.7% | 97.5% | 95.0% | 95.0% | 93.8% | |
| | | NR | % Cancelled Operations non-clinical (number of cancelled patients) Surgical | | <=1% | >1% | | 1.2% (43) | 1.3% (46) | 0.6% (24) | 0.9% (33) | 1.2% (44) | 1.1% (37) | 0.9% (33) | |
| | | NT | Urgent Operations cancelled for the second time | | 0 | >0 | | 0 | 1 | 2 | 0 | 0 | 0 | 0 | |
| | | NT | Cancelled operations not rebooked within 28 days - Surgical | | 0 | >0 | | 0 | 0 | 0 | 0 | 0 | 1 | 0 | |
| | | SOF | Clostridium Difficile Community Onset, Healthcare Associated | | | | | 2 | 2 | 3 | 5 | 1 | 1 | 4 | |
| | | SOF | E.coli bacteraemia cases Hospital Onset, Healthcare Associated | | <=6 | >6 | | 1 | 4 | 1 | 4 | 4 | 2 | 5 | |
| | | SOF | E.coli bacteraemia cases Community Onset, Healthcare Associated | | | | | 5 | 4 | 4 | 5 | 6 | 2 | 4 | |
| | | SOF | MRSA Bacteraemias >= 48 hours post admission | | 0 | >=1 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | L | Klebsiella spp Hospital Onset, Healthcare Associated | | <=2 | >2 | | 0 | 4 | 1 | 2 | 2 | 0 | 3 | |
| | | | Klebsiella Spp Community Onset Healthcare Associated | | | | | 1 | 0 | 2 | 2 | 2 | 1 | 1 | |
| | | L | Pseudomonas aeruginosa Hospital Onset, Healthcare Associated | | <=1 | >1 | | 4 | 0 | 0 | 1 | 0 | 2 | 0 | |
| | | | MSSA Post 48 Hours | | | | | 3 | 6 | 5 | 2 | 0 | 1 | | |
| | | | Flu - Healthcare Onset (+3 days) | | | | | | | | | | | 0 | |
| | | | Norovirus Outbreaks | | | | | 0 | 1 | 2 | 0 | 0 | 1 | 1 | |
| | | | Number of Hospital Acquired Pressure Ulcers Category 2 | Includes Medical Device Related | <=2 | >2 | | 3 | 4 | 1 | 1 | 1 | 3 | 2 | |
| | | | Hospital Acquired Category 3 Pressure Ulcer | Includes Medical Device Related | <=0 | >0 | | 0 | 2 | 0 | 1 | 1 | 1 | 0 | |
| | | | Hospital Acquired Category 4 Pressure Ulcer | | | | | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | | Hospital Acquired Category 2/3/4 pressure ulcer devise related (to be reported in one graph) | | | | | 2 | 0 | 0 | 0 | 0 | 1 | | |
| | | SOF | Never events | | 0 | >=1 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | | SOF | SHMI | | <=Expected | > Expected | | 0.95 | 0.94 | 0.93 | (LAG 4) | (LAG 4) | (LAG 4) | (LAG 4) | |
| | | | Mixed Sex Accomodation Breaches | | | | | 163 | 170 | 182 | 170 | 221 | 191 | 154 | |
| | People In Our Community | L | Delivery of Group financial plan | Variance from year to date plan | <=0 | >0 | | (£5.03m) | (£6.70m) | £0.01m | £0m | (£0.08m) | (£1.50m) | (£0.61m) | |
| | | L | Delivery of capital programme | Variance from year to date planned capital expenditure (Internally Funded Schemes) | -5% | <5% | | -57.9% | -33.1% | -0.5% | 67.3% | 51.9% | 69.7% | 65.7% | |
| | | L | Forecast delivery of capital programme | Forecast variance from annual planned capital expenditure | +/-5% | ><5% | | 0.0% | 0.0% | -0.5% | 0.0% | 0.0% | 0.0% | 0.0% | |
| | | L | Delivery of planned cash balance | Variance from year to date planned cash balance | +/-10% | ><10% | | -5.1% | -8.6% | -12.8% | 8.8% | 25.6% | 24.5% | 38.7% | |

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