University Hospitals Bristol
NHS Foundation Trust

# Quality and Performance Report

**June 2019**

## 1.1 OVERVIEW – Executive Summary

**Single Oversight Framework**

- The 62 Day Cancer standard for GP referrals achieved 86.8% for April which has achieved the national standard of 85%
- The measure for percentage of A&E patients seen in less than 4 hours was 78.0% for May. This did not achieve the 95% national standard or the improvement trajectory target of 90.5%.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 88.1% as at end of May. Although this did not achieve the national 92% standard, the improvement trajectory target of 87.9% was achieved.
- The percentage of Diagnostic patients waiting under 6 weeks at end of May was 93.4%, with 582 patients waiting 6+ weeks. This is lower than the national 99% standard. The maximum allowed breaches to achieve 99% was 88.

**Headline Indicators**

There were two Clostridium Difficile cases in May which keeps the Trust below the maximum allowed for the financial year of 57 cases. In addition, there were no MRSA cases in May. Pressure Ulcer incidence remained below target in May although Falls was slightly above, with a rate of 4.98 falls per 1000 beddays (133 falls). However no falls resulted in patient harm.

The headline measures from the monthly patient surveys and the Friends and Family Test remain above their minimum target levels in May 2019. In Complaints, 97% of formal complaints were responded to within deadline which achieved the 95% standard. 15% of March's complaint responses were re-opened due to complainant being dissatisfied with the original response.

Last Minute Cancelled Operations (LMCs) were at 1.5% of elective activity and equated to 100 cases.

**Workforce**

May 2019 compliance for Core Skills (mandatory/statutory) maintained static at 90% overall across the eleven core skills programmes and so achieved the standard. There was one reduction, of 1%, for Information Governance, which carries an 'all staff' annual update requirement, but 5 other core skills programmes improved.

In May 2019, total staffing was at 8864 full time equivalents (FTEs). Of this, 4.8% was Bank (429 FTE) and 1.3% was Agency (116 FTE). In addition, there had been 936 leavers over the previous 12 months giving a Turnover of 13.2%. Overall vacancy rate rose to 5.2% which is above the target of 5.0%

In May, total available FTE days were 261,189 of which 9,689 (3.7%) were lost to staff sickness The Employee Services team continue to support high volumes of Supporting Attendance cases with 324 open cases currently logged. The highest reasons for absence was reported as anxiety, stress and depression, gastrointestinal and musculoskeletal.

Appraisal compliance reduced to 73.9% from 75.3%, with no increases within all seven divisions. The corporate appraisal recovery plan remains in place with specific focus on: regular communications to all managers with a targeted message, an additional appraisal training session being delivered each month and a review of intranet tools and supporting Appraisal documentation.

## 1.2 OVERVIEW – Single Oversight Framework

**Financial Year 2018/19**

| Access Key Performance Indicator | | Quarter 1 2018/19 | | | Quarter 2 2018/19 | | | Quarter 3 2018/19 | | | Quarter 4 2018/19 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
| **A&E 4-hours Standard: 95%** | Actual | 83.96% | 91.14% | 92.84% | 90.26% | 90.07% | 85.00% | 89.16% | 84.24% | 83.05% | 84.50% | 81.05% | 81.23% |
| | "Trust Footprint" (Year To Date) | 92.05% | | | 91.77% | | | 90.84% | | | 89.84% | | |
| | Trajectory | 90% | 90% | 90% | 90.53% | 91.26% | 90.84% | 90.06% | 90.33% | 87% | 84% | 87% | 90% |
| | "Trust Footprint" Trajectory | 90.0% | | | 90.0% | | | 90.0% | | | 95.0% | | |
| **Cancer 62-day GP Standard: 85%** | Actual (Monthly) | 84.1% | 82.4% | 86.0% | 85.7% | 88.9% | 87.4% | 85.5% | 87.9% | 86.5% | 85.1% | 83.5% | 82.9% |
| | Actual (Quarterly) | 84.2% | | | 87.3% | | | 86.6% | | | 83.8% | | |
| | Trajectory (Monthly) | 81% | 83% | 79% | 83% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| | Trajectory(Quarterly) | 82.5% | | | 85% | | | 85% | | | 85% | | |
| **Referral to Treatment Standard: 92%** | Actual | 88.2% | 89.1% | 88.6% | 88.9% | 88.7% | 88.5% | 89.6% | 90.1% | 89.3% | 89.4% | 89.1% | 89.2% |
| | Trajectory | 88% | 88% | 88.5% | 88.5% | 88.7% | 88.5% | 88.5% | 88.0% | 87.0% | 86.0% | 87.0% | 87.0% |
| **6-week wait diagnostic Standard: 99%** | Actual | 96.8% | 97.6% | 97.8% | 97.9% | 97.1% | 98.1% | 98.4% | 96.9% | 93.8% | 93.3% | 96.9% | 95.5% |
| | Trajectory | 97.9% | 97.9% | 97.9% | 98.4% | 99.0% | 98.0% | 98.0% | 98.0% | 98.0% | 98.0% | 99.0% | 99.0% |

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved (with Walk In Centre uplift for A&E 4 Hour standard).
RED rating = national standard not achieved, the STF trajectory not achieved

Note on A&E "Trust Footprint":
In agreement with NHS England and NHS Improvement, each Acute Trust was apportioned activity from Walk In Centres (WIC) and Minor Injury Units (MIU) in their region. This apportionment is carried out and published by NHS England as "Acute Trust Footprint" data. This data is being used to assess whether a Trust achieved the recovery trajectory for each quarter. The A&E "Trust Footprint" data above relates to Trust performance after WIC and MIU data has been added.

## 1.2 OVERVIEW – Single Oversight Framework

**Financial Year 2019/20**

| Access Key Performance Indicator | | Quarter 1 2019/20 | | | Quarter 2 2019/20 | | | Quarter 3 2019/20 | | | Quarter 4 2019/20 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
| **A&E 4-hours** **Standard: 95%** | Actual | 78.3% | 78.0% | | | | | | | | | | |
| | Trajectory | 84.5% | 90.5% | 90.5% | 90.5% | 90.5% | 85.5% | 89.7% | 84.7% | 83.5% | 85.0% | 81.6% | 81.7% |
| **Cancer 62-day GP** **Standard: 85%** | Actual (Monthly) | 86.8% | | | | | | | | | | | |
| | Actual (Quarterly) | | | | | | | | | | | | |
| | Trajectory (Monthly) | 85% | 85% | 85% | 83% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| | Trajectory(Quarterly) | 85% | | | 85% | | | 85% | | | 85% | | |
| **Referral to Treatment** **Standard: 92%** | Actual | 89.0% | 88.1% | | | | | | | | | | |
| | Trajectory | 87.9% | 87.9% | 87.9% | 87.9% | 87.9% | 87.9% | 87.9% | 87.9% | 86.9% | 86.9% | 86.9% | 87.9% |
| **6-week wait diagnostic** **Standard: 99%** | Actual | 95.3% | 93.4% | | | | | | | | | | |
| | Trajectory | 96% | 96% | 97% | 97% | 98% | 99% | 99% | 99% | 99% | 99% | 99% | 99% |

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved (with Walk In Centre uplift for A&E 4 Hour standard).
RED rating = national standard not achieved, the STF trajectory not achieved

## 1.3 OVERVIEW – Key Performance Indicators Summary

Below is a summary of all the Key Performance Indicators reported in Section 2.

## 1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

| | Successes | Priorities |
|---|---|---|
| ACCESS | • Delivering the 62 day GP national standard in April, recovering compliance to 86.8% against an 85% standard.<br>• Referral To Treatment (RTT) Performance trajectories have been set for 2019/20. The confirmed month end position for May is 88.1% against a trajectory of 87.9%.<br>• The Trust waiting list trajectory for 2019/20 has been set to ensure that our waiting list size at end of March 2020 is at 29,206. At the end of May 2019 the waiting list size currently sits at 30,010 which is above trajectory at this point in the year but is normal for in-month fluctuation and reflects the number of routine cancellations that took place during the bank holidays in May.<br>• The diagnostic echocardiography service is predicting a return to delivering the 99% standard by end of quarter 2. Significant reduction in breach numbers has been delivered: 379 in January 2019, with 70 predicted for end of June.<br>• The implementation of electronic Referral Service (eRS) is being moved from project phase to business as usual. Negotiations with commissioners for certain clinics to be exempt are ongoing. Paper referral numbers remain low.<br>• The teledermatology service went live on eRS on 3rd June 2019; this enables GPs to request diagnostic advice for dermatological conditions by sending photographs to a consultant for review.<br>• The work with our commissioners to review the local patient access policy is now complete. | • Sustaining delivery of the GP Cancer 62 Day national standard of 85% in quarter 1<br>• Recovering performance against the 31 day first definitive treatment standard by preventing further surgical cancellations and recovering from the impact of previous cancellations<br>• Achieve the 99% Diagnostic standard from Quarter 3 2019/20.<br>• The total RTT waiting list size needs to be maintained below the March 2018 level during 2019/20. Continue to deliver RTT trajectory and performance above 88% in June 2019.<br>• The divisional focus remains on reducing Outpatient follow-ups that are overdue by more than 6 months<br>• The RTT Performance lead is representing UHB at the RTT Task and Finish Group. The purpose of the group is to have a standardised way of identifying patients who have been waiting for treatment for more than 26 weeks. This requires careful consideration prior to implementing plans to transfer patients to alternative providers where treatment could be undertaken sooner. There have been two meetings at this point and the current focus is to agree a standard data set across BNSSG with a view to look at shared capacity across local providers<br>• There is a system-wide (Bristol, North Somerset, South Glocs) outpatient transformation workshop on the 25th June for clinical and managerial staff. This will guide future opportunities to work smarter within outpatients.<br>• Much greater cross Trust working with NBT and Weston on outpatient transformation, it is hoped to achieve standardisation of pathways within identified specialities.<br>• The changes to the local access policy will be included into an internal Standard Operating Procedure (SOP), to be presented at Senior Leadership Team on 17th July for approval. |
| | **Opportunities** | **Risks and Threats** |
| ACCESS | • Opportunity to maintain cancer performance with new national rules for allocation of performance between providers – rules came into place from April 2019 and positive impact has been seen, impact evaluation and management is ongoing<br>• The improvement work around the Medway patient administration system (PAS) continues. An options paper will be written during June to document our proposal<br>• Working with system partners to reduce the number of patients in hospital for more than 21 days has the potential to release bedday savings. Tackling this cohort of patients is a 2019/20 requirement from NHS England.<br>• Work is underway to reduce follow-ups across the local health system: Bristol, North Somerset and South Gloucestershire (BNSSG). UHBristol will be working closely with North Bristol Trust and Weston to ensure pathway alignment for follow-up across BNSSG. The three specialities that have been identified are Ophthalmology, haematology and T&O. Clinicians in all three are being contacted to engage them in designing the proposed change.<br>• Further evaluation of advice and guidance is planned for 2019/20, it is hoped that this can be used to put forward a business case to support a tariff for advice and guidance for 20/21. | • Surgical cancellations of cancer patients have affected the 62 day GP, 31 day first definitive treatment, and 31 day subsequent surgery standards for cancer. Preventing further cancellations (which mainly occur due to lack of critical care beds) and recovering from the impact of previous cancellations are a high priority to return to compliance with all standards.<br>• Diagnostic 6 week wait standard of 99% was not delivered at end of May 2019. The recovery plan, as submitted to NHS Improvement, requires delivery by end of quarter 2 2019/20.<br>• The Trust continues to report 52 week breaches in Paediatric Services and Division of Surgery due to a number of cancellations by parents of children (Paediatric) and last minute cancellations due to other emergencies in Surgery. A revised plan has been agreed with commissioners to ensure that we have no 52 week waiting patients by September 2019.<br>• The local commissioners and NHSE/I have confirmed that there is no waiver for patients who have resulted in a 52 week breach due to patient choice. The fine is £2,500 per breach.<br>• Although the local access policy has been revised; the policy still includes a focus on allowing the patient to exercise their right to choice. This may result in difficulty in achieving ZERO long waiting patients so focus on this will continue at the weekly performance meetings chaired by the Deputy COO |

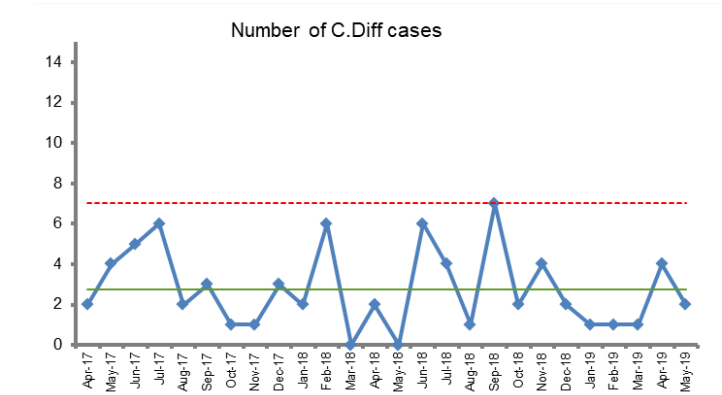
## 1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

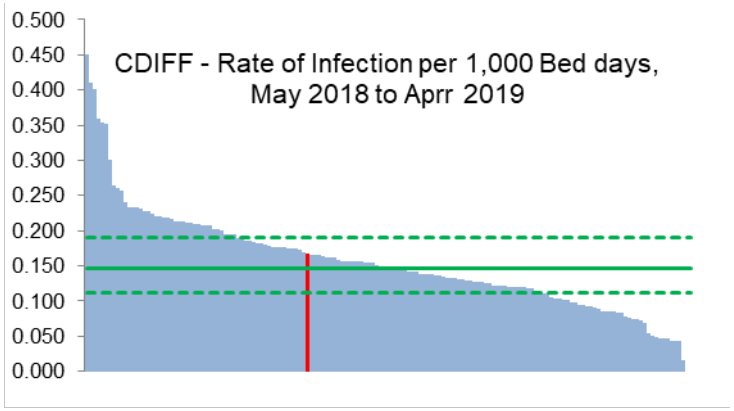
| | Successes | Priorities |
|---|---|---|
| QUALITY | • Sustained performance in the majority of quality metrics | • VTE risk assessment improving compliance. |
| | **Opportunities** | **Risks and Threats** |
| QUALITY | • We continue to work with commissioners and colleagues in neighbouring acute trusts to finalise an alternative consistent measure of the four harms which comprise the safety thermometer: falls, pressure ulcers, VTE and catheter associated urinary tract infections. | • There are no new risks or threats to quality and safety to report this month. |

## 1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

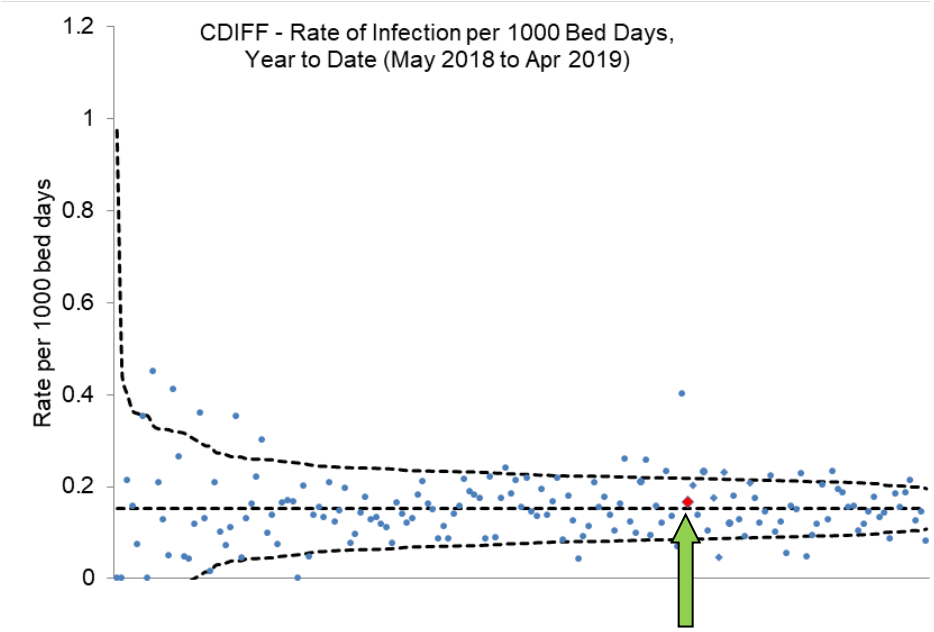
| | Successes | Priorities |
|---|---|---|
| WORKFORCE | • The psychological wellbeing plan which focuses on resources and training to support staff and managers with self-care and reduce stress in the workplace has seen over 300 staff attend one of the training programmes since they began in May.<br>• A full staff Friends and Family Test survey was undertaken during May and closed at a 27% response rate, an increase on the previous year of 18%.<br>• Overall compliance for the 11 Core Skills remains at 90% overall, with 'Remaining Essential Training' also holding at 95% overall. This is the best overall compliance for Essential Training the Trust has experienced since aligning all Core Skills with the standard of the UK Core Skills Training Framework (UK CSTF).<br>• EU Settlement Scheme support sessions have supported over 90 staff with their applications so far.<br>• The new intake of Doctors in Training and Trust Grades in the Emergency Department from August has been uploaded onto the Electronic Staff Record (ESR) & Health Roster 10 weeks in advance of their start date. This has allowed the rota to be written using health roster and the doctors have accessed an app to book their annual & study leave, improving their new starter experience.<br>• Improved return rates on Exit Interview Questionnaire. | • Development of the divisional improving staff experience plans as a result of the heat map data arriving in May; plans will be in place in by the end of June.<br>• A robust plan is in place to ensure the Workforce Diversity & Inclusion Strategy is delivered against its year 1 objectives supported by local Divisional plans which will all be in place by the end of June.<br>• Work on the Trust's new starter process progressed in the past month, with expectations to sign off on new processes by end July. If successful, new starters may be able to access eLearning as early as day two of corporate induction, allowing possible early release from current face-to-face induction training.<br>• Ongoing work with system partners to reduce high cost non-framework usage. |
| | **Opportunities** | **Risks and Threats** |
| WORKFORCE | • The key programmes of work outlined in the Workforce Diversity & Inclusion Strategy for the next 5 years are underway and a leaflet has been designed to inform staff of the key messages of the strategy.<br>• Final development of the new Pharmacy Recruitment video to support marketing and attraction to the varied roles in the Trust's Pharmacy services is due to go live in July. | • Failure to meet the 85% appraisal compliance target by the end of June.<br>• Resuscitation compliance is still lowest of the Core Skills at 76%. Provision of Resus training is being reviewed across the STP, to allow comparison of local provision against the national benchmark.<br>• Potential medical rota gaps that cannot be recruited to in time for the August rotation will increase the pressures on services.<br>• Employee Services Team capacity to deal with volumes of work including case work, policy development and provision of training for managers. |

| Infections – Clostridium Difficile (C.Diff) | |
|---|---|
| **Standards:** | Number of Trust Apportioned C.Diff cases to be below the national trajectory of 57 cases for 2019/20. Review of these cases with commissioners' alternate months to identify if there was a "lapse in care". |
| **Performance:** | There were two trust apportioned C.Diff cases in May 2019, giving six cases year-to-date. |
| **Commentary/ Actions:** | These cases require a review with our commissioners before determining if the cases will be Trust apportioned due to lapse in care. These cases are now attributed to the Trust after patients have been admitted for two days (day 3 of admission) This is new criteria from NHS Improvement which started in April 2019. The old criteria attributed cases to the Trust after three days of admission, (day four of admission).<br>There was one case of C-diff admitted within two days (community acquired) but had no admissions in the previous four weeks. This is part of the new reporting criteria. This case is not included in the Trust numbers. |
| **Ownership:** | Chief Nurse |



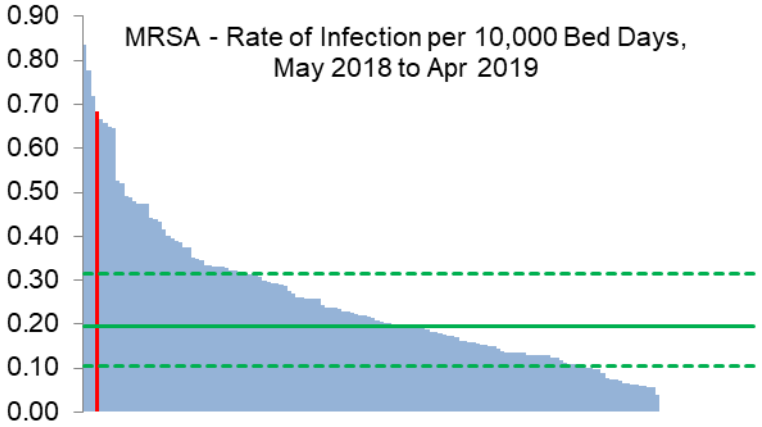

*Unbroken horizontal line is England median: dotted lines are upper & lower quartiles*

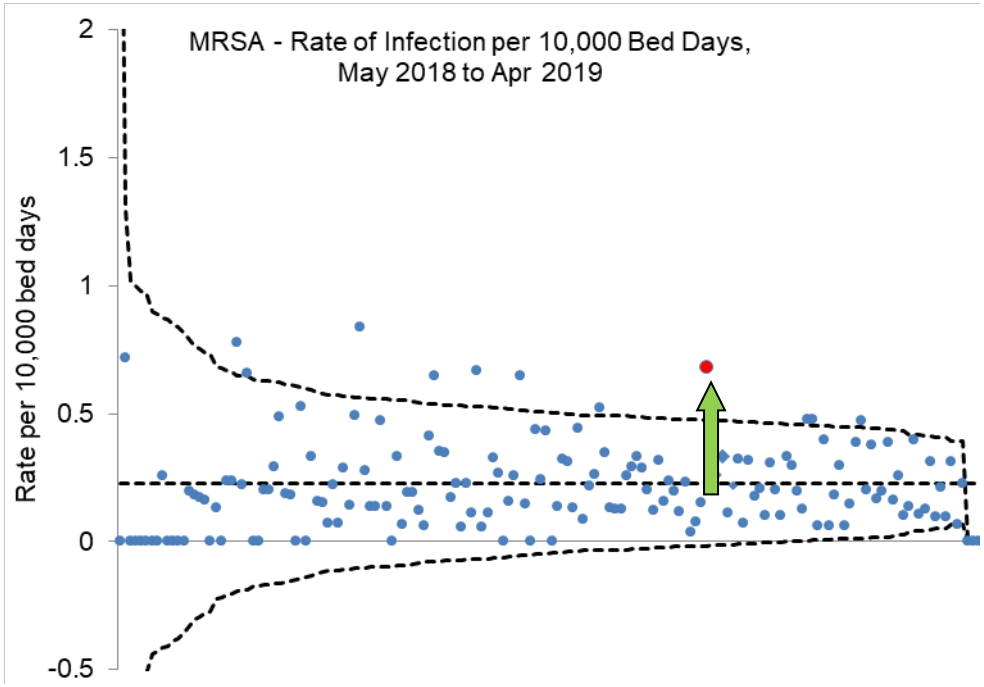



| CDIFF Cases | May-19 | 2019/2020 |
|---|---|---|
| Medicine | 0 | 1 |
| Specialised Services | 0 | 0 |
| Surgery | 0 | 1 |
| Women's and Children's | 2 | 4 |
| Grand Total | 0 | 6 |

| Infections – Methicillin-Resistant Staphylococcus Aureus (MRSA) | |
|---|---|
| **Standards:** | No Trust Apportioned MRSA cases. |
| **Performance:** | There were no trust apportioned MRSA cases in May 2019 and so zero cases year to date. |
| **Commentary/ Actions:** | Ongoing training and reporting mechanisms are continually being reviewed. |
| **Ownership:** | Chief Nurse |

| MRSA | May-19 | 2019/2020 |
|---|---|---|
| Medicine | 0 | 0 |
| Specialised Services | 0 | 0 |
| Surgery | 0 | 0 |
| Women's and Children's | 0 | 0 |
| Grand Total | 0 | 0 |

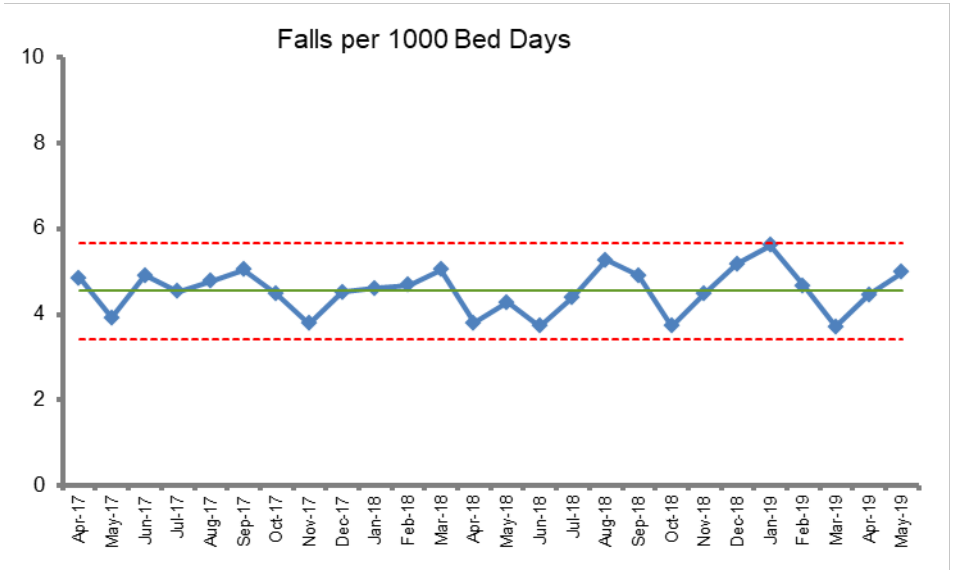


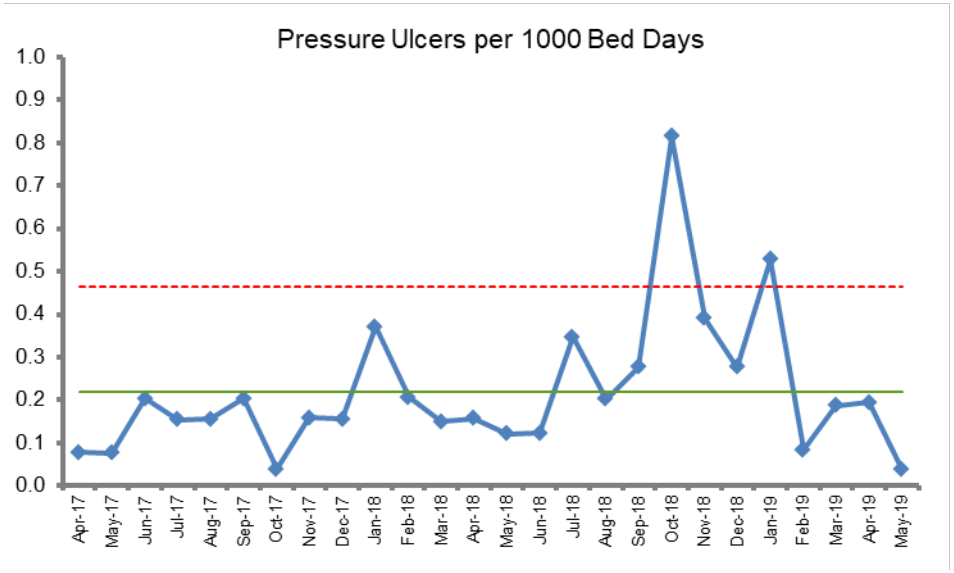

*Unbroken horizontal line is England median; dotted lines are upper & lower quartiles*

## 2.1 PERFORMANCE – Safe Domain

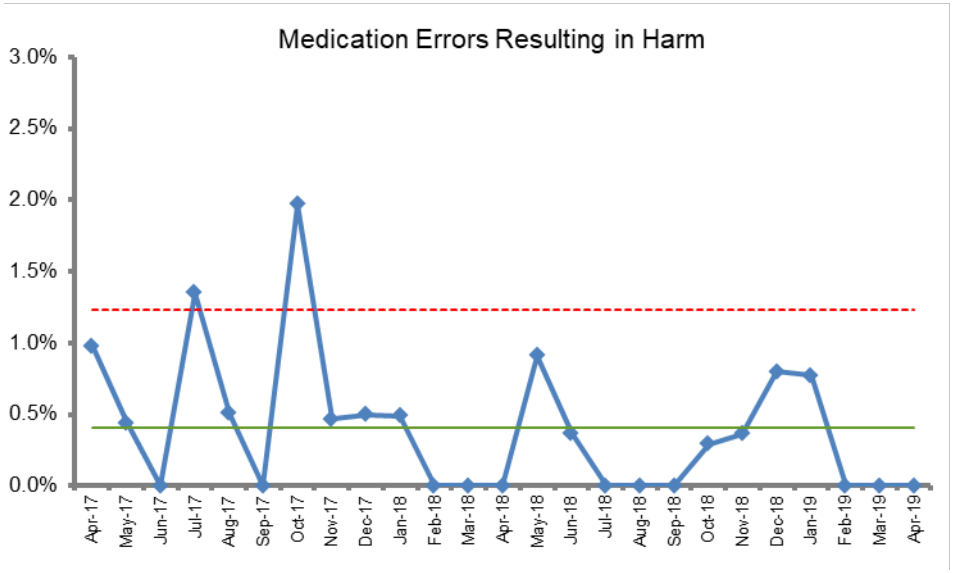
| Patient Falls | |
|---|---|
| **Standards:** | Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above) |
| **Performance:** | Falls rate for May was 4.98 per 1,000 beddays. This was 133 falls with zero resulting in harm. |
| **Commentary/ Actions:** | Actions being taken to reduce the risk of falls include:<br>1. Implementing actions required to achieve new 19/20 Falls CQUIN has commended, which include:<br>a. The revised draft multifactorial falls risk assessment, including a vision check will be approved at the next Falls Group in July.<br>b. Measuring lying and standing blood pressure measurement for all patients 65 and over<br>c. Ensuring no anti-psychotic, anxiolytics or hypnotics, are given during hospital stay or if required there should be documentation of rationale<br>d. Ensuring patient mobility assessment is documented within 24hrs or mobility aid provided within 24hrs<br>2. Quarterly audits will be undertaken to monitor progress against the CQUIN and progress and any actions required presented at the Falls Group. The first audit is due at the end of July<br>3. A revised Datix report following a fall within all adult areas to ensure all relevant information is captured to maximise learning from all falls incidents was approved in May. This will be launched in June.<br>4. The induction and patient safety teaching slides and E Learning package are being updated to reflect the change in practice required to achieve the 19/20 Falls CQUIN, aimed at reducing the number of falls<br>5. The 19/20 work and audit plans were approved at the May meeting and will be closely monitored and reviewed at each meeting. |
| **Ownership:** | Chief Nurse |

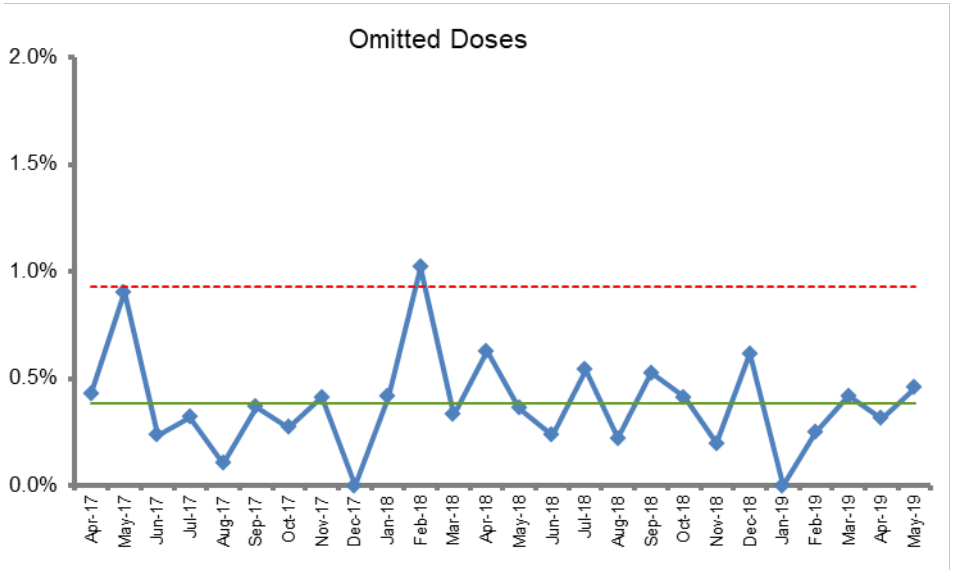


| Pressure Ulcers | |
|---|---|
| **Standards:** | Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers |
| **Performance:** | Pressure Ulcers rate for May was 0.04 per 1,000 beddays. There was one Pressure Ulcers in May, which was a Grades 2. So there were no grade 3 or 4 |
| **Commentary/ Actions:** | Pressure ulcer performance remains green (0.037 per 1,000 beddays).<br>The aim of the 2019/20 work plan is to reduce the number of developed on ward pressure ulcers.<br>1. The Tissue Viability Team continue to deliver monthly pressure ulcer training sessions and monthly wound assessment training sessions for staff. The team also deliver targeted/bespoke training to individual wards when indicated following an incident or on request<br>2. Continue documentation review and revision<br>• Revised adult pressure ulcer care plan launch in July. Work underway to revise maternity and paediatric care plans for consistency.<br>• Adult care plan audit planned for Jan 2020, to assess improvement in practice and take actions where required.<br>3. Review e-learning to ensure it meets NHS Improvement's core curriculum standards<br>4. Successful TV champions day (May 2019) with fifty-one participants. The focus for this day included factors affecting wound healing and treatment options.<br>5. All actions are monitored through the tissue viability steering group |
| **Ownership:** | Chief Nurse |



| Medicines Management | |
|---|---|
| **Standards:** | Number of medication errors resulting in harm to be below 0.5%. Note this measure is a month in arrears.<br>Of all the patients reviewed in a month, under 0.75% to have had a non-purposeful omitted dose of listed critical medication |
| **Performance:** | Zero moderate harm medication incidents were reported in April 2019, out of 256 cases audited.<br>Omitted doses were at 0.46% in May (3 cases out of 655 reviewed in areas using paper drug charts). |
| **Commentary/ Actions:** | The non-purposeful omitted critical medicines audit in areas using paper drug charts identified three unintentional omissions of medicines, returning a figure of 0.46% for May. This is well below the target of 0.75%. The unintentional omissions of medicines identified included a post-transplant immunosuppressant that was not available on a paediatric ward at the time that administration was required. There were two omitted doses reported from an adult respiratory ward. The first was an omitted dose of an opioid analgesic. The second reported omission involved a parenteral anticoagulant that had been given but administration was not signed for.<br>There were 19 harmful incidents in April. None of these caused moderate or greater harm, they were all reported as causing minor harm. The most common reason for a harmful medication incident was an omitted dose of medicine. This occurred six times. The most common reason for omission was because the administration was missed, but some incidents occurred because the prescription was not detailed enough to allow administration to take place safely.<br>There were two controlled drug record keeping errors that were reported in April, and one of incorrect storage of medication. As these incidents did not involve patients directly, it is unlikely that these incidents actually caused any harm to the patients. |
| **Ownership:** | Medical Director |



| Essential Training | |
|---|---|
| **Standards:** | Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90% |
| **Performance:** | In May 2019 Essential Training overall compliance remained static at 90% compared to the previous month. (This reporting always excludes Child Protection Level 3). |
| **Commentary/ Actions:** | May 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programmes. There was one reduction, of 1%, for Information Governance, which carries an 'all staff' annual update requirement, but 5 other core skills programmes improved.<br><br>Overall compliance for 'Remaining Essential Training' is also holding at 95% overall for the second month.<br>• Resuscitation compliance is still lowest of the Core Skills at 76%. Training is being reviewed across the STP to allow comparison of local provision against the national benchmark.<br>• Review of the Trust's new starter process progressed in the past month, with planned sign-off by end July. Ambition is for new starters to access eLearning as early as day two of corporate induction, allowing possible early release from current face-to-face induction training.<br>• The periodic revalidation of all Essential Training has commenced with an initial focus on provision at corporate induction and updates. A later review will take greater emphasis on aspects of quality. All programme leads, Subject Matter Experts (SME's), and other key advisors, are also asked to draw the Trust's attention to any perceived needs for new Essential Training, to meet new risk or legislation, or achieve competencies. All inputs will be collated in early July for action planning by the Corporate Education Governance Group. |
| **Ownership:** | Director of People |

| Essential Training | May-19 | KPI |
|---|---|---|
| Equality, Diversity and Human Rights | 97% | 90% |
| Fire Safety | 88% | 90% |
| Health, Safety and Welfare (formerly Health & Safety) | 94% | 90% |
| Infection Prevention and Control | 86% | 90% |
| Information Governance | 86% | 95% |
| Moving and Handling (formerly Manual Handling) | 88% | 90% |
| NHS Conflict Resolution Training | 94% | 90% |
| Preventing Radicalisation | 95% | 90% |
| Resuscitation | 76% | 90% |
| Safeguarding Adults | 94% | 90% |
| Safeguarding Children | 93% | 90% |

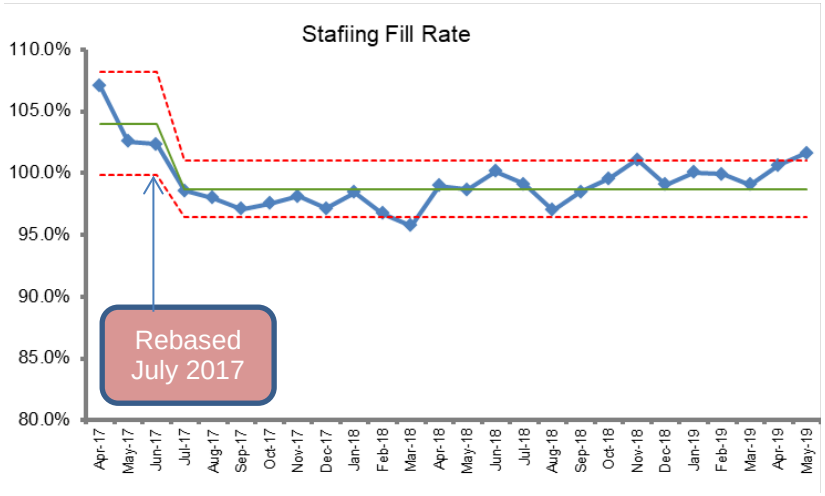
| Essential Training | May-19 | KPI |
|---|---|---|
| **UH Bristol NHS Foundation Trust** | 90% | **90%** |
| Diagnostics & Therapies | 92% | 90% |
| Medicine | 89% | 90% |
| Specialised Services | 91% | 90% |
| Surgery | 90% | 90% |
| Women's & Children's | 88% | 90% |
| Trust Services | 94% | 90% |
| Facilities & Estates | 93% | 90% |

| Nursing Staffing Levels | |
|---|---|
| **Standards:** | Staffing Fill Rate is the total hours worked divided by total hours planned. A figure over 100% indicates more hours worked than planned. No target agreed |
| **Performance:** | May's overall staffing level was at 101.6% (243,393 hours worked against 239,467 planned).<br>Registered Nursing (RN) level was at 98.3% and Nursing Assistant (NA) level was at 110.1% |
| **Commentary/ Actions:** | Overall for the month of May 2019, the trust had 98% cover for RN's on days and 99% RN cover for nights. The unregistered level of 103% for days and 120% for nights reflects the activity seen in May 2019. This was due primarily to NA specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night.<br>Ongoing Actions:<br>• Continue to validate temporary staffing assignments against agreed criteria. |
| **Ownership:** | Chief Nurse |

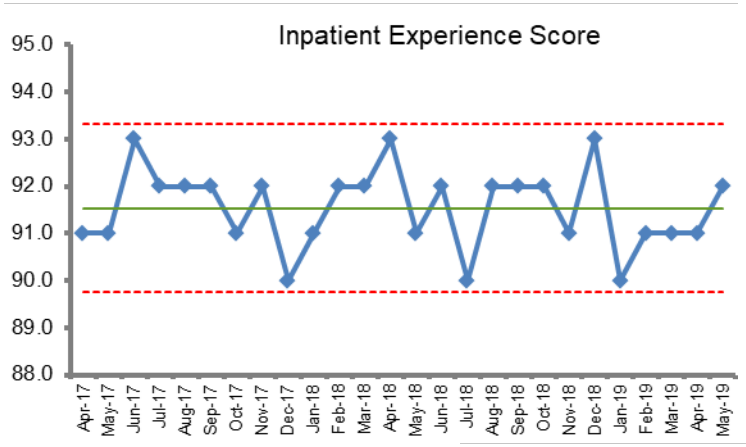
**MAY 2019 DATA**

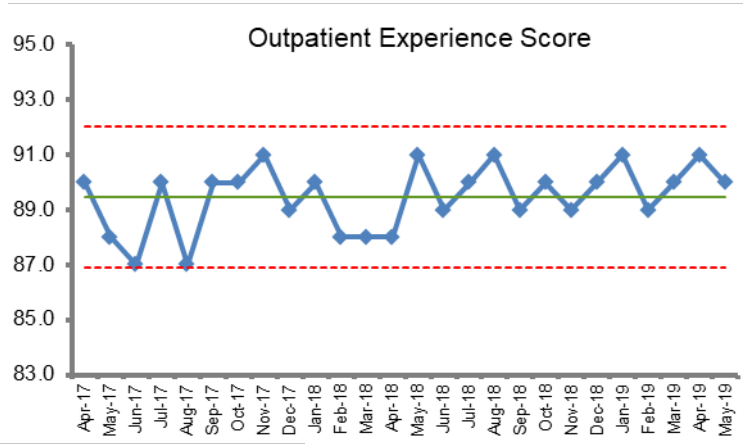
| | Day | Night | TOTAL |
|---|---|---|---|
| Registered Nurses | 98.2% | 98.5% | 98.3% |
| Nursing Assistants | 103.3% | 119.7% | 110.1% |
| **TOTAL** | **99.7%** | **104.1%** | **101.6%** |

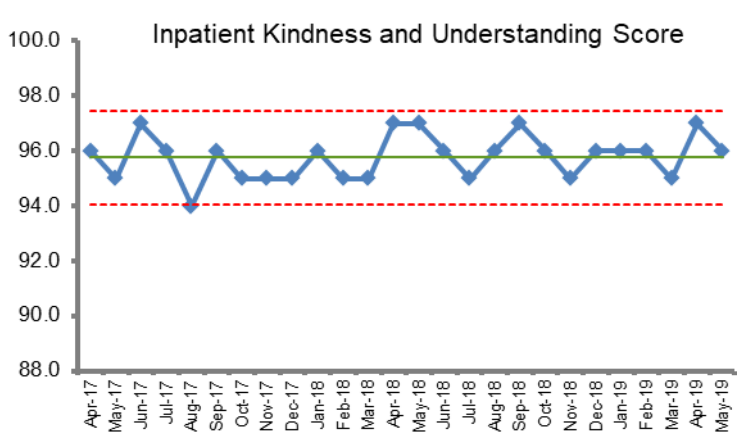
| | |
|---|---|
| Medicine | 110.0% |
| Specialised Services | 101.5% |
| Surgery | 103.8% |
| Women's and Children's | 94.8% |
| **TOTAL** | **101.6%** |



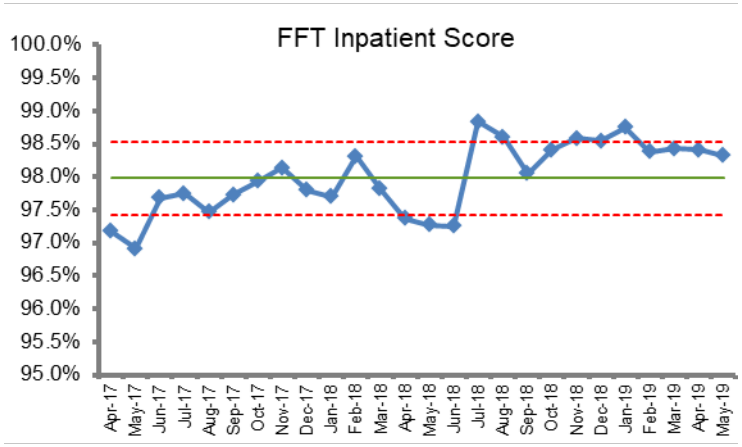
| Monthly Patient Survey | |
|---|---|
| **Standards:** | For the inpatient and outpatient Survey, 5 questions are combined to give a score out of 100. For inpatients, the target is to achieve 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target of 90 or over. |
| **Performance:** | For May 2019, the inpatient score was 92/100, for outpatients it was 90. For the kindness and understanding question it was 96. |
| **Commentary/ Actions:** | The headline measures from these surveys remained above their minimum target levels, indicating the continued provision of a positive patient experience at UH Bristol. |
| **Ownership:** | Chief Nurse |

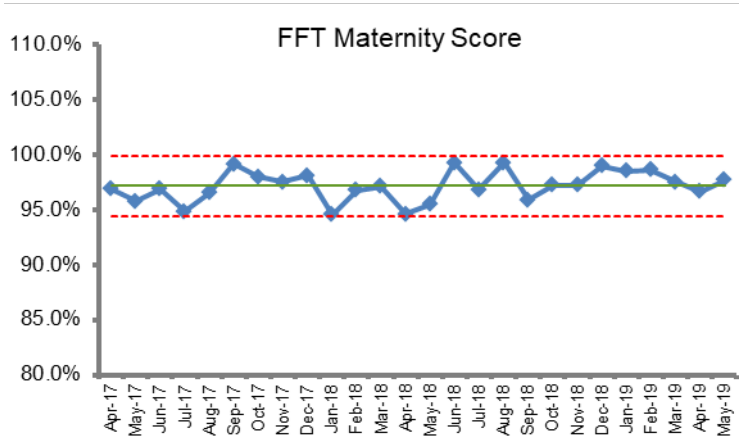


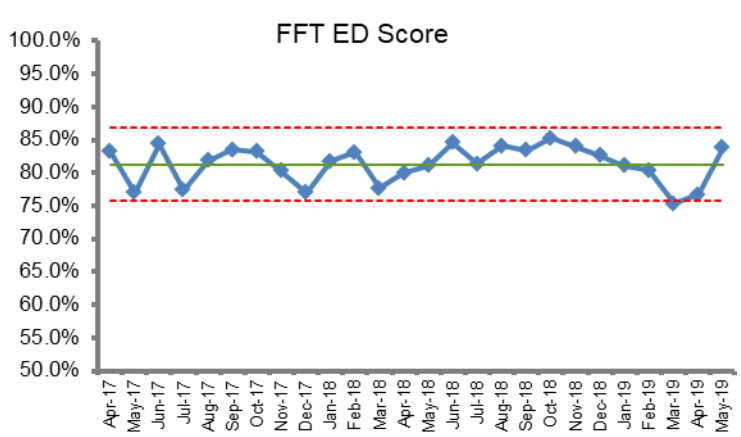



| Friends and Family Test (FFT) Score | |
|---|---|
| **Standards:** | The FFT score is the number of respondents who were likely or very likely to recommend the Trust, as a percentage of all respondents. Standard is that the score for inpatients should be above 90%. The Emergency Department minimum target is 70%. |
| **Performance:** | May's FFT score for Inpatient services was 98.3% (2521 out of 2564 surveyed). The ED score was 83.8% (1352 out of 1613 surveyed). The maternity score was 97.7% (432 out of 442 surveyed). |
| **Commentary/ Actions:** | The headline measures from these surveys remained above their minimum target levels. |
| **Ownership:** | Chief Nurse |



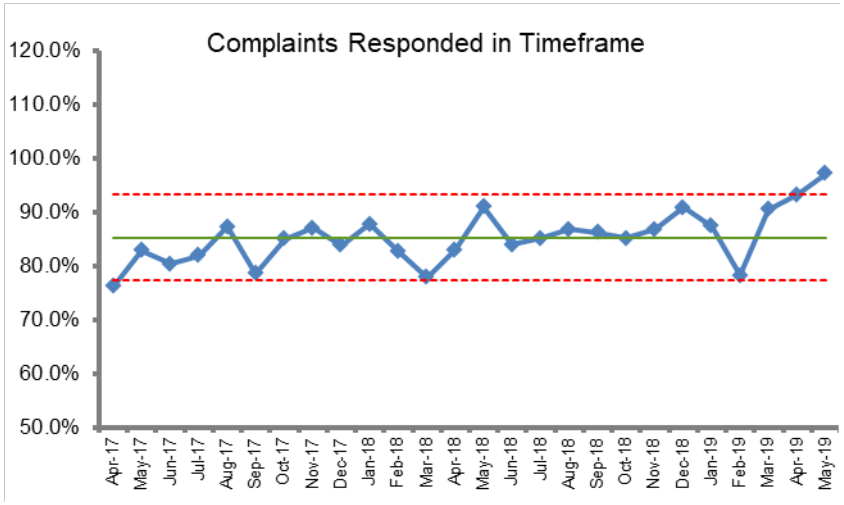



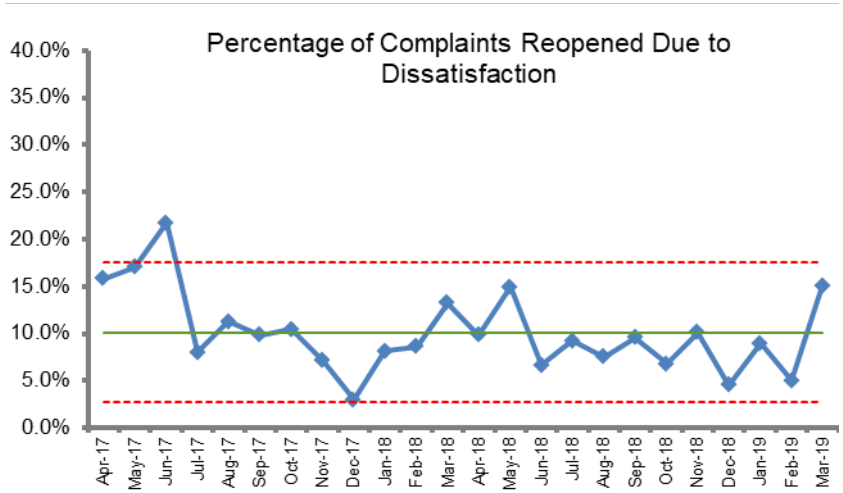




| | Response Rate | | Score | |
|---|---|---|---|---|
| | May-19 | 2019/2020 | May-19 | 2019/2020 |
| **Inpatients** | | | | |
| Medicine | 48.0% | 41.9% | 98.1% | 98.2% |
| Surgery | 41.0% | 38.5% | 98.3% | 98.5% |
| Specialised Services | 48.3% | 43.7% | 98.8% | 98.3% |
| Women's and Children's | 35.7% | 35.8% | 98.5% | 98.3% |
| **TOTAL** | **42.4%** | **39.3%** | **98.3%** | **98.4%** |
| **Emergency Department** | | | | |
| Bristol Royal Infirmary | 10.5% | 10.9% | 64.8% | 61.4% |
| Children's Hospital | 17.5% | 17.0% | 84.2% | 83.5% |
| Eye Hospital | 33.2% | 23.7% | 95.1% | 94.3% |
| **TOTAL** | **18.1%** | **15.9%** | **83.8%** | **80.8%** |
| **Maternity** | | | | |
| **TOTAL** | **30.4%** | **29.5%** | **97.7%** | **97.3%** |

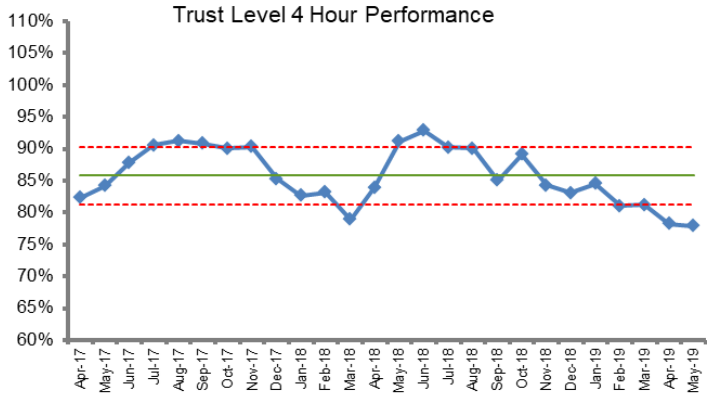
## 2.2 PERFORMANCE – Caring Domain

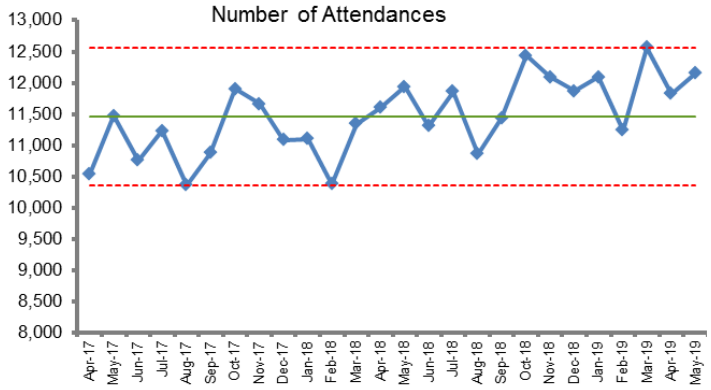
| Patient Complaints | |
|---|---|
| **Standards:** | For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe.<br>Of all formal complaints responded to, less than 5% should be re-opened because complainant is dissatisfied. |
| **Performance:** | In May, 69 out of 71 formal complaints were responded to with timeframe (97.2%)<br>Of the 53 formal complaints responded to in March, 8 resulted in the complainant being dissatisfied with the response (15.1%) |
| **Commentary/ Actions:** | There were two breaches from the 71 formal responses sent out in May; one each for the Divisions of Specialised Services and Medicine. One breach was caused by a delay in the Patient Support and Complaints Team (Medicine) and the other breach (for Specialised Services) was caused by a delay in the Patient Support & Complaints Team and the Executive Team.<br>The Trust's performance in responding to complaints via informal resolution within a timescale agreed with the complainant was 87% in May. This equates to 17 breaches from the 130 responses sent out in May. Of the 17 breaches recorded, six were from the Division of Surgery, four from the Division of Trust Services, three from the Division of Medicine and two each from the Divisions of Women & Children and Specialised Services.<br>The rate of dissatisfied complaints in March (this measure is reported two months in arrears) was 15.1%. This represents eight cases from the 53 first responses sent out during that month and is deterioration on the 5.0% reported last month in respect of responses sent out in February. |
| **Ownership:** | Chief Nurse |

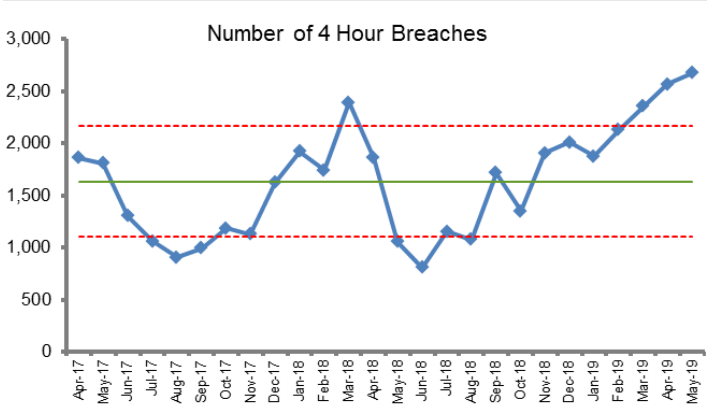


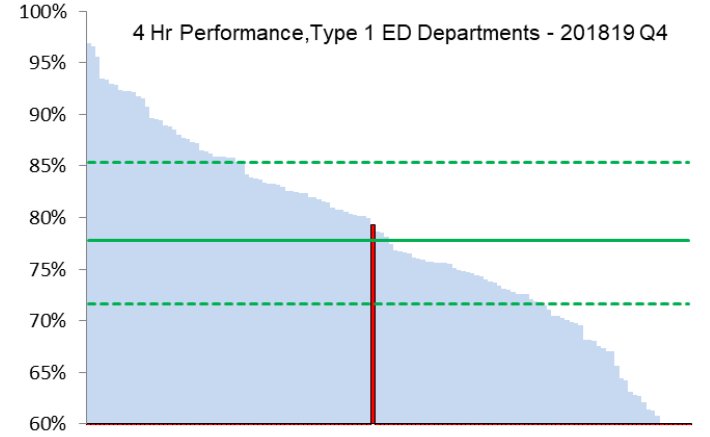



| Emergency Department (ED) 4 Hour Wait | |
|---|---|
| **Standards:** | Measured as length of time spent in the Emergency Department from arrival to departure/admission. The national standard is that at least 95% of patients should wait under 4 hours. The Trust's improvement trajectory is 90.5% for May. |
| **Performance:** | Trust level performance for May was 77.95% (12148 attendances and 2679 patients waiting over 4 hours). |
| **Commentary/ Actions:** | Performance at the Children's Hospital was 90.4% in May. The Bristol Royal Infirmary achieved 63.9% in May and the Eye Hospital achieved 98.4%. The Divisions are pulling together an urgent care action plan which will be overseen by the cross-Divisional Urgent Care Operational Group. The aim of the plan is to ensure the organisation is taking actions which will produce benefits to front door performance and quality metrics within the next 0-3 months, and also across the next 3-6 months and longer term period. Some of the longer term actions include recruiting to and embedding new ways of working at the front door, such as the Acute Frailty Service and the new tiers of staffing in the BRI ED. Recruitment to some of the ED roles is proving challenging, particularly at junior doctor level and we continue to review this as part of the ED Workforce Group. |
| **Ownership:** | Chief Operating Officer |



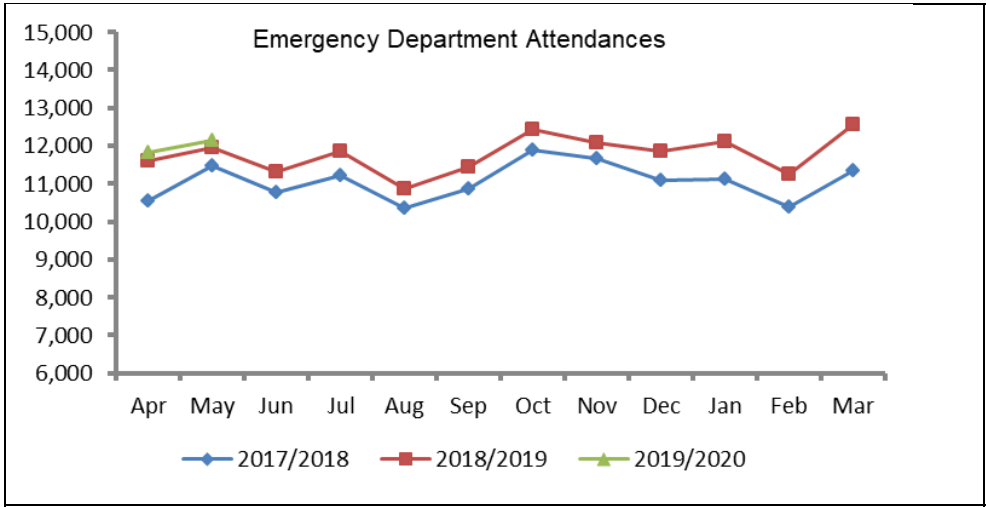



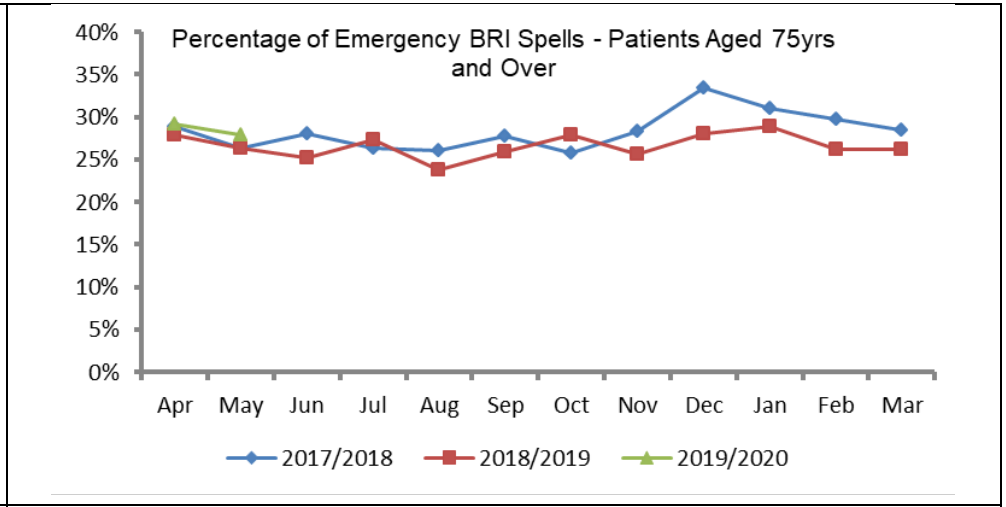



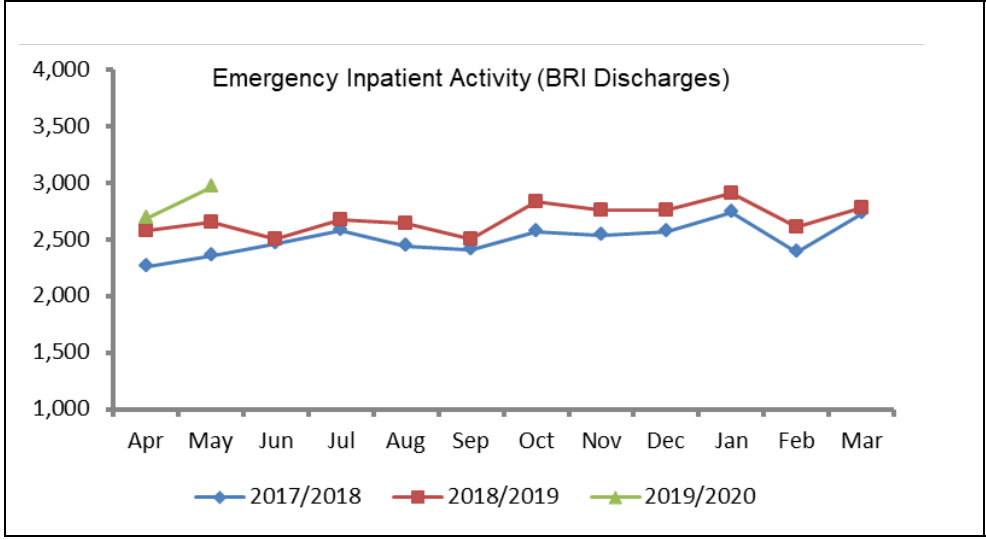



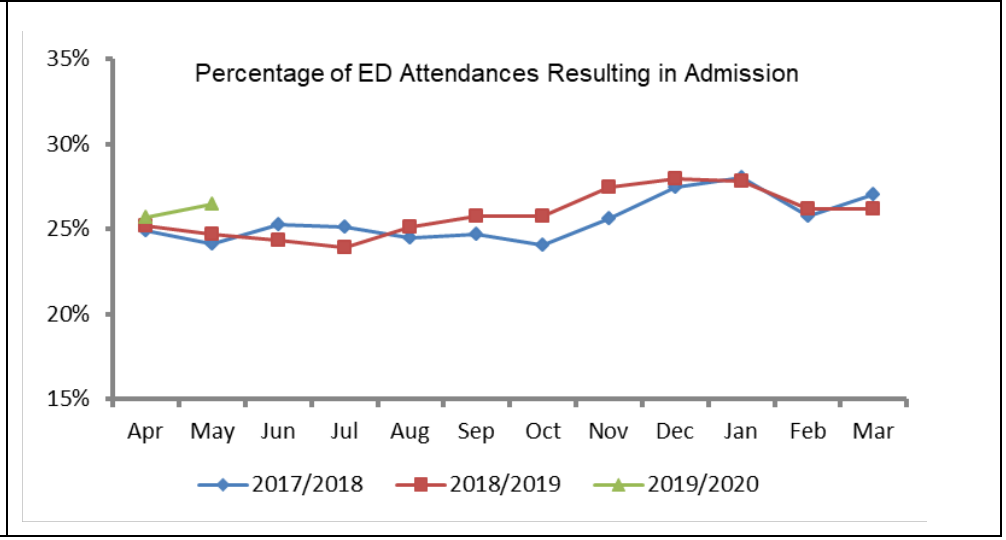

*Unbroken horizontal line is England median, dotted lines are upper & lower quartiles*

| | Attendances | | Under 4 Hours | | Performance | |
|---|---|---|---|---|---|---|
| | May-19 | 2019/2020 | May-19 | 2019/2020 | May-19 | 2019/2020 |
| BRI | 6331 | 12365 | 4043 | 7879 | 63.86% | 63.72% |
| Trust | 12148 | 23971 | 9469 | 18721 | 77.95% | 78.10% |



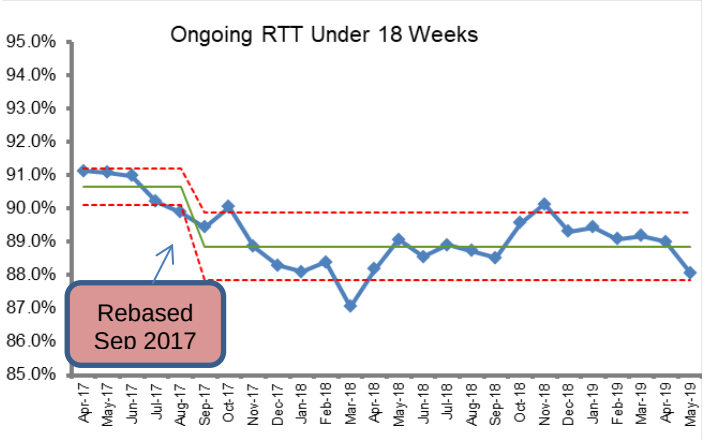



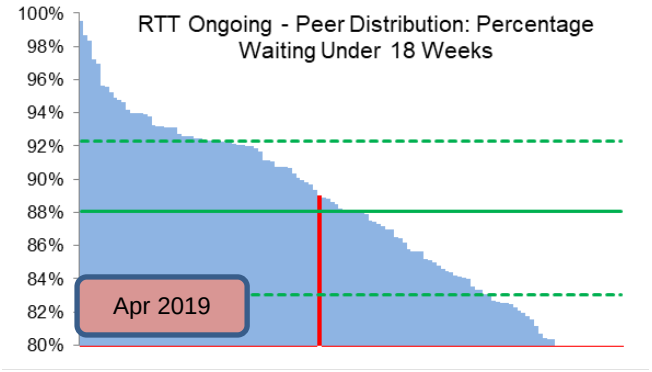



## 2.3 PERFORMANCE – Responsive Domain

| Referral to Treatment (RTT) | |
|---|---|
| **Standards:** | At each month-end, the Trust reports the number of patients on an ongoing RTT pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks. The Trust's improvement trajectory has been set at 87.9% for end of May. In addition, no-one should be waiting 52 weeks or over at the end of March 2019. |
| **Performance:** | At end of May, 88.1% of patients were waiting under 18 week (26,432 out of 30,010 patients). 11 patients were waiting 52+ weeks |
| **Commentary/ Actions:** | The 92% national standard was not met at the end of May. However the Trust has achieved, for 14 consecutive months, the RTT set recovery trajectory.<br>Key actions for 2019/20:<br>• Achieve zero 52 week waiting patients by September 2019<br>• Ensure the total waiting list size is below the March 2018 level of 29,207 at March 2020<br>• Ensure that set divisional trajectories continue to be achieved month on month. These have now been agreed and will be monitored and actioned through the weekly performance meetings, chaired by Deputy Chief Operating Officer. |
| **Ownership:** | Chief Operating Officer |



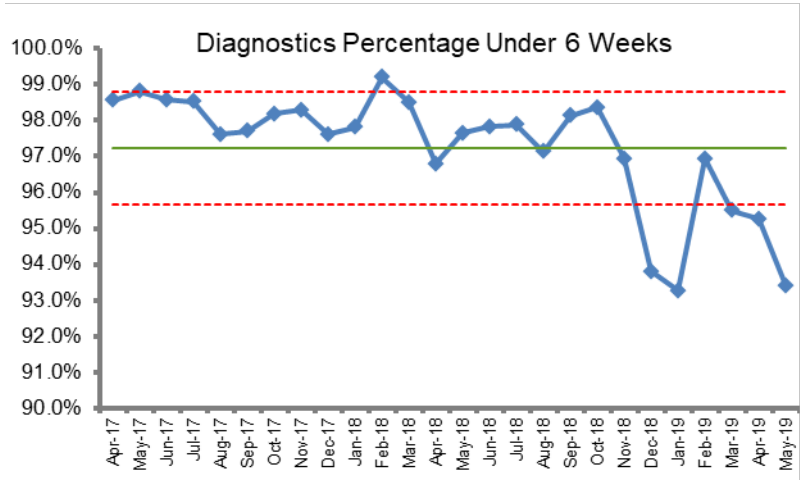



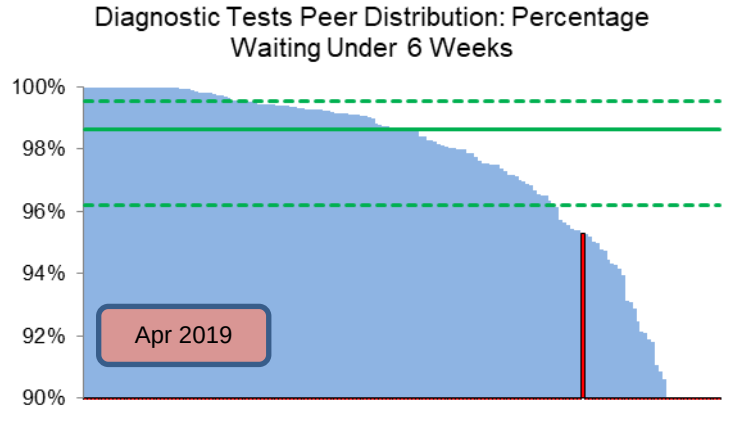

*Unbroken horizontal line is England median; dotted lines are upper & lower quartiles*

**Ongoing Pathways at May-19**

| | Ongoing Pathways | Ongoing Over 18 Weeks | Ongoing Performance |
|---|---|---|---|
| Cardiology | 2,406 | 507 | 78.9% |
| Cardiothoracic Surgery | 345 | 93 | 73.0% |
| Dermatology | 2,679 | 280 | 89.5% |
| ENT | 1,945 | 153 | 92.1% |
| Gastroenterology | 871 | 27 | 96.9% |
| General Medicine | 4 | 0 | 100.0% |
| Geriatric Medicine | 59 | 0 | 100.0% |
| Gynaecology | 1,426 | 166 | 88.4% |
| Neurology | 270 | 25 | 90.7% |
| Ophthalmology | 3,591 | 303 | 91.6% |
| Oral Surgery | 3,013 | 359 | 88.1% |
| Other (Clinical Genetics) | 745 | 17 | 97.7% |
| Other (Dental) | 2,575 | 251 | 90.3% |
| Other (General Surgery) | 1,622 | 385 | 76.3% |
| Other (Haem/Onc) | 214 | 4 | 98.1% |
| Other (Medicine) | 598 | 16 | 97.3% |
| Other (Other) | 419 | 9 | 97.9% |
| Other (Paediatric) | 5,496 | 855 | 84.4% |
| Other (Pain Relief) | 61 | 0 | 100.0% |
| Other (Thoracic Surgery) | 100 | 9 | 91.0% |
| Plastic Surgery | 2 | 2 | 0.0% |
| Rheumatology | 475 | 16 | 96.6% |
| Thoracic Medicine | 577 | 14 | 97.6% |
| Trauma & Orthopaedics | 510 | 87 | 82.9% |
| **TOTAL** | **30,010** | **3,578** | **88.1%** |

| Diagnostic Waits | |
|---|---|
| **Standards:** | Diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end. The Trust has committed to recovery by beginning of Quarter 3 2019/10 |
| **Performance:** | At end of May, 93.4% of patients were waiting under 6 weeks (8,257 out of 8,839 patients). There were 582 breaches of the 6-week standard. |
| **Commentary/ Actions:** | The Trust did not achieve the 99% national standard at end of May. The maximum number of breaches needed to achieve 99% was 88 breaches. The areas carrying the largest volume of breaches are Echocardiography, Non-obstetric ultrasound and CT Cardiac, see table below.<br>• Echos is on track to deliver the standard by end of Quarter 2, due to continued outsourcing until internal vacancies are filled and waiting list backlogs cleared<br>• For Ultrasound, staff vacancies have caused a reduction in available capacity. The service is running waiting list initiatives and utilising agency and locum sonographers to cover vacancies while permanent staff are recruited.<br>• CT Cardiac has experienced a growth in demand since October. Service has seen, on average, a 30% increase in referrals. Some of this increase is due to new NICE guidelines around CT Cardiac as a preferred exam for certain pathways. In addition, this is a complex modality where scans involve numerous staff (e.g. radiologist, radiographer, nurse), which makes outsourcing difficult<br>Full recovery trajectories for Ultrasound and CT Cardiac are under review with Chief Operating Officer and Divisional Director for Diagnostics and Therapies. |
| **Ownership:** | Chief Operating Officer |



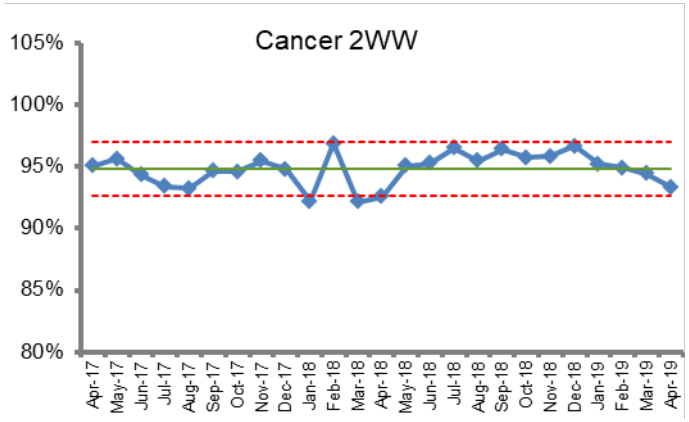



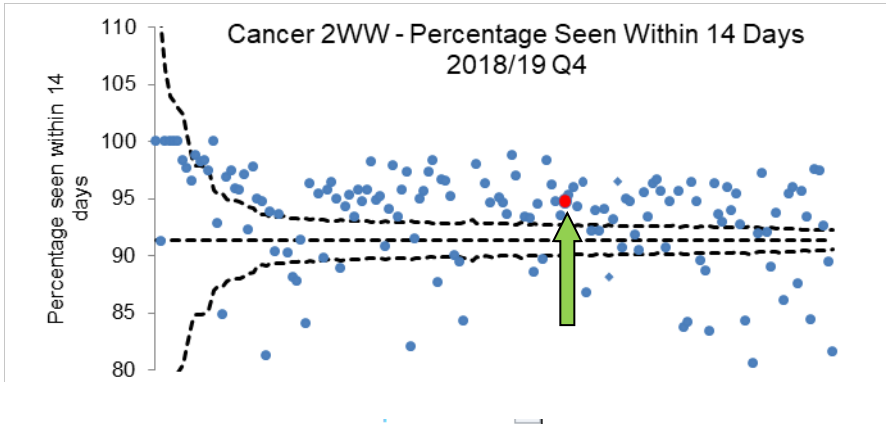

*Unbroken horizontal line is England median; dotted lines are upper & lower quartiles*

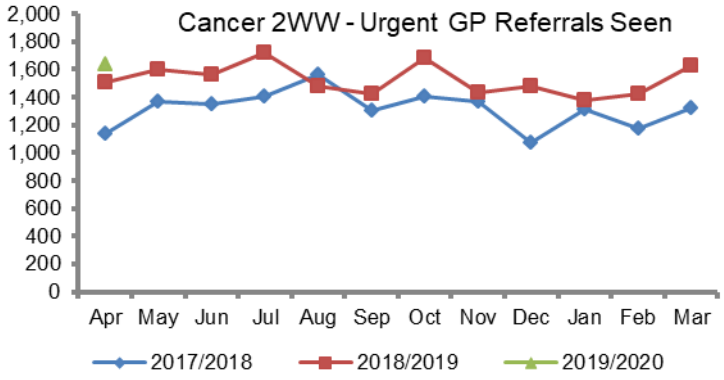
| Diagnostic Tests Waiting List at May-19 | | | | |
|---|---|---|---|---|
| | Under 6 Weeks | 6+ Weeks | Total Waiting | Percentage Under 6 Weeks |
| Audiology | 562 | 2 | 564 | 99.6% |
| Colonoscopy | 187 | 36 | 223 | 83.9% |
| CT | 1,387 | 62 | 1,449 | 95.7% |
| Cystoscopy | 3 | 0 | 3 | 100.0% |
| DEXA Scan | 187 | 0 | 187 | 100.0% |
| Echocardiography | 846 | 182 | 1,028 | 82.3% |
| Flexi Sigmoidoscopy | 62 | 14 | 76 | 81.6% |

| | Under 6 Weeks | 6+ Weeks | Total Waiting | Percentage Under 6 Weeks |
|---|---|---|---|---|
| Gastroscopy | 206 | 27 | 233 | 88.4% |
| MRI | 1,951 | 85 | 2,036 | 95.8% |
| Neurophysiology | 204 | 1 | 205 | 99.5% |
| Sleep Studies | 203 | 0 | 203 | 100.0% |
| Ultrasound | 2,459 | 173 | 2,632 | 93.4% |
| **Grand Total** | **8,257** | **582** | **8,839** | **93.4%** |

| Cancer Waiting Times – 2WW | |
|---|---|
| **Standards:** | Urgent GP-referred suspected cancer patients should be seen within 2 weeks of referral. The national standard is that each Trust should achieve at least 93% |
| **Performance:** | For April, 93.4% of patients were seen within 2 weeks (1531 out of 1640 patients). For 2018/19 quarter 1 achieved 94.3%, quarter 2 achieved 96.1%, quarter 3 achieved 96.0% and quarter 4 overall achieved 94.8%. |
| **Commentary/ Actions:** | The standard has been achieved in all four quarters in 2018/19 and for the first month of 2019/20.<br>The current robust performance management actions will continue through the weekly performance meetings. The Trust remains on track to deliver in quarter 1 of 2019/20. |
| **Ownership:** | Chief Operating Officer |



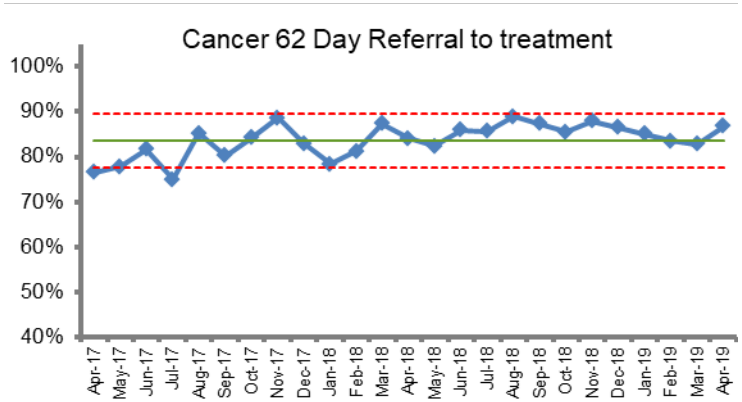



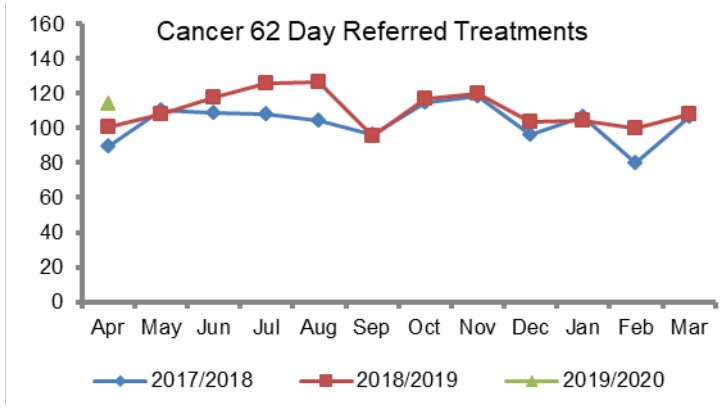



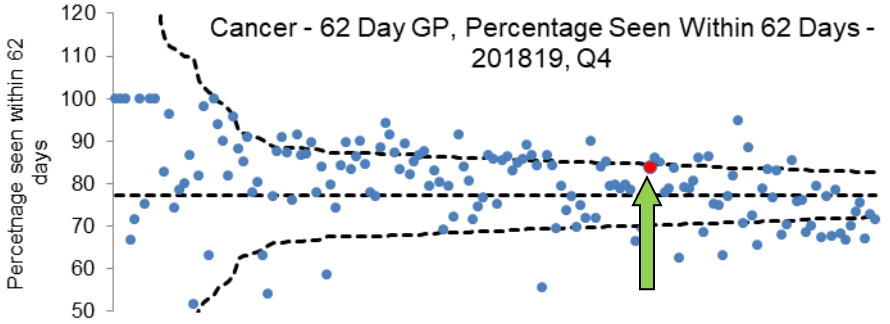

| | Cancer 2WW - Apr-19 | | |
|---|---|---|---|
| | Under 2 Weeks | Total Pathways | Performance |
| Other suspected cancer | 1 | 1 | 100.0% |
| Suspected acute leukaemia | 1 | 1 | 100.0% |
| Suspected children's cancer | 17 | 21 | 81.0% |
| Suspected gynaecological cancers | 100 | 110 | 90.9% |
| Suspected haematological malignancies e | 16 | 16 | 100.0% |
| Suspected head and neck cancers | 432 | 439 | 98.4% |
| Suspected lower gastrointestinal cancers | 186 | 199 | 93.5% |
| Suspected lung cancer | 32 | 32 | 100.0% |
| Suspected skin cancers | 658 | 728 | 90.4% |
| Suspected upper gastrointestinal cancers | 88 | 93 | 94.6% |
| **Grand Total** | **1,531** | **1,640** | **93.4%** |

## 2.3 PERFORMANCE – Responsive Domain

| Cancer Waiting Times – 62 Day | |
|---|---|
| **Standards:** | Urgent GP-referred suspected cancer patients should start first definitive treatment within 62 days of referral. National standard is that Trusts should achieve at least 85%. The improvement trajectory, as submitted to NHS Improvement, has also been set at 85%. |
| **Performance:** | For April, 86.8% of patients were seen within 62 days (99.0 out of 114 patients). For 2018/19 quarter 1 finished at 84.2%, quarter 2 finished at 87.3%, quarter 3 finished at 86.6% and quarter 4 finished at 83.8% |
| **Commentary/ Actions:** | The Trust returned to compliance in April 2019 (86.8%) following changes to the national waiting times rules for allocating performance on shared pathways between providers. This reduced the impact of delays at other providers (which made up over half of all breaches in February and March 2019).<br>To maintain compliance, the Trust must ensure it continues its strong management of all patients on cancer pathways, focussing on early pathways and diagnostics. Achieving the new '24 day' standard following receipt of a tertiary referral is also important in order to see the benefit of the changed rules. Preventing surgical cancellations and recovering from the impact of previous cancellations is essential to maintaining compliance. |
| **Ownership:** | Chief Operating Officer |



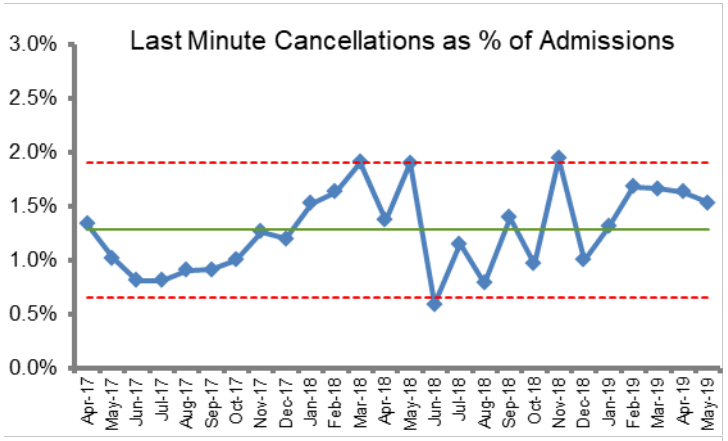



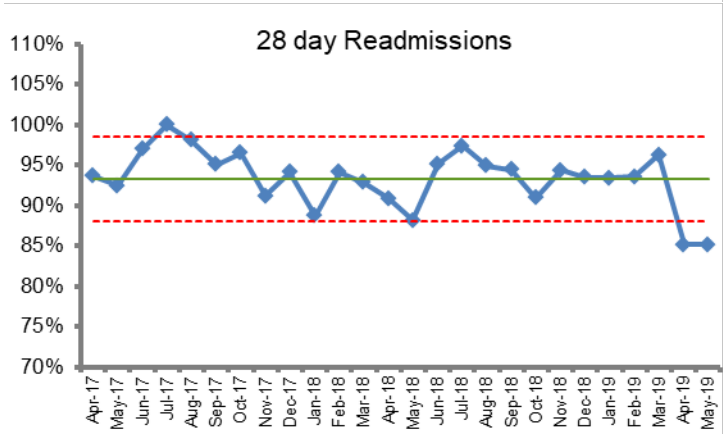



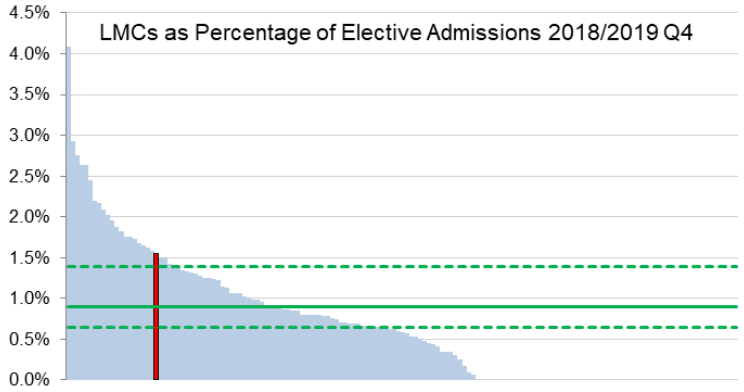

Cancer 62 Day - Apr-19

| | Within Target | Total Pathways | Performance |
|---|---|---|---|
| Breast | 3.0 | 4.0 | 75.0% |
| Gynaecological | 7.0 | 8.5 | 82.4% |
| Haematological | 3.5 | 4.5 | 77.8% |
| Head and Neck | 7.0 | 9.5 | 73.7% |
| Lower Gastrointestinal | 8.0 | 10.0 | 80.0% |
| Lung | 7.0 | 10.5 | 66.7% |
| Other | 3.5 | 3.5 | 100.0% |
| Sarcoma | 4.5 | 5.5 | 81.8% |
| Skin | 42.0 | 42.5 | 98.8% |
| Upper Gastrointestinal | 12.5 | 14.0 | 89.3% |
| Urological | 1.0 | 1.5 | 66.7% |
| **Grand Total** | **99.0** | **114.0** | **86.8%** |

| Last Minute Cancelled Operations | |
|---|---|
| **Standards:** | This covers elective admissions that are cancelled on the day of admission by the hospital, for non-clinical reasons. The total number for the month should be less than 0.8% of all elective admissions. Also, 95% of these cancelled patients should be re-admitted within 28 days |
| **Performance:** | In May there were 100 last minute cancellations, which was 1.5% of elective admissions.<br>Of the 108 cancelled in April, 92 (85.2%) had been re-admitted within 28 days. This means 16 patients breached the 28 day readmission standard. |
| **Commentary/ Actions:** | The most common reason for cancellation was "No beds available" (34 cancellations). There were 7 in Medicine, 17 in Cardiac Services, 13 in ENT & Thoracics, 27 in Gastrointestinal Surgery, 13 in Ophthalmology, 4 in Trauma & Orthopaedics, 11 in Dental Services and 8 in Paediatrics.<br>Of the sixteen 28 day breaches: 5 were Dental, 6 were ENT/Thoracics, 3 were General Surgery, 1 was Ophthalmology and 1 was Gynaecology. |
| **Ownership:** | Chief Operating Officer |



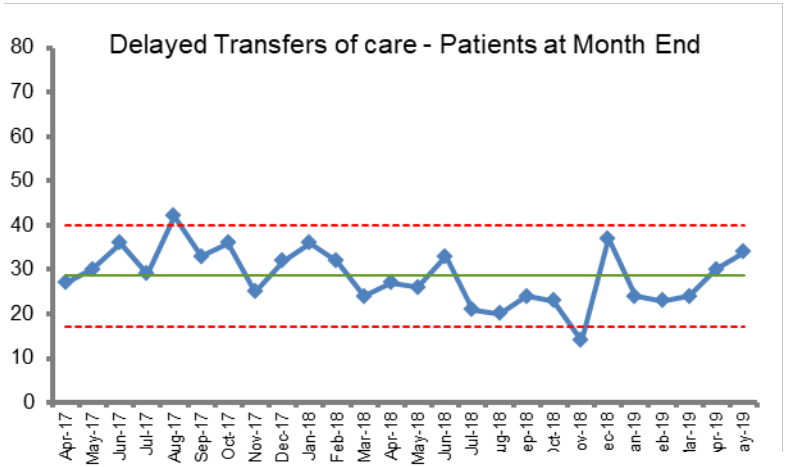



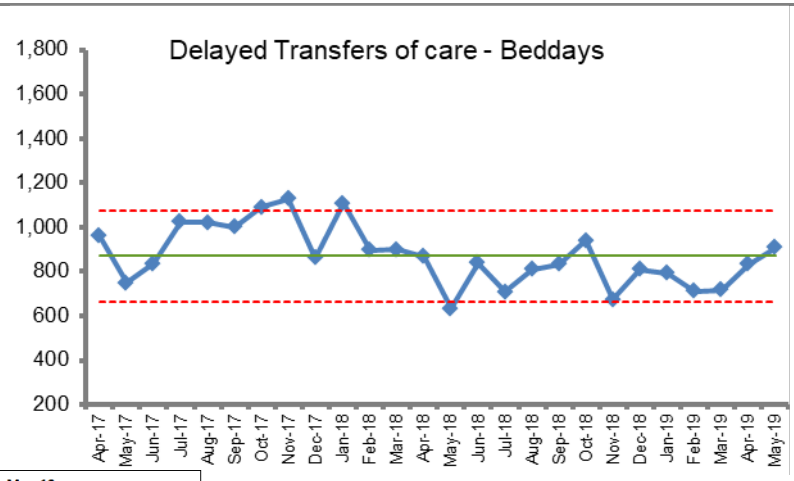

*Unbroken horizontal line is England median; dotted lines are upper & lower quartiles*

| Cancellation Reason | Total |
|---|---|
| No Beds Available | 34 |
| Other Emergency Patient Prioritised | 15 |
| AM list over-ran | 9 |
| No HDU Beds | 7 |
| Technician Not Available | 6 |
| Theatre Repairs required | 6 |
| List did not start on time | 4 |
| Other Non Emergency Patient Prioritised | 4 |
| Surgeon Unavailable | 3 |
| Booking Error | 3 |
| Other clinically complicated Patient in theatre | 3 |
| Equipment Unavailable | 2 |
| List Overbooked | 2 |
| Infection | 1 |
| Anaesthetist Unavailable | 1 |
| **Grand Total** | **100** |

## 2.3 PERFORMANCE – Responsive Domain

| Delayed Transfers of Care (DToC) | |
|---|---|
| **Standards:** | Patients who are medically fit for discharge should wait a "minimal" amount of time in an acute bed. |
| **Performance:** | In May there were 34 Delayed Transfer of Care patients as at month-end (including 11 at South Bristol), and 909 beddays consumed by DToC patients. |
| **Commentary/ Actions:** | The Integrated Care Bureau model continues to work well in relation to early identification of patients approaching discharge ready and agreement with partners regarding the most appropriate pathway for discharge. This is clearly demonstrated by consistently high number of patients on the Green To Go (G2G) list, however the number of formal Delayed Transfers of Care remains stable at approximately 30.<br>Where community capacity is available the ICB facilitates a smooth and timely discharge. However demand for Home First in particular is exceeding capacity and patients are experiencing delays in hospital as a result. At the end of May there were 8 patients delayed awaiting HomeFirst with another 4 within operational standards. 19 patients were either waiting for Social Care allocation or being assessed of which 10 had exceeded the operational standard, and there were 10 delays for patients waiting for a domiciliary package of care although on this occasion this was split evenly between self-funders and those funded by social care. Introducing the Single Referral Form for rehabilitation transfers to South Bristol Hospital has enabled a small number of patients to go straight home with HomeFirst or to an alternative, less acute, rehab setting. Beds at South Bristol Hospital which are not required for care of the elderly patients or rehab patients are being used for patients awaiting HomeFirst as their discharge plan is already agreed and the therapy available can ensure their functionality is maintained whilst waiting to go home. |
| **Ownership:** | Chief Operating Officer |

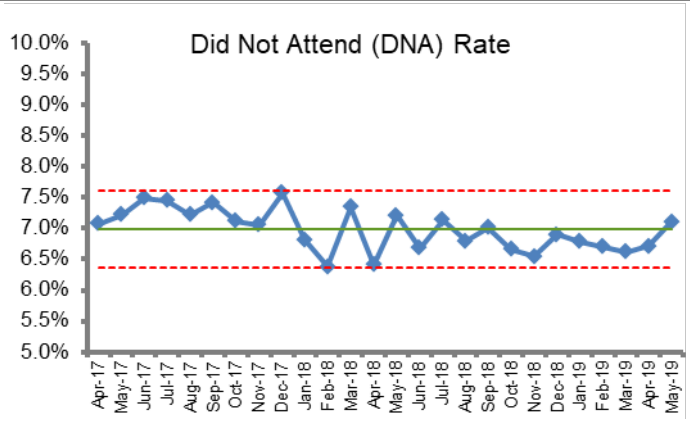


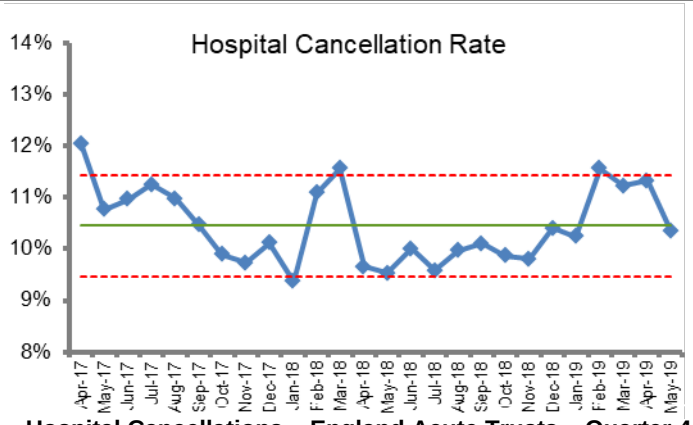




| | | | May-19 | | | |
|---|---|---|---|---|---|---|
| Code | Reason | Accountable | Patients (Acute) | Beddays (Acute) | Patients (Non-Acute) | Beddays (Non-Acute) |
| A | Completion of assessment | Both | 3 | 124 | 5 | 46 |
| | | NHS | 3 | 48 | 0 | 16 |
| | | Social Care | 7 | 152 | 4 | 104 |
| Di | Care Home Placement | NHS | 0 | 7 | 0 | 8 |
| | | Social Care | 0 | 33 | 1 | 30 |
| Dii | Care Home Placement | NHS | 4 | 61 | 0 | 19 |
| | | Social Care | 2 | 67 | 0 | 9 |
| E | Care package in own home | NHS | 2 | 27 | 0 | 6 |
| | | Social Care | 1 | 75 | 1 | 20 |
| F | Community equipment / adaptions | Both | 0 | 0 | 0 | 7 |
| | | NHS | 0 | 0 | 0 | 14 |
| | | Social Care | 1 | 12 | 0 | 7 |
| G | Patient or family choice | NHS | 0 | 1 | 0 | 9 |
| H | Disputes | NHS | 0 | 0 | 0 | 7 |
| TOTAL | | | 23 | 607 | 11 | 302 |

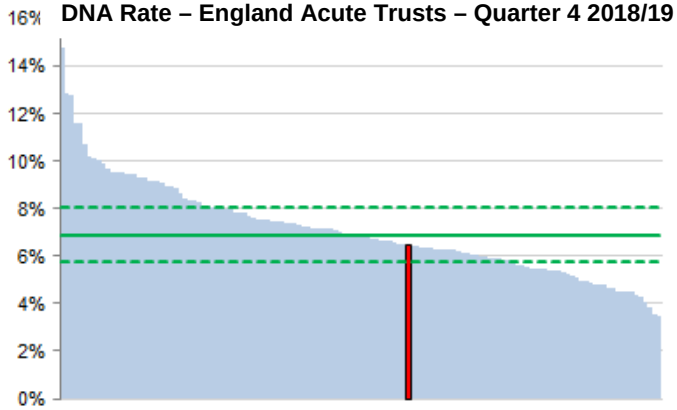
## 2.3 PERFORMANCE – Responsive Domain

| Outpatient Measures | |
|---|---|
| **Standards:** | The Did Not Attend (DNA) Rate is the number of outpatient appointments where the patient did not attend, as a percentage of all attendances and DNAs The Hospital Cancellation Rate is the number of outpatient appointments cancelled by the hospital, as a percentage of all outpatient appointments made. DNA Target at Trust level is to be below 6.7%, with an amber tolerance of between 6.7% and 7.2%. For Hospital Cancellations, the target is to be on or below 9.7% with an amber tolerance from 10.7% to 9.7%.. |
| **Performance:** | In May there were 9,553 hospital-cancelled appointments, which was 10.4% of all appointments made. There were 4713 appointments that were DNA'ed, which was 7.1% of all planned attendances. |
| **Commentary/ Actions:** | All divisions have set targets to reduce DNA's in specific specialities as part of the productivity workstreams for 2019/20. The Outpatient Steering Group (OSG) will monitor progress towards the targets set by each division and reviewing the Trust DNA rate on a monthly basis. The trend towards a more stable DNA rate is thought to be due to patients having greater choice over when and where they are seen for their first outpatient appointment through e-RS and the ongoing work to reduce the number of patients who are overdue their follow-up by more than 6 months. The increase in hospital cancellation rate is due to the introduction of e-RS, which whilst it allows the patient to book an appointment, if they require a different speciality or a particular clinic their original appointment will be cancelled to allow the correct appointment to be booked. Patients are informed their appointment is not confirmed until they receive confirmation following triage. Work is ongoing to review description of services to improve the number of appointments booked to the correct service first time. |
| **Ownership:** | Chief Operating Officer |

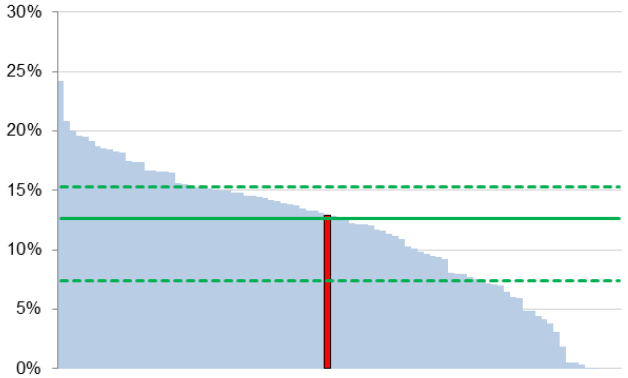



**DNA Rate – England Acute Trusts – Quarter 4 2018/19**




**Hospital Cancellations – England Acute Trusts – Quarter 4 2018/19**

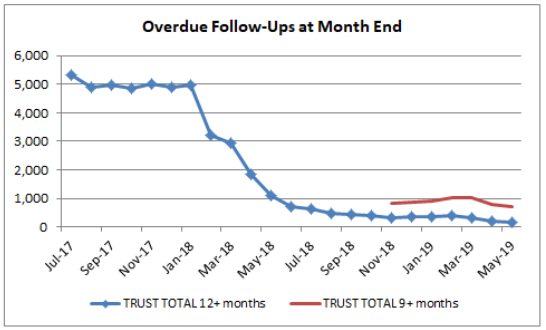



*Unbroken horizontal line is England median; dotted lines are upper & lower quartiles*

## 2.3 PERFORMANCE – Responsive Domain

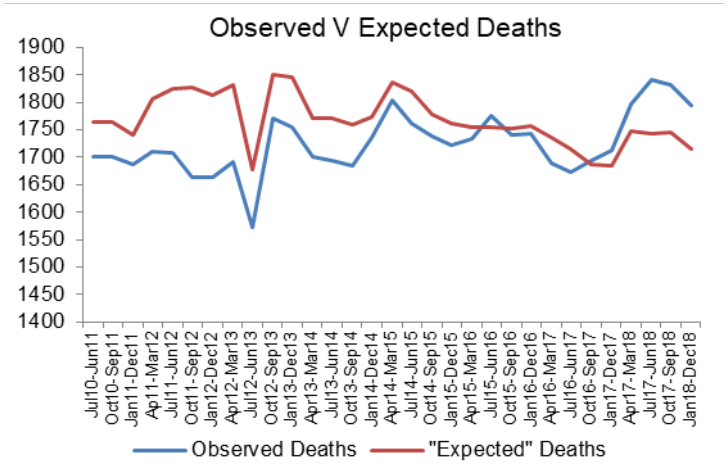
| Outpatient – Overdue Follow-Ups | |
|---|---|
| **Standards:** | This measure looks at referrals where the patient is on a "Partial Booking List", which indicates the patient is to be seen again in Outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can be reported. The current aim is to have no-one more than 12 months overdue |
| **Performance:** | As at end of May, number overdue by 12+ months is 145 and overdue by 9+ months is 710. |
| **Commentary/ Actions:** | Significant progress has been made by the divisions, through regular weekly review at the Wednesday performance meeting. Focus has now moved to the 9+ month's overdue patients for surgery, specialised services and Women's and Children's. Medicine division are focusing on the patients who have waited more than 6 months.<br>To re-focus attention on this area, divisions have now signed-up to recovery trajectories for key specialties, and an operational scorecard has been created for review at the weekly divisional performance meetings. This will allow a managed and targeted approach to reducing overdue follow-ups across all divisions and specialties.<br>Further transformation work is planned with BEH who now have a project manager in post for 1 year; this work will be supported by the CCG. |
| **Ownership:** | Chief Operating Officer |

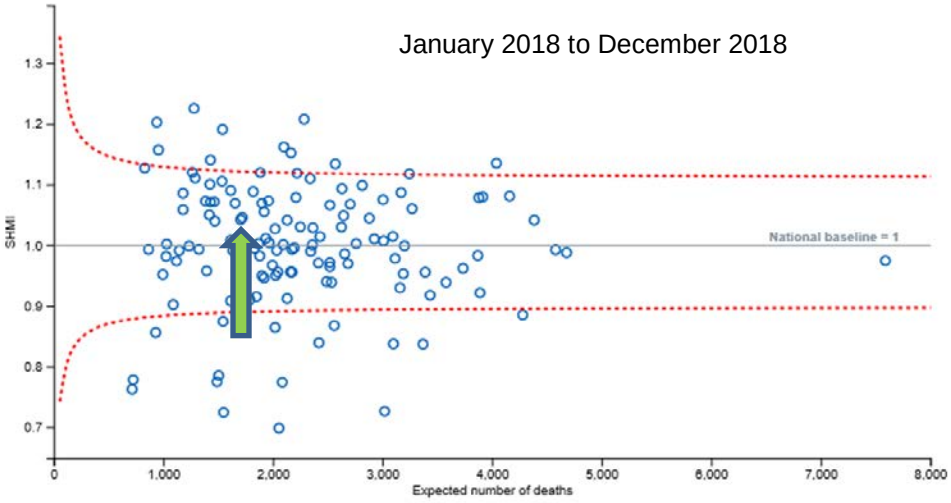
| | | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outpatients Overdue by 12+ Months | Diagnostics and Therapies | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Medicine | 1,113 | 1,045 | 1,111 | 1,252 | 1,336 | 1,276 | 1,345 | 1,245 | 1,105 | 461 | 133 | 23 | 5 | 7 | 3 | 3 | 2 | 3 | 4 | 3 | 3 | 3 | 3 |
| | Specialised Services | 563 | 432 | 442 | 295 | 353 | 387 | 400 | 367 | 383 | 188 | 206 | 214 | 208 | 95 | 58 | 67 | 7 | 5 | 8 | 12 | 0 | 0 | 34 |
| | Surgery | 1,200 | 1,058 | 1,015 | 934 | 947 | 922 | 887 | 717 | 573 | 444 | 221 | 92 | 17 | 3 | 0 | 0 | 0 | 0 | 11 | 23 | 49 | 61 | 62 |
| | Women's and Children's | 2,451 | 2,364 | 2,400 | 2,381 | 2,398 | 2,299 | 2,330 | 868 | 888 | 756 | 526 | 387 | 387 | 371 | 375 | 322 | 323 | 350 | 351 | 360 | 282 | 150 | 46 |
| | **TRUST TOTAL 12+ months** | **5,327** | **4,899** | **4,968** | **4,862** | **5,034** | **4,884** | **4,962** | **3,197** | **2,949** | **1,849** | **1,086** | **716** | **617** | **476** | **436** | **392** | **332** | **358** | **374** | **398** | **334** | 214 | 145 |
| Outpatients Overdue by 9+ Months | Diagnostics and Therapies | | | | | | | | | | | | | | | | | 3 | 2 | 0 | 0 | 0 | 0 | 0 |
| | Medicine | | | | | | | | | | | | | | | | | 20 | 4 | 4 | 3 | 4 | 4 | 3 |
| | Specialised Services | | | | | | | | | | | | | | | | | 125 | 95 | 142 | 247 | 253 | 181 | 261 |
| | Surgery | | | | | | | | | | | | | | | | | 125 | 124 | 108 | 146 | 216 | 264 | 272 |
| | Women's and Children's | | | | | | | | | | | | | | | | | 565 | 620 | 640 | 629 | 530 | 349 | 174 |
| | **TRUST TOTAL 9+ months** | | | | | | | | | | | | | | | | | **838** | **845** | **894** | **1025** | **1003** | 798 | 710 |



| Mortality - Summary Hospital Mortality Indicator (SHMI) | |
|---|---|
| **Standards:** | This is the national measure published by NHS Digital .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Summary Hospital Mortality Indicator (SHMI) covers deaths in-hospital and deaths within 30 days of discharge. It is published quarterly as covers a rolling 12 –month period. Data is published 6 months in arrears. |
| **Performance:** | Latest SHMI data is for 12 month period January 2018 to December 2018. The SHMI was 104.6 (1796 deaths and 1716 "expected"). Data is updated quarterly by NHS Digital. |
| **Commentary/ Actions:** | The latest published Summary Hospital Mortality Indicator was for 12 months to December 2018 and was 104.6 and in NHS Digital's "as expected" category. The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required. Please also see narrative for HSMR below. |
| **Ownership:** | Medical Director |

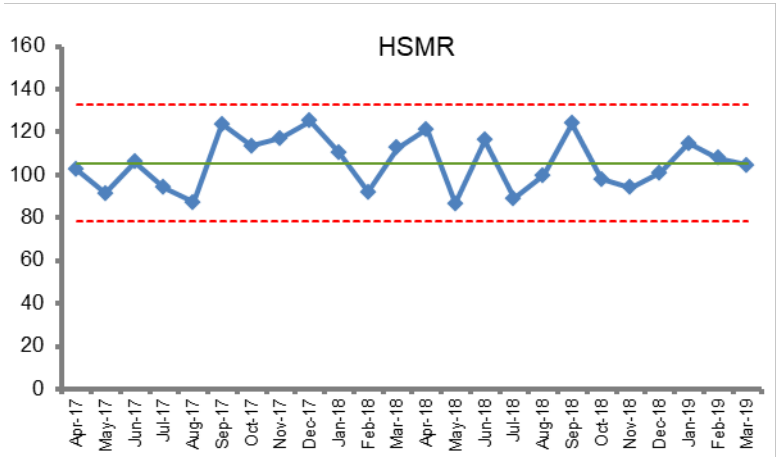
| Timeframe | Banding | Observed Deaths | "Expected" Deaths | SHMI |
|---|---|---|---|---|
| Jul15-Jun16 | As Expected | 1,775 | 1,754 | 101.2 |
| Oct15-Sep16 | As Expected | 1,741 | 1,752 | 99.4 |
| Jan16-Dec16 | As Expected | 1,743 | 1,758 | 99.1 |
| Apr16-Mar17 | As Expected | 1,690 | 1,737 | 97.3 |
| Jul16-Jun17 | As Expected | 1,674 | 1,714 | 97.6 |
| Oct16-Sep17 | As Expected | 1,693 | 1,686 | 100.4 |
| Jan17-Dec17 | As Expected | 1,712 | 1,684 | 101.7 |
| Apr17-Mar18 | As Expected | 1,796 | 1,748 | 102.7 |
| Jul17-Jun18 | As Expected | 1,841 | 1,744 | 105.6 |
| Oct17-Sep18 | As Expected | 1,833 | 1,745 | 105.0 |
| Jan18-Dec18 | As Expected | 1,795 | 1,715 | 104.7 |

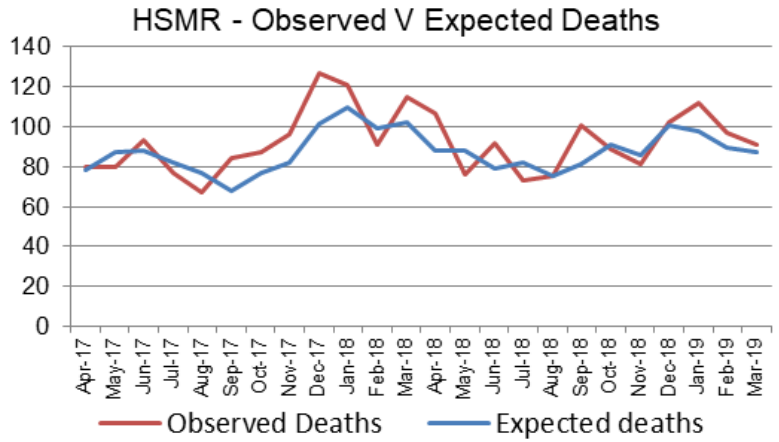


## 2.4 PERFORMANCE – Effective Domain

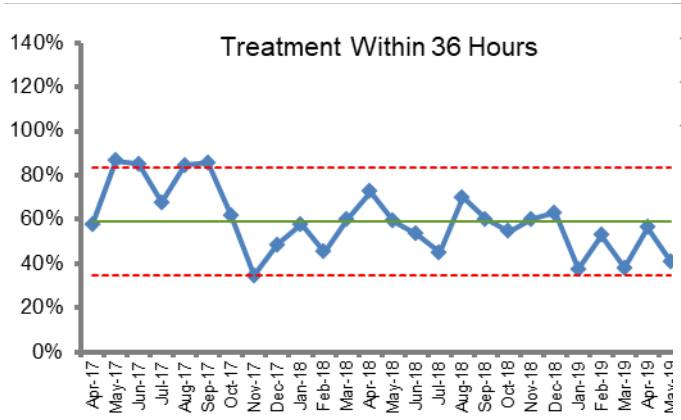
| Mortality – Hospital Standardised Mortality Ratio (HSMR) | |
|---|---|
| **Standards:** | This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100.<br>The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths |
| **Performance:** | Latest HSMR data is for March 2019. The HSMR was 105 (91 deaths and 87 "expected") |
| **Commentary/ Actions:** | As previously reported, actions are being taken in response to the detailed report into the Trust's HSMR and mortality for acute myocardial infarction. These actions include improving palliative care coding and improvements in repatriating patients to their local hospital following acute coronary intervention. It will take several months before the impact of actions is seen in HSMR |
| **Ownership:** | Medical Director |

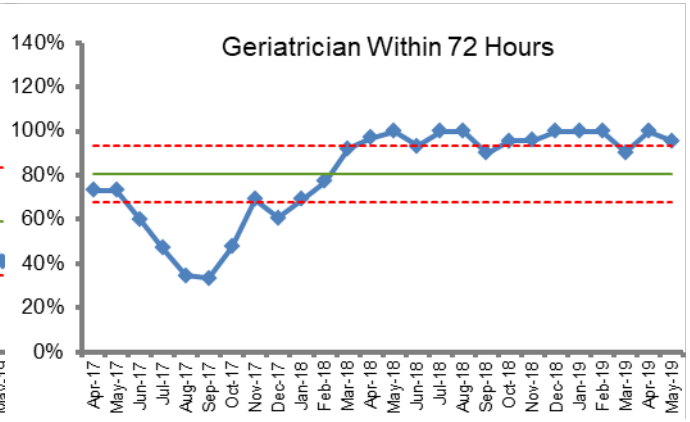


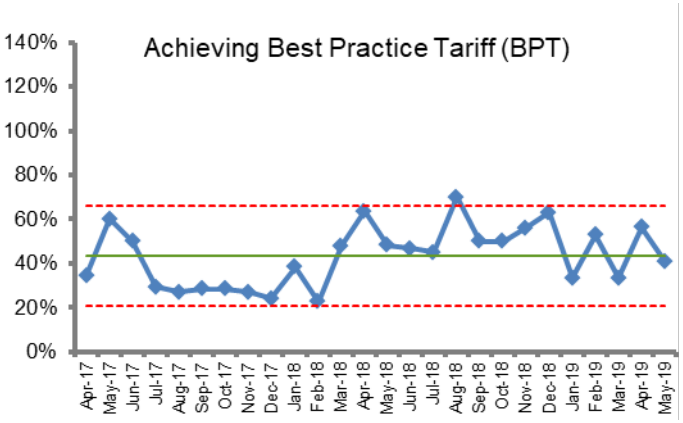



## 2.4 PERFORMANCE – Effective Domain

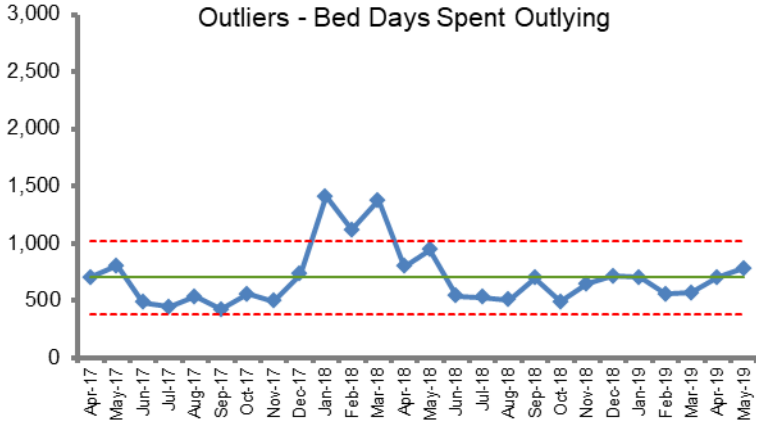
| Fracture Neck of Femur | |
|---|---|
| **Standards:** | Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%. |
| **Performance:** | In May, there were 24 patients discharged following an admission for fractured neck of femur, of which 22 were eligible for Best Practice Tariff (BPT).<br>For the 36 hour target, 41% (9 patients) were seen with target. For the 72 hour target, 15 of the 16 (96%) were seen within target.<br>9 patients (41%) achieved all elements of the Best Practice Tariff. |
| **Commentary/ Actions:** | Actions :<br>• Reviewing ability to provide full day trauma operating to allow for prioritisation of fractured neck of femur on trauma lists<br>• Reviewing ability to accommodate trauma overruns as required<br>• Continue to create additional capacity for trauma as possible by taking down other lists or using vacant theatre sessions<br>• Additional consultants being recruited who will support the fractured neck of femur pathway. Interviews are planned for the end of July.<br>• Appointment of an ortho-geriatrician. Interviews planned for then end of July 2019.<br>• Refresh of orthopaedic consultant job plans to provide more resilience to the team and cover for the orthopaedic on call trauma service. |
| **Ownership:** | Medical Director |

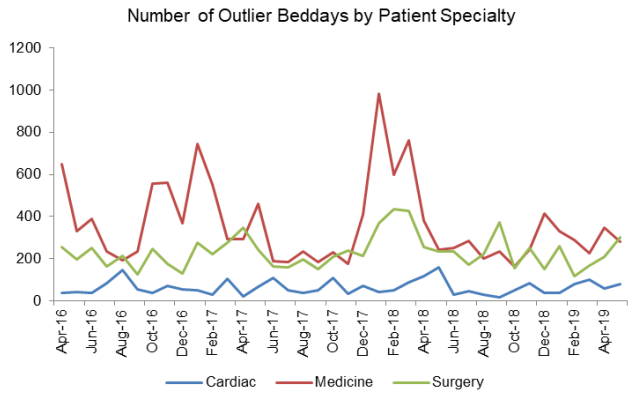


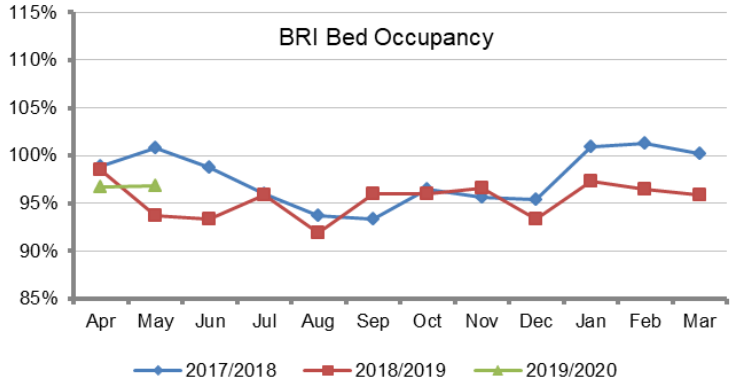



| Outliers | |
|---|---|
| **Standards:** | This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets. |
| **Performance:** | In May there were 782 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight). |
| **Commentary/ Actions:** | The May target of no more than 815 beddays was achieved. Of all the outlying beddays 281 were Medicine patients, 175 were Specialised Services patients and 302 were Surgery patients.<br>Within Specialised Services, a Standing Operating procedure has been developed for pre-emptive boarding into the Heart Institute. In addition, consultants have trialled a new ward round model to determine whether this supports flow and the initial data looks positive; there is now a longer trial for a period of 13 weeks.<br>The Surgery division continues to progress the urgent care model, emergency care pathways and ambulatory care. |
| **Ownership:** | Chief Operating Officer |

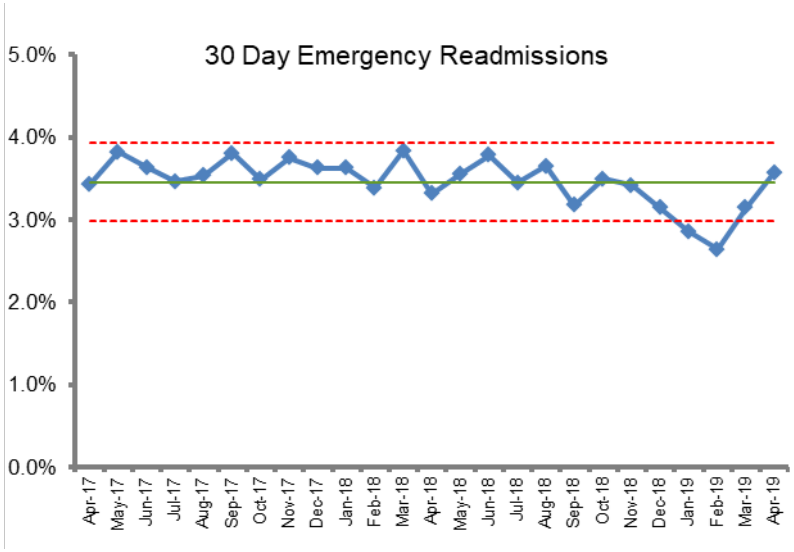


## 2.4 PERFORMANCE – Effective Domain

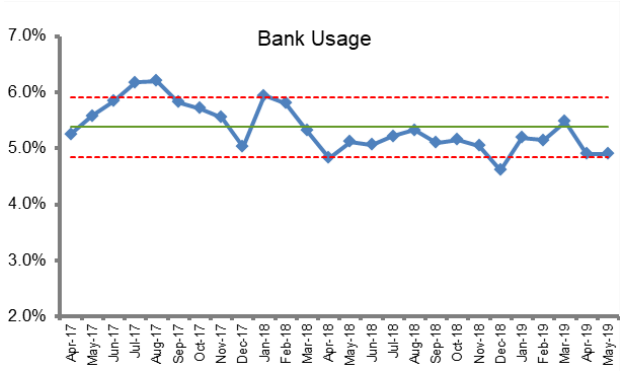
| 30 Day Emergency Readmissions | |
|---|---|
| **Standards:** | This reports on patients who are re-admitted as an emergency to the Trust within 30 days of being discharged. This can be in an unrelated specialty; it purely looks to see if there was a readmission. This uses Payment By Results (PbR) rules, which excludes certain pathways such as Cancer and Maternity. The target for the Trust is to remain below 2017/18 total of 3.62%, with a 10% amber tolerance down to 3.26%. |
| **Performance:** | In April, there were 12,487 discharges, of which 446 (3.57%) had an emergency re-admission within 30 days. |
| **Commentary/ Actions:** | 9.7% of Medicine division discharges were re-admitted within 30 days as an emergency, 3.6% from Surgery and 1.1% from Specialised Services. Data is monitored on a regular basis through divisional performance reviews and is included on the speciality performance reports.<br>The Colorectal team have recently undertaken an audit looking at Surgical Site Infections (SSIs) and plan to develop a business case which should see a reduction in length of stay and readmission rates. Plans within the emergency care pathway should prevent readmissions, for example, nurse led follow-up telephone calls 24 hours post discharge. |
| **Ownership:** | Chief Operating Officer |

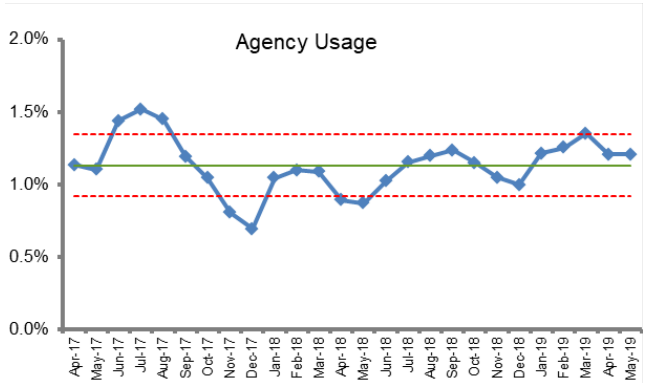



**Discharges in April 2019**

| | Emergency Readmissions | Total Discharges | % Readmissions |
|---|---|---|---|
| Diagnostics and Therapies | 2 | 36 | 5.56% |
| Medicine | 249 | 2,557 | 9.74% |
| Specialised Services | 32 | 2,803 | 1.14% |
| Surgery | 114 | 3,155 | 3.61% |
| Women's and Children's | 47 | 3,852 | 1.22% |
| **TRUST TOTAL** | **446** | **12,487** | **3.57%** |

| Bank and Agency Usage | |
|---|---|
| **Standards:** | Usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2018/19.<br>The red threshold is 10% over the monthly target. |
| **Performance:** | In May 2019, total staffing was at 8864 FTE. Of this, 4.8% was Bank (429 FTE) and 1.3% was Agency (116 FTE) |
| **Commentary/ Actions:** | **Agency usage** increased by 8.8 FTE.<br>The largest increase was seen in the division of Trust Services with 9.3 FTE compared to 4.3 FTE in the previous month.<br>The largest reduction was seen in the division of Surgery, decreasing to 20.1 FTE from 22.1 FTE the previous month.<br>The largest staff group increase was within Admin & Clerical increasing to 9.3 FTE from 4.3 FTE in the previous month.<br><br>**Bank usage** reduced by 4.4 FTE.<br>The largest increase was seen in the division of Trust Services, increasing to 33.5 FTE from 24.8 FTE the previous month.<br>The largest reduction was seen in Women's and Children's, decreasing to 60.0 FTE from 69.0 FTE the previous month.<br>The largest staff group increase was within Ancillary increasing to 48.6 FTE from 44.6 FTE in the previous month.<br>• Ongoing project with BNSSG partners to drive down high cost nurse agency supply.<br>• Active recruitment continues to the Trust Staff Bank, with 4 new Registered Nurse appointments and 7 Registered Nurses being reappointed to the Bank in May.<br>• A targeted 'Get set for summer' recruitment campaign to the Bank is underway. |
| **Ownership:** | Director of People |



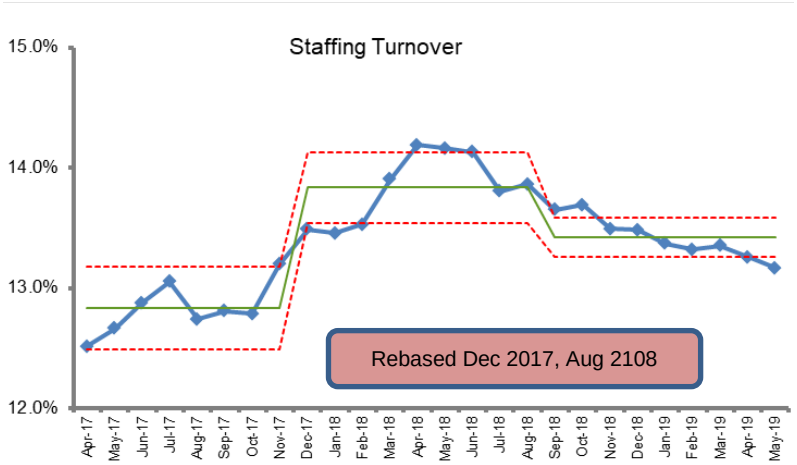




| Bank | May FTE | May Actual % | KPI |
|---|---|---|---|
| **UH Bristol NHS Foundation Trust** | **429.1** | **4.8%** | **4.6%** |
| Diagnostics & Therapies | 11.1 | 1.1% | 1.5% |
| Medicine | 115.6 | 8.8% | 9.0% |
| Specialised Services | 68.3 | 6.5% | 6.2% |
| Surgery | 95.2 | 5.2% | 5.4% |
| Women's & Children's | 60.0 | 2.9% | 1.6% |
| Trust Services | 33.5 | 3.9% | 3.3% |
| Facilities & Estates | 45.5 | 6.0% | 6.3% |

| Agency | May FTE | May Actual % | KPI |
|---|---|---|---|
| **UH Bristol NHS Foundation Trust** | **115.6** | **1.3%** | **0.8%** |
| Diagnostics & Therapies | 11.8 | 1.2% | 1.0% |
| Medicine | 39.5 | 3.0% | 1.8% |
| Specialised Services | 14.1 | 1.3% | 1.0% |
| Surgery | 20.1 | 1.1% | 0.7% |
| Women's & Children's | 20.5 | 1.0% | 0.4% |
| Trust Services | 9.3 | 1.1% | 0.6% |
| Facilities & Estates | 0.3 | 0.0% | 0.5% |

## 2.5 PERFORMANCE – Efficient Domain

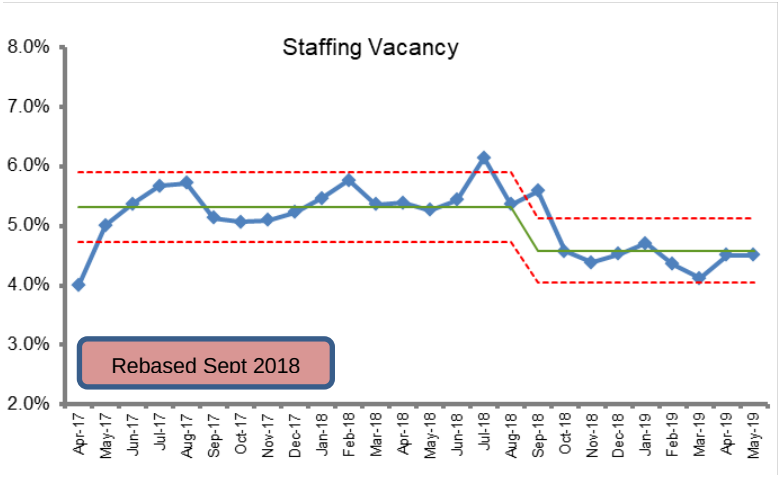
| Staffing Levels (Turnover) | |
|---|---|
| **Standards:** | Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory. |
| **Performance:** | In May 2019, there had been 936 leavers over the previous 12 months with 7109 FTE staff in post on average over that period; giving a Turnover of 936 / 7109 = 13.2% |
| **Commentary/ Actions:** | Turnover reduced to 13.2% from 13.3% last month, with increases in three divisions – Facilities & Estates, Specialised Services, and Surgery.<br>The largest divisional reduction was seen within Diagnostic & Therapies reducing to 10.2% from 10.7% the previous month.<br>The largest divisional increase was seen within Medicine increasing to 13.3% from 13.0% the previous month.<br>The biggest reduction in staff group was seen within Additional Clinical Services (1.4 percentage points).<br>The largest increase in staff group was seen within Nursing and Midwifery Unregistered (0.5 percentage points).<br>Actions:<br>• Development of the divisional improving staff experience plans in response to the staff survey heat map data will be in place in by the end of June.<br>• Following a reduced return rate, exit interview returns have improved with 65% of leavers responding in May. Detailed analysis of the survey responses are undertaken for each of the Divisions on a monthly basis.<br>• Work-streams to address the top 6 reasons for leaving from the exit returns are in progress through the Retention Group, wellbeing initiatives, Staff Survey Action Plans and in conjunction with the Education Team.<br>• Work-streams are established as part of the 12-month NHSI Clinical Retention Programme with initiatives being shared across other staff groups too, to maximise outcomes and impact. |
| **Ownership:** | Director of People |




| Turnover | May-19 | KPI |
|---|---|---|
| **UH Bristol NHS Foundation Trust** | 13.2% | **13.3%** |
| Diagnostics & Therapies | 10.2% | 10.4% |
| Medicine | 15.1% | 14.8% |
| Specialised Services | 16.8% | 15.3% |
| Surgery | 13.5% | 13.7% |
| Women's & Children's | 11.4% | 11.8% |
| Trust Services | 13.6% | 14.1% |
| Facilities & Estates | 13.3% | 14.6% |

## 2.5 PERFORMANCE – Efficient Domain

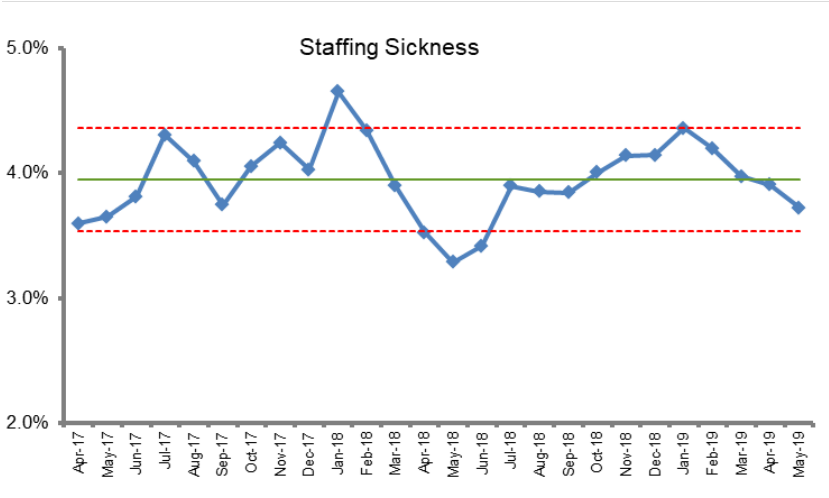
| Staffing Levels (Vacancy) | |
|---|---|
| **Standards:** | Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%. |
| **Performance:** | In May 2019, funded establishment was 8778 FTE, with 459 FTE as vacancies (5.2%). |
| **Commentary/ Actions:** | Overall vacancies increased to 5.2% compared to 4.5% in the previous month.<br>There were four staff group increases, the largest being within Nursing Staff increasing to 213.9 FTE from 179.1 FTE the previous month.<br>The largest staff group vacancy reduction was seen within Ancillary staff reducing to 70.6 FTE from 76.1 FTE the previous month.<br>Facilities & Estates had the largest Divisional reduction to 63.0 FTE from 71.4 FTE the previous month.<br>Actions<br>• With apprenticeship provision resumed for Nursing Assistants, a positive improvement in numbers of applications has been seen in May 2019; an increase to 73 applications in May from 16 in April. New monthly tracking has been introduced to monitor Nursing Assistant applications and conversion to hire.<br>• As part of a schedule of open days and career events, a successful RN open day was held on 22nd May with 16 offers made<br>• Interviews are scheduled for the end of June for the Trust's new Talent Acquisition Manager role. This post will have a significant focus on hard to fill clinical posts across the organisation.<br>• Phase one of the new recruitment website goes live beginning of July, creating a one stop platform for marketing and recruitment purposes. |
| **Ownership:** | Director of People |




| Vacancy | May-19 | KPI |
|---|---|---|
| **UH Bristol** | 5.2% | **5.0%** |
| Diagnostics & Therapies | 6.2% | **5.0%** |
| Medicine | 5.8% | **5.0%** |
| Specialised Services | 7.5% | **5.0%** |
| Surgery | 6.3% | **5.0%** |
| Women's & Children's | 1.3% | **5.0%** |
| Trust Services | 4.7% | **5.0%** |
| Facilities & Estates | 8.1% | **5.0%** |

## 2.5 PERFORMANCE – Efficient Domain

| Staff Sickness | |
|---|---|
| **Standards:** | Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2018/19. The red threshold is 0.5% over the monthly target. |
| **Performance:** | In May, total available FTE days were 261,189 of which 9,689 (3.7%) were lost to staff sickness |
| **Commentary/ Actions:** | Sickness absence reduced to 3.7% from 3.9%, with reductions in four divisions.<br>The largest divisional reduction was seen in Surgery reducing to 3.8% from 4.4% the previous month.<br>Trust Services saw the largest divisional increase to 3.7% from 3.3% the previous month.<br>The largest staff group increase was seen in Healthcare Scientists, rising to 2.6% from 2.2% the previous month.<br>The largest staff group reduction was seen within Nursing and Midwifery Unregistered reducing to 7.3% from 8.3% the previous month.<br>Actions:<br>• The Employee Services team continue to support high volumes of Supporting Attendance cases with 324 open cases currently logged.<br>• Highest reasons for absence being reported as anxiety, stress and depression, gastrointestinal and musculoskeletal<br>• An online training tool is under development to support managers effectively manage staff absence.<br>• Ongoing workplace wellbeing training continues to support staff with stress related issues alongside manager training which increases awareness and builds the confidence to recognise the symptoms in their teams. Over 300 staff have now attended one of these programmes since they began in May; this is supported by a number of guides and supporting documents which are available on HR Web. |
| **Ownership:** | Director of People |



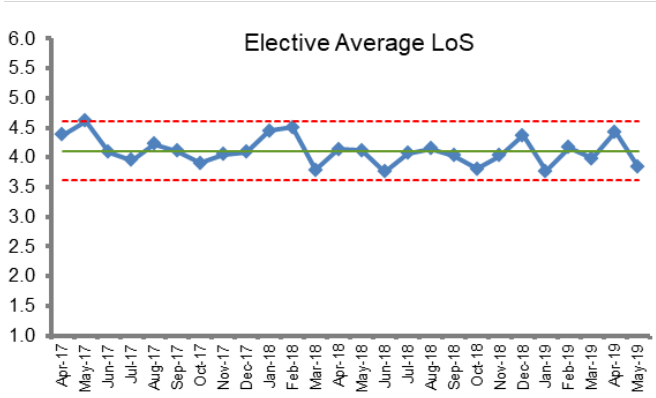

| Sickness | May-19 | KPI |
|---|---|---|
| **UH Bristol** | 3.7% | **3.6%** |
| Diagnostics & Therapies | 2.9% | 3.0% |
| Medicine | 3.7% | 3.7% |
| Specialised Services | 3.5% | 3.3% |
| Surgery | 3.8% | 3.6% |
| Women's & Children's | 3.4% | 3.6% |
| Trust Services | 3.7% | 2.5% |
| Facilities & Estates | 6.1% | 5.8% |

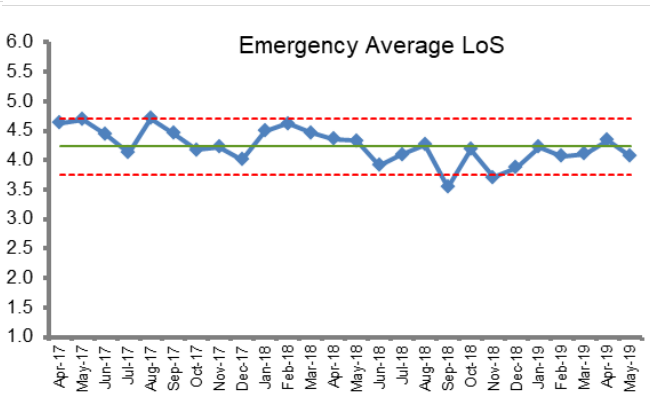
## 2.5 PERFORMANCE – Efficient Domain

| Staff Appraisal | |
|---|---|
| **Standards:** | Staff Appraisal in measured as a percentage of staff excluding consultants who have had their appraisal signed-off.<br>The target is 85% Trust-wide. |
| **Performance:** | In May 2019, 6,085 members of staff were compliant out of 8,236 (73.9%) |
| **Commentary/ Actions:** | Appraisal compliance reduced to 73.9% from 75.3%, with no increases within all seven divisions.<br>The largest divisional reduction was seen within Diagnostic and Therapies reducing to 86.3% from 88.7% the previous month, however they still remain compliant against target. The biggest reduction from a non-compliant Division was Women's & Children's, dropping by 2%.<br><br>The corporate appraisal recovery plan remains in place with specific focus on:<br>• Regular communications to all managers with a targeted message<br>• An additional appraisal training session being delivered each month<br>• Review of the intranet's HRWeb and supporting Appraisal documentation has commenced ahead of a policy review in the Autumn<br>• Effective targeting is currently in place of low compliance areas to further support mitigation of this risk supported by 'Hotspot' reports. |
| **Ownership:** | Director of People |

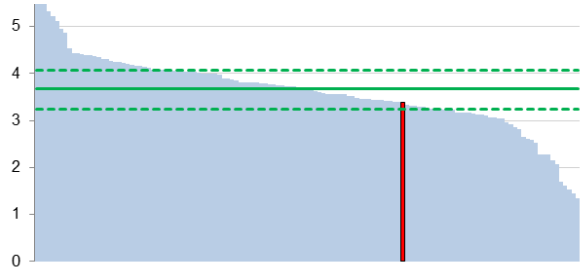
| Appraisal (Non-Consultant) | Apr-19 | May-19 | KPI |
|---|---|---|---|
| **UH Bristol NHS Foundation Trust** | 75.3% | 73.9% | **85.0%** |
| Diagnostics & Therapies | 88.7% | 86.3% | 85.0% |
| Medicine | 67.1% | 66.2% | 85.0% |
| Specialised Services | 84.9% | 84.9% | 85.0% |
| Surgery | 69.6% | 68.3% | 85.0% |
| Women's & Children's | 72.4% | 70.4% | 85.0% |
| Trust Services | 71.2% | 70.0% | 85.0% |
| Facilities & Estates | 79.6% | 78.2% | 85.0% |

| Average Length of Stay | |
|---|---|
| **Standards:** | Average Length of Stay is the number of beddays (1 beddays = 1 bed occupied at 12 midnight) for all inpatients discharged in the month, divided by number of discharges. |
| **Performance:** | In May there were 6,909 discharges that consumed 25,799 beddays, giving an overall average length of stay of 3.73 days. |
| **Commentary/ Actions:** | In Surgery a spike was seen in April and May due to significant number of patients with delayed discharge on A602 (Trauma & Orthopaedics). All patients have plans in place and the ward is working closely with the Integrated Discharge Service (IDS) team. In addition a divisional group has been set up to focus on length of stay as part of the Surgery working smarter initiative. Work streams include a review of specialty level Clinical Utilisation Review (CUR) reports and how we use the CUR information operationally, a review of criteria led discharge and a review of the data collection process for Enhanced Recovery After Surgery (ERAS). The division continue to review patients with a length of stay of 14+ days through weekly meeting with senior nursing teams.<br>In Specialised Services:<br>• Work is ongoing to implement the Day of Surgery Model for Cardiac Surgery patients and to also improve the pre-op element of the patient journey – this will be implemented on 5 August but with a changeover period so the benefits will be from September 2019.<br>• Action plan developed highlighting all of the work streams in place to improve patient flow within the Heart Institute and Oncology Centre<br>• Transformation project underway looking at inpatient echocardiography processes – all of the data and current processes have been collected and next steps is to redesign the process.<br>• New work stream being developed looking at the booking of catheter laboratory procedures<br>• Weekly ward meeting established to review CUR data and patients with a long length of stay. |
| **Ownership:** | Chief Operating Officer |



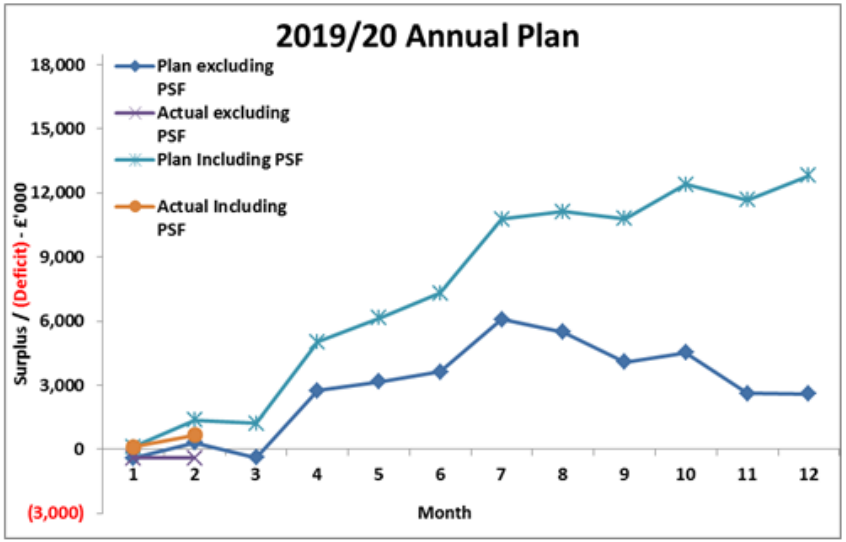

Average Length of Stay – England Trusts 2018/19 Quarter 4

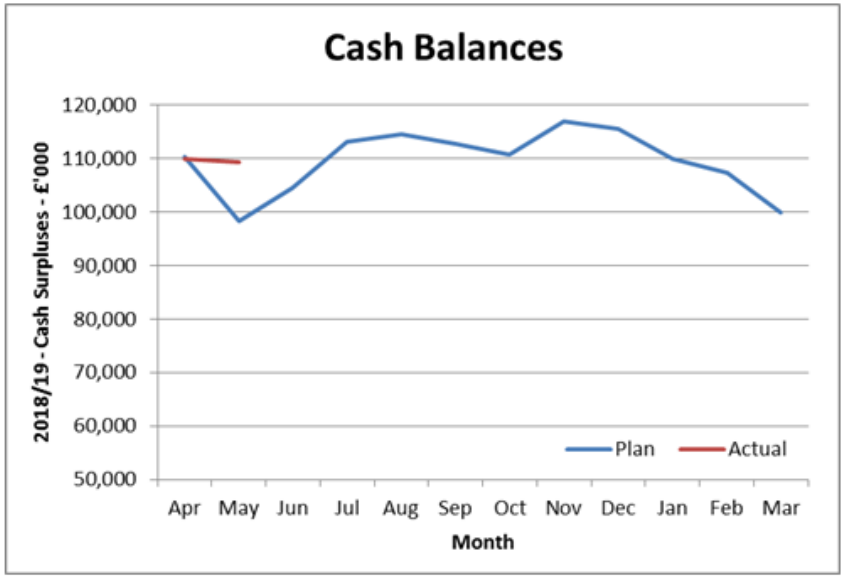



*Unbroken horizontal line is England median; dotted lines are upper & lower quartiles*

**Length of Stay of Inpatients at month-end**

| **May-19** | 7+ Days | 14+ Days | 21+ Days | 28+ Days |
|---|---|---|---|---|
| Bristol Children's Hospital | 63 | 39 | 29 | 25 |
| Bristol Haematology & Oncology Centre | 30 | 20 | 13 | 10 |
| Bristol Royal Infirmary | 215 | 126 | 81 | 55 |
| South Bristol Hospital | 56 | 51 | 41 | 33 |
| St Michael's Hospital | 27 | 17 | 15 | 12 |
| **TRUST TOTAL** | **397** | **256** | **182** | **138** |
| Bristol Royal Infirmary Divisional Breakdown: | | | | |
| Medicine | 111 | 66 | 50 | 37 |
| Specialised Services | 51 | 33 | 16 | 8 |
| Surgery, Head & Neck | 53 | 27 | 15 | 10 |



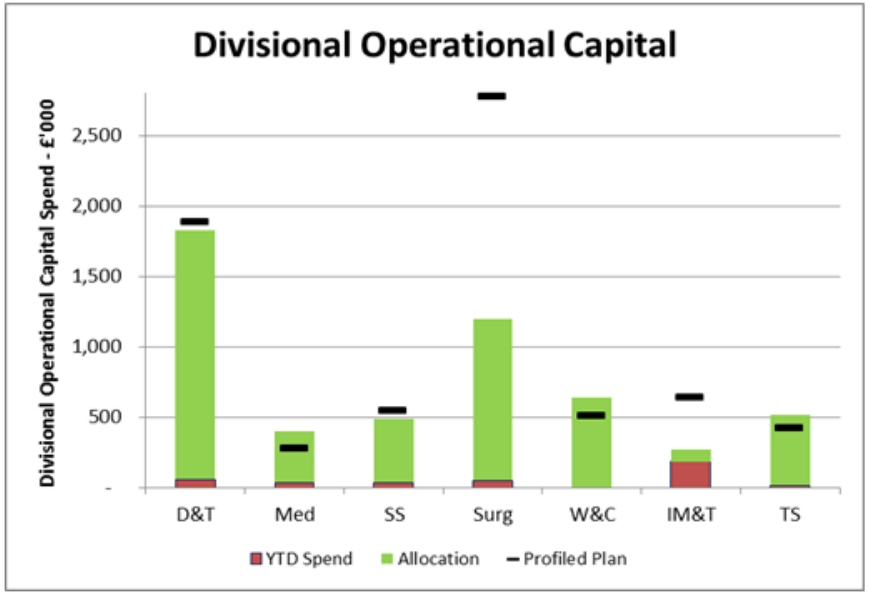



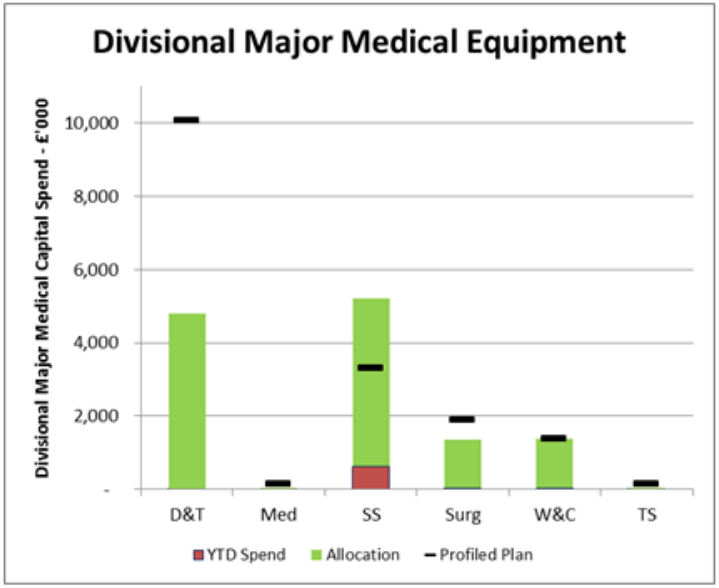

| Divisional Actual Spend - £'000 | | | | |
|---|---|---|---|---|
| | In Month | | Plan for | FOT |
| Divisional Agency | Apr | May | Year | Outturn |
| **Nursing & Midwifery** | 684 | 660 | **6,499** | **8,064** |
| **Medical** | | | | **0** |
| Consultants | 72 | 82 | **644** | **924** |
| Other Medical | 56 | 20 | **212** | **456** |
| **Other** | 140 | 144 | **1,384** | **1,704** |
| **Total** | **952** | **906** | **8,739** | **11,148** |

| YTD Variance to Budget Surplus/(Deficit) - £'000 | | |
|---|---|---|
| Division | Apr | May |
| Diagnostics & Therapies | (4) | (39) |
| Medicine | (167) | (320) |
| Specialised Services | (54) | 13 |
| Surgery | (175) | (659) |
| Women's & Children's | (215) | (311) |
| Estates & facilities | (5) | (9) |
| Trust Services | 4 | 3 |
| Other Corporate Services | 42 | 29 |
| **Total** | **(574)** | **(1,293)** |

| In Month Variance to Budget Surplus/(Deficit) - £'000 | | |
|---|---|---|
| Subjective Heading | Apr | May |
| Nursing & Midwifery Pay | (604) | (491) |
| Medical & Dental Pay | (360) | (187) |
| Other Pay | 242 | 197 |
| Non Pay | 954 | 189 |
| Income from Operations | (173) | (94) |
| Income from Activities | (632) | (336) |
| **Total** | **(573)** | **(722)** |


| 2019/20 Capital Programme | | | Year to date | | |
|---|---|---|---|---|---|
| Internal Plan | Subjective Heading | Profiled Plan / FOT | Profiled Plan | Actual spend | Variance |
| £m | | £m | £m | £m | £m |
| | **Sources of Funding** | | | | |
| 8.60 | PDC | 8.60 | - | - | - |
| 3.80 | Donations - Cash | 3.79 | 0.01 | 0.05 | 0.04 |
| - | Donations - Direct | 0.01 | 0.01 | 0.01 | - |
| | Cash: | | | | |
| 25.53 | Depreciation | 25.53 | 4.19 | 3.98 | (0.212) |
| 0.68 | Insurance Claim | 0.68 | 0.09 | 0.09 | - |
| 18.77 | Cash balances | 18.70 | (2.21) | (1.83) | 0.39 |
| **57.38** | **Total Funding** | **57.32** | **2.09** | **2.30** | **0.21** |
| | **Application/Expenditure** | | | | |
| (25.74) | Strategic Schemes | (25.73) | (0.49) | (0.36) | 0 |
| (18.07) | Medical Equipment | (18.07) | (0.69) | (0.71) | (0.02) |
| (14.55) | Operational Capital | (14.49) | (0.46) | (0.68) | (0.22) |
| (2.42) | Fire Improvement Programme | (2.42) | - | (0.07) | (0.07) |
| (14.72) | Information Technology | (14.72) | (0.33) | (0.32) | 0 |
| (4.59) | Estates Replacement | (4.59) | (0.13) | (0.17) | (0.04) |
| **(80.10)** | **Gross Expenditure** | **(80.03)** | **(2.09)** | **(2.30)** | **(0.21)** |
| 22.71 | In-year Slippage | 22.71 | - | - | - |
| **(57.38)** | **Net Expenditure** | **(57.32)** | **(2.09)** | **(2.30)** | **(0.21)** |

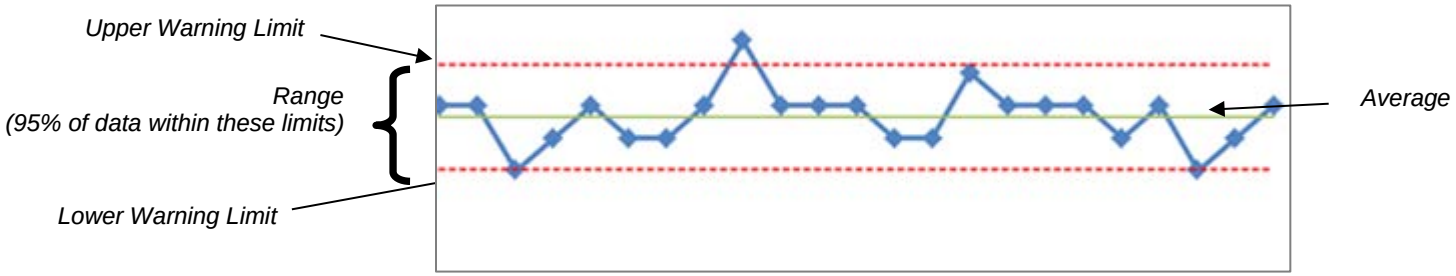


# APPENDIX 1 – Explanation of SPC Charts

In Section 2, some of the metrics are being presented using Statistical Process Control (SPC) charts

An example chart is shown below:




The blue line is the Trust's monthly data and the green solid line is the monthly average for that data. The red dashed lines are called "warning limits" and are derived from the Trust's monthly data and is a measure of the variation present in the data. If the process does not change, then 95% of all future data points will lie between these two limits.

If a process changes, then the limits can be re-calculated and a "step change" will be observed. There are different signals to look for, to identify if a process has changed. Examples would be a run of 7 data points going up/down or 7 data points one side of the average. These step changes should be traceable back to a change in operational practice; they do not occur by chance.

## A2 APPENDIX 2 External Views of the Trust

This section provides details of the ratings and scores published by the Care Quality Commission (CQC), NHS Choices website and Monitor. A breakdown of the currently published score is provided, along with details of the scoring system and any changes to the published scores from the previous reported period.

## Care Quality Commission

**Ratings for the main University Hospitals Bristol NHS Foundation Trust sites**
(March 2017)

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Urgent & Emergency Medicine** | Good | Outstanding | Good | Requires improvement | Outstanding | Good |
| **Medical care** | Good | Good | Good | Good | Good | Good |
| **Surgery** | Good | Good | Outstanding | Good | Outstanding | Outstanding |
| **Critical care** | Good | Good | Good | Requires improvement | Good | Good |
| **Maternity & Family Planning** | Good | Good | Good | Good | Outstanding | Good |
| **Services for children and young people** | Good | Outstanding | Good | Good | Good | Good |
| **End of life care** | Good | Good | Good | Good | Good | Good |
| **Outpatients & Diagnostic Imaging** | Good | Not rated | Good | Good | Good | Good |
| **Overall** | Good | Outstanding | Good | Requires improvement | Outstanding | **Outstanding** |

## NHS Choices

**Website**
The NHS Choices website has a 'Services Near You' page, which lists the nearest hospitals for a location you enter. This page has ratings for hospitals (rather than trusts) based upon a range of data sources.

| Site | User ratings | Recommended by staff | Mortality rate (within 30 days) | Food choice & Quality |
|---|---|---|---|---|
| BCH | 5 stars | OK | OK | ✓ 98.5% |
| STM | 5 stars | OK | OK | ✓ 98.4% |
| BRI | 4 stars | OK | OK | ✓ 96.5% |
| BDH | 3 stars | OK | OK | Not available |
| BEH | 4.5 Stars | OK | OK | ✓ 91.7% |

Stars – maximum 5
OK = Within expected range
✓ = Among the best (top 20%)
! = Among the worst
Please refer to appendix 1 for our site abbreviations.

## SAFE, CARING & EFFECTIVE

| Topic | ID | Title | Annual 18/19 | Annual 19/20 YTD | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Quarterly 18/19 Q2 | Quarterly 18/19 Q3 | Quarterly 18/19 Q4 | Quarterly 19/20 Q1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Safety** | | | | | | | | | | | | | | | | | | | | |
| Infections | DA01 | MRSA Trust Apportioned Cases | 6 | 0 | 2 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 |
| | DA02 | MSSA Trust Apportioned Cases | 34 | 12 | 4 | 2 | 3 | 1 | 1 | 3 | 3 | 3 | 2 | 4 | 5 | 7 | 6 | 7 | 9 | 12 |
| | DA03 | CDiff Trust Apportioned Cases | 31 | 6 | 6 | 4 | 1 | 7 | 2 | 4 | 2 | 1 | 1 | 1 | 4 | 2 | 12 | 8 | 3 | 6 |
| | DA06 | EColi Trust Apportioned Cases | 83 | 14 | 7 | 7 | 8 | 12 | 7 | 0 | 7 | 5 | 5 | 8 | 6 | 8 | 27 | 14 | 18 | 14 |
| C.Diff "Avoidables" | DA03B | CDiff Trust Apportioned Cases - Lapse in Care | 9 | 0 | 1 | 2 | 0 | 2 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 4 | 2 | 1 | 0 |
| | DA03D | CDiff Trust Apportioned Cases - Still Under Review | 3 | 4 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 3 | 0 | 0 | 4 |
| Infection Checklists | DB01 | Hand Hygiene Audit Compliance | 97% | 95.7% | 97.4% | 97.7% | 97.2% | 98% | 97% | 96.5% | 96.8% | 96.3% | 96.6% | 96.7% | 95.6% | 95.7% | 97.6% | 96.8% | 96.6% | 95.7% |
| | DB02 | Antibiotic Compliance | 78.9% | 78.9% | 83% | 84.6% | 77.4% | 75.1% | 76.7% | 75.7% | 85% | 79.1% | 66.3% | 68% | 76.1% | 84.2% | 79.6% | 77.6% | 72.2% | 78.9% |
| Cleanliness Monitoring | DC01 | Cleanliness Monitoring - Overall Score | - | - | 95% | 95% | 95% | 95% | 95% | 96% | 95% | 96% | 96% | 95% | 96% | 96% | - | - | - | - |
| | DC02 | Cleanliness Monitoring - Very High Risk Areas | - | - | 98% | 97% | 97% | 97% | 98% | 98% | 97% | 97% | 98% | 98% | 98% | 98% | - | - | - | - |
| | DC03 | Cleanliness Monitoring - High Risk Areas | - | - | 96% | 96% | 95% | 95% | 96% | 96% | 96% | 96% | 97% | 97% | 97% | 96% | - | - | - | - |
| Serious Incidents | S02 | Number of Serious Incidents Reported | 70 | 10 | 4 | 4 | 8 | 8 | 4 | 10 | 4 | 3 | 7 | 5 | 7 | 3 | 20 | 18 | 15 | 10 |
| | S02a | Number of Confirmed Serious Incidents | 58 | - | 4 | 4 | 8 | 6 | 4 | 8 | 3 | 2 | 5 | 1 | - | - | 18 | 15 | 8 | - |
| | S02b | Number of Serious Incidents Still Open | 10 | 10 | - | - | - | 1 | 0 | 2 | 0 | 1 | 2 | 4 | 7 | 3 | 1 | 2 | 7 | 10 |
| | S03 | Serious Incidents Reported Within 48 Hours | 98.6% | 100% | 100% | 100% | 100% | 100% | 100% | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 94.4% | 100% | 100% |
| | S03a | Serious Incidents - 72 Hour Report Completed Within Timescale | 94.3% | 90% | 100% | 75% | 100% | 100% | 100% | 80% | 75% | 100% | 100% | 100% | 85.7% | 100% | 95% | 83.3% | 100% | 90% |
| | S04 | Serious Incident Investigations Completed Within Timescale | 96.8% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 80% | 100% | 100% | 100% | 100% | 100% | 93.8% | 100% |
| | S04a | Overdue Exec Commissioned Non-SI Investigations | 10 | 2 | 1 | 2 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 4 | 0 | 1 | 2 |
| Never Events | S01 | Total Never Events | 5 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 2 | 0 | 0 | 1 | 0 | 0 | 1 | 3 | 1 | 0 |
| Patient Safety Incidents | S06 | Number of Patient Safety Incidents Reported | 17839 | 2400 | 1445 | 1566 | 1539 | 1510 | 1517 | 1511 | 1371 | 1520 | 1551 | 1570 | 1373 | 1027 | 4615 | 4399 | 4641 | 2400 |
| | S06b | Patient Safety Incidents Per 1000 Beddays | 58.56 | 45.72 | 59.13 | 60.39 | 62.35 | 59.72 | 58.92 | 58.92 | 54.11 | 57.27 | 64.61 | 58.94 | 53.22 | 38.47 | 60.81 | 57.33 | 60.13 | 45.72 |
| | S07 | Number of Patient Safety Incidents - Severe Harm | 88 | 8 | 10 | 5 | 3 | 9 | 9 | 7 | 5 | 7 | 4 | 10 | 7 | 1 | 17 | 21 | 21 | 8 |
| Patient Falls | AB01 | Falls Per 1,000 Beddays | 4.48 | 4.72 | 3.72 | 4.4 | 5.27 | 4.9 | 3.73 | 4.48 | 5.17 | 5.61 | 4.67 | 3.72 | 4.46 | 4.98 | 4.85 | 4.46 | 4.66 | 4.72 |
| | AB06a | Total Number of Patient Falls Resulting in Harm | 27 | 3 | 1 | 1 | 5 | 2 | 2 | 1 | 2 | 3 | 1 | 3 | 3 | 0 | 8 | 5 | 7 | 3 |
| Pressure Ulcers Developed in the Trust | DE01 | Pressure Ulcers Per 1,000 Beddays | 0.295 | 0.114 | 0.123 | 0.347 | 0.203 | 0.277 | 0.816 | 0.39 | 0.276 | 0.527 | 0.083 | 0.188 | 0.194 | 0.037 | 0.277 | 0.495 | 0.272 | 0.114 |
| | DE02 | Pressure Ulcers - Grade 2 | 80 | 5 | 3 | 8 | 4 | 7 | 18 | 8 | 7 | 13 | 2 | 5 | 4 | 1 | 19 | 33 | 20 | 5 |
| | DE04A | Pressure Ulcers - Grade 3 or 4 | 10 | 1 | 0 | 1 | 1 | 0 | 3 | 2 | 0 | 1 | 0 | 0 | 1 | 0 | 2 | 5 | 1 | 1 |
| Venous Thrombo-embolism (VTE) | N01 | Adult Inpatients who Received a VTE Risk Assessment | 98.3% | 98.3% | 98.5% | 98.3% | 98.7% | 98.4% | 98.4% | 98% | 98.3% | 98.2% | 98% | 98.7% | 98.5% | 98.2% | 98.5% | 98.2% | 98.3% | 98.3% |
| | N02 | Percentage of Adult Inpatients who Received Thrombo-prophylaxis | 92.6% | 93.3% | 91.1% | 95% | 93.4% | 89.6% | 87.8% | 92.2% | 95.5% | 91.4% | 88.6% | 94.5% | 93.4% | 93.2% | 92.9% | 91.1% | 91.9% | 93.3% |
| | N04 | Number of Hospital Associated VTEs | 39 | - | 3 | 4 | 6 | 3 | 2 | 2 | 6 | 6 | - | - | - | - | 13 | 10 | 6 | - |
| | N04A | Number of Potentially Avoidable Hospital Associated VTEs | 2 | - | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | - | - | - | - | 1 | 0 | 0 | - |
| | N04B | Number of Hospital Associated VTEs - Report Not Received To Date | 16 | - | 0 | 2 | 2 | 0 | 1 | 1 | 4 | 5 | - | - | - | - | 4 | 6 | 5 | - |
| Nutrition Audit | WB10 | Fully and Accurately Completed Screening within 24 Hours | 91.1% | - | 92% | - | - | 90.4% | - | - | 92.1% | - | - | 89.9% | - | - | 90.4% | 92.1% | 89.9% | - |
| Safety | Y01 | WHO Surgical Checklist Compliance | 99.8% | 99.8% | 99.7% | 99.9% | 99.8% | 99.8% | 99.8% | 99.8% | 99.8% | 99.8% | 99.8% | 99.9% | 99.9% | 99.6% | 99.8% | 99.8% | 99.8% | 99.8% |
| Medicines | WA01 | Medication Incidents Resulting in Harm | 0.29% | 0% | 0.37% | 0% | 0% | 0% | 0.29% | 0.36% | 0.8% | 0.77% | 0% | 0% | 0% | - | 0% | 0.46% | 0.28% | 0% |
| | WA03 | Non-Purposeful Omitted Doses of the Listed Critical Medication | 0.37% | 0.39% | 0.24% | 0.54% | 0.22% | 0.53% | 0.41% | 0.2% | 0.62% | 0% | 0.25% | 0.42% | 0.31% | 0.46% | 0.4% | 0.39% | 0.24% | 0.39% |

# APPENDIX 3 – Trust Scorecards

| Topic | ID | Title | Annual 18/19 | Annual 19/20 YTD | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Quarterly 18/19 Q2 | Quarterly 18/19 Q3 | Quarterly 18/19 Q4 | Quarterly 19/20 Q1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deteriorating Patient | AR03 | National Early Warning Scores (NEWS) Acted Upon | 88% | - | 95% | 88% | 84% | 90% | 93% | 96% | 87% | 83% | 91% | 85% | - | - | 87% | 92% | 86% | - |
| Out of Hours | TD05 | Out of Hours Discharges (8pm-7am) | 8.7% | 8.3% | 8.9% | 10.3% | 9.5% | 9.4% | 9.2% | 8.7% | 8.7% | 7.9% | 6.4% | 7% | 8.3% | 8.3% | 9.7% | 8.9% | 7.1% | 8.3% |
| Timely Discharges | TD03 | Percentage of Patients With Timely Discharge (7am-12Noon) | 23.9% | 23% | 24.6% | 24.1% | 24.5% | 24.3% | 23.7% | 25.1% | 23.1% | 23% | 23.1% | 22.8% | 22.5% | 23.5% | 24.3% | 24% | 23% | 23% |
| | TD03D | Number of Patients With Timely Discharge (7am-12Noon) | 9815 | 1554 | 800 | 810 | 824 | 804 | 832 | 926 | 816 | 821 | 718 | 839 | 749 | 805 | 2438 | 2574 | 2378 | 1554 |
| Staffing Levels | RP01 | Staffing Fill Rate - Combined | 99.3% | 101.1% | 100.1% | 99.1% | 97% | 98.5% | 99.6% | 101.1% | 99.1% | 100.1% | 99.9% | 99.1% | 100.6% | 101.6% | 98.2% | 99.9% | 99.7% | 101.1% |
| **Clinical Effectiveness** | | | | | | | | | | | | | | | | | | | | |
| Mortality | X04 | Summary Hospital Mortality Indicator (SHMI) - National Data | 105.1 | - | 105.6 | - | - | 105 | - | - | 104.6 | - | - | - | - | - | 105 | 104.6 | - | - |
| | X02 | Hospital Standardised Mortality Ratio (HSMR) | 104.7 | - | 116.3 | 89.1 | 99.8 | 123.9 | 97.9 | 94 | 101 | 114.7 | 108 | 104.6 | - | - | 104.4 | 97.8 | 109.3 | - |
| Readmissions | C01 | Emergency Readmissions Percentage | 3.3% | 3.57% | 3.78% | 3.45% | 3.65% | 3.17% | 3.49% | 3.42% | 3.15% | 2.85% | 2.64% | 3.15% | 3.57% | - | 3.43% | 3.36% | 2.89% | 3.57% |
| Fracture Neck of Femur | U02 | Fracture Neck of Femur Patients Treated Within 36 Hours | 56.3% | 47.4% | 53.3% | 45% | 70% | 60% | 54.5% | 60% | 63.2% | 37.5% | 52.9% | 38.1% | 56.3% | 40.9% | 58.3% | 59.1% | 41.9% | 47.4% |
| | U03 | Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours | 97% | 97.4% | 93.3% | 100% | 100% | 90% | 95.5% | 96% | 100% | 100% | 100% | 90.5% | 100% | 95.5% | 96.7% | 97% | 96.8% | 97.4% |
| | U04 | Fracture Neck of Femur Patients Achieving Best Practice Tariff | 51.3% | 47.4% | 46.7% | 45% | 70% | 50% | 50% | 56% | 63.2% | 33.3% | 52.9% | 33.3% | 56.3% | 40.9% | 55% | 56.1% | 38.7% | 47.4% |
| | U05 | Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours) | - | - | 50.6 | 61.3 | 79.3 | 63.6 | - | - | - | - | - | - | - | - | - | - | - | - |
| Stroke Care | O01 | Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour | 51.1% | 52.8% | 66.7% | 34.3% | 48.3% | 51.9% | 53.8% | 51.3% | 45.7% | 51.1% | 48.3% | 69.2% | 52.8% | - | 44% | 50.4% | 56.6% | 52.8% |
| | O02 | Stroke Care: Percentage Spending 90%+ Time On Stroke Unit | 84.2% | 72.2% | 89.7% | 82.9% | 89.7% | 92.6% | 66.7% | 92.3% | 85.7% | 80% | 100% | 82.1% | 72.2% | - | 87.9% | 81.4% | 85.8% | 72.2% |
| | O03 | High Risk TIA Patients Starting Treatment Within 24 Hours | 58.6% | 55.2% | 63.2% | 30.8% | 66.7% | 46.7% | 55.6% | 73.3% | 50% | 50% | 84.6% | 90% | 69.2% | 43.8% | 47.5% | 63.3% | 75.5% | 55.2% |
| Dementia | AC01 | Dementia - FAIR Question 1 - Case Finding Applied | 83% | 85.9% | 77.6% | 74.7% | 80.2% | 79.8% | 79% | 89% | 86.8% | 88.2% | 86.4% | 81.5% | 84.2% | 87.6% | 78% | 84.7% | 85.4% | 85.9% |
| | AC02 | Dementia - FAIR Question 2 - Appropriately Assessed | 94.3% | 94.9% | 89.5% | 94.9% | 97.7% | 91.2% | 93.6% | 92.6% | 89.1% | 98% | 95.9% | 100% | 94.1% | 95.8% | 94.9% | 91.8% | 97.9% | 94.9% |
| | AC03 | Dementia - FAIR Question 3 - Referred for Follow Up | 85.7% | 77.8% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 50% | 71.4% | 83.3% | 66.7% | 100% | 100% | 75% | 77.8% |
| Outliers | J05 | Ward Outliers - Beddays Spent Outlying. | 7708 | 1486 | 543 | 531 | 507 | 697 | 492 | 649 | 716 | 702 | 559 | 567 | 704 | 782 | 1735 | 1857 | 1828 | 1486 |
| **Patient Experience** | | | | | | | | | | | | | | | | | | | | |
| Monthly Patient Surveys | P01d | Patient Survey - Patient Experience Tracker Score | - | - | 92 | 90 | 92 | 92 | 92 | 91 | 93 | 90 | 91 | 91 | 91 | 92 | 91 | 92 | 91 | 91 |
| | P01g | Patient Survey - Kindness and Understanding | - | - | 96 | 95 | 96 | 97 | 96 | 95 | 96 | 96 | 96 | 95 | 97 | 96 | 96 | 96 | 96 | 97 |
| | P01h | Patient Survey - Outpatient Tracker Score | - | - | 89 | 90 | 91 | 89 | 90 | 89 | 90 | 91 | 89 | 90 | 91 | 90 | 90 | 90 | 90 | 90 |
| Friends and Family Test Coverage | P03a | Friends and Family Test Inpatient Coverage | 35.1% | 39.4% | 33.7% | 35.6% | 35.4% | 29.1% | 36.5% | 27.8% | 38.7% | 32.2% | 40.5% | 34.6% | 36.3% | 42.4% | 33.5% | 34.1% | 35.5% | 39.4% |
| | P03b | Friends and Family Test ED Coverage | 16% | 15.9% | 18.4% | 17.3% | 17.4% | 17% | 16.9% | 14.6% | 13.6% | 16% | 15.2% | 11.6% | 13.8% | 18.1% | 17.2% | 15.1% | 14.2% | 15.9% |
| | P03c | Friends and Family Test MAT Coverage | 18.3% | 29.5% | 11.2% | 14% | 9.8% | 23.1% | 31.4% | 19.2% | 14.1% | 20.2% | 23% | 20.6% | 28.5% | 30.4% | 15.6% | 21.6% | 21.2% | 29.5% |
| Friends and Family Test Score | P04a | Friends and Family Test Score - Inpatients | 98.2% | 98.4% | 97.3% | 98.8% | 98.6% | 98.1% | 98.4% | 98.6% | 98.5% | 98.7% | 98.4% | 98.4% | 98.4% | 98.3% | 98.5% | 98.5% | 98.5% | 98.4% |
| | P04b | Friends and Family Test Score - ED | 82.1% | 80.8% | 84.6% | 81.4% | 84.1% | 83.4% | 85.2% | 84% | 82.6% | 81.1% | 80.4% | 75.4% | 76.7% | 83.8% | 82.9% | 84.1% | 79.2% | 80.8% |
| | P04c | Friends and Family Test Score - Maternity | 97.3% | 97.3% | 99.3% | 96.8% | 99.3% | 95.9% | 97.2% | 97.3% | 99% | 98.5% | 98.7% | 97.5% | 96.7% | 97.7% | 96.9% | 97.6% | 98.3% | 97.3% |
| Patient Complaints | T01 | Number of Patient Complaints | 1845 | 345 | 140 | 148 | 143 | 152 | 169 | 193 | 101 | 167 | 155 | 171 | 184 | 161 | 443 | 463 | 493 | 345 |
| | T03a | Formal Complaints Responded To Within Trust Timeframe | 86.1% | 95.4% | 84% | 85.2% | 86.8% | 86.3% | 85.1% | 86.9% | 90.9% | 87.5% | 78.3% | 90.6% | 93.2% | 97.2% | 86.1% | 87.1% | 85.2% | 95.4% |
| | T03b | Formal Complaints Responded To Within Divisional Timeframe | 85.5% | 96.2% | 78.7% | 85.2% | 86.8% | 82.2% | 90.5% | 84.8% | 88.6% | 87.5% | 85% | 92.5% | 93.2% | 98.6% | 84.4% | 87.6% | 88.2% | 96.2% |
| | T05A | Informal Complaints Responded To Within Trust Timeframe | 83.7% | 88.7% | 81.3% | 87.5% | 83.3% | 86.8% | 73.6% | 84.2% | 81.5% | 80% | 89.9% | 81.7% | 90.6% | 86.9% | 85.9% | 80.1% | 84% | 88.7% |
| | T04c | Percentage of Responses where Complainant is Dissatisfied | 9.11% | - | 6.67% | 9.26% | 7.55% | 9.59% | 6.76% | 10.1% | 4.54% | 8.93% | 5% | 15.09% | - | - | 8.89% | 7.83% | 9.47% | - |

## RESPONSIVE

| Topic | ID | Title | Annual 18/19 | Annual 19/20 YTD | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Quarterly 18/19 Q2 | Quarterly 18/19 Q3 | Quarterly 18/19 Q4 | Quarterly 19/20 Q1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referral to Treatment (RTT) Performance | A03 | Referral To Treatment Ongoing Pathways Under 18 Weeks | 89% | 88.5% | 88.6% | 88.9% | 88.7% | 88.5% | 89.6% | 90.1% | 89.3% | 89.4% | 89.1% | 89.2% | 89% | 88.1% | 88.7% | 89.7% | 89.2% | 88.5% |
| | A03a | Referral To Treatment Number of Ongoing Pathways Over 18 Weeks | - | - | 3377 | 3208 | 3290 | 3354 | 3000 | 2810 | 2975 | 2915 | 3100 | 3081 | 3161 | 3578 | - | - | - | - |
| Referral to Treatment (RTT) Wait Times | A06 | Referral To Treatment Ongoing Pathways Over 52 Weeks | 144 | 25 | 9 | 11 | 7 | 10 | 9 | 14 | 7 | 16 | 21 | 13 | 14 | 11 | 28 | 30 | 50 | 25 |
| | A07 | Referral To Treatment Ongoing Pathways 40+ Weeks | - | - | 129 | 126 | 119 | 113 | 113 | 111 | 139 | 147 | 161 | 119 | 115 | 136 | - | - | - | - |
| Cancer (2 Week Wait) | E01a | Cancer - Urgent Referrals Seen In Under 2 Weeks | 95.3% | 93.4% | 95.3% | 96.5% | 95.5% | 96.4% | 95.7% | 95.8% | 96.6% | 95.2% | 94.9% | 94.4% | 93.4% | - | 96.1% | 96% | 94.8% | 93.4% |
| | E01c | Cancer - Urgent Referrals Stretch Target | 56.5% | 43.8% | 56.7% | 60.6% | 66.4% | 68.8% | 57% | 62.8% | 54.2% | 63.7% | 46.5% | 49% | 43.8% | - | 65.2% | 58% | 52.7% | 43.8% |
| Cancer (31 Day) | E02a | Cancer - 31 Day Diagnosis To Treatment (First Treatments) | 97.2% | 95.4% | 94.7% | 97.4% | 99.2% | 99.1% | 98.8% | 98.5% | 98.6% | 97% | 96.5% | 98.3% | 95.4% | - | 98.5% | 98.6% | 97.2% | 95.4% |
| | E02b | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug) | 98.4% | 98.4% | 97.6% | 96.1% | 100% | 99.1% | 99.4% | 97.2% | 99% | 99.2% | 99.1% | 100% | 98.4% | - | 98.4% | 98.6% | 99.5% | 98.4% |
| | E02c | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery) | 96.1% | 95.9% | 95.6% | 98.2% | 96.2% | 98.1% | 100% | 98.3% | 96.2% | 95% | 96.3% | 97.6% | 95.9% | - | 97.5% | 98.2% | 96.2% | 95.9% |
| | E02d | Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy) | 95.8% | 96.4% | 91.6% | 97.1% | 97.4% | 95.6% | 97.6% | 98.1% | 98.2% | 95.7% | 98% | 94.1% | 96.4% | - | 96.8% | 97.9% | 96% | 96.4% |
| Cancer (62 Day) | E03a | Cancer 62 Day Referral To Treatment (Urgent GP Referral) | 85.6% | 86.8% | 86% | 85.7% | 88.9% | 87.4% | 85.5% | 87.9% | 86.5% | 85.1% | 83.5% | 82.9% | 86.8% | - | 87.3% | 86.6% | 83.8% | 86.8% |
| | E03b | Cancer 62 Day Referral To Treatment (Screenings) | 66.7% | 71.4% | 41.7% | 100% | 60% | 100% | 100% | 100% | 90% | 35.7% | 75% | 66.7% | 71.4% | - | 83.3% | 96% | 47.6% | 71.4% |
| | E03c | Cancer 62 Day Referral To Treatment (Upgrades) | 83.7% | 95% | 84.4% | 77.7% | 84.7% | 86.8% | 85.6% | 91.3% | 88.5% | 86.8% | 74.7% | 91.8% | 95% | - | 82.6% | 88.4% | 84.6% | 95% |
| | E03f | Cancer Urgent GP Referrals - Numbers Treated after Day 103 | 54 | 3.5 | 5.5 | 2 | 5.5 | 4 | 7.5 | 3.5 | 4 | 4 | 3 | 7 | 3.5 | - | 11.5 | 15 | 14 | 3.5 |
| Cancelled Operations | F01 | Last Minute Cancelled Operations - Percentage of Admissions | 1.31% | 1.58% | 0.59% | 1.15% | 0.79% | 1.39% | 0.97% | 1.94% | 1% | 1.31% | 1.68% | 1.66% | 1.63% | 1.53% | 1.1% | 1.31% | 1.54% | 1.58% |
| | F01a | Number of Last Minute Cancelled Operations | 1059 | 208 | 39 | 79 | 54 | 89 | 71 | 138 | 61 | 94 | 109 | 115 | 108 | 100 | 222 | 270 | 318 | 208 |
| | F02 | Cancelled Operations Re-admitted Within 28 Days | 93.4% | 85.2% | 95.2% | 97.4% | 94.9% | 94.4% | 91% | 94.4% | 93.5% | 93.4% | 93.6% | 96.3% | 85.2% | 85.2% | 95.3% | 93% | 94.7% | 85.2% |
| Admissions Cancelled Day Before | F07 | Percentage of Admissions Cancelled Day Before | 1.67% | 2.02% | 1.67% | 0.41% | 1.53% | 2.05% | 1.82% | 1.91% | 1.37% | 1.75% | 2.17% | 0.85% | 1.65% | 2.39% | 1.31% | 1.72% | 1.58% | 2.02% |
| | F07a | Number of Admissions Cancelled Day Before | 1348 | 265 | 110 | 28 | 105 | 131 | 134 | 136 | 83 | 126 | 141 | 59 | 109 | 156 | 264 | 353 | 326 | 265 |
| Primary PCI | H02 | Primary PCI - 150 Minutes Call to Balloon Time | 73.2% | 83.9% | 81.8% | 70.6% | 79.3% | 72% | 69% | 71.1% | 62.5% | 71.4% | 76.7% | 65.2% | 83.9% | - | 73.9% | 67.5% | 70.3% | 83.9% |
| | H03a | Primary PCI - 90 Minutes Door to Balloon Time | 91.9% | 96.8% | 100% | 91.2% | 93.1% | 96% | 92.9% | 89.5% | 90% | 88.6% | 93.3% | 87% | 96.8% | - | 93.2% | 90.8% | 89.2% | 96.8% |
| Diagnostic Waits | A05 | Diagnostics 6 Week Wait (15 Key Tests) | 96.72% | 94.34% | 97.83% | 97.88% | 97.13% | 98.13% | 98.36% | 96.94% | 93.81% | 93.28% | 96.93% | 95.5% | 95.27% | 93.42% | 97.72% | 96.43% | 95.26% | 94.34% |
| Outpatients | R03 | Outpatient Hospital Cancellation Rate | 10.1% | 10.8% | 10% | 9.6% | 10% | 10.1% | 9.9% | 9.8% | 10.4% | 10.2% | 11.6% | 11.2% | 11.3% | 10.4% | 9.9% | 10% | 11% | 10.8% |
| | R05 | Outpatient DNA Rate | 6.8% | 6.9% | 6.7% | 7.1% | 6.8% | 7% | 6.7% | 6.5% | 6.9% | 6.8% | 6.7% | 6.6% | 6.7% | 7.1% | 7% | 6.7% | 6.7% | 6.9% |
| Outpatient Ratio | R01 | Follow-Up To New Ratio | 2.12 | 2.1 | 2.05 | 2.1 | 2.11 | 2.13 | 2.14 | 2.17 | 2.14 | 2.2 | 2.25 | 2.13 | 2.09 | 2.1 | 2.11 | 2.15 | 2.19 | 2.1 |
| ERS | BC01 | ERS - Available Slot Issues Percentage | 16.5% | 15.4% | 23.8% | 22.9% | 22.1% | 15.5% | 10.9% | 13.8% | 13.5% | 12.5% | 16.8% | 17.3% | 13.9% | 16.9% | 19.9% | 12.6% | 15.5% | 15.4% |

# APPENDIX 3 – Trust Scorecards

| Topic | ID | Title | Annual | | Monthly Totals | | | | | | | | | | | | Quarterly Totals | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 18/19 | 19/20 YTD | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | 18/19 Q2 | 18/19 Q3 | 18/19 Q4 | 19/20 Q1 |
| Delayed Discharges | Q01A | Acute Delayed Transfers of Care - Patients | 216 | 45 | 25 | 17 | 11 | 16 | 18 | 10 | 26 | 20 | 13 | 20 | 22 | 23 | 44 | 54 | 53 | 45 |
| | Q02A | Non-Acute Delayed Transfers of Care - Patients | 80 | 19 | 8 | 4 | 9 | 8 | 5 | 4 | 11 | 4 | 10 | 4 | 8 | 11 | 21 | 20 | 18 | 19 |
| | Q01B | Acute Delayed Transfers of Care - Beddays | 6744 | 1216 | 632 | 503 | 586 | 513 | 691 | 482 | 568 | 653 | 550 | 519 | 609 | 607 | 1602 | 1741 | 1722 | 1216 |
| | Q02B | Non-Acute Delayed Transfers of Care - Beddays | 2590 | 525 | 207 | 204 | 225 | 321 | 250 | 191 | 243 | 138 | 161 | 198 | 223 | 302 | 750 | 684 | 497 | 525 |
| Green To Go List | AQ06A | Green To Go List - Number of Patients (Acute) | - | - | 60 | 54 | 42 | 55 | 39 | 47 | 51 | 48 | 65 | 62 | 53 | 56 | - | - | - | - |
| | AQ06B | Green To Go List - Number of Patients (Non Acute) | - | - | 21 | 17 | 19 | 24 | 21 | 14 | 26 | 7 | 30 | 19 | 26 | 25 | - | - | - | - |
| | AQ07A | Green To Go List - Beddays (Acute) | - | - | 1836 | 1571 | 1621 | 1562 | 1608 | 1620 | 1693 | 1814 | 1894 | 1962 | 1882 | 2435 | - | - | - | - |
| | AQ07B | Green To Go List - Beddays (Non-Acute) | - | - | 459 | 618 | 570 | 753 | 681 | 580 | 616 | 463 | 631 | 819 | 759 | 842 | - | - | - | - |
| Length of Stay | J03 | Average Length of Stay (Spell) | 3.79 | 3.89 | 3.66 | 3.8 | 3.92 | 3.52 | 3.87 | 3.62 | 3.76 | 3.83 | 3.74 | 3.78 | 4.05 | 3.73 | 3.75 | 3.75 | 3.79 | 3.89 |
| | J04D | Percentage Length of Stay 14+ Days | 6.3% | 6.8% | 6.3% | 6.5% | 6.5% | 5.8% | 6.9% | 6% | 6% | 6.6% | 6.4% | 6.4% | 7.2% | 6.5% | 6.2% | 6.3% | 6.5% | 6.8% |
| 14 Day LOS Patients | C07 | Number of 14+ Day Length of Stay Patients at Month End | - | - | 243 | 234 | 211 | 233 | 224 | 212 | 200 | 221 | 234 | 222 | 247 | 256 | - | - | - | - |
| AMU | J35 | Percentage of Cardiac AMU Wardstays | 3.6% | 3.6% | 2% | 1.3% | 0.5% | 0% | 3.4% | 4.1% | 3.7% | 4% | 6.3% | 5.6% | 3.6% | 3.7% | 0.6% | 3.8% | 5.2% | 3.6% |
| | J35A | Percentage of Cardiac AMU Wardstays Under 24 Hours | 36.1% | 28.3% | 50% | 25% | 25% | - | 23.3% | 45.9% | 52.9% | 55.6% | 24.5% | 24% | 39.3% | 18.8% | 25% | 41.6% | 32.6% | 28.3% |

## Emergency Department Indicators

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED - Time In Department | B01 | ED Total Time in Department - Under 4 Hours | 86.34% | 78.1% | 92.84% | 90.26% | 90.07% | 85% | 89.16% | 84.24% | 83.05% | 84.5% | 81.05% | 81.23% | 78.25% | 77.95% | 88.44% | 85.53% | 82.27% | 78.1% |
| | *This is measured against the national standard of 95%* | | | | | | | | | | | | | | | | | | | |
| ED - Time in Department (Differentials) | BB14 | ED Total Time in Department - Under 4 Hours (STP) | 86.34% | 78.1% | 92.84% | 90.26% | 90.07% | 85% | 89.16% | 84.24% | 83.05% | 84.5% | 81.05% | 81.23% | 78.25% | 77.95% | 88.44% | 85.53% | 82.27% | 78.1% |
| | BB07 | BRI ED - Percentage Within 4 Hours | 78.39% | 63.72% | 89.08% | 84.8% | 83.37% | 75.44% | 81.79% | 78.89% | 73.49% | 74.67% | 69.23% | 70.33% | 63.57% | 63.86% | 81.27% | 78.07% | 71.46% | 63.72% |
| | BB03 | BCH ED - Percentage Within 4 Hours | 93.05% | 91.15% | 96.26% | 96.39% | 97.9% | 94.16% | 95.05% | 85.39% | 91.02% | 92.92% | 90.46% | 89.39% | 91.96% | 90.38% | 96.02% | 90.38% | 90.9% | 91.15% |
| | BB04 | BEH ED - Percentage Within 4 Hours | 97.38% | 97.21% | 97.66% | 96.19% | 98.75% | 97.46% | 98.67% | 97.34% | 97.12% | 97.7% | 98.02% | 97.07% | 96.1% | 98.39% | 97.49% | 97.76% | 97.58% | 97.21% |
| | *This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets* | | | | | | | | | | | | | | | | | | | |
| Trolley Waits | B06 | ED 12 Hour Trolley Waits | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Time to Initial Assessment | B02 | ED Time to Initial Assessment - Under 15 Minutes | 95.6% | 96.9% | 98% | 94.8% | 95.3% | 96.2% | 95.4% | 93.4% | 92.1% | 97.7% | 97.9% | 96.5% | 96.8% | 97% | 95.4% | 93.6% | 97.3% | 96.9% |
| | B02b | ED Time to Initial Assessment - Data Completness | 97.2% | 98% | 99.1% | 97.2% | 96.1% | 97.3% | 97.2% | 97.6% | 95.2% | 96.5% | 97.4% | 99% | 97.6% | 98.4% | 96.9% | 96.6% | 97.6% | 98% |
| Time to Start of Treatment | B03 | ED Time to Start of Treatment - Under 60 Minutes | 49.3% | 46.9% | 51.3% | 50.8% | 55.6% | 48% | 53.1% | 44.8% | 46.9% | 48.9% | 45.2% | 43.9% | 46.1% | 47.6% | 51.4% | 48.3% | 46% | 46.9% |
| | B03b | ED Time to Start of Treatment - Data Completeness | 96.9% | 96.3% | 97.3% | 96.8% | 97.1% | 96.6% | 97.1% | 97% | 97% | 97.5% | 96.7% | 96.4% | 96.6% | 96% | 96.8% | 97.1% | 96.9% | 96.3% |
| Others | B04 | ED Unplanned Re-attendance Rate | 3.3% | 3.3% | 2.8% | 2.9% | 2.7% | 3.2% | 3.9% | 4.4% | 3.8% | 3.2% | 3.3% | 3.6% | 3.5% | 3.2% | 2.9% | 4% | 3.3% | 3.3% |
| | B05 | ED Left Without Being Seen Rate | 1.7% | 1.7% | 1.7% | 1.9% | 1.6% | 2.2% | 2.1% | 1.8% | 1.6% | 1.3% | 1.6% | 2.1% | 1.6% | 1.8% | 1.9% | 1.8% | 1.7% | 1.7% |
| Ambulance Handovers | BA09 | Ambulance Handovers - Over 30 Minutes | 698 | 183 | 54 | 45 | 58 | 71 | 74 | 65 | 59 | 42 | 57 | 50 | 96 | 87 | 174 | 198 | 149 | 183 |
| Acute Medical Unit (AMU) | J35 | Percentage of Cardiac AMU Wardstays | 3.6% | 3.6% | 2% | 1.3% | 0.5% | 0% | 3.4% | 4.1% | 3.7% | 4% | 6.3% | 5.6% | 3.6% | 3.7% | 0.6% | 3.8% | 5.2% | 3.6% |
| | J35a | Percentage of Cardiac AMU Wardstays Under 24 Hours | 36.1% | 28.3% | 50% | 25% | 25% | - | 23.3% | 45.9% | 52.9% | 55.6% | 24.5% | 24% | 39.3% | 18.8% | 25% | 41.6% | 32.6% | 28.3% |

## FINANCIAL MEASURES

| Topic | Title | Monthly Totals Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Year To Date Annual Plan Surplus / (Deficit) £'000 | Annual Plan excluding PSF | (416) | 302 | (389) | 2,740 | 3,171 | 3,633 | 6,086 | 5,489 | 4,521 | 4,521 | 2,622 | 2,593 |
| | Actual excluding PSF | (416) | (410) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Annual Plan including PSF | 117 | 1,368 | 1,209 | 5,030 | 6,153 | 7,308 | 10,773 | 11,118 | 10,793 | 12,402 | 11,674 | 12,815 |
| | Actual Plan including PSF | 117 | 656 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Year to Date Variance Divisional Position Favourable / (Adverse) £'000 | Diagnostics & Therapies | (4) | (39) | | | | | | | | | | |
| | Medicine | (167) | (320) | | | | | | | | | | |
| | Specialised Services | (54) | 13 | | | | | | | | | | |
| | Surgery | (175) | (659) | | | | | | | | | | |
| | Women's & Children's | (215) | (311) | | | | | | | | | | |
| | Estates & facilities | (5) | (9) | | | | | | | | | | |
| | Trust Services | 4 | 3 | | | | | | | | | | |
| | Other Corporate Services | 42 | 29 | | | | | | | | | | |
| | **Total** | **(574)** | **(1,293)** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Year To Date Savings Actuals £'000 | Diagnostics & Therapies | | 299 | | | | | | | | | | |
| | Medicine | | 231 | | | | | | | | | | |
| | Specialised Services | | 381 | | | | | | | | | | |
| | Surgery | | 572 | | | | | | | | | | |
| | Women's & Children's | | 660 | | | | | | | | | | |
| | Estates & facilities | | 120 | | | | | | | | | | |
| | Trust Services | | 134 | | | | | | | | | | |
| | Other Corporate Services | | 195 | | | | | | | | | | |
| | **Total** | **0** | **2,591** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| In Month Variance Subjective Analysis Favourable / (Adverse) £'000 | Nursing & Midwifery Pay | (604) | (491) | | | | | | | | | | |
| | Medical & Dental Pay | (360) | (187) | | | | | | | | | | |
| | Other Pay | 242 | 197 | | | | | | | | | | |
| | Non Pay | 954 | 189 | | | | | | | | | | |
| | Income from Operations | (173) | (94) | | | | | | | | | | |
| | Income from Activities | (632) | (336) | | | | | | | | | | |
| | **Total** | **(573)** | **(722)** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| In Month Agency Expenditure Actuals £'000 | Nursing & Midwifery | 684 | 660 | | | | | | | | | | |
| | Medical | | | | | | | | | | | | |
| | Consultants | 72 | 82 | | | | | | | | | | |
| | Other Medical | 56 | 20 | | | | | | | | | | |
| | Other | 140 | 144 | | | | | | | | | | |
| | **Total** | **952** | **906** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Cash £'000 | Actual Cash | **110,000** | **109,402** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Capital Spend £'000 | Actual Capital Expenditure | **916** | **2,300** | | | | | | | | | | |

# APPENDIX 4 – Changes To Metrics

## Single Oversight Framework

- Monthly Emergency Department 4 Hour Trajectory set to 0.5% above 2018/19 levels,
- "Acute Trust Footprint" data for ED 4 hour performance is not continuing
- 18 Week Referral To Treatment trajectory set to 87.9%, except December, January and February where it is 86.9%
- Diagnostic 6 week wait recovery trajectory shows 99% compliance by quarter 3.
- Cancer standards to deliver the national constitutional standard during 2019/20. For the 62 Day GP standard this is 85%

## Other Metrics

- Outpatient Cancellation and DNA rates to be reviewed at Outpatient Steering Group. Thresholds may be amended in future months.
- C. Difficile cases. These cases are now attributed to the Trust after patients have been admitted for two days (day 3 of admission). This is new criteria from NHSI which started in April 2019. The old criteria attributed cases to the Trust after three days of admission, (day four of admission).
- C. Difficile cases. Total allowable cases for the year has been set at 57
- E.Coli number of cases will be have additional measures of "catheter related" and "line related". Aim to deliver 10% reduction year-on-year.
- Venous Thrombo-embolism (VTE) risk assessment target reduced to 95% as that is the national target.
- Safety Thermometer Harm measures removed in anticipation of locally agreed alternative system measures
- Sepsis measures (in Clinical Effectiveness section of the Quality Scorecard) to be removed. These were CQUIN targets that were achieved by the end of 2018/19. Quarterly audits will continue to provide assurance that improvement is sustained. This will be reported through the Trust's Patient Safety Programme.
- Remove Dementia Carers metric as other ways to engage with, and obtain feedback from carers are being pursued, e.g. dementia café, Public Patient Involvement (PPI) events
- Complaint resolution time to include a second measure for Informal complaints. Resolution time for Formal complaints will remain as a metric. Divisional response compliance metric to be removed (although will be included in quarterly complaints reports)
- Complainant Dissatisfaction targets to be changed to 8% (Green) and 12% (Red). Case analysis shows that the previous target of 5% was not realistic.