University Hospitals Bristol
NHS Foundation Trust

Quality and Performance Report

August 2019

1.1 OVERVIEW – Executive Summary

Care Quality Commission (CQC)
The CQC published their latest inspection report on 13th August 2019. The Trust retained its OUTSTANDING rating with details below and in Appendix 2.

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019

Single Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 84.0% for June and 85.7% for Quarter 1 overall. So the national standard of 85% was narrowly missed in June but was achieved overall for the quarter.
- The measure for percentage of A&E patients seen in less than 4 hours was 81.9% for July. 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 86.5% as at end of July. This did not achieve the national 92% standard or the improvement trajectory target of 87.9%.
- The percentage of Diagnostic patients waiting under 6 weeks at end of July was 96.2%, with 307 patients waiting 6+ weeks. This is lower than the national 99% standard. However, this was an improvement on June which had 579 patients waiting over 6 weeks.

Headline Indicators
There were five Clostridium Difficile cases in July but this still keeps the Trust below the maximum allowed for the financial year of 57 cases. In addition, there were no MRSA cases in July. Pressure ulcer and patient falls incidence remained below target in July, with one grade 3 pressure ulcers and two falls resulting in harm.

The headline measures from the monthly patient surveys and the Friends and Family Test remain above their minimum target levels in July 2019. In Complaints, 90% of formal complaints were responded to within deadline which is below the Trust standard of 95%. 8.5% of May's complaint responses were re-opened due to complainant being dissatisfied with the original response.

Last Minute Cancelled Operations (LMCs) were at 1.3% of elective activity and equated to 88 cases. 8 patients were not re-admitted within 28 days following an LMC.

Workforce
July 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs, for the fourth consecutive month. Appraisal compliance increased slightly to 73.5% with all divisions being non-compliant against their target.

Bank and Agency Usage (5.5% and 1.2% respectively) remains above the Trust's targets. Turnover increased slightly to 13.6% and the vacancy rate increased from 5.5% to 6.0%. A review of activity will be undertaken to understand the vacancy issues across all staff groups; this will be through the newly established Recruitment sub-group.

Staff sickness absence increased to 4.14% from 4.10%, with reductions in three divisions. Over 350 staff and managers have attended the workplace wellbeing training which supports staff with stress related issues supported by a suite of self-help guidesThe Trust was selected to undertake the South West NHS Healthy Weight Declaration pilot designed to improve staff health both in and out of the workplace supported by the creation of an 'eating well' guide for staff

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%	81.5%	81.9%								
	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%	86.0%	84.0%									
	Actual (Quarterly)	85.7%											
	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%	87.5%	86.5%								
	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%	93.5%	96.2%								
	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	• Delivery of the 62 day GP national standard in April and sustaining this in May (both months >86%), and for quarter 1 as a whole. • For the 6 week diagnostic standard there has been a significant reduction in the non-obstetric ultrasound and echocardiography services. Ultrasound backlog (numbers waiting 6+ weeks) has fallen from 173 in May to 4 in July. Echos has fallen from 379 in January to 59 in July. • The non-obstetric ultrasound diagnostic waiting list has shown significant improvement in 6 week breaches: 173 at end of May, down to 4 at end of July. • The implementation of electronic Referral Service (eRS) is now business as usual. There were only 11 appointments with paper referrals in July 2019. • Bristol Royal Infirmary ED have been recruiting into some new roles, including two ED consultants who start in September, and a new acute frailty team which will be in place by early winter. • The work with our commissioners to review the local patient access policy is now complete. The new SOP and policy are on the DMS and a communications email sent out by Medical Director to the clinicians.	• Recover the GP Cancer 62 Day standard of 85% in July and quarter 2. • Recover performance against the 31 day first definitive treatment standard by preventing further surgical cancellations and recovering from the impact of previous cancellations • Recover performance against the subsequent radiotherapy standard following deterioration due to the extensive cleaning requirement. • July's Referral To Treatment performance was slightly below the 87.9% standard; the Trust achieved 86.5%. We continue to focus on returning to standard where activity allows. • Divisional focus remains on reducing Outpatient follow-ups that are overdue by more than 6 months • Delivery of the 6 week wait diagnostic standard for CT Cardiac to be achieved from January 2020. Division are working through capacity & demand to ensure the new CT Scanner (due for installation November 2019) and existing capacity will be sufficient to meet ongoing demand

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

	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. • The improvement work around the Medway patient administration system (PAS) continues and will take into consideration the plans around the Weston Merger. An initial meeting around staffing levels have taken place between the RTT Performance Lead and the Deputy Chief Executive and Chief Operating Officer, the conversations will continue. The improvement work is reliant on increasing the staffing levels in the corporate Performance team in order for the work to commence. • The outpatients BNSSG STP has been chosen to be part of the national Elective Care Transformation Programme, led by NHSI. This will enable whole system transformation and provided training and networking opportunities to staff and patients representatives. • A system-wide review of Endoscopy services is underway, across BNSSG, to assess potential for better utilisation of capacity across the region and improving pathway flow. • Three specialities have been identified to review reducing follow-ups across the system: Ophthalmology, haematology and T&O. Clinicians in all three are being contacted to engage them in designing the proposed change.	• 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. • 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 and this has been mandated within the divisions. • 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, per month. • 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 maintaining ZERO long waiting patients so focus on this will continue at the weekly performance meetings chaired by the Deputy COO • Due diligence work has commenced with Weston, there is a risk the delivery of RTT Performance, average waits and coping with general workload at UHB is under threat whilst supporting and carry out data quality checks on Weston data and the priorities require careful consideration. • Without an allocation of 1 WTE or 0.5 WTE RTT analysts in the Corporate Performance team, there is insufficient resource available to move forward with Medway business rules development in advance of the Weston Merger. This requires resolving as a matter of some urgency.

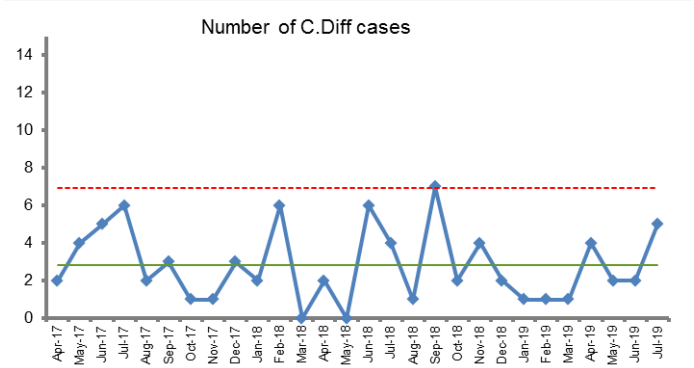
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

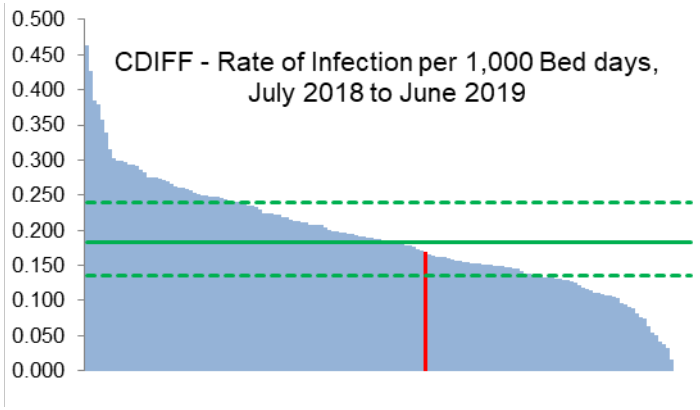
	Successes	Priorities
QUALITY	• Non-purposeful omission of critical medicines continues to be below the green threshold with only one case of 543 reviewed. • Patient experience indicators continue to show the majority of patients have a good experience. This was borne out in the Care Quality Commission's inspection report published August 2019 which gave an overall outstanding rating for 'caring'.	• One "wrong site surgery" never event was reported in July at Bristol Eye Hospital whereby the wrong patient underwent laser eye surgery. The incident is under a full investigation. The initial report suggests that two identifiers were not independently sought from the patient prior to commencing treatment. The patient treated came into the treatment room accompanied by a relative when the correct patient's name was called. • The latest published Summary Hospital Mortality Indicator was for 12 months to February 2019 and was 106.9 and in NHS Digital's "as expected" category. All actions but one in response to an overall SHMI and HSMR remaining above 100, have been completed. The outstanding action relates to extending the field size for submission of co-morbidity codes for patients to ensure completeness of data capture. This is delayed until at least November 2019 due to the need for a new server in a downstream software data warehouse in order to support these additional codes. In addition, a change of coding of mode of admission for some oncology patients will bring us into line with other acute providers and should have an impact on SHMI and HSMR. 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 mortality indicators.
	Opportunities	**Risks and Threats**
QUALITY	• Data flows from the e-observations system for adult patients on the timeliness of patient observations will shortly be routinely available for clinical teams to support them to identify hot spots and drive needed improvements in the recognition and response to patient deterioration. Additional data to support other areas for improving the care of deteriorating patients is being collected via manual audits to inform further improvement actions.	• As planned, we changed to recording VTE risk assessments using clinical notes in Medway on 1st August 2019. The data for August, once complete, will show a significant drop in compliance due to a change in ways of working for clinical staff and some patients who were admitted before 1st August will not have their initial VTE risk assessment captured via the new system. This risk is being mitigated via training for all new doctors who started in August 2019 on the new system for recording VTE risk assessments and on-going support to clinical teams is being provided by the Transformation Team to increase recording.

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

	Successes	Priorities
WORKFORCE	• July 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programmes, and also at 95% for 'Remaining Essential Training', for the fourth consecutive month. • All Divisional Diversity & Inclusion Plans have been approved by Divisional Boards and provide targeted solutions to mobilise the delivery of the Trust strategy at a local level. • Return rates for exit questionnaires have improved significantly over the past 2 months, seeing return rates of over 80%. • Successful 'Return to Practice' campaign with 10 candidates recruited to start in September 2019. • Successful EU nurse recruitment during the last month with 16 offers made to registered nurses across Medicine, Surgery and Specialised Services. • The Emergency Department as the first department going live with the new Allocate medical software realised the benefits of the new process redesign for the August rotation, allowing new doctors to request leave and have visibility of rotas prior to starting.	• Ensure Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) Reports & Action Plans are approved for publication. • Delivery of Seasonal Influenza implementation plan to ensure CQUIN target of 80% vaccination of frontline clinical workers is achieved by end of Feb 2020. • Roll out of new E Learning for Supporting Attendance and a roll out of further Investigating Officer training for managers. • Gaining further traction with the implementation of e-rostering for medical staff, to realise the productivity efficiencies required. • A review of the Occupational Health business model is underway to identify opportunities to increase income and service delivery efficiencies, creating a resilient operational platform. The review is due to be completed in October 2019. Recruitment to vacant posts within the APOHS structure has now been approved which will realise an improvement with key performance targets such as staff referrals.
	Opportunities	**Risks and Threats**
WORKFORCE	• Approval received to reduce the external H&S audit to alternate years from the current annual basis. This will be closely monitored to ensure that current standards/compliance is not reduced/compromised, but is anticipated to provide additional time and resources within the Safety team. • Clinical Talent Acquisition Manager commences in post 2 September 2019 to target business critical clinical roles. • Implementing the agreed bank incentives for registered nurses working on the Trust Staff Bank, to realise an increase in hours undertaken on the Nurse Bank to support the BNSSG&B collaborative approach to significantly reducing high cost agency effective from Sept 2019.	• Appraisal compliance continues not to meet target. Robust mitigations continue. • Risk of agency nurses not migrating to lower cost agencies or to the Trust's Staff Bank, impacting the ambitions of the BNSSG&B reduction in high cost agency programme. • The potential impact on the workforce, particularly the Trust's valued EU staff, with BREXIT plans continuing. • The impact of the pension tax and annual allowance continues to cause concern for the sustainability of the workforce.

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 five trust apportioned C.Diff cases in July 2019, giving 13 cases year-to-date.
Commentary/ Actions:	The five cases are oncology and bone marrow transplant patients, who are most susceptible to infections. These cases require a review with our commissioners before determining if the cases will be Trust apportioned due to lapse in care. Cases of C. Difficle are now attributed to the trust after patients have been admitted for two days (day three of admission) This is new criteria from NHS Improvement, which started in April 2019 and a new Trust limit has been set of 57 cases for 2019/20. The previous criteria attributed cases to the Trust after three days of admission, (day four of admission).
Ownership:	Chief Nurse





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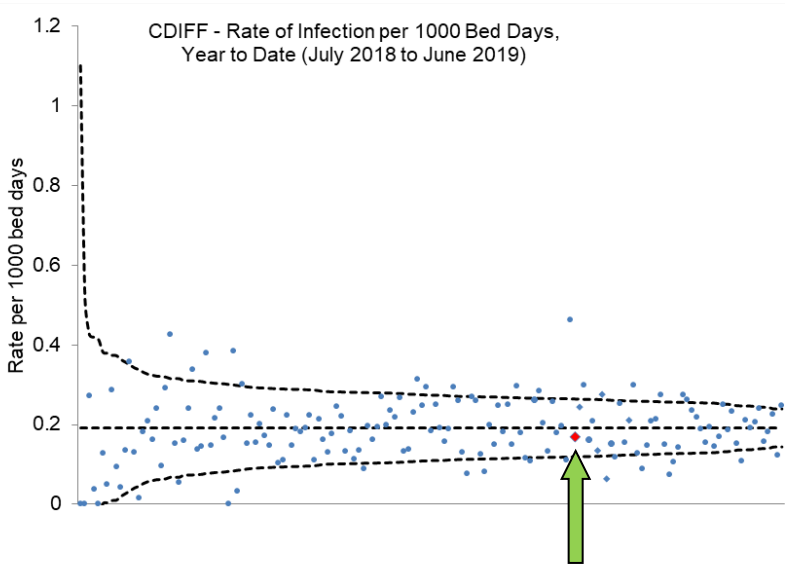
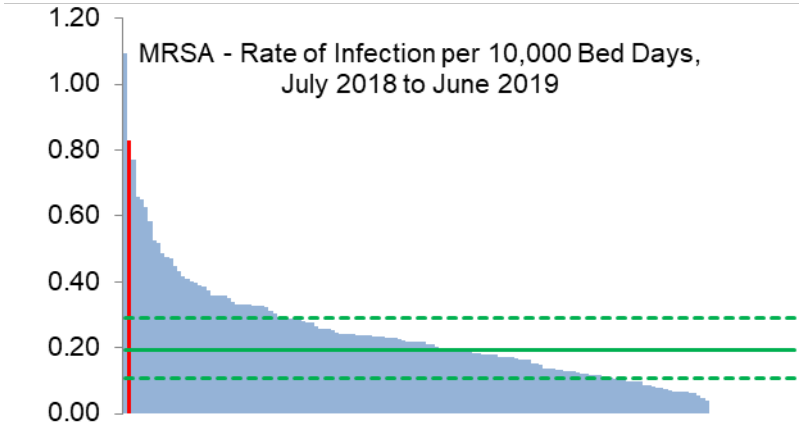
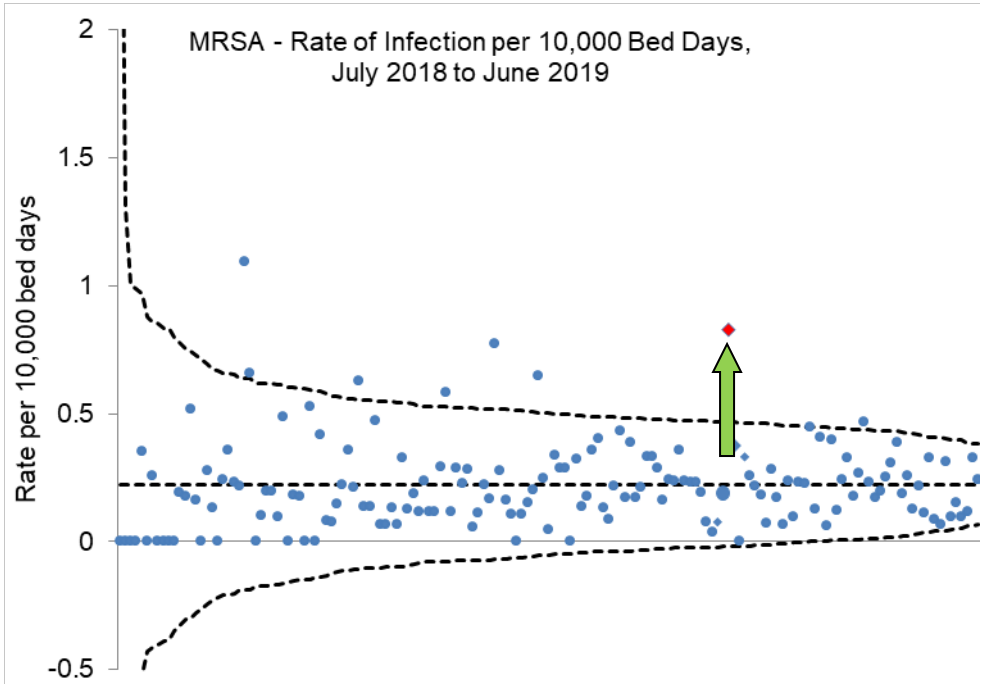


CDIFF Cases	Jul-19	2019/2020
Medicine	0	2
Specialised Services	1	1
Surgery	0	1
Women's and Children's	4	9
Grand Total	5	13

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

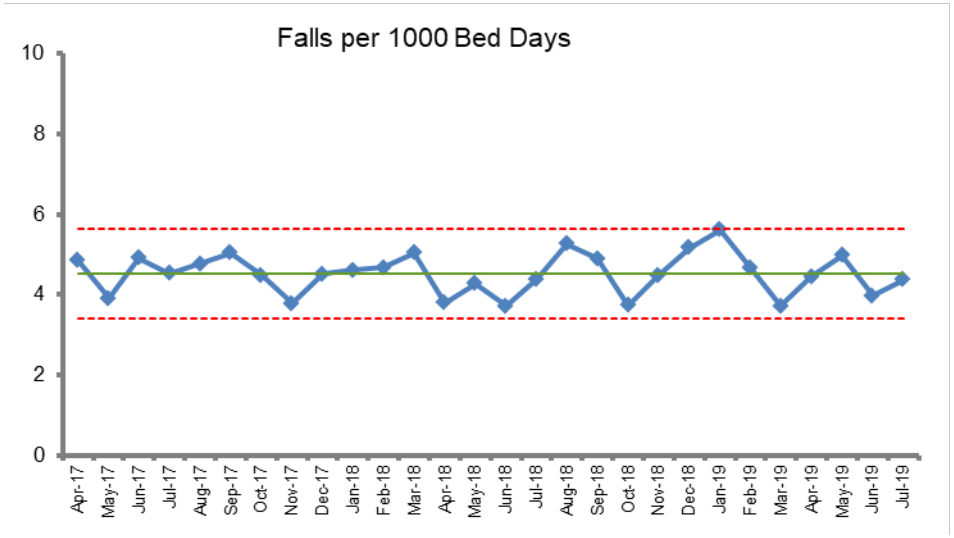
MRSA	Jul-19	2019/2020
Medicine	0	0
Specialised Services	0	0
Surgery	0	0
Women's and Children's	0	0
Grand Total	0	0



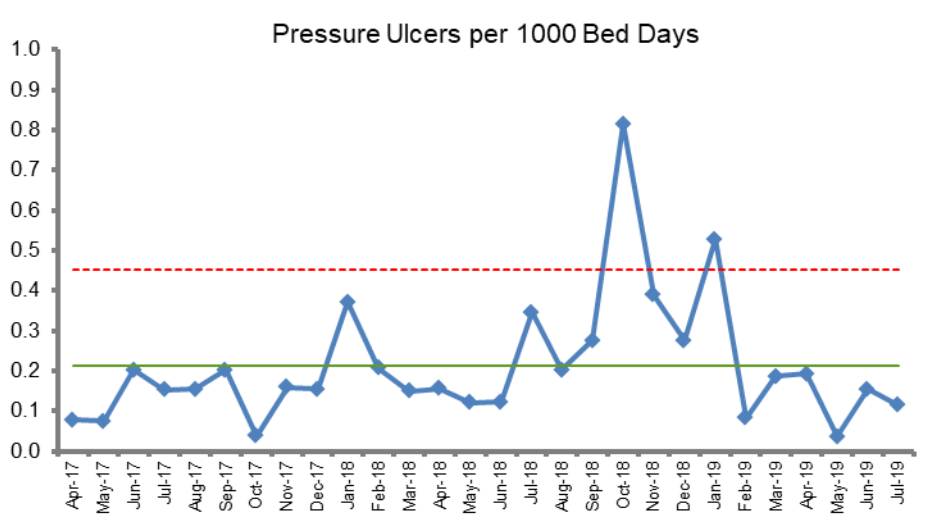


Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

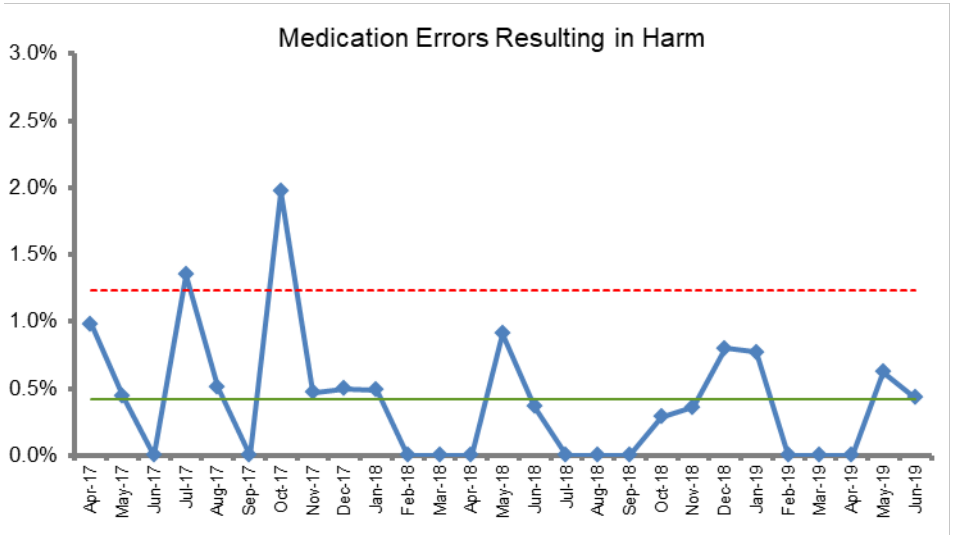
Patient Falls	
Standards:	Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above)
Performance:	Falls rate for July was 4.37 per 1,000 beddays. This was 114 falls with two resulting in harm.
Commentary/ Actions:	The actions being taken remain as: 1. Implementing actions required to achieve new 2019/20 Falls CQUIN has commenced, which include: a. The revised draft multifactorial falls risk assessment, including a vision check which will be tested across the Trust with a group set up to review how this is operationalised and make any amendments before final approval. b. Measuring lying and standing blood pressure measurement for all patients 65 and over c. Ensuring no anti-psychotic, anxiolytics or hypnotics, are given during hospital stay or if required there should be documentation of rationale d. Ensuring patient mobility assessment is documented within 24hrs or mobility aid provided within 24hrs 2. The 2019/20 Falls Group work and audit plans were approved at the June meeting and will be closely monitored and reviewed at each meeting.
Ownership:	Chief Nurse

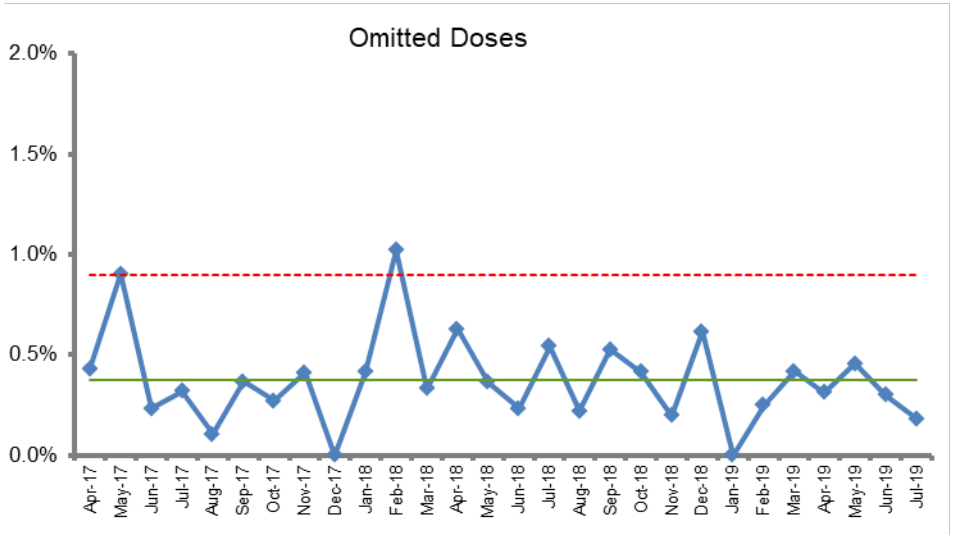


Pressure Ulcers	
Standards:	Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers
Performance:	Pressure Ulcers rate for July was 0.115 per 1,000 beddays. There were two category 2 pressure ulcers in June, and one category three pressure ulcer.
Commentary/ Actions:	The grade three pressure ulcer occurred in the Division of Surgery and is under full investigation. There were no category 4 pressure ulcers The aim of the 2019/20 Tissue Viability Group work plan is to reduce the number of pressure ulcers developed on wards. • 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. • Re-circulate posters to display in clinical areas regarding pressure prevention and skin checks. • Review and update tissue viability champions' role descriptions. • Deep tissue injury incidents which are currently under investigation – immediate local actions identified and implemented. 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. Of all the patients reviewed in a month, under 0.75% to have had a non-purposeful omitted dose of listed critical medication
Performance:	One moderate harm medication incidents were reported in June 2019, out of 231 cases audited (0.43%) Omitted doses were at 0.18% in July (1 case out of 543 reviewed in areas using paper drug charts).
Commentary/ Actions:	The moderate harm incident was previously reported in the July 2019 Board report, alongside details of an incident involving this patient in May. It concerned a patient who suffered a stroke, because their anticoagulation for atrial fibrillation was held inappropriately due to the patient having an acute kidney injury. This event is currently under investigation as a serious incident.
Ownership:	Medical Director





2.1 PERFORMANCE – Safe Domain

Essential Training	
Standards:	Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%
Performance:	In July 2019 Essential Training overall compliance remained static at 90% compared to the previous month (excluding Child Protection Level 3).
Commentary/ Actions:	July 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs. There were two reductions, of 1%, for Fire Safety, and Information Governance. There was one increase, of 3%, for Resuscitation. Overall compliance for 'Remaining Essential Training' is also holding at 95% overall for the fourth consecutive month. • Following a recent SLT decision, and upon recommendations of the Medical Director Team, the e-learning modules for *News: Acute Care* and *ReSPECT Awareness* are now required Essential Training for all Trust doctors - particularly those arriving with the August induction. The programmes appear now on the learning plans of the target audience, but compliance figures for these two programmes will be noted in future monthly reporting. • Of the 11 Core Skills, Resus made the largest gain this month (3%), moving to 79% compliance. Further recommendations to improve provision of Resus at induction will become operational in August month, and should further improve compliance in September reporting. • Manual Handling training has now been split into two levels to mirror the NHS Core Skills Framework. Level 1 Non-Clinical and Level 2 Clinical. Self-Assessment Questions were embedded into the Portal from June 2019 allowing staff to make an assessment on which training session to book onto.
Ownership:	Director of People

Essential Training	Jul-19	KPI
Equality, Diversity and Human Rights	97%	90%
Fire Safety	87%	90%
Health, Safety and Welfare (formerly Health & Safety)	93%	90%
Infection Prevention and Control	86%	90%
Information Governance	85%	95%
Moving and Handling (formerly Manual Handling)	89%	90%
NHS Conflict Resolution Training	93%	90%
Preventing Radicalisation	95%	90%
Resuscitation	79%	90%
Safeguarding Adults	94%	90%
Safeguarding Children	93%	90%

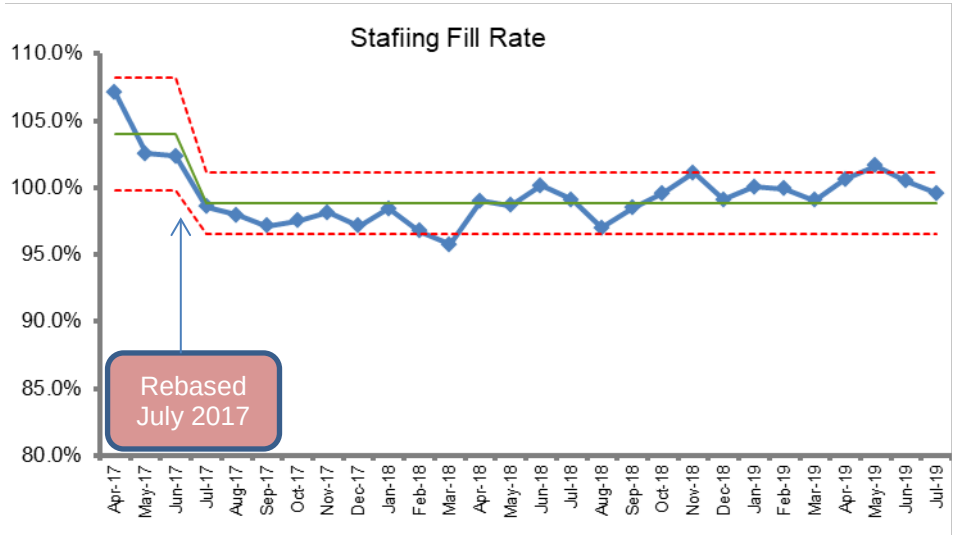
Essential Training	Jul-19	KPI
UHBristol NHS Foundation Trust	90%	90%
Diagnostics & Therapies	92%	90%
Facilities & Estates	93%	90%
Medicine	89%	90%
Specialised Services	92%	90%
Surgery	90%	90%
Trust Services	93%	90%
Women's & Children's	88%	90%

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:	July's overall staffing level was at 99.6% (240,384 hours worked against 241,382 planned). Registered Nursing (RN) level was at 95.4 % and Nursing Assistant (NA) level was at 110.5%
Commentary/ Actions:	Overall for the month of July 2019, the trust had 95% cover for RN's on days and 96% RN cover for nights. The unregistered level of 105% for days and 118% for nights reflects the activity seen in July 2019. This was due primarily to NA specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night. Ongoing Actions • Continue to validate temporary staffing assignments against agreed criteria.
Ownership:	Chief Nurse

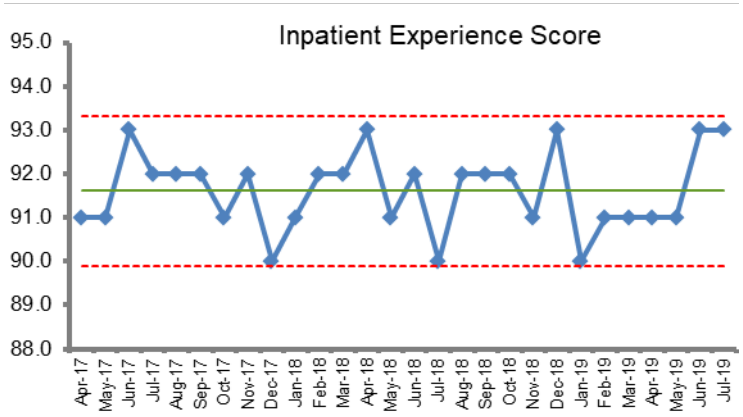
JULY 2019 DATA

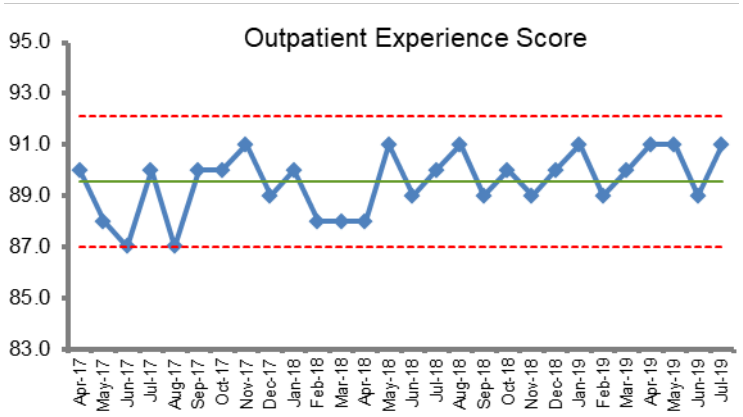
	Day	Night	TOTAL
Registered Nurses	95.0%	95.8%	95.4%
Nursing Assistants	105.3%	117.7%	110.5%
TOTAL	**98.0%**	**101.5%**	**99.6%**

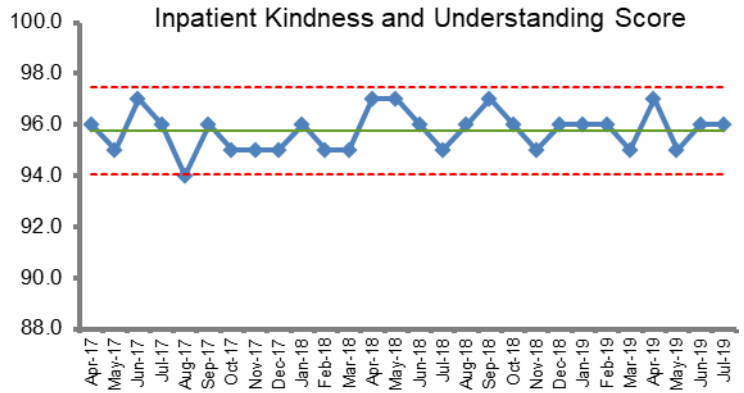
Medicine	107.6%
Specialised Services	101.9%
Surgery	102.6%
Women's and Children's	91.4%
TOTAL	**99.6%**



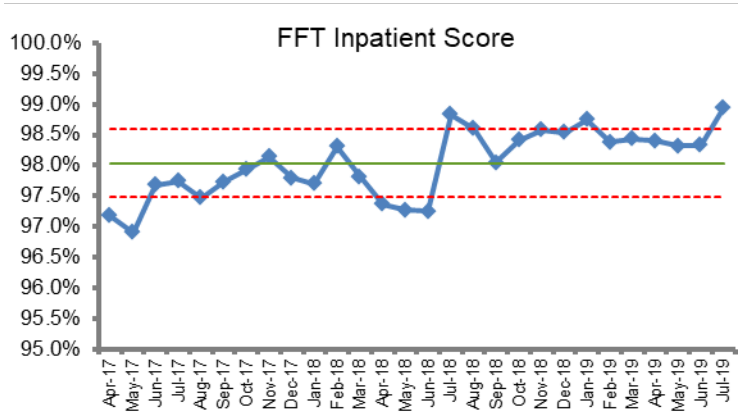
Monthly Patient Survey	
Standards:	For the inpatient and outpatient Survey, 5 questions are combined to give a score out of 100. For inpatients, the target is to achieve 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target of 90 or over.
Performance:	For July 2019, the inpatient score was 93/100, for outpatients it was 91. 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

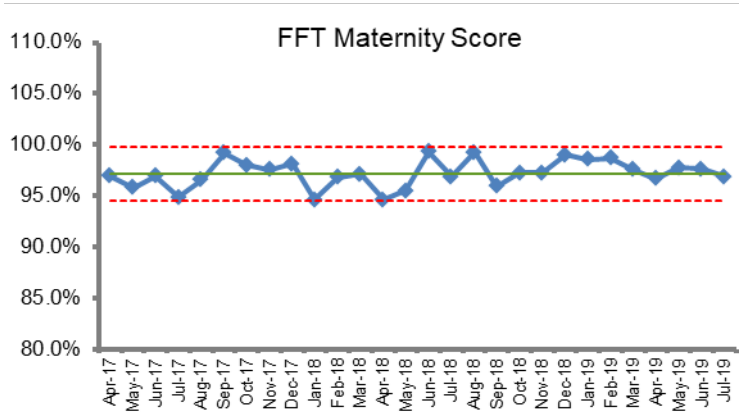


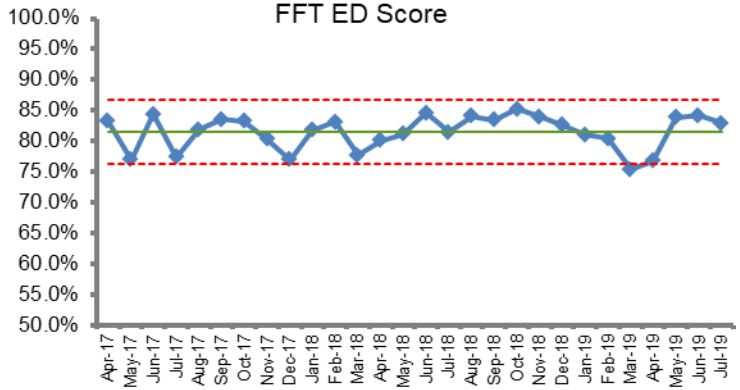




Friends and Family Test (FFT) Score	
Standards:	The FFT score is the number of respondents who were likely or very likely to recommend the Trust, as a percentage of all respondents. Standard is that the score for inpatients should be above 90%. The Emergency Department minimum target is 70%.
Performance:	July's FFT score for Inpatient services was 98.9% (2531 out of 2558 surveyed). The ED score was 82.9% (1298 out of 1565 surveyed). The maternity score was 96.9% (405 out of 418 surveyed).
Commentary/ Actions:	The headline measures from these surveys remained above their minimum target levels.
Ownership:	Chief Nurse



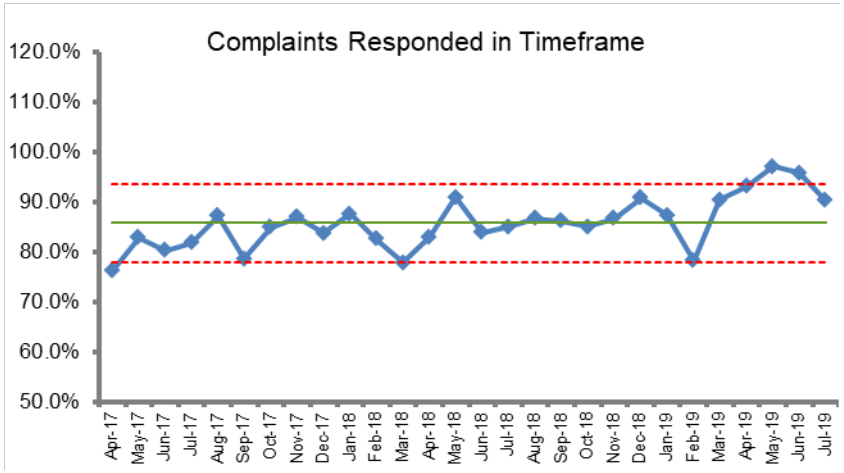


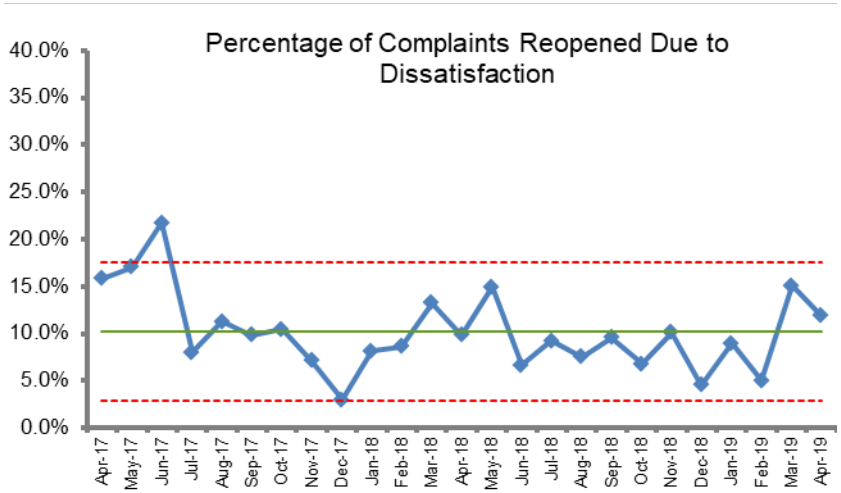


	Response Rate		Score	
	Jul-19	2019/2020	Jul-19	2019/2020
Inpatients				
Medicine	40.1%	42.4%	98.4%	98.0%
Surgery	42.0%	37.5%	99.6%	98.9%
Specialised Services	41.2%	40.3%	97.3%	98.4%
Women's and Children's	32.1%	33.7%	99.1%	98.4%
TOTAL	**39.4%**	**38.1%**	**98.9%**	**98.5%**
Emergency Department				
Bristol Royal Infirmary	11.7%	11.6%	65.9%	64.6%
Children's Hospital	17.7%	17.1%	86.3%	84.5%
Eye Hospital	27.4%	26.6%	93.8%	94.5%
TOTAL	**17.4%**	**17.0%**	**82.9%**	**82.3%**
Maternity				
TOTAL	**30.1%**	**28.3%**	**96.9%**	**97.2%**

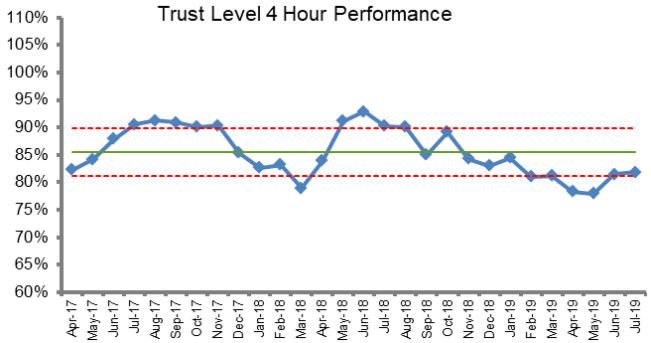
2.2 PERFORMANCE – Caring Domain

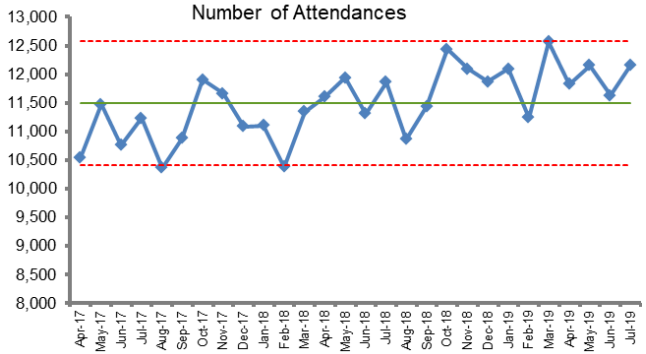
Patient Complaints	
Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe, with a lower tolerance (Red) of 85%. Of all formal complaints responded to, less than 8% should be re-opened because complainant is dissatisfied, with an upper tolerance (Red) of 12%.
Performance:	In July, 75 out of 83 formal complaints were responded to with timeframe (90.4%) Of the 71 formal complaints responded to in May, 6 resulted in the complainant being dissatisfied with the response (8.5%)
Commentary/ Actions:	**Response Time.** Three of the eight breaches were due to capacity issues within the Patient Support and Complaints Team. The other five breaches were attributable to delays within the Division; one for the Division of Medicine, one for Trust Services and three for Specialised Services. It should however be noted that at the time of writing this report, the Divisions have not yet had an opportunity to validate this data. The Trust's performance in responding to complaints via informal resolution within a timescale agreed with the complainant was 85% in July. This equates to 17 breaches from the 112 responses sent out in July. Of the 17 breaches recorded, five were from the Division of Surgery, four were from the Division of Medicine, there were three each for Specialised Services and Women & Children and two were for Trust Services. The Division of Diagnostics & Therapies achieved 100% for both formal and informal responses. **Dissatisfied** six cases from the 71 first responses sent out during that month and is an improvement on the 11.9% reported last month in respect of responses sent out in April 2019.
Ownership:	Chief Nurse

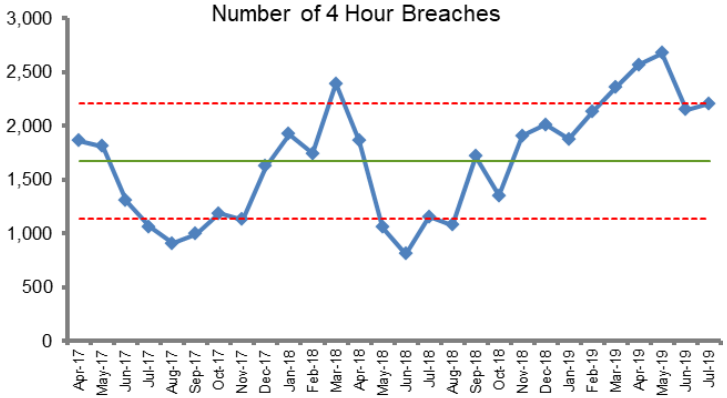


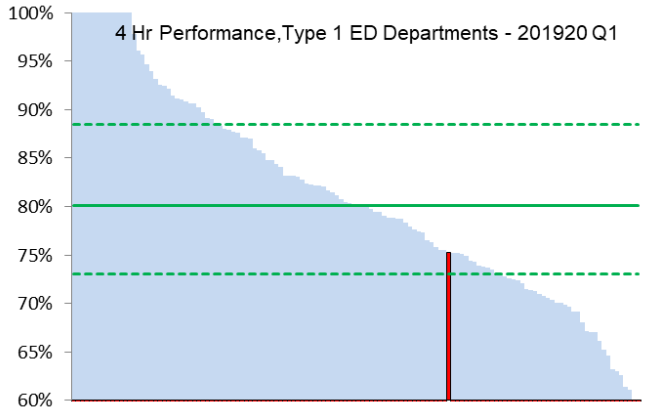


Emergency Department (ED) 4 Hour Wait	
Standards:	Measured as length of time spent in the Emergency Department from arrival to departure/admission. The national standard is that at least 95% of patients should wait under 4 hours. The Trust's improvement trajectory is 90.5% for July.
Performance:	Trust level performance for July was 81.86% (12156 attendances and 2205 patients waiting over 4 hours).
Commentary/ Actions:	Performance at the Bristol Royal Infirmary (BRI) remains below trajectory, with continued growth in attendances. The department have completed three audits in the last month to ascertain what is driving demand. Results of the audits show that between 20-30% of all attendances at the BRI ED each day could have been seen at a lower intensity venue, such as primary care. Next steps are to formulate an action plan, together with the commissioners, to start addressing this. Linked to this we are working with partners on the new System Recovery Plan, which supports the internal actions we are taking through the plan held by the UHB Urgent Care Steering Group. Within the Division of Medicine there has been recruitment into some new roles, including two ED consultants who start in September, and a new acute frailty team which will be in place by early winter.
Ownership:	Chief Operating Officer





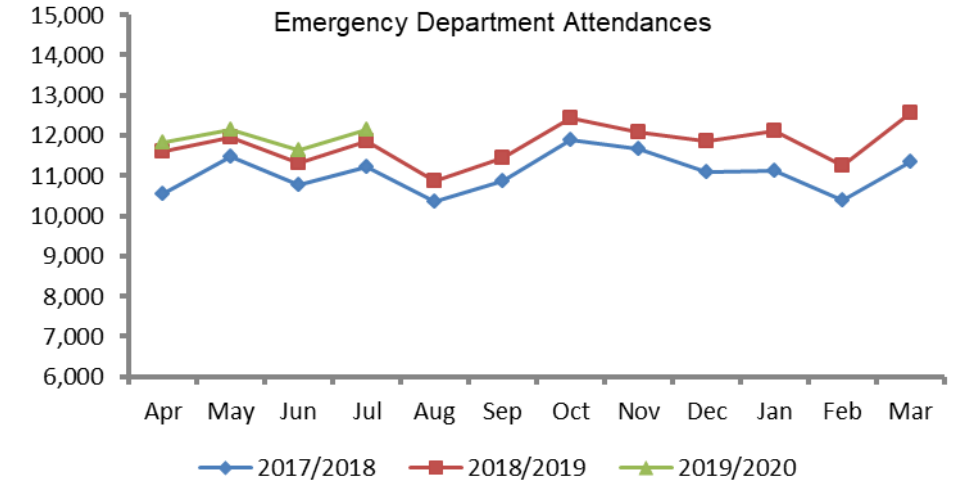


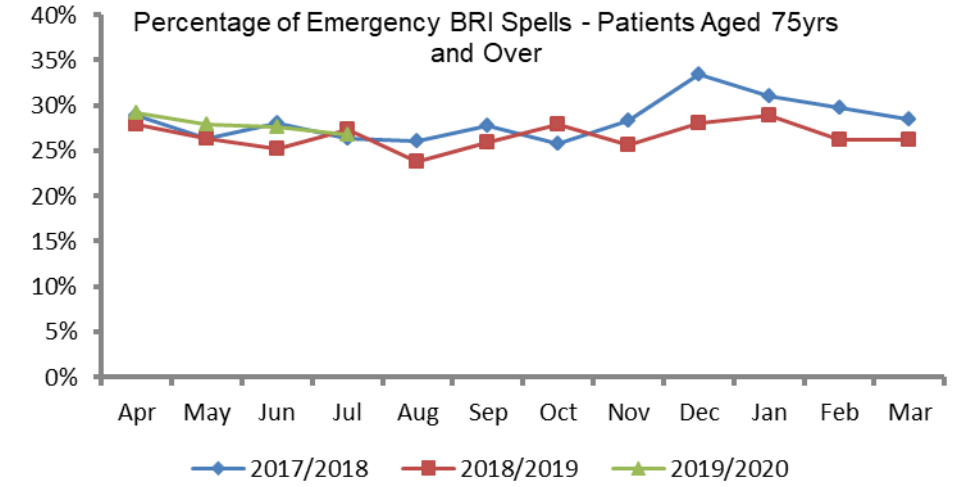


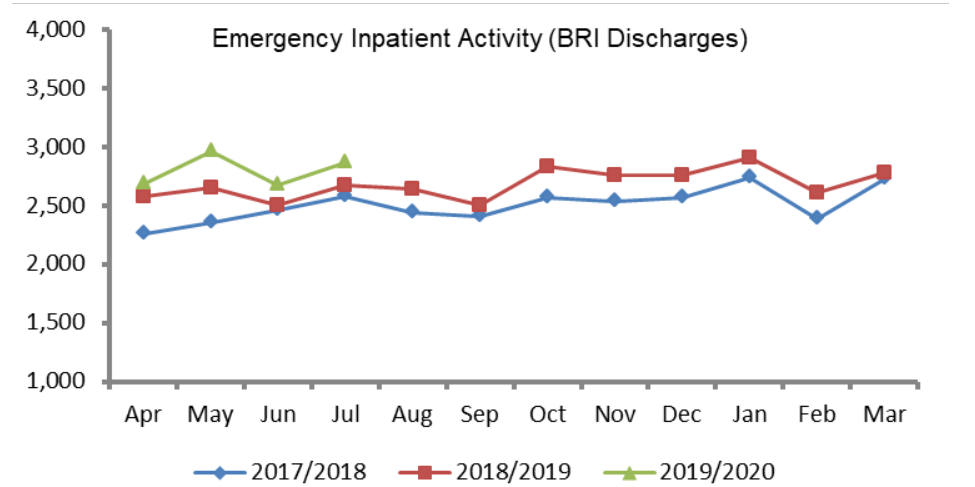
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

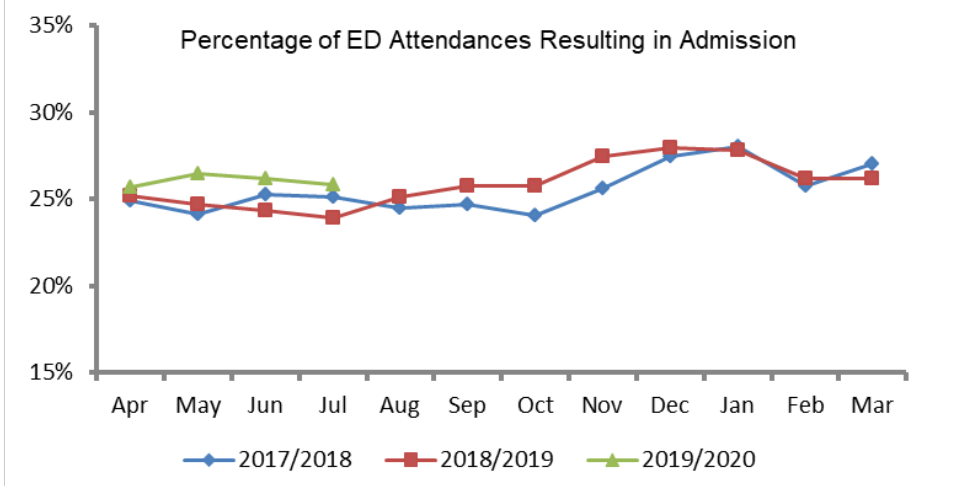
2.3 PERFORMANCE – Responsive Domain

	Attendances		Under 4 Hours		Performance	
	Jul-19	2019/2020	Jul-19	2019/2020	Jul-19	2019/2020
BRI	6371	24746	4393	16406	68.95%	66.30%
Trust	12156	47752	9951	38144	81.86%	79.88%



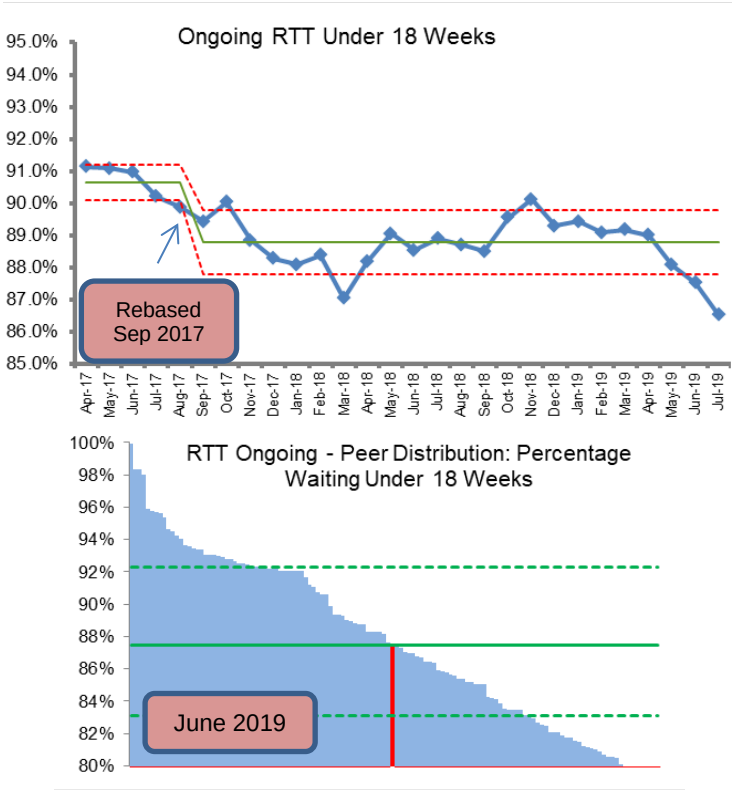






2.3 PERFORMANCE – Responsive Domain

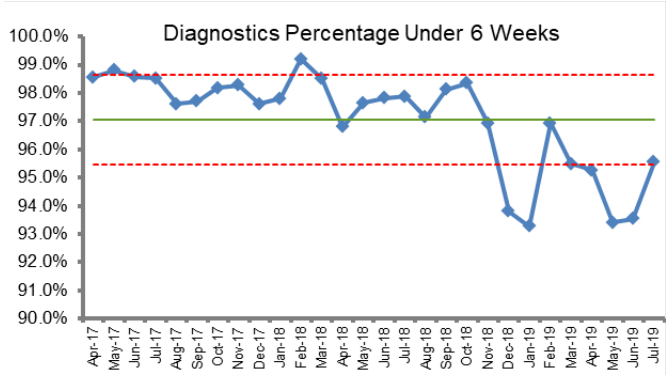
Referral to Treatment (RTT)	
Standards:	At each month-end, the Trust reports the number of patients on an ongoing RTT pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks. The Trust's improvement trajectory has been set at 87.9% for end of July. In addition, no-one should be waiting 52 weeks or over at the end of March 2019.
Performance:	At end of July, 86.5% of patients were waiting under 18 week (28,494 out of 32,930 patients). 9 patients were waiting 52+ weeks
Commentary/ Actions:	The 92% national standard was not met at the end of July and the improvement trajectory of 87.9% was missed. However the Trust had achieved, for 14 consecutive months, the RTT set recovery trajectory prior to June. Key actions for 2019/20: • Achieve zero 52 week waiting patients by September 2019 • Ensure the total waiting list size is below the March 2018 level of 29,207 at March 2020 • Ensure performance is restored to trajectory levels, reviewed and managed through the weekly performance meetings with divisions. All divisions have agreed a trajectory for their area that delivers the overall Trust target when aggregated. Focus will be on ensuring there is sufficient capacity to admit the required number of patients or to see them in outpatients.
Ownership:	Chief Operating Officer

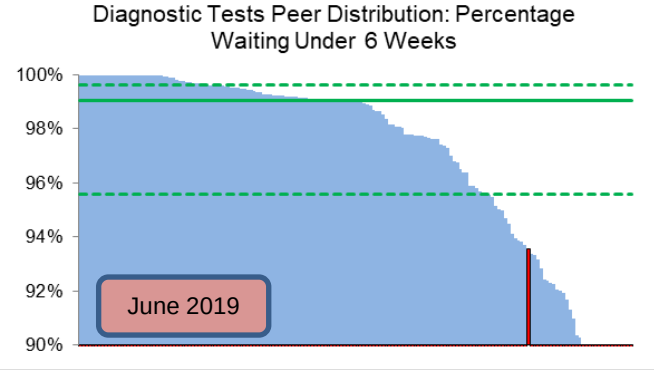


Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

	Ongoing Pathways at Jul-19		
	Ongoing Pathways	Ongoing Over 18 Weeks	Ongoing Performance
Cardiology	2,697	516	80.9%
Cardiothoracic Surgery	343	86	74.9%
Dermatology	2,813	327	88.4%
ENT	2,082	140	93.3%
Gastroenterology	995	19	98.1%
General Medicine	9	0	100.0%
Geriatric Medicine	95	2	97.9%
Gynaecology	1,491	242	83.8%
Neurology	279	32	88.5%
Ophthalmology	4,130	317	92.3%
Oral Surgery	3,423	575	83.2%
Other (Clinical Genetics)	769	27	96.5%
Other (Dental)	2,958	527	82.2%
Other (General Surgery)	1,645	456	72.3%
Other (Haem/Onc)	218	6	97.2%
Other (Medicine)	575	24	95.8%
Other (Other)	445	4	99.1%
Other (Paediatric)	5,950	993	83.3%
Other (Pain Relief)	51	0	100.0%
Other (Thoracic Surgery)	145	15	89.7%
Plastic Surgery	0	0	-
Rheumatology	582	28	95.2%
Thoracic Medicine	649	9	98.6%
Trauma & Orthopaedics	586	91	84.5%
TOTAL	**32,930**	**4,436**	**86.5%**

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 4 2019/10
Performance:	At end of July, 96.2 % of patients were waiting under 6 weeks (7,742 out of 8,049 patients). There were 307 breaches of the 6-week standard.
Commentary/ Actions:	The Trust did not achieve the 99% national standard at end of July. The maximum number of breaches needed to achieve 99% was 80 breaches. • The Ultrasound backlog of 153 (as at March 2019) has now been cleared and the service is now able to deliver the 99% standard going forward, • Echos is on track to deliver the standard by start of Quarter 3, due to continued outsourcing until internal vacancies are filled and waiting list backlogs cleared.. • MRI breach volumes are in Cardiac MRI (31) and Paediatrics (53). Cardiac MRI are running waiting list initiatives to clear the one-off backlog by September. Paediatric MRI is planned to recover by January 2020 • CT Cardiac recovery is reliant on the installation/upgrade of a new cardiac-compatible CT scanner, which is due during Quarter 3. The division has worked through the capacity and demand issues for the remainder of the year and is predicting recovery by January 2020 • Adult Endoscopy have recruited a second Clinical Fellow, to commence sessions in December, ensuring recovery by January 2020.
Ownership:	Chief Operating Officer





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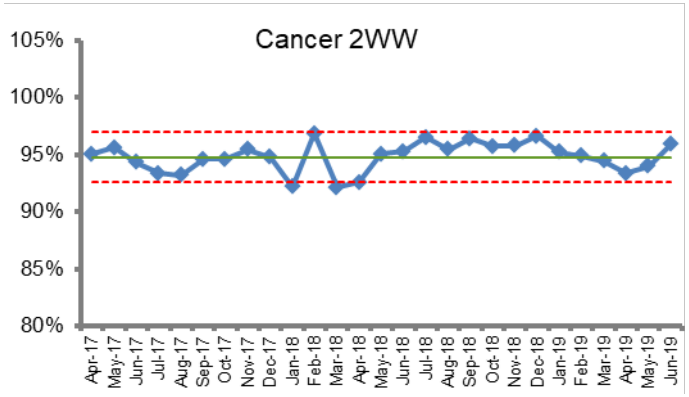
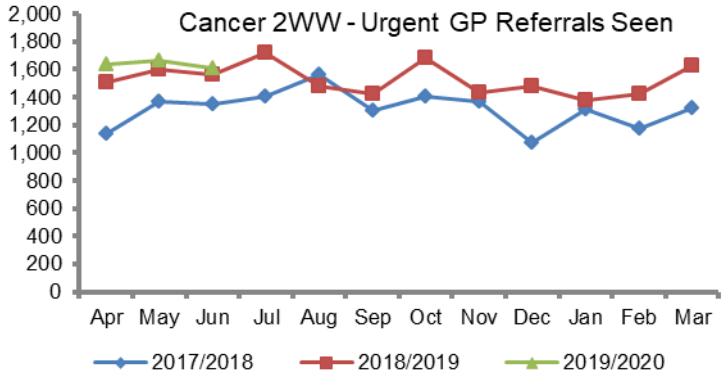
Diagnostic Tests Waiting List at Jul-19				
	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Audiology	758	0	758	100.0%
Colonoscopy	192	70	262	73.3%
CT	1,300	80	1,380	94.2%
Cystoscopy	1	0	1	100.0%
DEXA Scan	237	1	238	99.6%
Echocardiography	853	59	912	93.5%
Flexi Sigmoidoscopy	73	30	103	70.9%

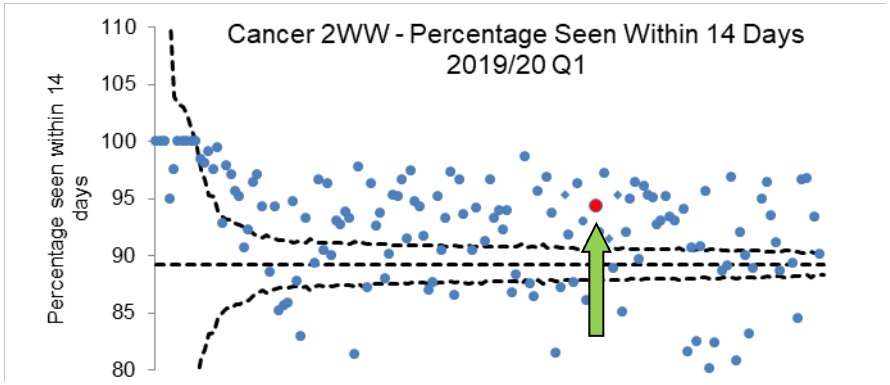
	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Gastroscopy	216	32	248	87.1%
MRI	1,753	84	1,837	95.4%
Neurophysiology	206	0	206	100.0%
Sleep Studies	202	0	202	100.0%
Ultrasound	1,925	4	1,929	99.8%
Grand Total	**7,716**	**360**	**8,076**	**95.5%**

2.3 PERFORMANCE – Responsive Domain

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 June, 95.9% of patients were seen within 2 weeks (1540 out of 1606 patients). Quarter 1 2019/20 achieved 94.4%.
Commentary/ Actions:	The standard has been achieved in each quarter since 2018/19 Q1. July 2019 is currently compliant. However a 33% increase in two week wait skin referrals compared to same period last year has caused deterioration to the 2 week first appointment standard in August and is being closely managed
Ownership:	Chief Operating Officer



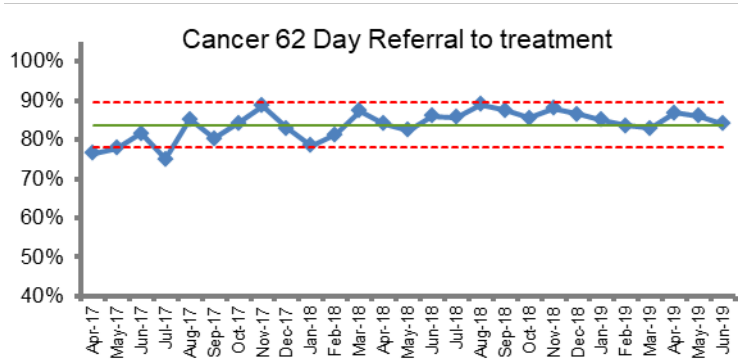


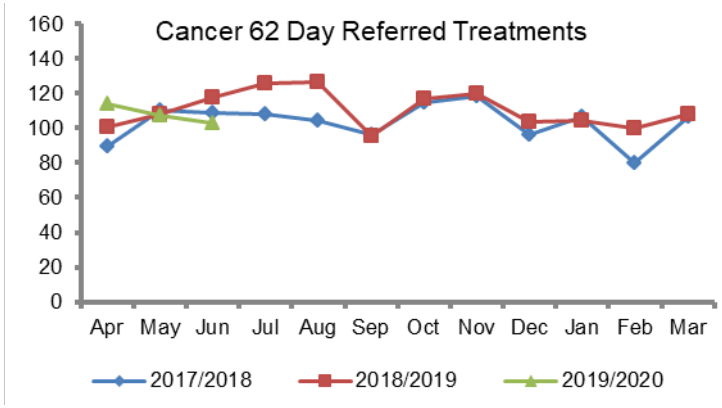


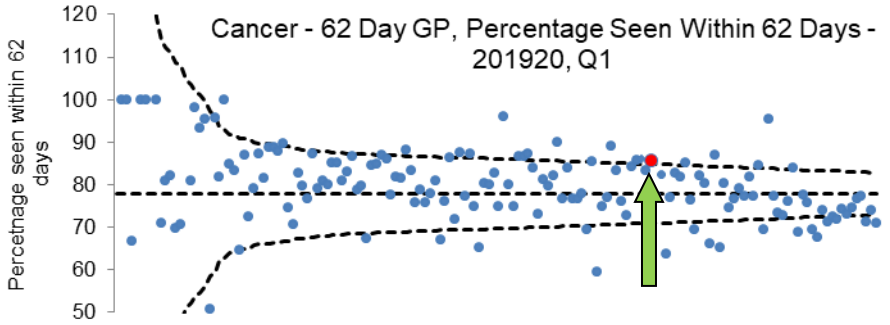
	Cancer 2WW - Jun-19		
	Under 2 Weeks	**Total Pathways**	**Performance**
Other suspected cancer	1	1	100.0%
Suspected children's cancer	27	28	96.4%
Suspected gynaecological cancers	112	128	87.5%
Suspected haematological malignancies e	11	11	100.0%
Suspected head and neck cancers	360	374	96.3%
Suspected lower gastrointestinal cancers	164	178	92.1%
Suspected lung cancer	28	28	100.0%
Suspected skin cancers	738	755	97.7%
Suspected upper gastrointestinal cancers	99	103	96.1%
Grand Total	**1,540**	**1,606**	**95.9%**

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 June, 84.0% of patients were seen within 62 days (86.5 out of 103.0 patients). Quarter 1 2019/20 achieved 85.7%
Commentary/ Actions:	The Trust returned to compliance in April 2019 (86.8%) and sustained this in May (86.0%) although narrowly missed the standard in June. However Quarter 1 overall did achieve the standard. From April there were 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). 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. The July position is close to compliance but is dependent on validation.
Ownership:	Chief Operating Officer



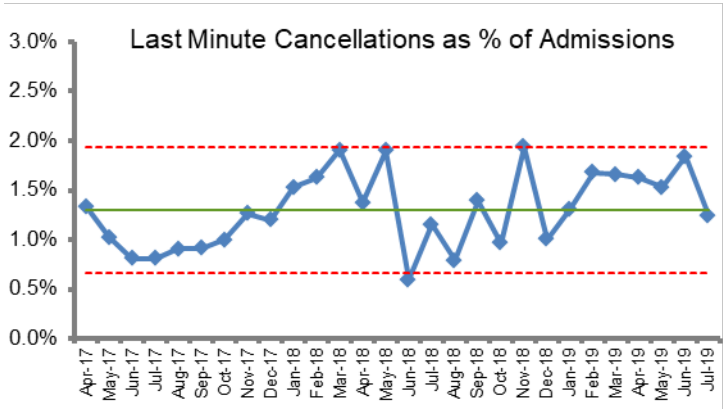


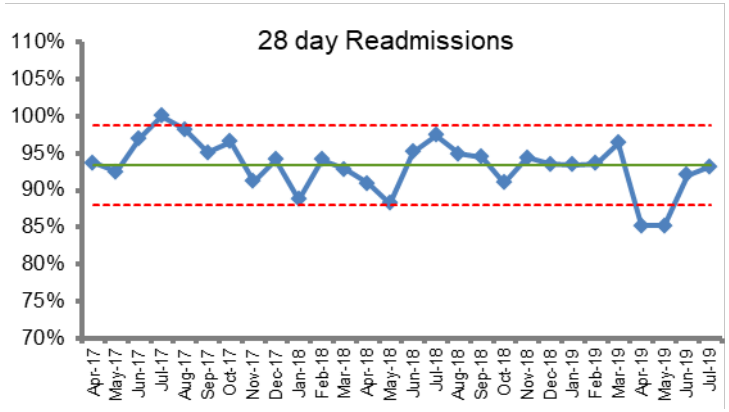


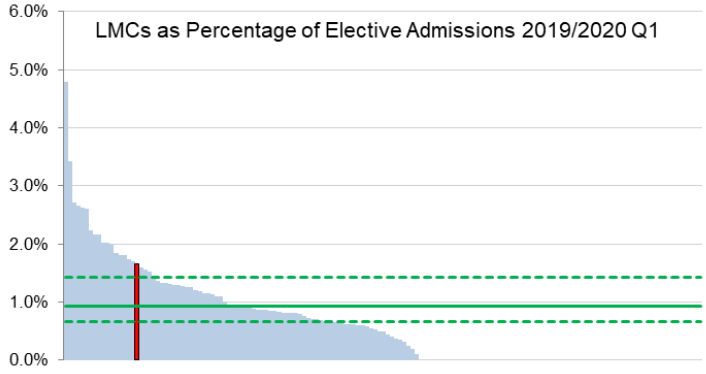
Cancer 62 Day - Jun-19

	Within Target	Total Pathways	Performance
Acute leukaemia	2.0	2.0	100.0%
Breast	0.5	0.5	100.0%
Gynaecological	6.5	9.5	68.4%
Haematological (Excluding Acute Leukae	4.5	8.0	56.3%
Head and Neck	5.0	10.0	50.0%
Lower Gastrointestinal	5.0	5.5	90.9%
Lung	12.5	14.0	89.3%
Other	2.5	2.5	100.0%
Sarcoma	0.5	0.5	100.0%
Skin	40.5	42.5	95.3%
Upper Gastrointestinal	5.0	6.0	83.3%
Urological (Excluding Testicular)	2.0	2.0	100.0%
Grand Total	**86.5**	**103.0**	**84.0%**

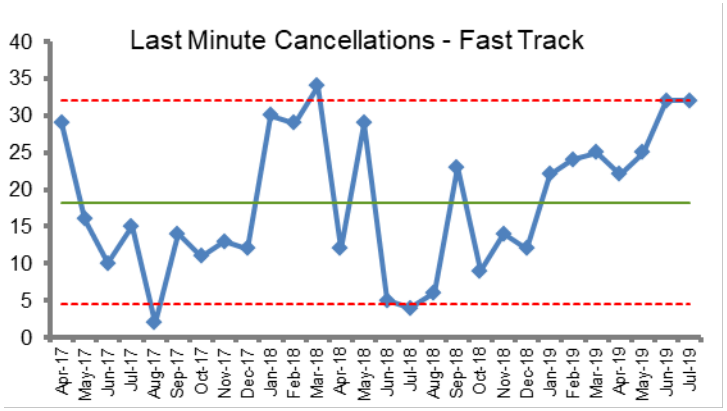
Last Minute Cancelled Operations	
Standards:	This covers elective admissions that are cancelled on the day of admission by the hospital, for non-clinical reasons. The total number for the month should be less than 0.8% of all elective admissions. Also, 95% of these cancelled patients should be re-admitted within 28 days
Performance:	In July there were 88 last minute cancellations, which was 1.3% of elective admissions. Of the 117 cancelled in June, 109 (93.2%) had been re-admitted within 28 days. This means eight patients breached the 28 day readmission standard.
Commentary/ Actions:	The most common reason for cancellation was "No HDU Beds" (12 cancellations). There were 2 in Medicine, 8 in Cardiac Services, 16 in ENT & Thoracics, 25 in Gastrointestinal Surgery, 15 in Ophthalmology, 3 in Trauma & Orthopaedics, 11 in Dental Services, 4 in Gynaecology and 2 in Paediatrics. Of the eight 28 day breaches: 1 was Dental, 2 were ENT/Thoracics, 4 were General Surgery and 1 was T&O.
Ownership:	Chief Operating Officer

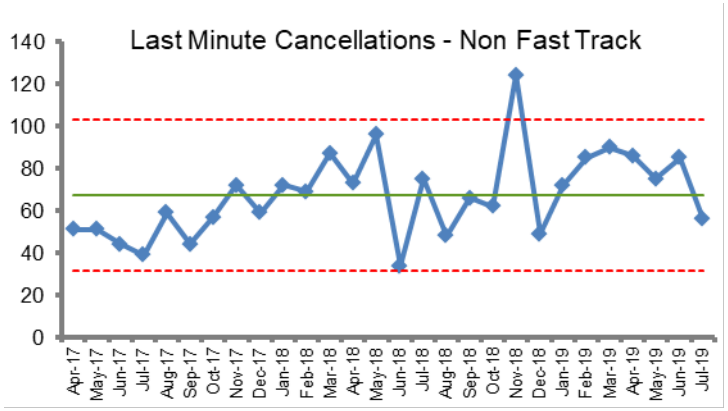






Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

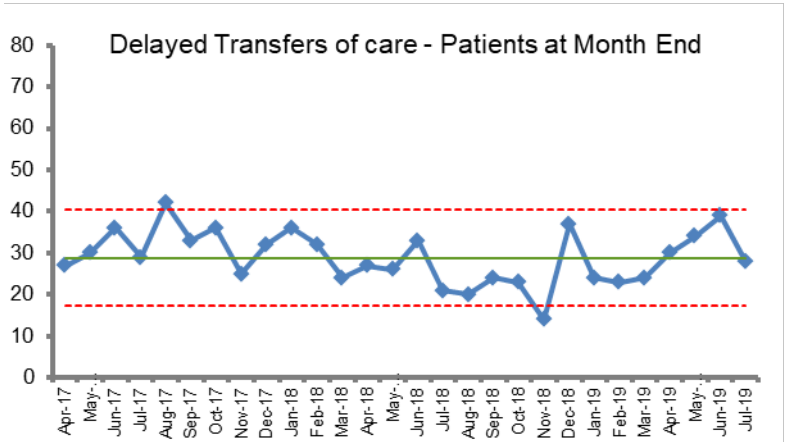


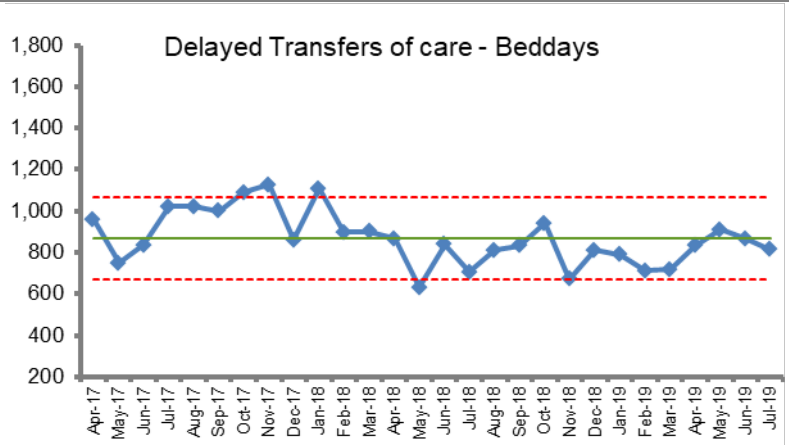


Cancellation Reason	Fast Track	Routine	Urgent	TOTAL
No HDU Beds	10	1	1	12
AM list over-ran	2	2	5	9
No Beds Available	2	2	4	8
Other clinically complicated Patient in theatre	6	1	1	8
Equipment Unavailable	2	0	5	7
Equipment Failure	0	3	4	7
Anaesthetist Unavailable	0	6	0	6
Surgeon Unavailable	0	3	2	5
Other Emergency Patient Prioritised	0	4	1	5
Booking Error	3	2	0	5
List Overbooked	1	3	0	4
No ITU Beds	4	0	0	4
No Theatre Staff	0	2	1	3
List did not start on time	1	1	0	2
Notes Not Available	1	0	0	1
Surgeon Taken Ill	0	1	0	1
Infection	0	1	0	1
TOTAL	**32**	**32**	**24**	**88**

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 July there were 28 Delayed Transfer of Care patients as at month-end (including 9 at South Bristol), and 815 beddays consumed by DToC patients.
Commentary/ Actions:	The Integrated Care Bureau (ICB) 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 25 - 35 Where community capacity is available, the ICB facilitates a smooth and timely discharge. However demand for HomeFirst continues to exceed capacity and patients are experiencing delays in hospital as a result. Delays for HomeFirst are approximately 10% of the total G2G at the end of the month. This is a reflection of the summer months and availability of staff to support domiciliary care. 20% of the G2G patients were either waiting for Social Care allocation or being assessed, and another 20% of patients were waiting for a domiciliary package of care split between self-funders and those funded by social care. The issue with HomeFirst is mainly availability of the homecare element as there is capacity to deliver therapy assessments. Access to reablement generally remains a significant issue for patients in Bristol.
Ownership:	Chief Operating Officer

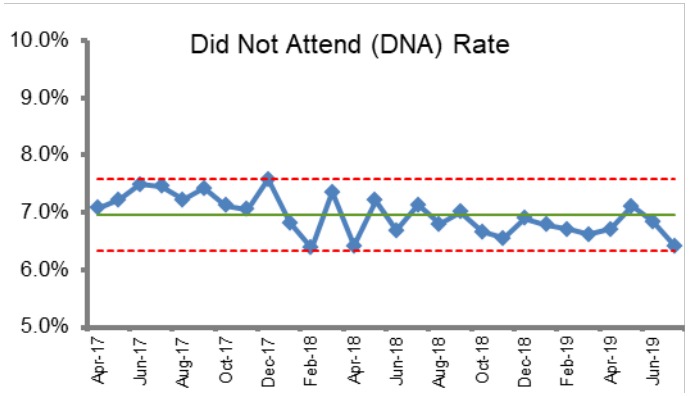


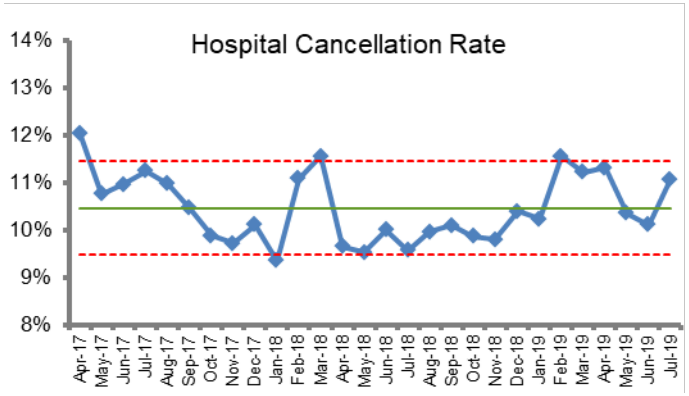


			Jul-19			
Code	Reason	Accountable	Patients (Acute)	Beddays (Acute)	Patients (Non-Acute)	Beddays (Non-Acute)
A	Completion of assessment	Both	2	45	1	68
		NHS	0	7	0	25
		Social Care	4	92	1	23
B	Public Funding	NHS	0	0	0	6
C	Further non acute NHS care	NHS	0	9	0	0
Di	Care Home Placement	NHS	3	38	1	14
		Social Care	0	27	0	0
Dii	Care Home Placement	NHS	1	28	0	4
		Social Care	1	61	3	30
E	Care package in own home	NHS	0	32	1	22
		Social Care	6	136	2	74
F	Community equipment / adaptions	NHS	0	3	0	0
		Social Care	1	22	0	17
G	Patient or family choice	NHS	1	29	0	0
I	Housing - patient not covered by NH	NHS	0	3	0	0
TOTAL			19	532	9	283

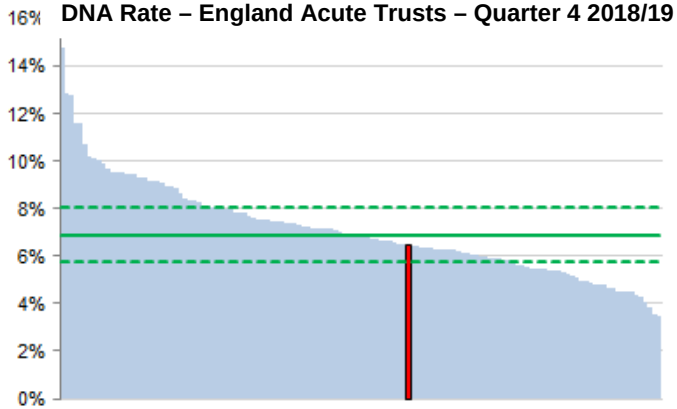
2.3 PERFORMANCE – Responsive Domain

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 July there were 10,655 hospital-cancelled appointments, which was 11.1% of all appointments made. There were 4,408 appointments that were DNA'ed, which was 6.4% 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

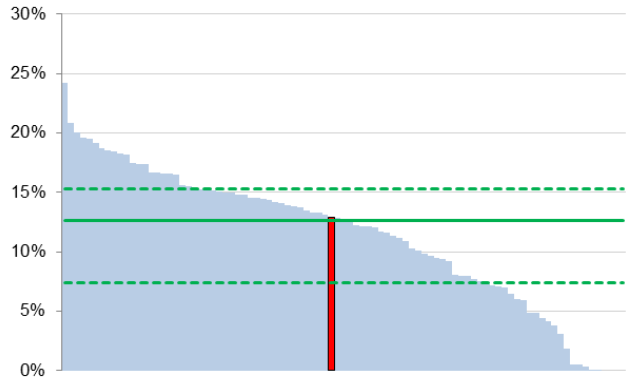




DNA Rate – England Acute Trusts – Quarter 4 2018/19



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

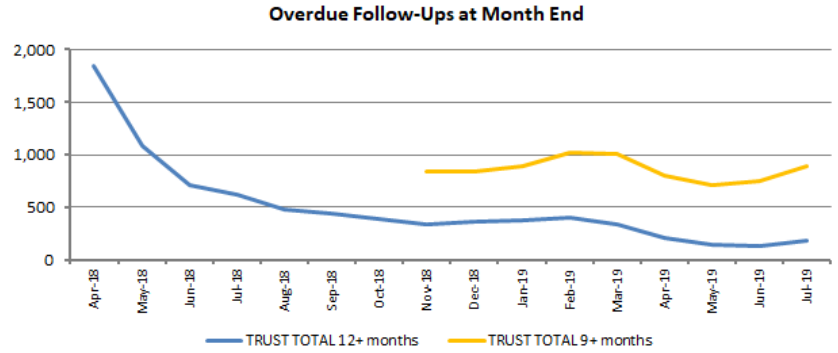


Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

2.3 PERFORMANCE – Responsive Domain

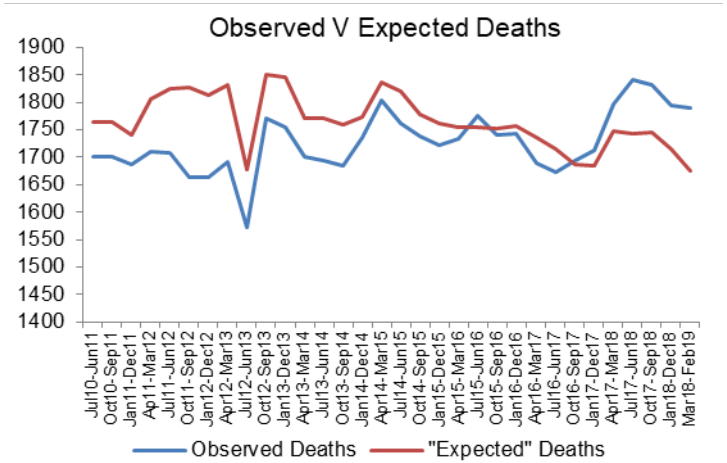
Outpatient – Overdue Follow-Ups	
Standards:	This measure looks at referrals where the patient is on a "Partial Booking List", which indicates the patient is to be seen again in Outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can be reported. The current aim is to have no-one more than 12 months overdue
Performance:	As at end of July, number overdue by 12+ months is 184 and overdue by 9+ months is 888.
Commentary/ Actions:	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.
Ownership:	Chief Operating Officer

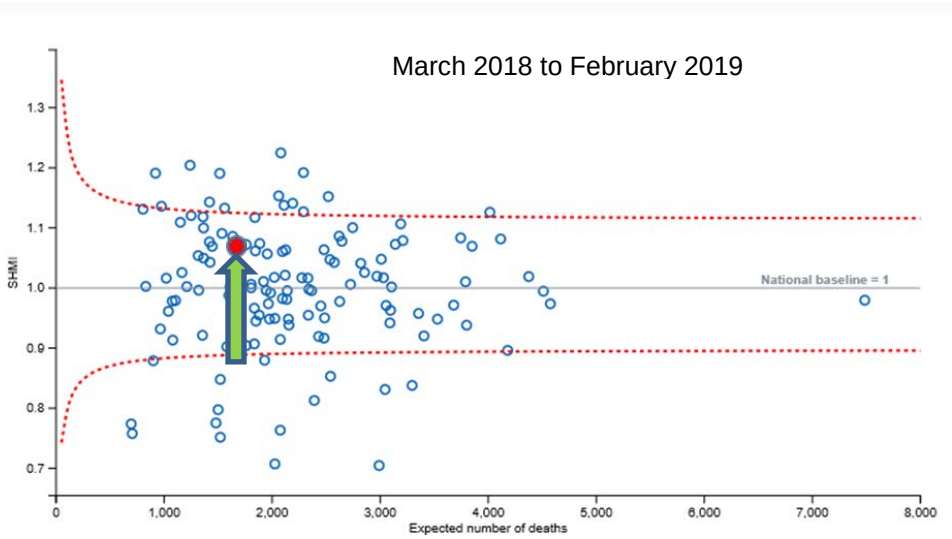
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Outpatients Overdue by 12+ Months	Diagnostics and Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Medicine	461	133	23	5	7	3	3	2	3	4	3	3	3	3	3	3
	Specialised Services	188	206	214	208	95	58	67	7	5	8	12	0	0	34	62	90
	Surgery	444	221	92	17	3	0	0	0	0	11	23	49	61	62	66	91
	Women's and Children's	756	526	387	387	371	375	322	323	350	351	360	282	150	46	3	
	TRUST TOTAL 12+ months	**1,849**	**1,086**	**716**	**617**	**476**	**436**	**392**	**332**	**358**	**374**	**398**	**334**	**214**	**145**	**134**	**184**
Outpatients Overdue by 9+ Months	Diagnostics and Therapies								3	2	0	0	0	0	0	2	0
	Medicine								20	4	4	3	4	4	3	3	4
	Specialised Services								125	95	142	247	253	181	261	278	323
	Surgery								125	124	108	146	216	264	272	333	450
	Women's and Children's								565	620	640	629	530	349	174	128	111
	TRUST TOTAL 9+ months								**838**	**845**	**894**	**1025**	**1003**	**798**	**710**	**744**	**888**



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 now published monthly and covers a rolling 12 –month period. Data is published 6 months in arrears.
Performance:	Latest SHMI data is for 12 month period March 2018 to February 2019. The SHMI was 106.9 (1790 deaths and 1675 "expected"). The Trust is in NHS Digital's "As Expected" category.
Commentary/ Actions:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required. All actions but one in response to an overall SHMI and HSMR remaining above 100, have been completed. The outstanding action relates to extending the field size for submission of co-morbidity codes for patients to ensure completeness of data capture, which is delayed until at least November 2019 due to a need for a new server in a downstream software data warehouse in order to support these additional codes. Please also see narrative for HSMR below with respect to mortality specifically for acute myocardial infarction.
Ownership:	Medical Director

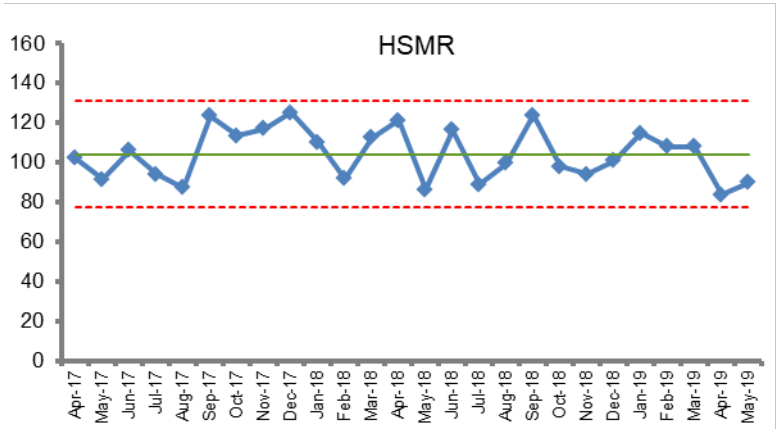
Timeframe	Banding	Observed Deaths	"Expected" Deaths	SHMI
Jul15-Jun16	As Expected	1,775	1,754	101.2
Oct15-Sep16	As Expected	1,741	1,752	99.4
Jan16-Dec16	As Expected	1,743	1,758	99.1
Apr16-Mar17	As Expected	1,690	1,737	97.3
Jul16-Jun17	As Expected	1,674	1,714	97.6
Oct16-Sep17	As Expected	1,693	1,686	100.4
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

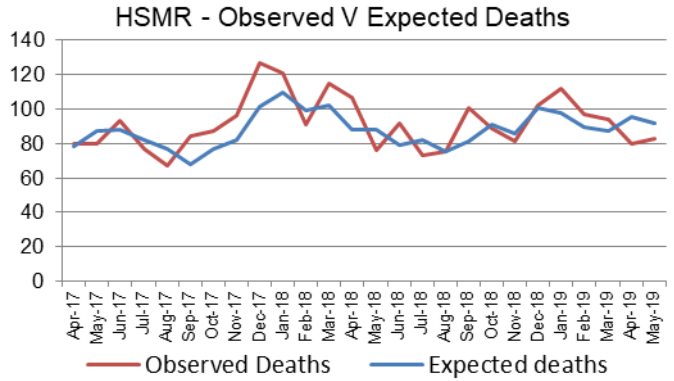




2.4 PERFORMANCE – Effective Domain

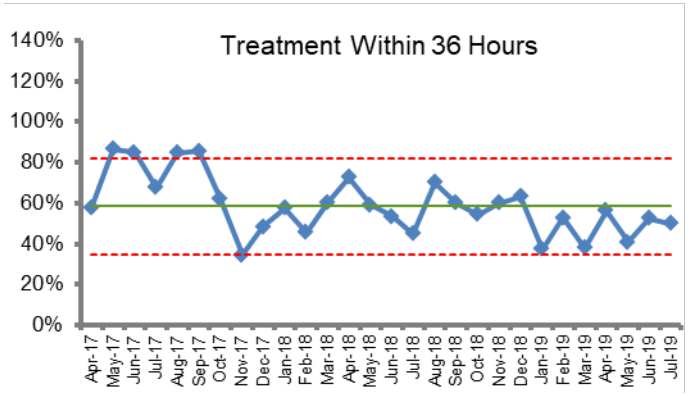
Mortality – Hospital Standardised Mortality Ratio (HSMR)	
Standards:	This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths
Performance:	Latest HSMR data is for May 2019. The HSMR was 90.1 (83 deaths and 92 "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

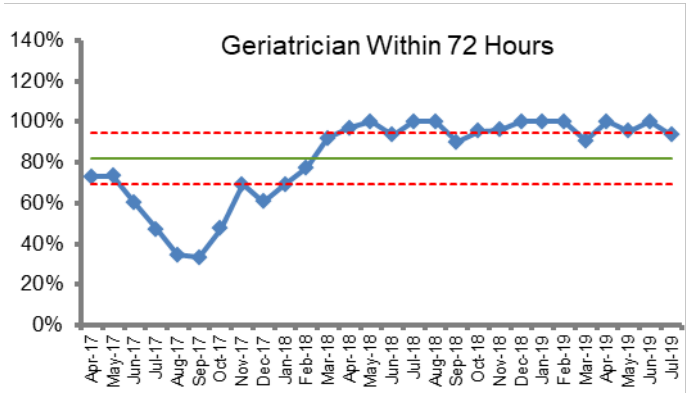


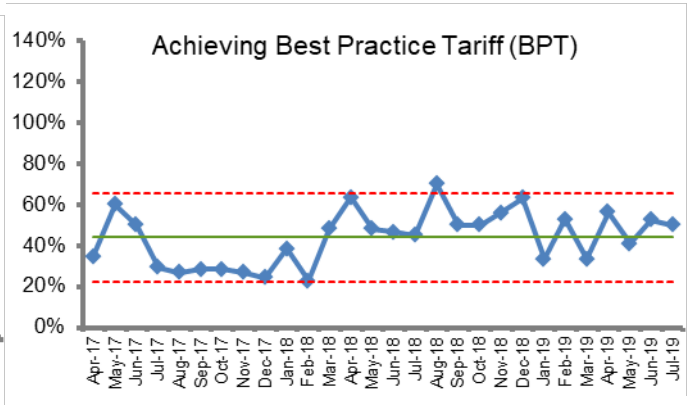


2.4 PERFORMANCE – Effective Domain

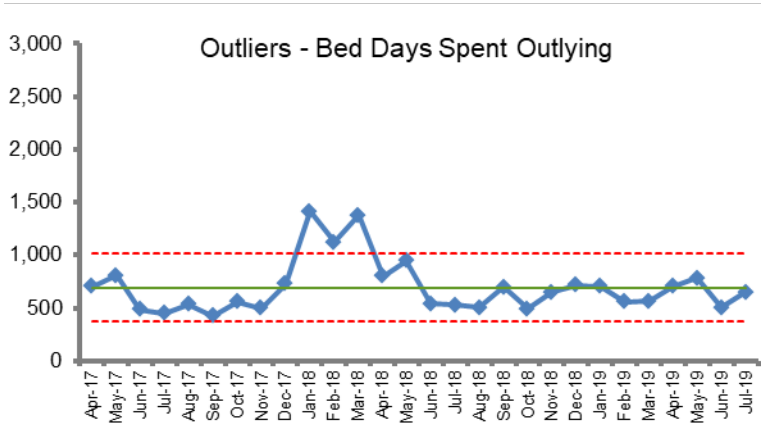
Fracture Neck of Femur	
Standards:	Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%.
Performance:	In July, there were 33 patients discharged following an admission for fractured neck of femur, of which 30 were eligible for Best Practice Tariff (BPT). For the 36 hour target, 50% (15 patients) were seen with target. For the 72 hour target, 28 patients (93%) were seen within target. 15 patients (50%) achieved all elements of the Best Practice Tariff.
Commentary/ Actions:	Challenges resulting in patients not being seen within 36 hours: • Access to trauma operating theatre • Consultant availability to operate Actions : • Reviewing ability to provide full day trauma operating to allow for prioritisation of fractured neck of femur on trauma lists • Continue to create additional capacity for trauma as possible by taking down other lists or using vacant theatre sessions • Additional consultants have been recruited who will support the fractured neck of femur pathway. Their likely start date is November 2019. . • From October 2019 A604 will become the 'Silver Trauma Unit', which will focus on elderly trauma patients.
Ownership:	Medical Director

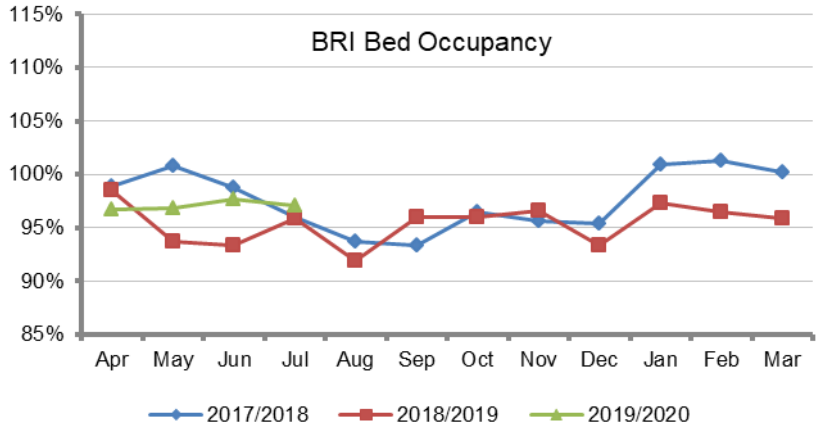


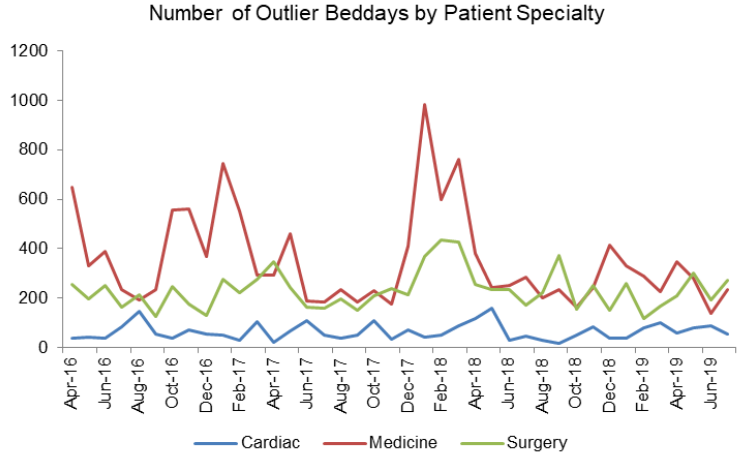




Outliers	
Standards:	This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.
Performance:	In July there were 645 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight).
Commentary/ Actions:	The July target of no more than 562 beddays was not achieved. Of all the outlying beddays 234 were Medicine patients, 142 were Specialised Services patients and 270 were Surgery patients. Although July did not achieve the target of fewer than 562 outlier beddays, the total number is still within normal process limits. All adult Divisions continue to outlie and Medicine are still using the extra capacity ward (A512). Within Cardiac, a Standing Operating procedure has been developed for pre-emptive boarding into the Heart Institute and further development is now required for the Oncology Centre. Consultants are also trialling a new ward round model to determine whether this supports flow and the initial data looks positive and there is now a longer trial for a period of 13 weeks.
Ownership:	Chief Operating Officer

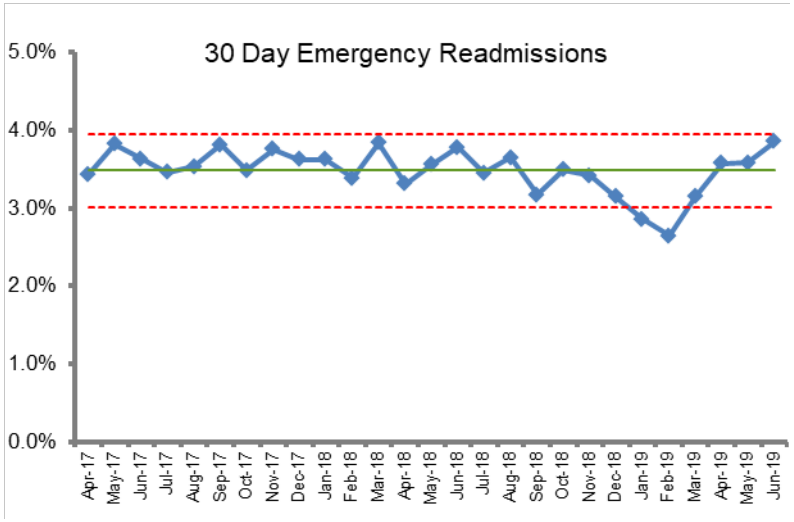






2.4 PERFORMANCE – Effective Domain

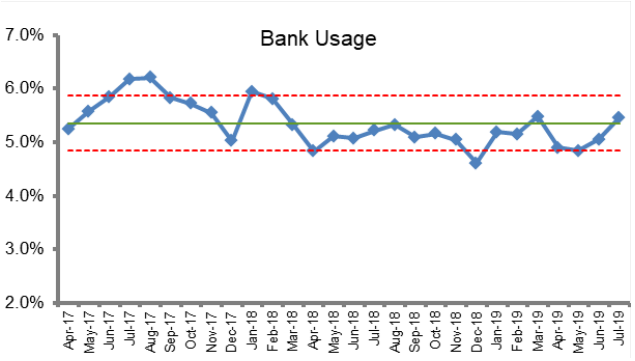
30 Day Emergency Readmissions	
Standards:	This reports on patients who are re-admitted as an emergency to the Trust within 30 days of being discharged. This can be in an unrelated specialty; it purely looks to see if there was a readmission. This uses Payment By Results (PbR) rules, which excludes certain 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 June, there were 12,273 discharges, of which 473 (3.85%) had an emergency re-admission within 30 days.
Commentary/ Actions:	9.4% of Medicine division discharges were re-admitted within 30 days as an emergency, 3.7% from Surgery and 1.8% from Specialised Services. Although July exceeded the target of 3.62%, this is still within normal process limits. Data is monitored on a regular basis through divisional performance reviews and is included on the speciality performance reports.
Ownership:	Chief Operating Officer

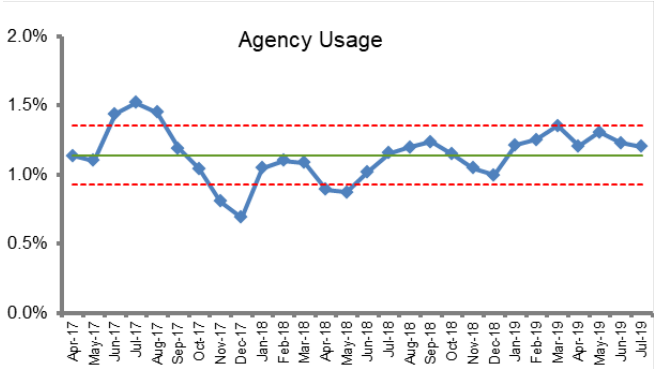


Discharges in June 2019

	Emergency Readmissions	Total Discharges	% Readmissions
Diagnostics and Therapies	0	27	0.00%
Medicine	239	2,551	9.37%
Specialised Services	49	2,701	1.81%
Surgery	114	3,072	3.71%
Women's and Children's	71	3,910	1.82%
TRUST TOTAL	**473**	**12,273**	**3.85%**

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. The red threshold is 10% over the monthly target.
Performance:	In July 2019, total staffing was at 8921 FTE. Of this, 5.5% was Bank (487 FTE) and 1.2% was Agency (107 FTE)
Commentary/ Actions:	**Agency usage** reduced by 2.2 FTE. The largest reduction was seen in the division of Trust Services, decreasing to 0.0 FTE from 8.3 FTE the previous month. The largest increase was seen in the division of Surgery with 22.3 FTE compared to 18.8 FTE in the previous month. The largest staff group increase was within Health Professionals increasing to 13.4 FTE from 10.4 FTE in the previous month. **Bank usage** increased by 37.7 FTE. The largest increase was seen in the division of Medicine, increasing to 139.4 FTE from 116.0 FTE the previous month. The largest reduction was seen in the division of Surgery, decreasing to 100.8 FTE from 107.7 FTE the previous month. The largest staff group increase was within Nursing and Midwifery increasing to 312.3 FTE from 291.8 FTE in the previous month. Actions: • Go-live of the reduction in high cost nurse agency programme is 2 Sept 2019 across the BNSSG & Bath. Both system wide and local mitigations are in place, ensuring patient safety remains uncompromised. • Communication will be disseminated across the Trust describing the bank incentives which the Senior Leadership Team have agreed, supporting the ambitions of the nurse agency reduction programme. • The Trust's 'Get Set For Summer' recruitment campaign remains live supporting the recruitment to the staff bank for all staff groups. The last month has seen 22 new NA's and 6 RN's reappointed to the Bank.
Ownership:	Director of People



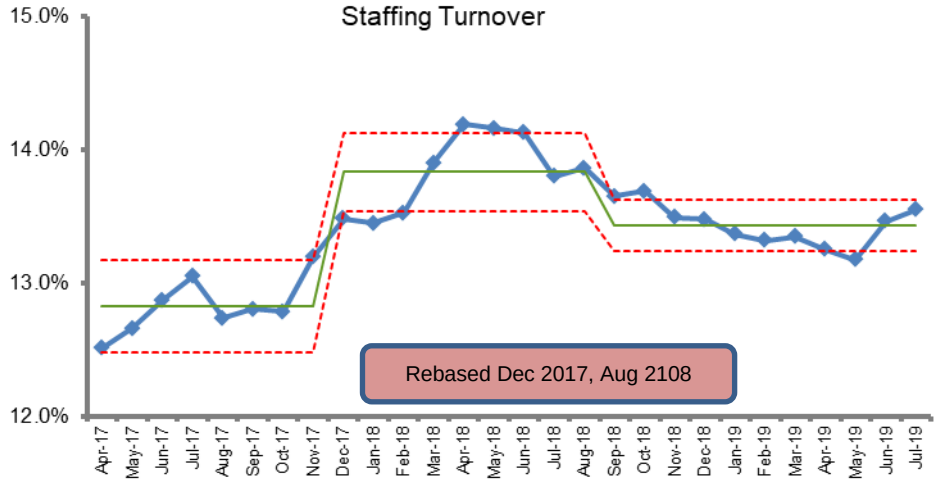


Bank	Jul FTE	Jul Actual %	KPI
UH Bristol NHS Foundation Trust	**486.8**	**5.5%**	**4.6%**
Diagnostics & Therapies	15.0	1.4%	1.5%
Medicine	139.4	10.6%	9.1%
Specialised Services	71.4	6.7%	6.2%
Surgery	100.8	5.5%	5.2%
Women's & Children's	74.2	3.6%	1.4%
Trust Services	32.9	3.9%	3.6%
Facilities & Estates	53.0	6.9%	6.4%

Agency	Jul FTE	Jul Actual %	KPI
UH Bristol NHS Foundation Trust	**107.3**	**1.2%**	**0.9%**
Diagnostics & Therapies	10.8	1.0%	1.0%
Medicine	34.8	2.6%	1.7%
Specialised Services	18.5	1.8%	1.2%
Surgery	22.3	1.2%	0.6%
Women's & Children's	20.6	1.0%	0.4%
Trust Services	0.0	0.0%	0.9%
Facilities & Estates	0.3	0.0%	0.5%

2.5 PERFORMANCE – Efficient Domain

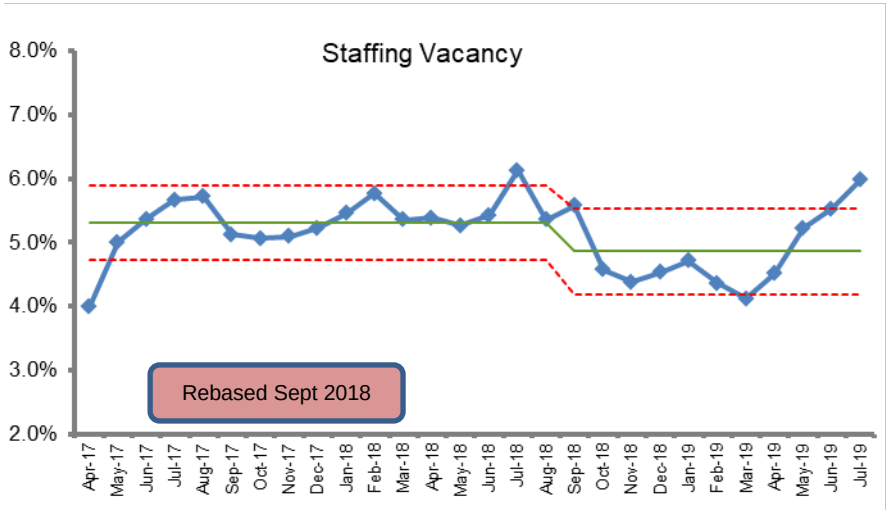
Staffing Levels (Turnover)	
Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In July 2019, there had been 965 leavers over the previous 12 months with 7123 FTE staff in post on average over that period; giving a Turnover of 965 / 7123 = 13.6%.
Commentary/ Actions:	Turnover increased to 13.6% from 13.5% last month, with increases in four divisions – Diagnostics and Therapies, Facilities and Estates, Medicine, and Trust Services. The largest divisional reduction was seen within Specialised Services reducing to 16.1% from 16.5% the previous month. The largest divisional increase was seen within Diagnostics and Therapies increasing to 11.9% from 10.9% the previous month. The biggest reduction in staff group was seen within Medical and Dental (1.2 percentage points). The largest increase in staff group was seen within Administrative and Clerical (0.9 percentage points). Actions: • Work with divisional colleagues is underway to support interventions required from the improving staff experience plans to ensure there is a focus on engagement as we work towards the 'You said we did' in the autumn. • Return rates for exit questionnaires have significantly improved over the past 2 months with June and July seeing return rates of over 80%. • The quarterly exit data report will be available end of August. Monthly narrative is analysed by Divisional HR Consultants.
Ownership:	Director of People



Turnover	Jul-19	KPI
UH Bristol NHS Foundation Trust	13.6%	**13.2%**
Diagnostics & Therapies	11.9%	10.6%
Medicine	16.0%	14.6%
Specialised Services	16.1%	14.8%
Surgery	13.3%	13.3%
Women's & Children's	11.6%	11.7%
Trust Services	14.9%	14.4%
Facilities & Estates	13.3%	15.0%

2.5 PERFORMANCE – Efficient Domain

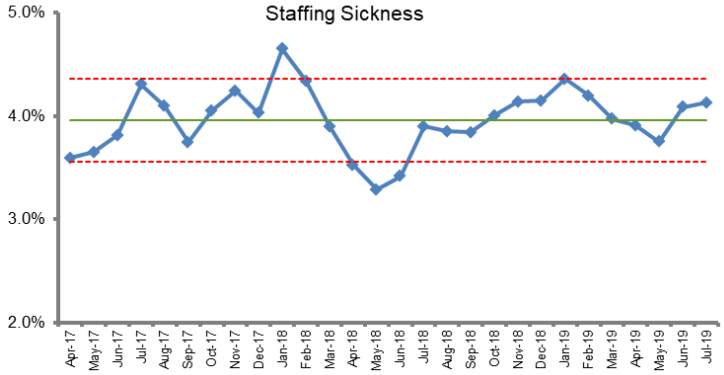
Staffing Levels (Vacancy)	
Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In July 2019, funded establishment was 8857 FTE, with 530 FTE as vacancies (6.0%).
Commentary/ Actions:	Overall vacancies increased to 6.0% compared to 5.5% in the previous month. There were all five staff group increases, the largest being within Admin and Clerical increasing to 123.1 FTE from 108.2 FTE the previous month. There no staff group reductions. Diagnostics and Therapies had the largest Divisional reduction to 60.3 FTE from 61.8 FTE the previous month. Actions: • A review of activity will be undertaken to understand the vacancy issues across all staff groups. This will be through the newly established Recruitment sub-group. • Successful 'Return to Practice' campaign has been held with 10 candidates appointed to commence training in September 2019. • 15 apprentice Health Care Support Workers and 9 offers made to experienced NAs were made in July, with 10 apprentice and 11 experienced starters taking up post. First cohort has commenced under the new model provided by Weston College. • Successful EU nurse recruitment during the last month with 16 offers made to registered nurses across Medicine, Surgery and Specialised Services.
Ownership:	Director of People



Vacancy	Jul-19	KPI
UH Bristol	6.0%	**5.0%**
Diagnostics & Therapies	5.6%	**5.0%**
Medicine	8.1%	**5.0%**
Specialised Services	7.2%	**5.0%**
Surgery	7.0%	**5.0%**
Women's & Children's	2.5%	**5.0%**
Trust Services	6.2%	**5.0%**
Facilities & Estates	8.0%	**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 July, total available FTE days were 260,594 of which 10,784 (4.1%) were lost to staff sickness.
Commentary/ Actions:	Sickness absence increased to 4.14% from 4.10%, with reductions in three divisions. The Divisions of Medicine, Surgery and Women's and Children's all reduced by 0.1% compared with the previous month. Facilities and Estates saw the largest divisional increase to 7.0% from 6.4% the previous month. The largest staff group increase was seen in Healthcare Scientists, rising to 3.9% from 2.5% the previous month. The largest staff group reduction was seen within Additional Clinical Services reducing to 5.3% from 5.9% the previous month. Actions: • Over 350 staff and managers have attended the workplace wellbeing training which supports staff with stress related issues supported by a suite of self-help guides • The Trust was selected to undertake the South West NHS Healthy Weight Declaration pilot designed to improve staff health both in and out of the workplace supported by the creation of an 'eating well' guide for staff. • A review of the E Learning for managers on supporting attendance is now complete. This will be launched in September with articles in Newsbeat and on HR Web to raise awareness. • Employee Services continue to offer ad hoc surgeries and face to face support for managers where required. • Recruitment to vacancy gaps in the Occupational Health Service will begin to support an improving picture with staff referrals
Ownership:	Director of People



Sickness	Jul-19	KPI
UH Bristol	4.1%	**3.8%**
Diagnostics & Therapies	2.9%	3.0%
Medicine	4.2%	4.7%
Specialised Services	3.6%	3.4%
Surgery	4.3%	3.6%
Women's & Children's	3.9%	3.7%
Trust Services	3.8%	2.7%
Facilities & Estates	7.0%	6.3%

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. The target is 85% Trust-wide.
Performance:	In July 2019, 6,042 members of staff were compliant out of 8,225 (73.5%)

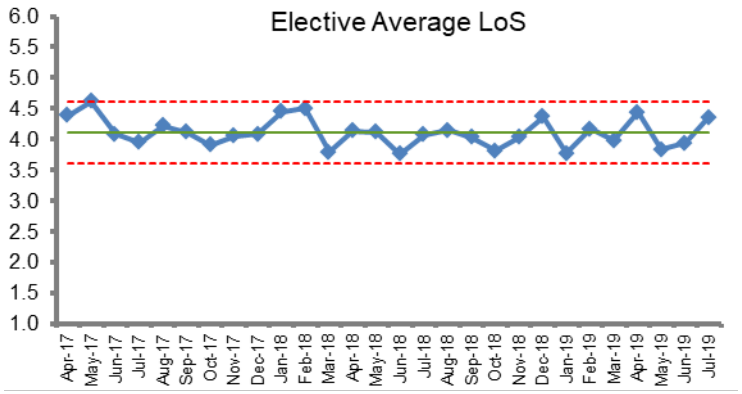
Commentary/ Actions:	Overall appraisal compliance increased to 73.5% (from 73.4%). There were increases in two divisions; Medicine and Women's & Children's.
	With the largest divisional increase seen in Women's and Children's increasing to 74.0% (from 71.7% the previous month).
	The largest divisional reduction was seen within Facilities and Estates, reducing to 74.8% (from 76.0% the previous month).
	All divisions are non-compliant.
	Actions:
	• A recovery plan continues focusing on action with areas of low compliance.
	• Support includes:
	  ◦ Fortnightly communications to all managers promoting appraisal support resources.
	  ◦ Appraisal training frequency has increased, allowing 30 managers to attend each month.
	  ◦ A number of new guides for staff and managers is held on HRWeb.
	• The delegation functionality in the e-appraisal system has gone live. Welcomed by managers with large teams, giving them the ability to delegate appraisals within the system.

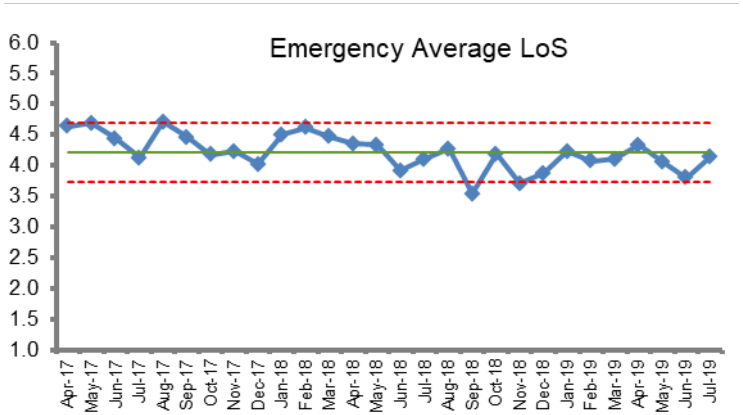
Ownership:	Director of People

Appraisal (Non-Consultant)	Jul-19	Jun-19	KPI
UH Bristol NHS Foundation Trust	73.5%	73.4%	**85.0%**
Diagnostics & Therapies	83.8%	84.9%	85.0%
Medicine	67.8%	67.1%	85.0%
Specialised Services	82.6%	83.3%	85.0%
Surgery	66.6%	67.6%	85.0%
Women's & Children's	74.0%	71.7%	85.0%
Trust Services	67.9%	68.5%	85.0%
Facilities & Estates	74.8%	76.0%	85.0%

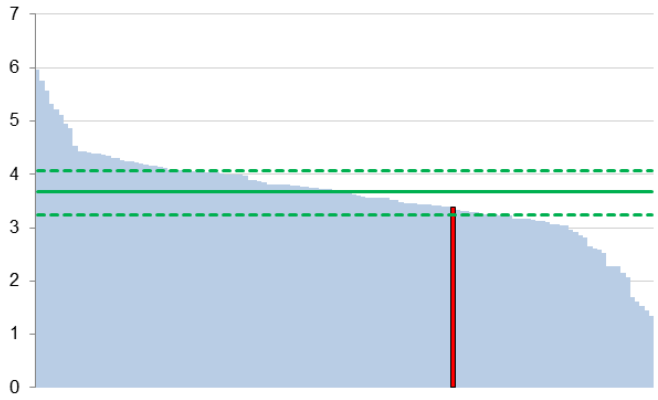
2.5 PERFORMANCE – Efficient Domain

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 July there were 6,816 discharges that consumed 26,121 beddays, giving an overall average length of stay of 3.83 days.
Commentary/ Actions:	The Children's Hospital overall length of stay has stayed around the average over the last couple of months and overall (emergency and elective) proportion of zero length of stay has increased as they have increased the number of day cases. They are continuing to have a number of patients with length of stay greater than 14 days above the weekly average, though have now started to reduce the number of patients with a length of stay greater than 28 days. This is a combination of emergency and elective patients with the vast majority of patients being acutely unwell. Some initiatives are planned to start in the next month, aimed at reducing length of stay including a campaign approach to Criteria Led Discharge to further embed this within the hospital and roll out new conditions; increase in capacity for our community nursing team to support with new pathways from the Children's ED and further capacity for those patients requiring IV antibiotics as well as implement the ambulatory enteral feeding pathway. They are also starting an enhanced recovery programme in Cardiac in September and making progress in developing the infrastructure needed to implement a pre assessment model for other surgical specialities. All division continue to use Clinical Utilisation Review (CUR) data to minimise delays day to day as well as consider where there are capacity gaps to inform business planning for 2020/21. Within Cardiac services All patients for cardiac surgery are now being bought in on the day of surgery unless there are clinical reasons why this is not appropriate, this has been supported by an anaesthetic led pre-op to make sure all cardiac surgery patients are fit for surgery. Also work is ongoing to improve flow with the development of nurse led discharge for electrophysiology (EP) and percutaneous coronary intervention (PCI) patients.
Ownership:	Chief Operating Officer





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



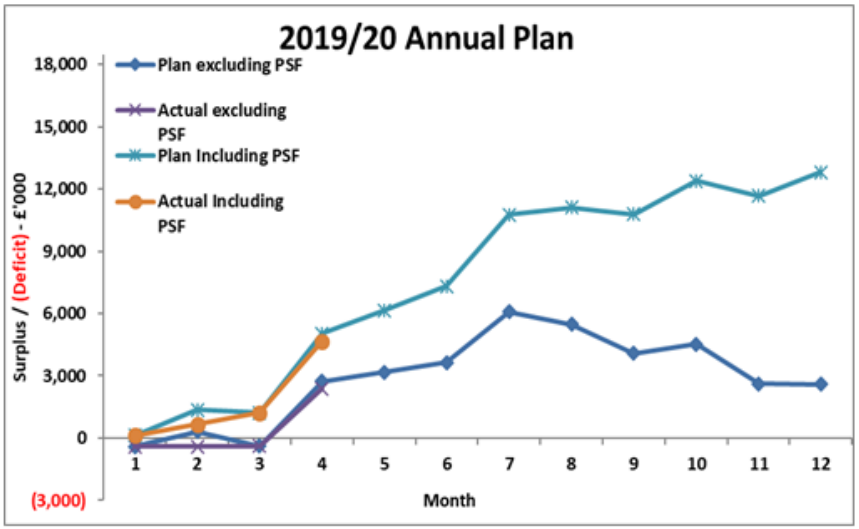
Length of Stay of Inpatients at month-end

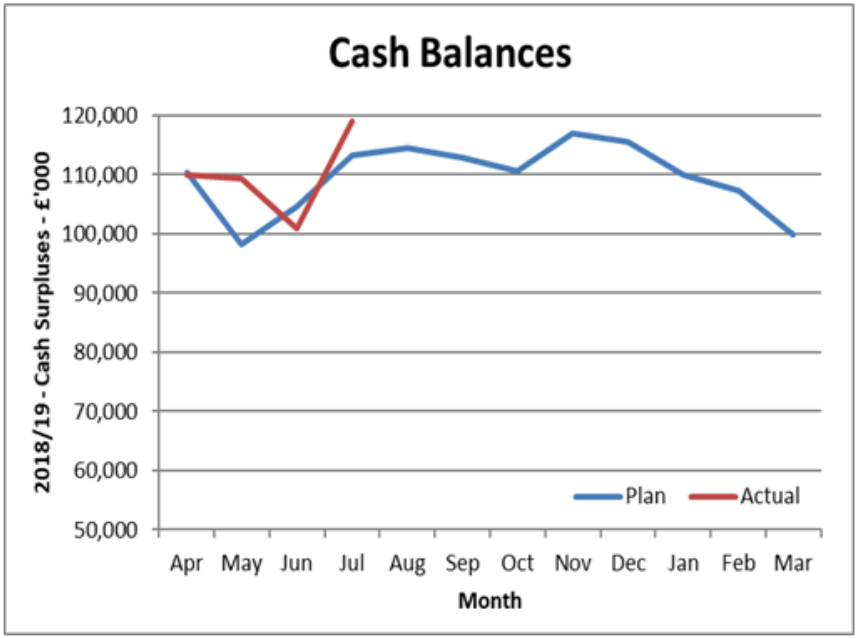
Jul-19	7+ Days	14+ Days	21+ Days	28+ Days
Bristol Children's Hospital	50	39	30	27
Bristol Haematology & Oncology Centre	23	17	11	8
Bristol Royal Infirmary	199	113	74	60
South Bristol Hospital	55	49	44	35
St Michael's Hospital	26	19	14	12
TRUST TOTAL	356	238	173	142

Bristol Royal Infirmary Divisional Breakdown:

Medicine	109	65	44	34
Specialised Services	43	25	12	9
Surgery, Head & Neck	47	23	18	17

2.6 FINANCIAL PERFORMANCE

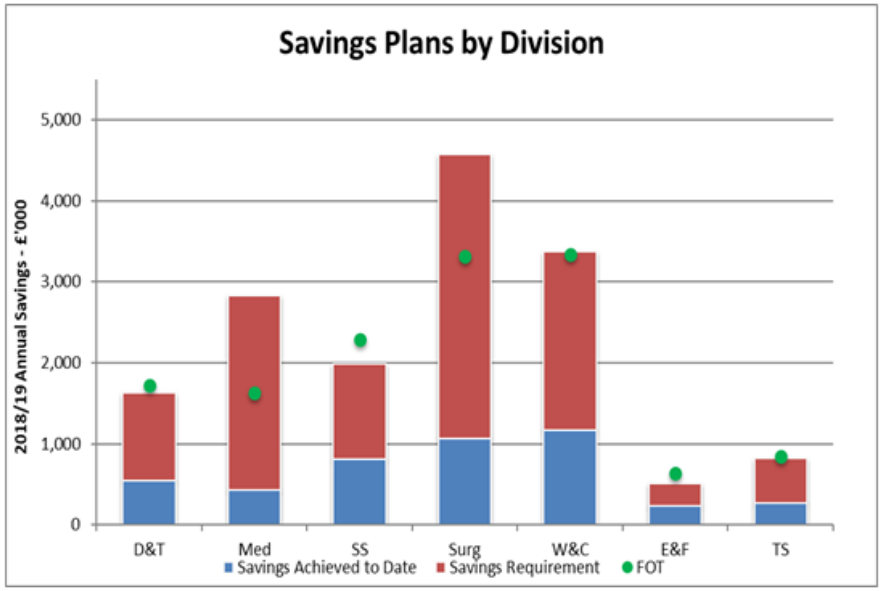




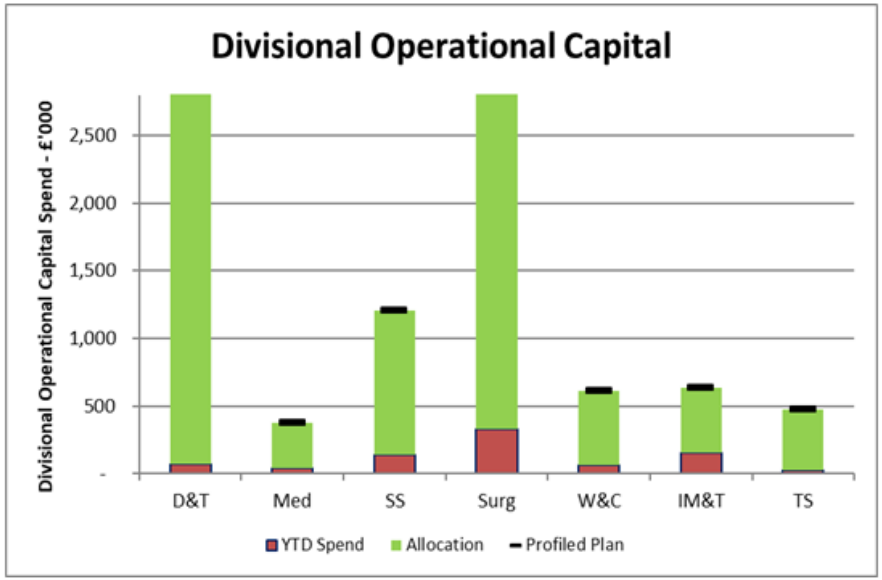
Divisional Actual Spend - £'000						
	In Month				Plan for Year	FOT Outturn
Divisional Agency	Apr	May	Jun	Jul		
Nursing & Midwifery	684	660	648	626	6,499	8,064
Medical						0
Consultants	72	82	92	93	644	924
Other Medical	56	20	85	108	212	456
Other	140	144	131	154	1,384	1,704
Total	952	906	956	981	8,739	11,148

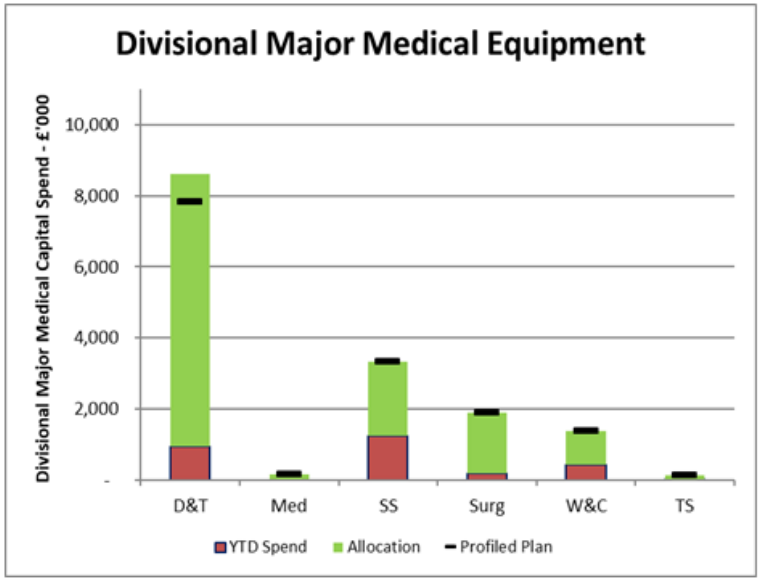
YTD Variance to Budget Surplus/(Deficit) - £'000				
Division	Apr	May	Jun	Jul
Diagnostics & Therapies	(4)	(39)	(56)	(66)
Medicine	(167)	(320)	(502)	(701)
Specialised Services	(54)	13	201	82
Surgery	(175)	(659)	(1,168)	(1,867)
Women's & Children's	(215)	(311)	(407)	(534)
Estates & facilities	(5)	(9)	(13)	(24)
Trust Services	4	3	(33)	17
Other Corporate Services	42	29	(85)	(37)
Total	(574)	(1,293)	(2,063)	(3,130)

In Month Variance to Budget Surplus/(Deficit) - £'000				
Subjective Heading	Apr	May	Jun	Jul
Nursing & Midwifery Pay	(604)	(491)	(484)	(502)
Medical & Dental Pay	(360)	(187)	(445)	(433)
Other Pay	243	197	109	289
Non Pay	954	189	356	(108)
Income from Operations	(173)	(94)	(2)	(18)
Income from Activities	(632)	(336)	(301)	(303)
Total	(572)	(722)	(767)	(1,075)



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	-	-	-
2.31	Donations - Cash	2.31	0.20	0.71	0.51
0.01	Donations - Direct	0.01	0.01	0.01	-
	Cash:				
25.53	Depreciation	25.53	8.40	8.48	0.1
0.68	Insurance Claim	0.68	0.28	0.28	-
5.32	Cash balances	5.32	(1.20)	(1.60)	(0.40)
42.46	**Total Funding**	**42.46**	**7.68**	**7.87**	**0.19**
	Application/Expenditure				
18.62	Strategic Schemes	18.61	0.98	0.96	(0.02)
17.57	Medical Equipment	16.85	2.48	2.90	0.42
17.27	Operational Capital	17.21	1.86	1.76	(0.10)
2.42	Fire Improvement Programme	2.17	0.25	0.16	(0.09)
14.75	Information Technology	14.72	1.46	1.62	0.17
4.43	Estates Replacement	4.43	0.65	0.46	(0.19)
75.06	**Gross Expenditure**	**73.99**	**7.68**	**7.87**	**0.19**
(32.60)	In-year Slippage	(31.54)	-	-	-
42.46	**Net Expenditure**	**42.46**	**7.68**	**7.87**	**0.19**

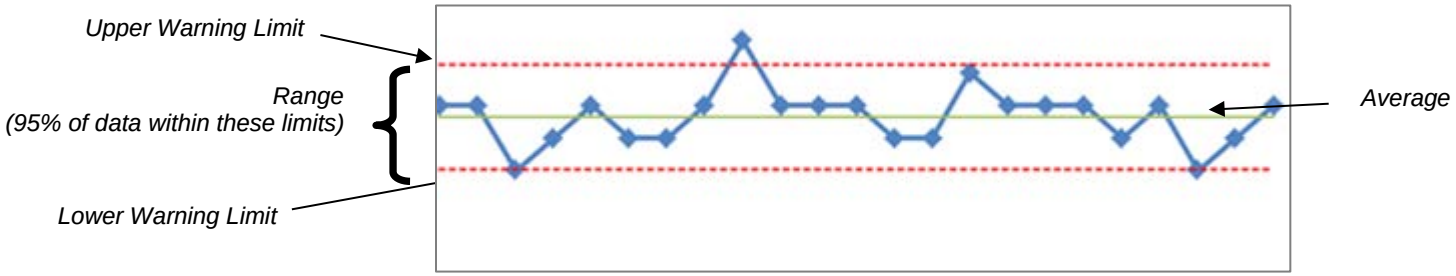




APPENDIX 1 – Explanation of SPC Charts

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 Care Quality Commission Rating

The Care Quality Commission (CQC) published their latest inspection report on 16th August 2019. Full details can be found here: https://www.cqc.org.uk/provider/RA7

The overall rating was OUTSTANDING, and the breakdown by domain and category is shown below.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Care	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Requires improvement →← May 2019	Good ↓ May 2019	Requires improvement ↓ May 2019
Medical Care (including older people's care)	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Good →← May 2019	Good →← May 2019	Outstanding →← May 2019	Outstanding ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
Services for children and young people	Good →← May 2019	Outstanding →← May 2019	Good →← May 2019	Good →← May 2017	Outstanding ↑ May 2019	Outstanding ↑ May 2019
End of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Maternity	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Outpatients and diagnostics	Good Mar 2017	Not rated	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Overall trust	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			18/19	19/20 YTD	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Patient Safety																				
Infections	DA01	MRSA Trust Apportioned Cases	6	0	0	1	1	0	0	0	1	0	0	0	0	0	1	1	0	0
	DA02	MSSA Trust Apportioned Cases	34	22	3	1	1	3	3	3	2	4	5	6	5	6	7	9	16	6
	DA03	CDiff Trust Apportioned Cases	31	13	1	7	2	4	2	1	1	1	4	2	2	5	8	3	8	5
	DA06	EColi Trust Apportioned Cases	83	37	8	12	7	0	7	5	5	8	6	8	9	14	14	18	23	14
C.Diff "Avoidables"	DA03B	CDiff Trust Apportioned Cases - Lapse in Care	10	1	1	2	1	0	1	0	0	1	1	0	0	0	2	1	1	0
	DA03D	CDiff Trust Apportioned Cases - Still Under Review	2	8	0	2	0	0	0	0	0	0	1	0	2	5	0	0	3	5
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97%	96.2%	97.2%	98%	97%	96.5%	96.8%	96.3%	96.6%	96.7%	95.6%	95.7%	96.6%	96.9%	96.8%	96.6%	95.9%	96.9%
	DB02	Antibiotic Compliance	78.9%	80.1%	77.4%	75.1%	76.7%	75.7%	85%	79.1%	66.3%	68%	76.1%	84.2%	80.2%	88.6%	77.6%	72.2%	79.1%	88.6%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	95%	95%	96%	95%	96%	96%	95%	96%	96%	95%	96%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	97%	98%	98%	97%	97%	98%	98%	98%	98%	98%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	95%	95%	96%	96%	96%	96%	97%	97%	97%	96%	96%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	70	28	8	8	4	10	4	3	7	5	7	3	8	10	18	15	18	10
	S02a	Number of Confirmed Serious Incidents	63	7	8	6	4	8	3	2	6	5	7	-	-	-	15	13	7	-
	S02b	Number of Serious Incidents Still Open	5	21	-	1	0	2	0	1	1	0	0	3	8	10	2	2	11	10
	S03	Serious Incidents Reported Within 48 Hours	98.6%	100%	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	94.4%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	94.3%	96.4%	100%	100%	100%	80%	75%	100%	100%	100%	85.7%	100%	100%	100%	83.3%	100%	94.4%	100%
	S04	Serious Incident Investigations Completed Within Timescale	96.8%	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%	100%	93.8%	100%	100%
	S04a	Overdue Exec Commissioned Non-SI Investigations	10	4	2	0	0	0	0	1	0	0	1	1	1	1	0	1	3	1
Never Events	S01	Total Never Events	5	2	1	0	0	1	2	0	0	1	0	0	1	1	3	1	1	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	17839	5875	1539	1510	1517	1511	1371	1520	1551	1570	1373	1027	1765	1710	4399	4641	4165	1710
	S06b	Patient Safety Incidents Per 1000 Beddays	58.56	56.34	62.35	59.72	58.92	58.92	54.11	57.27	64.61	58.94	53.22	38.47	68.73	65.54	57.33	60.13	53.28	65.54
	S07	Number of Patient Safety Incidents - Severe Harm	88	24	3	9	9	7	5	7	4	10	7	1	6	10	21	21	14	10
Patient Falls	AB01	Falls Per 1,000 Beddays	4.48	4.45	5.27	4.9	3.73	4.48	5.17	5.61	4.67	3.72	4.46	4.98	3.97	4.37	4.46	4.66	4.48	4.37
	AB06a	Total Number of Patient Falls Resulting in Harm	27	5	5	2	2	1	2	3	1	3	3	0	0	2	5	7	3	2
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.295	0.125	0.203	0.277	0.816	0.39	0.276	0.527	0.083	0.188	0.194	0.037	0.156	0.115	0.495	0.272	0.128	0.115
	DE02	Pressure Ulcers - Grade 2	80	11	4	7	18	8	7	13	2	5	4	1	4	2	33	20	9	2
	DE04A	Pressure Ulcers - Grade 3 or 4	10	2	1	0	3	2	0	1	0	0	1	0	0	1	5	1	1	1
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.3%	98.3%	98.7%	98.4%	98.4%	98%	98.3%	98.2%	98%	98.7%	98.5%	98.2%	98.2%	98.2%	98.2%	98.3%	98.3%	98.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	92.6%	93.4%	93.4%	89.6%	87.8%	92.2%	95.5%	91.4%	88.6%	94.5%	93.4%	93.2%	94.2%	93.1%	91.1%	91.9%	93.5%	93.1%
	N04	Number of Hospital Associated VTEs	52	9	6	3	2	2	6	5	10	4	4	5	0	-	10	19	9	-
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	3	0	0	0	0	0	0	0	1	0	0	0	0	-	0	1	0	-
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	15	7	2	0	1	0	2	4	2	1	3	4	0	-	3	7	7	-
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	91.1%	84.4%	-	90.4%	-	-	92.1%	-	-	89.9%	-	-	84.4%	-	92.1%	89.9%	84.4%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.9%	99.9%	99.6%	99.9%	99.9%	99.8%	99.8%	99.8%	99.9%
Medicines	WA01	Medication Incidents Resulting in Harm	0.29%	0.37%	0%	0%	0.29%	0.36%	0.8%	0.77%	0%	0%	0%	0.62%	0.43%	-	0.46%	0.28%	0.37%	-
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.37%	0.32%	0.22%	0.53%	0.41%	0.2%	0.62%	0%	0.25%	0.42%	0.31%	0.46%	0.3%	0.18%	0.39%	0.24%	0.37%	0.18%

APPENDIX 3 – Trust Scorecards

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	18/19	19/20 YTD	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	88%	-	84%	90%	93%	96%	87%	83%	91%	85%	-	-	-	-	92%	86%	-	-
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	8.7%	7.8%	9.5%	9.4%	9.2%	8.7%	8.7%	7.9%	6.4%	7%	8.3%	8.3%	8.3%	6.5%	8.9%	7.1%	8.3%	6.5%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	23.9%	22.9%	24.5%	24.3%	23.7%	25.1%	23.1%	23%	23.1%	22.8%	22.5%	23.5%	22.1%	23.3%	24%	23%	22.7%	23.3%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	9815	3074	824	804	832	926	816	821	718	839	749	805	705	815	2574	2378	2259	815
Staffing Levels	RP01	Staffing Fill Rate - Combined	99.3%	100.6%	97%	98.5%	99.6%	101.1%	99.1%	100.1%	99.9%	99.1%	100.6%	101.6%	100.5%	99.6%	99.9%	99.7%	100.9%	99.6%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Quarterly Data	105.1	-	-	105	-	-	104.6	-	-	-	-	-	-	-	104.6	-	-	-
	X04A	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	106.8	-	-	-	-	-	-	106.8	106.9	-	-	-	-	-	-	106.8	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	105	86.8	99.8	123.9	97.9	94	101	114.7	108	108.1	83.7	90.1	-	-	97.8	110.4	86.8	-
Readmissions	C01	Emergency Readmissions Percentage	3.3%	3.67%	3.65%	3.17%	3.49%	3.42%	3.15%	2.85%	2.64%	3.15%	3.57%	3.58%	3.85%	-	3.36%	2.89%	3.67%	-
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	56.3%	49.4%	70%	60%	54.5%	60%	63.2%	37.5%	52.9%	38.1%	56.3%	40.9%	52.4%	50%	59.1%	41.9%	49.2%	50%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	97%	96.6%	100%	90%	95.5%	96%	100%	100%	100%	90.5%	100%	95.5%	100%	93.3%	97%	96.8%	98.3%	93.3%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.3%	49.4%	70%	50%	50%	56%	63.2%	33.3%	52.9%	33.3%	56.3%	40.9%	52.4%	50%	56.1%	38.7%	49.2%	50%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	79.3	63.6	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	51.1%	46.1%	48.3%	51.9%	53.8%	51.3%	45.7%	51.1%	48.3%	69.2%	52.8%	44.4%	41%	-	50.4%	56.6%	46.1%	-
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	84.2%	76.5%	89.7%	92.6%	66.7%	92.3%	85.7%	80%	100%	82.1%	72.2%	85.2%	74.4%	-	81.4%	85.8%	76.5%	-
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.6%	62%	66.7%	46.7%	55.6%	73.3%	50%	50%	84.6%	90%	69.2%	43.8%	28.6%	92.9%	63.3%	75.5%	50%	92.9%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	83%	85.8%	80.2%	79.8%	79%	89%	86.8%	88.2%	86.4%	81.5%	84.2%	87.6%	85.8%	85.8%	84.7%	85.4%	85.8%	85.8%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	94.3%	93.3%	97.7%	91.2%	93.6%	92.6%	89.1%	98%	95.9%	100%	94.1%	95.8%	85.2%	94.6%	91.8%	97.9%	92.9%	94.6%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	85.7%	84.6%	100%	100%	100%	100%	100%	100%	50%	71.4%	83.3%	66.7%	100%	100%	100%	75%	81.8%	100%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	7708	2634	507	697	492	649	716	702	559	567	704	782	503	645	1857	1828	1989	645
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	92	92	92	91	93	90	91	91	91	91	93	93	92	91	91	93
	P01g	Patient Survey - Kindness and Understanding	-	-	96	97	96	95	96	96	96	95	97	95	96	96	96	96	96	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	91	89	90	89	90	91	89	90	91	91	89	91	90	90	90	91
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.1%	38.2%	35.4%	29.1%	36.5%	27.8%	38.7%	32.2%	40.5%	34.6%	36.3%	42.4%	34.4%	39.4%	34.1%	35.5%	37.7%	39.4%
	P03b	Friends and Family Test ED Coverage	16%	17%	17.4%	17%	16.9%	14.6%	13.6%	16%	15.2%	11.6%	13.8%	18.1%	18.7%	17.4%	15.1%	14.2%	16.8%	17.4%
	P03c	Friends and Family Test MAT Coverage	18.3%	28.3%	9.8%	23.1%	31.4%	19.2%	14.1%	20.2%	23%	20.6%	28.5%	30.4%	24.1%	30.1%	21.6%	21.2%	27.7%	30.1%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	98.2%	98.5%	98.6%	98.1%	98.4%	98.6%	98.5%	98.7%	98.4%	98.4%	98.4%	98.3%	98.3%	98.9%	98.5%	98.5%	98.4%	98.9%
	P04b	Friends and Family Test Score - ED	82.1%	82.3%	84.1%	83.4%	85.2%	84%	82.6%	81.1%	80.4%	75.4%	76.7%	83.8%	84.2%	82.9%	84.1%	79.2%	82%	82.9%
	P04c	Friends and Family Test Score - Maternity	97.3%	97.2%	99.3%	95.9%	97.2%	97.3%	99%	98.5%	98.7%	97.5%	96.7%	97.7%	97.6%	96.9%	97.6%	98.3%	97.4%	96.9%
Patient Complaints	T01	Number of Patient Complaints	1845	679	143	152	169	193	101	167	155	171	184	161	166	168	463	493	511	168
	T03a	Formal Complaints Responded To Within Trust Timeframe	86.1%	93.9%	86.8%	86.3%	85.1%	86.9%	90.9%	87.5%	78.3%	90.6%	93.2%	97.2%	95.9%	90.4%	87.1%	85.2%	95.5%	90.4%
	T03b	Formal Complaints Responded To Within Divisional Timeframe	85.5%	95%	86.8%	82.2%	90.5%	84.8%	88.6%	87.5%	85%	92.5%	93.2%	98.6%	98%	91.6%	87.6%	88.2%	96.6%	91.6%
	T05A	Informal Complaints Responded To Within Trust Timeframe	83.7%	87.9%	83.3%	86.8%	73.6%	84.2%	81.5%	80%	89.9%	81.7%	90.6%	86.9%	89.8%	84.8%	80.1%	84%	89%	84.8%
	T04c	Percentage of Responses where Complainant is Dissatisfied	9.11%	10%	7.55%	9.59%	6.76%	10.1%	4.54%	8.93%	5%	15.09%	11.86%	8.45%	-	-	7.83%	9.47%	10%	-

RESPONSIVE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			18/19	19/20 YTD	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	-	-	88.7%	88.5%	89.6%	90.1%	89.3%	89.4%	89.1%	89.2%	89%	88.1%	87.5%	86.5%	-	-	-	-
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	3290	3354	3000	2810	2975	2915	3100	3081	3161	3578	3874	4436	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	144	45	7	10	9	14	7	16	21	13	14	11	11	9	30	50	36	9
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	119	113	113	111	139	147	161	119	115	136	128	152	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	95.3%	94.4%	95.5%	96.4%	95.7%	95.8%	96.6%	95.2%	94.9%	94.4%	93.4%	94%	95.9%	-	96%	94.8%	94.4%	-
	E01c	Cancer - Urgent Referrals Stretch Target	56.5%	47.9%	66.4%	68.8%	57%	62.8%	54.2%	63.7%	46.5%	49%	43.8%	45.6%	54.7%	-	58%	52.7%	47.9%	-
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	97.2%	94.9%	99.2%	99.1%	98.8%	98.5%	98.6%	97%	96.5%	98.3%	95.4%	94.1%	95.1%	-	98.6%	97.2%	94.9%	-
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98.4%	98.5%	100%	99.1%	99.4%	97.2%	99%	99.2%	99.1%	100%	98.4%	97.9%	99.1%	-	98.6%	99.5%	98.5%	-
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	96.1%	92.1%	96.2%	98.1%	100%	98.3%	96.2%	95%	96.3%	97.6%	95.9%	90.9%	89.7%	-	98.2%	96.2%	92.1%	-
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	95.8%	92.7%	97.4%	95.6%	97.6%	98.1%	98.2%	95.7%	98%	94.1%	96.4%	89.6%	91.8%	-	97.9%	96%	92.7%	-
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85.6%	85.7%	88.9%	87.4%	85.5%	87.9%	86.5%	85.1%	83.5%	82.9%	86.8%	86%	84%	-	86.6%	83.8%	85.7%	-
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	66.7%	82.6%	60%	100%	100%	100%	90%	35.7%	75%	66.7%	71.4%	100%	83.3%	-	96%	47.6%	82.6%	-
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	83.7%	89.7%	84.7%	86.8%	85.6%	91.3%	88.5%	86.8%	74.7%	91.8%	95%	89.6%	83.5%	-	88.4%	84.6%	89.7%	-
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	54	10	5.5	4	7.5	3.5	4	4	3	7	3.5	3.5	3	-	15	14	10	-
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	1.31%	1.55%	0.79%	1.39%	0.97%	1.94%	1%	1.31%	1.68%	1.66%	1.63%	1.53%	1.84%	1.25%	1.31%	1.54%	1.67%	1.25%
	F01a	Number of Last Minute Cancelled Operations	1059	413	54	89	71	138	61	94	109	115	108	100	117	88	270	318	325	88
	F02	Cancelled Operations Re-admitted Within 28 Days	93.4%	88.9%	94.9%	94.4%	91%	94.4%	93.5%	93.4%	93.6%	96.3%	85.2%	85.2%	92%	93.2%	93%	94.7%	87.3%	93.2%
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	1.67%	1.87%	1.53%	2.05%	1.82%	1.91%	1.37%	1.75%	2.17%	0.85%	1.65%	2.39%	1.62%	1.81%	1.72%	1.58%	1.89%	1.81%
	F07a	Number of Admissions Cancelled Day Before	1348	496	105	131	134	136	83	126	141	59	109	156	103	128	353	326	368	128
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	73.2%	71%	79.3%	72%	69%	71.1%	62.5%	71.4%	76.7%	65.2%	83.9%	61.8%	68.6%	-	67.5%	70.3%	71%	-
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	91.9%	90%	93.1%	96%	92.9%	89.5%	90%	88.6%	93.3%	87%	96.8%	88.2%	85.7%	-	90.8%	89.2%	90%	-
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	-	-	97.13%	98.13%	98.36%	96.94%	93.81%	93.28%	96.93%	95.5%	95.27%	93.41%	93.54%	96.19%	-	-	-	-
Outpatients	R03	Outpatient Hospital Cancellation Rate	10.1%	10.7%	10%	10.1%	9.9%	9.8%	10.4%	10.2%	11.6%	11.2%	11.3%	10.4%	10.1%	11.1%	10%	11%	10.6%	11.1%
	R05	Outpatient DNA Rate	6.8%	6.8%	6.8%	7%	6.7%	6.5%	6.9%	6.8%	6.7%	6.6%	6.7%	7.1%	6.8%	6.4%	6.7%	6.7%	6.9%	6.4%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.12	2.13	2.11	2.13	2.14	2.17	2.14	2.2	2.25	2.13	2.09	2.1	2.21	2.12	2.15	2.19	2.13	2.12
ERS	BC01	ERS - Available Slot Issues Percentage	16.5%	16.2%	22.1%	15.5%	10.9%	13.8%	13.5%	12.5%	16.8%	17.3%	13.9%	16.9%	15.8%	17.9%	12.6%	15.5%	15.5%	17.9%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Monthly Totals Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Quarterly Totals 18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	216	91	11	16	18	10	26	20	13	20	22	23	27	19	54	53	72	19
	Q02A	Non-Acute Delayed Transfers of Care - Patients	80	40	9	8	5	4	11	4	10	4	8	11	12	9	20	18	31	9
	Q01B	Acute Delayed Transfers of Care - Beddays	6744	2373	586	513	691	482	568	653	550	519	609	607	625	532	1741	1722	1841	532
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	2590	1051	225	321	250	191	243	138	161	198	223	302	243	283	684	497	768	283
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	42	55	39	47	51	48	65	62	53	56	61	48	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	19	24	21	14	26	7	30	19	26	25	27	31	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	1621	1562	1608	1620	1693	1814	1894	1962	1882	2435	1916	1986	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	570	753	681	580	616	463	631	819	759	842	830	877	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	3.79	3.8	3.92	3.52	3.87	3.62	3.76	3.83	3.74	3.78	4.05	3.73	3.61	3.83	3.75	3.79	3.8	3.83
	J04D	Percentage Length of Stay 14+ Days	6.3%	6.6%	6.5%	5.8%	6.9%	6%	6%	6.6%	6.4%	6.4%	7.2%	6.5%	6%	6.6%	6.3%	6.5%	6.6%	6.6%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	211	233	224	212	200	221	234	222	247	256	262	238	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	3.6%	4.6%	0.5%	0%	3.4%	4.1%	3.7%	4%	6.3%	5.6%	3.6%	3.7%	6.9%	4.4%	3.8%	5.2%	4.7%	4.4%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	36.1%	28.8%	25%	-	23.3%	45.9%	52.9%	55.6%	24.5%	24%	39.3%	18.8%	21.6%	40%	41.6%	32.6%	25.2%	40%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	86.34%	79.88%	90.07%	85%	89.16%	84.24%	83.05%	84.5%	81.05%	81.23%	78.25%	77.95%	81.48%	81.86%	85.53%	82.27%	79.2%	81.86%
		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%	79.88%	90.07%	85%	89.16%	84.24%	83.05%	84.5%	81.05%	81.23%	78.25%	77.95%	81.48%	81.86%	85.53%	82.27%	79.2%	81.86%
	BB07	BRI ED - Percentage Within 4 Hours	78.39%	66.3%	83.37%	75.44%	81.79%	78.89%	73.49%	74.67%	69.23%	70.33%	63.57%	63.86%	68.78%	68.95%	78.07%	71.46%	65.38%	68.95%
	BB03	BCH ED - Percentage Within 4 Hours	93.05%	92.67%	97.9%	94.16%	95.05%	85.39%	91.02%	92.92%	90.46%	89.39%	91.96%	90.38%	93.61%	94.82%	90.38%	90.9%	91.96%	94.82%
	BB04	BEH ED - Percentage Within 4 Hours	97.38%	97.53%	98.75%	97.46%	98.67%	97.34%	97.12%	97.7%	98.02%	97.07%	96.1%	98.39%	97.55%	98.16%	97.76%	97.58%	97.32%	98.16%
		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	1	0	0	0	0	0	0	0	0	0	1	0	0	0
Time to Initial Assessment	B02	ED Time to Initial Assessment - Under 15 Minutes	95.6%	97.5%	95.3%	96.2%	95.4%	93.4%	92.1%	97.7%	97.9%	96.5%	96.8%	97%	98.3%	98%	93.6%	97.3%	97.4%	98%
	B02b	ED Time to Initial Assessment - Data Completness	97.2%	98.1%	96.1%	97.3%	97.2%	97.6%	95.2%	96.5%	97.4%	99%	97.6%	98.4%	98%	98.3%	96.6%	97.6%	98%	98.3%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	49.3%	48.4%	55.6%	48%	53.1%	44.8%	46.9%	48.9%	45.2%	43.9%	46.1%	47.6%	49.9%	50.1%	48.3%	46%	47.9%	50.1%
	B03b	ED Time to Start of Treatment - Data Completeness	96.9%	96.4%	97.1%	96.6%	97.1%	97%	97%	97.5%	96.7%	96.4%	96.6%	96%	96.1%	96.8%	97.1%	96.9%	96.2%	96.8%
Others	B04	ED Unplanned Re-attendance Rate	3.3%	3.3%	2.7%	3.2%	3.9%	4.4%	3.8%	3.2%	3.3%	3.6%	3.5%	3.2%	3.1%	3.4%	4%	3.3%	3.3%	3.4%
	B05	ED Left Without Being Seen Rate	1.7%	1.7%	1.6%	2.2%	2.1%	1.8%	1.6%	1.3%	1.6%	2.1%	1.6%	1.8%	1.6%	1.7%	1.8%	1.7%	1.7%	1.7%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	698	274	58	71	74	65	59	42	57	50	96	87	55	36	198	149	238	36
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	3.6%	4.6%	0.5%	0%	3.4%	4.1%	3.7%	4%	6.3%	5.6%	3.6%	3.7%	6.9%	4.4%	3.8%	5.2%	4.7%	4.4%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	36.1%	28.8%	25%	-	23.3%	45.9%	52.9%	55.6%	24.5%	24%	39.3%	18.8%	21.6%	40%	41.6%	32.6%	25.2%	40%

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)	(378)	2,382	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	1,220	4,672	0	0	0	0	0	0	0	0
Year to Date Variance Divisional Position Favourable / (Adverse) £'000	Diagnostics & Therapies	(4)	(39)	(56)	(66)								
	Medicine	(167)	(320)	(502)	(701)								
	Specialised Services	(54)	13	201	82								
	Surgery	(175)	(659)	(1,168)	(1,867)								
	Women's & Children's	(215)	(311)	(407)	(534)								
	Estates & facilities	(5)	(9)	(13)	(24)								
	Trust Services	4	3	(33)	17								
	Other Corporate Services	42	29	(85)	(37)								
	Total	**(574)**	**(1,293)**	**(2,063)**	**(3,130)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Year To Date Savings Actuals £'000	Diagnostics & Therapies		299	438	543								
	Medicine		231	324	426								
	Specialised Services		381	555	811								
	Surgery		572	788	1,063								
	Women's & Children's		660	941	1,171								
	Estates & facilities		120	183	232								
	Trust Services		134	202	270								
	Other Corporate Services		195	292	382								
	Total	**0**	**2,591**	**3,723**	**4,897**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
In Month Variance Subjective Analysis Favourable / (Adverse) £'000	Nursing & Midwifery Pay	(604)	(491)	(484)	(502)								
	Medical & Dental Pay	(360)	(187)	(445)	(433)								
	Other Pay	243	197	109	289								
	Non Pay	954	189	356	(108)								
	Income from Operations	(173)	(94)	(2)	(18)								
	Income from Activities	(632)	(336)	(301)	(303)								
	Total	**(572)**	**(722)**	**(767)**	**(1,075)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
In Month Agency Expenditure Actuals £'000	Nursing & Midwifery	684	660	648	626								
	Medical												
	Consultants	72	82	92	93								
	Other Medical	56	20	85	108								
	Other	140	144	131	154								
	Total	**952**	**906**	**956**	**981**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash £'000	Actual Cash	**110,000**	**109,402**	**100,954**	**119,042**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capital Spend £'000	Actual Capital Expenditure	**916**	**2,300**	**4,704**	**7,868**								